National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim: Professional

837

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Table of Contents

1 Purpose and Overview 13

1.1 Document Purpose 13
1.1.1 Trading Partner Agreements 13
1.1.2 The HIPAA Role in Implementation Guides 14

1.2 Version and Release 14

1.3 Business Use and Definition 14
1.3.1 Terminology 15
1.3.2 Batch and Real Time Definitions 16

1.4 Information Flows 16
1.4.1 National Standard Format (NSF) 17
1.4.2 Coordination of Benefits 17
1.4.2.1 Coordination of Benefits Data Models — Detail 17
1.4.2.2 Coordination of Benefits — Correction Detail 20
1.4.3 Service Line Procedure Code Bundling and Unbundling 23
1.4.4 Payer-to-Payer COB 30
1.4.5 Crosswalking COB Data Elements 31

1.5 Property and Casualty 33

2 Data Overview 33

2.1 Overall Data Architecture 33

2.2 Loop Labeling and Use 34
2.2.1 Required and Situational Loops 35

2.3 Data Use by Business Use 36
2.3.1 Table 1 — Transaction Control Information 36
2.3.1.1 837 Table 1 — Header Level 36
2.3.1.2 Hierarchical Level Data Structure 37
2.3.2 Table 2 — Detail Information 37
2.3.2.1 HL Segment 37

2.4 Loop ID-1000 40

2.5 The Claim 42

2.6 Interactions with Other Transactions 43
2.6.1 Functional Acknowledgment (997) 43
2.6.2 Unsolicited Claim Status (277) 43
2.6.3 Remittance Advice (835) 43

2.7 National Uniform Claim Committee 43

2.8 Limitations to the Size of a Claim/Encounter (837) Transaction 44

2.9 Use of Data Segment and Elements Marked "Situational" 44

3 Transaction Set 45

3.1 Presentation Examples 45

Transaction Set Listing 51

Segments

ST Transaction Set Header 62
BHT Beginning of Hierarchical Transaction 63
REF Transmission Type Identification 66
NM1 Submitter Name 67
N2 Additional Submitter Name Information 70
PER Submitter EDI Contact Information 71
NM1 Receiver Name 74
N2 Receiver Additional Name Information 76
HL Billing/Pay-to Provider Hierarchical Level 77
PRV Billing/Pay-to Provider Specialty Information 79
CUR Foreign Currency Information 81
NM1 Billing Provider Name 84
N2 Additional Billing Provider Name Information 87
N3 Billing Provider Address 88
N4 Billing Provider City/State/ZIP Code 89
REF Billing Provider Secondary Identification 91
REF Credit/Debit Card Billing Information 94
PER Billing Provider Contact Information 96
NM1 Pay-to Provider Name 99
N2 Additional Pay-to Provider Name Information 102
N3 Pay-to Provider Address 103
N4 Pay-to Provider City/State/ZIP Code 104
REF Pay-to-Provider Secondary Identification 106
HL Subscriber Hierarchical Level 108
SBR Subscriber Information 110
PAT Patient Information 114
NM1 Subscriber Name 117
N2 Additional Subscriber Name Information 120
N3 Subscriber Address 121
N4 Subscriber City/State/ZIP Code 122
DMG Subscriber Demographic Information 124
REF Subscriber Secondary Identification 126
REF Property and Casualty Claim Number 128
NM1 Payer Name 130
N2 Additional Payer Name Information 133
N3 Payer Address 134
N4 Payer City/State/ZIP Code 135
REF Payer Secondary Identification 137
NM1 Responsible Party Name 139
N2 Additional Responsible Party Name Information 142
N3 Responsible Party Address 143
N4 Responsible Party City/State/ZIP Code 144
NM1 Credit/Debit Card Holder Name 146
N2 Additional Credit/Debit Card Holder Name Information 149
REF Credit/Debit Card Information 150
HL Patient Hierarchical Level 152

PAT Patient Information 154
NM1 Patient Name 157
N2 Additional Patient Name Information 160
N3 Patient Address 161
N4 Patient City/State/ZIP Code 162
DMG Patient Demographic Information 164
REF Patient Secondary Identification 166
REF Property and Casualty Claim Number 168
CLM Claim Information 170
DTP Date - Order Date 180
DTP Date - Initial Treatment 182
DTP Date - Referral Date 184
DTP Date - Date Last Seen 186
DTP Date - Onset of Current Illness/Symptom 188
DTP Date - Acute Manifestation 190
DTP Date - Similar Illness/Symptom Onset 192
DTP Date - Accident 194
DTP Date - Last Menstrual Period 196
DTP Date - Last X-ray 197
DTP Date - Estimated Date of Birth 199
DTP Date - Hearing and Vision Prescription Date 200
DTP Date - Disability Begin 201
DTP Date - Disability End 203
DTP Date - Last Worked 205
DTP Date - Authorized Return to Work 206
DTP Date - Admission 208
DTP Date - Discharge 210
DTP Date - Assumed and Relinquished Care Dates 212
PWK Claim Supplemental Information 214
CN1 Contract Information 217
AMT Credit/Debit Card Maximum Amount 219
AMT Patient Amount Paid 220
AMT Total Purchased Service Amount 221
REF Service Authorization Exception Code 222
REF Mandatory Medicare (Section 4081) Crossover Indicator 224
REF Mammography Certification Number 226
REF Prior Authorization or Referral Number 227
REF Original Reference Number (ICN/DCN) 229
REF Clinical Laboratory Improvement Amendment (CLIA) Number 231
REF Repriced Claim Number 233
REF Adjusted Repriced Claim Number 235
REF Investigational Device Exemption Number 236
REF Claim Identification Number for Clearing Houses and Other Transmission Intermediaries 238
REF Ambulatory Patient Group (APG) 240
REF Medical Record Number 241
REF Demonstration Project Identifier 242
K3 File Information 244
NTE Claim Note 246
CR1 Ambulance Transport Information 248
CR2 Spinal Manipulation Service Information 251

CRC Ambulance Certification 257
CRC Patient Condition Information: Vision 260
CRC Homebound Indicator 263
HI Health Care Diagnosis Code 265
HCP Claim Pricing/Repricing Information 271
CR7 Home Health Care Plan Information 276
HSD Health Care Services Delivery 278
NM1 Referring Provider Name 282
PRV Referring Provider Specialty Information 285
N2 Additional Referring Provider Name Information 287
REF Referring Provider Secondary Identification 288
NM1 Rendering Provider Name 290
PRV Rendering Provider Specialty Information 293
N2 Additional Rendering Provider Name Information 295
REF Rendering Provider Secondary Identification 296
NM1 Purchased Service Provider Name 298
REF Purchased Service Provider Secondary Identification 301
NM1 Service Facility Location 303
N2 Additional Service Facility Location Name Information 306
N3 Service Facility Location Address 307
N4 Service Facility Location City/State/ZIP 308
REF Service Facility Location Secondary Identification 310
NM1 Supervising Provider Name 312
N2 Additional Supervising Provider Name Information 315
REF Supervising Provider Secondary Identification 316
SBR Other Subscriber Information 318
CAS Claim Level Adjustments 323
AMT Coordination of Benefits (COB) Payer Paid Amount 332
AMT Coordination of Benefits (COB) Approved Amount 333
AMT Coordination of Benefits (COB) Allowed Amount 334
AMT Coordination of Benefits (COB) Patient Responsibility Amount 335
AMT Coordination of Benefits (COB) Covered Amount 336
AMT Coordination of Benefits (COB) Discount Amount 337
AMT Coordination of Benefits (COB) Per Day Limit Amount 338
AMT Coordination of Benefits (COB) Patient Paid Amount 339
AMT Coordination of Benefits (COB) Tax Amount 340
AMT Coordination of Benefits (COB) Total Claim Before Taxes Amount 341
DMG Subscriber Demographic Information 342
OI Other Insurance Coverage Information 344

MOA Medicare Outpatient Adjudication Information 347
NM1 Other Subscriber Name 350
N2 Additional Other Subscriber Name Information 353
N3 Other Subscriber Address 354
N4 Other Subscriber City/State/ZIP Code 355
REF Other Subscriber Secondary Identification 357
NM1 Other Payer Name 359
N2 Additional Other Payer Name Information 362
PER Other Payer Contact Information 363
DTP Claim Adjudication Date 366
REF Other Payer Secondary Identifier 368
REF Other Payer Prior Authorization or Referral Number 370
REF Other Payer Claim Adjustment Indicator 372
NM1 Other Payer Patient Information 374
REF Other Payer Patient Identification 376
NM1 Other Payer Referring Provider 378
REF Other Payer Referring Provider Identification 380
NM1 Other Payer Rendering Provider 382
REF Other Payer Rendering Provider Secondary Identification 384
NM1 Other Payer Purchased Service Provider 386
REF Other Payer Purchased Service Provider Identification 388
NM1 Other Payer Service Facility Location 390
REF Other Payer Service Facility Location Identification 392
NM1 Other Payer Supervising Provider 394
REF Other Payer Supervising Provider Identification 396
LX Service Line 398
SV1 Professional Service 400
SV4 Prescription Number 408
PWK DMERC CMN Indicator 410
CR1 Ambulance Transport Information 412
CR2 Spinal Manipulation Service Information 415
CR3 Durable Medical Equipment Certification 421
CR5 Home Oxygen Therapy Information 423
CRC Ambulance Certification 427
CRC Hospice Employee Indicator 430
CRC DMERC Condition Indicator 432
DTP Date - Service Date 435
DTP Date - Certification Revision Date 437
DTP Date - Referral Date 439
DTP Date - Begin Therapy Date 440
DTP Date - Last Certification Date 442
DTP Date - Order Date 444
DTP Date - Date Last Seen 445
DTP Date - Test 447
DTP Date - Oxygen Saturation/Arterial Blood Gas Test 449
DTP Date - Shipped 451
DTP Date - Onset of Current Symptom/Illness 452
DTP Date - Last X-ray 454

DTP Date - Acute Manifestation 456
DTP Date - Initial Treatment 458
DTP Date - Similar Illness/Symptom Onset 460
QTY Anesthesia Modifying Units 462
MEA Test Result 464
CN1 Contract Information 466
REF Repriced Line Item Reference Number 468
REF Adjusted Repriced Line Item Reference Number 469
REF Prior Authorization or Referral Number 470
REF Line Item Control Number 472
REF Mammography Certification Number 474
REF Clinical Laboratory Improvement Amendment (CLIA) Identification 475
REF Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification 477
REF Immunization Batch Number 478
REF Ambulatory Patient Group (APG) 479
REF Oxygen Flow Rate 480
REF Universal Product Number (UPN) 482
AMT Sales Tax Amount 484
AMT Approved Amount 485
AMT Postage Claimed Amount 486
K3 File Information 487
NTE Line Note 488
PS1 Purchased Service Information 489
HSD Health Care Services Delivery 491
HCP Line Pricing/Repricing Information 495
NM1 Rendering Provider Name 501
PRV Rendering Provider Specialty Information 504
N2 Additional Rendering Provider Name Information 506
REF Rendering Provider Secondary Identification 507
NM1 Purchased Service Provider Name 509
REF Purchased Service Provider Secondary Identification 512
NM1 Service Facility Location 514
N2 Additional Service Facility Location Name Information 517
N3 Service Facility Location Address 518
N4 Service Facility Location City/State/ZIP 519
REF Service Facility Location Secondary Identification 521
NM1 Supervising Provider Name 523
N2 Additional Supervising Provider Name Information 526
REF Supervising Provider Secondary Identification 527
NM1 Ordering Provider Name 529
N2 Additional Ordering Provider Name Information 532
N3 Ordering Provider Address 533
N4 Ordering Provider City/State/ZIP Code 534
REF Ordering Provider Secondary Identification 536
PER Ordering Provider Contact Information 538

NM1 Referring Provider Name 541
PRV Referring Provider Specialty Information 544
N2 Additional Referring Provider Name Information .. 546
REF Referring Provider Secondary Identification 547
NM1 Other Payer Prior Authorization or Referral Number 549
REF Other Payer Prior Authorization or Referral Number 552
SVD Line Adjudication Information 554
CAS Line Adjustment 558
DTP Line Adjudication Date 566
LQ Form Identification Code 567
FRM Supporting Documentation 569
SE Transaction Set Trailer 572

4 EDI Transmission Examples for Different Business Uses 573

4.1 Professional 573
4.1.1 Example 1 573
4.1.2 Example 2 577
4.1.3 Example 3 582
4.1.4 Example 4 602

4.2 Property and Casualty 606
4.2.1 Example 1 606
4.2.2 Example 2 611
4.2.3 Example 3 616

A ASC X12 Nomenclature A.1

A.1 Interchange and Application Control Structures A.1
A.1.1 Interchange Control Structure A.1
A.1.2 Application Control Structure Definitions and Concepts A.2
A.1.2.1 Basic Structure A.2
A.1.2.2 Basic Character Set A.2
A.1.2.3 Extended Character Set A.2
A.1.2.4 Control Characters A.3
A.1.2.5 Base Control Set A.3
A.1.2.6 Extended Control Set A.3
A.1.2.7 Delimiters A.4
A.1.3 Business Transaction Structure Definitions and Concepts A.4
A.1.3.1 Data Element A.4
A.1.3.2 Composite Data Structure A.6
A.1.3.3 Data Segment A.7
A.1.3.4 Syntax Notes A.7
A.1.3.5 Semantic Notes A.7
A.1.3.6 Comments A.7
A.1.3.7 Reference Designator A.7
A.1.3.8 Condition Designator A.8
A.1.3.9 Absence of Data A.9
A.1.3.10 Control Segments A.9

A.1.3.11 Transaction Set....A.10
A.1.3.12 Functional Group....A.12
A.1.4 Envelopes and Control Structures....A.12
A.1.4.1 Interchange Control Structures....A.12
A.1.4.2 Functional Groups....A.13
A.1.4.3 HL Structures....A.13
A.1.5 Acknowledgments....A.14
A.1.5.1 Interchange Acknowledgment, TA1....A.14
A.1.5.2 Functional Acknowledgment, 997....A.14

B EDI Control Directory....B.1

B.1 Control Segments....B.3
ISA Interchange Control Header....B.3
IEA Interchange Control Trailer....B.7
GS Functional Group Header....B.8
GE Functional Group Trailer....B.10
TA1 Interchange Acknowledgment....B.11

B.2 Functional Acknowledgment Transaction Set, 997....B.15
ST Transaction Set Header....B.16
AK1 Functional Group Response Header....B.18
AK2 Transaction Set Response Header....B.19
AK3 Data Segment Note....B.20
AK4 Data Element Note....B.22
AK5 Transaction Set Response Trailer....B.24
AK9 Functional Group Response Trailer....B.27
SE Transaction Set Trailer....B.30

C External Code Sources....C.1

5 Countries, Currencies and Funds....C.1
22 States and Outlying Areas of the U.S.....C.1
41 Universal Product Code....C.2
51 ZIP Code....C.2
77 X12 Directories....C.3
121 Health Industry Identification Number....C.3
130 Health Care Financing Administration Common Procedural Coding System....C.4
131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure....C.4
139 Claim Adjustment Reason Code....C.5
235 Claim Frequency Type Code....C.5
237 Place of Service from Health Care Financing Administration Claim Form....C.5
240 National Drug Code by Format....C.6
245 National Association of Insurance Commissioners (NAIC) Code....C.6
411 Remittance Remark Codes....C.6
513 Home Infusion EDI Coalition (HIEC) Product/Service Code List....C.7
522 Health Industry Labeler Identification Code....C.7
540 Health Care Financing Administration National PlanID....C.7

D Change Summary D.1

E Data Element Name Index E.1

F NSF Mapping F.1

F.1 X12N-NSF Map F.1

F.2 Complete NSF to ASC X12N 837 Map F.17

G Credit/Debit Card Use G.1

G.1 Credit/Debit Card Scenario 837 Transaction Set G.1

H Medicare Primary, Secondary and Supplemental Payers H.1

H.1 How to Indicate Whether Medicare is Primary or Secondary H.1

H.2 How to Indicate Other Payers Supplementary to Medicare H.1

I National Uniform Claim Committee Recommendations I.1

I.1 National Uniform Claim Committee (NUCC) I.1

J X12N 837 Professional Implementation Guide Alias Index J.1

K Loop 2440 Example K.1

1 Purpose and Overview

1.1 Document Purpose

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical.

This is the implementation guide for the ANSI ASC X12N 837 Health Care Claims (837) transaction for professional claims and/or encounters. This implementation guide provides standardized data requirements and content for all users of the 837. The purpose of this implementation guide is to expedite the goal of achieving a totally electronic data interchange health encounter/claims processing and payment environment. This implementation guide provides a definitive statement of what data translators must be able to handle in this version of the 837. The implementation guide also specifies limits and guidance to what a provider (submitter) can place in an 837. This implementation guide is intended to be compliant with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its associated rules.

1.1.1 Trading Partner Agreements

It is appropriate and prudent for payers to have trading partner agreements that go with the standard Implementation Guides. This is because there are 2 levels of scrutiny that all electronic transactions must go through.

First is standards compliance. These requirements MUST be completely described in the Implementation Guides for the standards, and NOT modified by specific trading partners.

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation. For example, while a certain code may be valid in an IG, a specific trading partner may not process transactions which utilize that specific code. This would be important to communicate in a trading partner agreement.

It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to the standard
- Utilize any code or data values which are not valid (because they are either marked "not used" in the IG or they are not in the standard X12 transaction at all) in the standard Implementation Guide
- Change the meaning or intent of the standard Implementation Guide

These types of companion documents should exist solely for the purpose of clarification, and should not be required for acceptance of a transaction as valid.

1.1.2 The HIPAA Role in Implementation Guides

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191 - known as HIPAA) includes provisions for Administrative Simplification, which require the Secretary of Department of Health and Human Services to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

Detailed Implementation Guides for each standard must be available at the time of the adoption of HIPAA standards so that health plans, providers, clearinghouses, and software vendors can ready their information systems and application software for compliance with the standards. Consistent usage of the standards, including loops, segments, data elements, etc., across all guides is mandatory to support the Secretary's commitment to standardization.

This Implementation Guide has been developed for use as a HIPAA Implementation Guide for Health claims or equivalent encounter information. Should the Secretary adopt the X12N 837 Health Care Professional Claim transaction as an industry standard, this Implementation Guide describes the consistent industry usage called for by HIPAA. When adopted under HIPAA, the X12 837 Health Care Professional Claim transaction cannot be implemented except as described in this Implementation Guide.

1.2 Version and Release

This implementation guide is based on the October 1997 ASC X12 standards, referred to as Version 4, Release 1, Sub-release 0 (004010).

1.3 Business Use and Definition

The ASC X12 standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each trading partner must provide these specific requirements separately.

This implementation guide is intended to provide assistance in developing and executing the electronic transfer of health encounter and health claim data. With a few exceptions, this implementation guide does not contain payer-specific instructions. Trading partners agreements are not allowed to set data specifications that conflict with the HIPAA implementations. Payers are required by law to have the capability to send/receive all HIPAA transactions. For example, a payer who does not pay claims with certain home health information must still be able to electronically accept on their front end an 837 with all the home health data. The payer cannot up-front reject such a claim. However, that does not mean that the payer is required to bring that data into their adjudication system. The payer, acting in accordance with policy and contractual agreements, can ignore data within the 837 data set. In light of this, it is permissible for trading partners to specify a subset of an implementation guide as data they are able to *process* or act upon

most efficiently. A provider who sends the payer in the example above home health data has just wasted their resources and the resources of the payer. Thus, it behooves trading partners to be clear about the specific data within the 837 (i.e., a subset of the HIPAA implementation guide data) they require or would prefer to have in order to efficiently adjudicate a claim. The subset implementation guide must not contain any loops, segments, elements or codes that are not included in the HIPAA implementation guide. In addition, the order of data must not be changed. Trading partners cannot up-front, reject a claim based on the standard HIPAA transaction.

1.3.1 Terminology

Certain terms have been defined to have a specific meaning within this guide. The following terms are particularly key to understanding and using this guide.

Dependent
In the hierarchical loop coding, the dependent code indicates the use of the patient hierarchical loop (Loop 2000C).

Destination Payer
The destination payer is the payer who is specified in the Subscriber/Payer loop (Loop ID-2010BB).

Patient
The term “patient” is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber’s insurance plan. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 2.3.2.1 for further details. Every effort has been made to ensure that the meaning of the word “patient” is clear in its specific context.

Provider
In a generic sense, the provider is the entity that originally submitted the claim/encounter. A provider may also have provided or participated in some aspect of the health care service described in the transaction. Specific types of providers are identified in this implementation guide (e.g., billing provider, referring provider).

Secondary Payer
The term “secondary payer” indicates any payer who is not the primary payer. The secondary payer may be the secondary, tertiary, or even quaternary payer.

Subscriber
The subscriber is the person whose name is listed in the health insurance policy. Other synonymous terms include “member” and/or “insured.” In some cases the subscriber is the same person as the patient. See the definition of patient, and see Section 2.3.2.1 for further details.

Transmission Intermediary
A transmission intermediary is any entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term “intermediary” is not used to convey a specific Medicare contractor type.

1.3.2 Batch and Real Time Definitions

Within telecommunications, there are multiple methods used for sending and receiving business transactions. Frequently, different methods involve different timings. Two methods applicable for EDI transactions are batch and real time. This guide is intended for use in a Batch only environment.

Batch - When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. In a batch mode, the sender sends multiple transactions to the receiver, either directly or through a switch (clearinghouse), and does not remain connected while the receiver processes the transactions. If there is an associated business response transaction (such as a 271 response to a 270 for eligibility), the receiver creates the response transaction for the sender off-line. The original sender typically reconnects at a later time (the amount of time is determined by the original receiver or switch) and picks up the response transaction. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day if it has been received by a predetermined cut off time.

Important: When in batch mode, the 997 Functional Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors (see section A.1.5.1 for details).

Real Time - Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute.

Important: When in real time mode, the receiver must send a response of either the response transaction, a 997 Functional Acknowledgment, or a TA1 segment (for details on the TA1 segment, see section A.1.5.1).

Generally speaking, the 837 functions in a batch mode with the possible exception of preadjudication or predetermination of benefits situations (determined by trading partner agreements).

1.4 Information Flows

The Health Care Claim Transaction for Professional Claims/Encounters (837) is intended to originate with the health care provider or the health care provider's designated agent. It may also originate with payers in an encounter reporting situation. The 837 provides all necessary information to allow the destination payer to at least begin to adjudicate the claim. The 837 coordinates with a variety of other transactions including, but not limited to, the following: Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). See Section 2.6, Interactions with Other Transactions, for a summary description of these interactions.

1.4.1 National Standard Format (NSF)

As an aid to the initial implementation for National Standard Format (NSF) users, Appendix F, NSF Mapping, maps the NSF data elements to the elements' locations on the 837. Version 003.01 of the HCFA NSF is the basis of this map. However, due to factors such as the differences between variable and fixed-length records, the map can not provide one-to-one correspondence.

1.4.2 Coordination of Benefits

One primary goal of this specific version and release of the 837 is to further develop the capability of handling coordination of benefits (COB) in a totally EDI environment. Electronic data interchange COB is predicated upon using two transactions — the 837 and the 835 (Health Care Claim Payment/Advice). See Sections 1.4.2.1and 1.4.2.2 for details about the two methods of using the 837 in conjunction with the 835 to achieve electronic COB. See Section 4, EDI Transmission Examples for Different Business Uses, for several detailed examples.

Trading partners must understand that EDI COB can not be achieved efficiently without using both the 837 and the 835 transactions. Furthermore, EDI COB creates a new interdependence in the health care industry. Previously, if Payer A chose not to develop the capability to send electronic remittance advices (835s), the effect was largely limited to its provider trading partners. However, if Payer A chooses not to implement electronic remittance advices, this now affects all other payers who are involved in COB over a claim with Payer A. In other words, if Payer A as a secondary payer wishes to achieve EDI COB, Payer A must rely on all other payers who are primary to it on any claim to also implement the 835.

1.4.2.1 Coordination of Benefits Data Models — Detail

The 837 transaction handles two models of coordinating benefits. Both models are discussed in section 1.4.2.2, Coordination of Benefits - Correction Detail. See section 4, EDI Transmission Examples for Different Business Uses, for examples of these models. The implementation guide contains notes on each COB-related

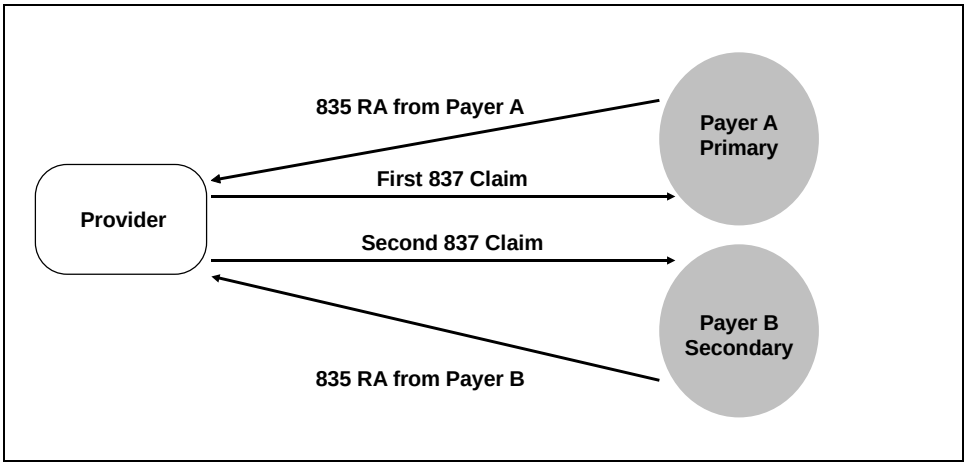


Figure 1. Provider-to-Payer-to-Provider COB Model

data element specifying when it is used. See the final HIPAA rules for more information on COB.

Model 1 — Provider-to-Payer-to-Provider

Step 1. In model 1, the provider originates the transaction and sends the claim information to Payer A, the primary payer. See figure 1, Provider-to-Payer-to-Provider COB Model. The Subscriber loop (Loop ID-2000B) contains information about the person who holds the policy with Payer A. Loop ID-2320 contains information about Payer B and the subscriber who holds the policy with Payer B. In this model, the primary payer adjudicates the claim and sends an electronic remittance advice (RA) transaction (835) back to the provider. The 835 contains the claim adjustment reason codes that applies to that specific claim. The claim adjustment reason codes detail what was adjusted and why.

Step 2. Upon receipt of the 835, the provider sends a second health care claim transaction (837) to Payer B, the secondary payer. The Subscriber loop (Loop ID-2000B) now contains information about the subscriber who holds the policy from Payer B. The information about the subscriber for Payer A is now placed in Loop ID-2320. Any total amounts paid at the claim level go in the AMT segments in Loop ID-2300. Any claim level adjustments codes are retrieved from the 835 from Payer A and put in the CAS (Claims Adjustment) segment in Loop ID-2320. Claim level amounts are placed in the AMT segment at the Loop ID 2320 level. Line Level adjustment reason codes are retrieved similarly from the 835 and go in the CAS segment in the 2430 loop. Payer B adjudicates the claim and sends the provider an electronic remittance advice.

Step 3. If there are additional payers (not shown in figure 1, Provider-to-Payer-to-Provider COB Model), step 2 is repeated with the Subscriber loop (Loop ID-2000B) having information about the subscriber who holds the policy from Payer C, the tertiary payer. COB information specific to Payer B is included by running the Loop ID-2320 again and specifying the payer as secondary, and, if necessary, by running Loop ID-2430 again for any line level adjudications.

Model 2 — Provider-to-Payer-to-Payer

Step 1. In model 2, the provider originates the transaction and sends claim information to Payer A, the primary payer. See figure 2, Provider-to-Payer-to-Payer COB Model. The Subscriber loop (Loop-ID 2000B) contains information about the person who holds the policy with Payer A. All other subscriber/payer informa-

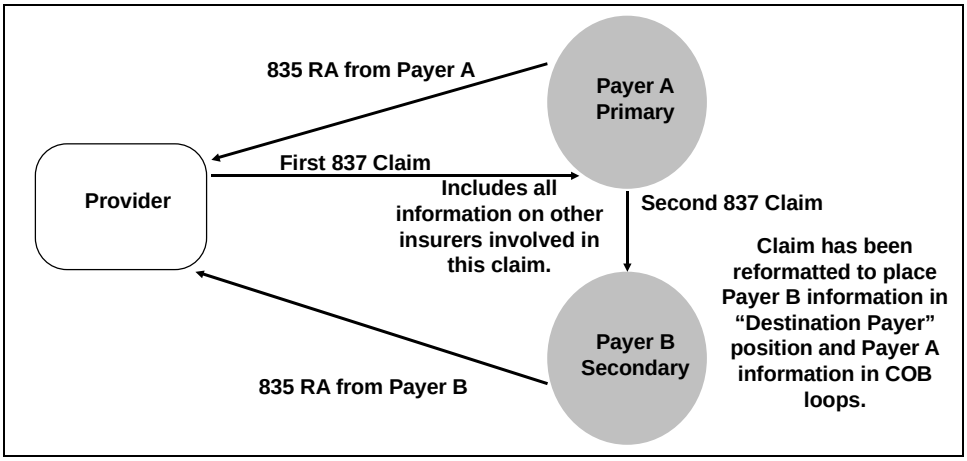


Figure 2. Provider-to-Payer-to-Payer COB Model

tion is included in Loop-ID 2320. In this model, the primary payer adjudicates the claim and sends an 835 back to the provider.

Step 2. Payer A reformats the 837 and sends it to the secondary payer. In reformatting the claim, Payer A takes the information about their subscriber and places it in Loop ID-2320. Payer A also takes the information about Payer B, the secondary payer/subscriber, and places it in the appropriate fields in the Subscriber Loop ID-2000B. Then Payer A sends the claim to Payer B. All COB information from Payer A is placed in the appropriate Loop ID-2320 and/or Loop ID-2430.

Step 3. Payer B receives the claim from Payer A and adjudicates the claim. Payer B sends an 835 to the provider. If there is a tertiary payer, Payer B performs step 2 (not shown in figure 2, Provider-to-Payer-to-Payer COB Model).

1.4.2.1.1 Coordination of Benefits — Claim Level

The destination payer's information is located in Loop ID-2010BB. In addition, any destination payer specific claim information (e.g., referral number), is located in the 2300 loop. All provider identifiers in the 2310 and 2420 loops are specific to the destination payer.

Loop ID-2320 occurs once for each payer responsible for the claim, except for the payer receiving the 837 transaction set (destination payer).

Loop ID-2320 contains the following:

- claim level adjustments
- other subscriber demographics
- various amounts
- other payer information
- assignment of benefits indicator
- patient signature indicator

Inside Loop ID-2320, Loop ID-2330 contains the information for the payer and the subscriber. As the claim moves from payer to payer, the destination payer's information in Loop ID-2000B and Loop ID-2010BB must be exchanged with the next payer's information from Loop ID-2320/2330. The table below shows claim level loop ID and payer information.

Sending the Claim to the First Destination Payer:

2000B/2010BB	First (usually the primary) payer
2320/2330	Second payer
2320/2330	Third payer (repeat 2320/2330 loops as needed for additional payers).

Sending the Claim to the Second Destination Payer:

2000B/2010BB	Second (usually the secondary) payer
2320/2330	Primary payer
2320/2330	Third payer
2320/2330	Any other payer (repeat 2320/2330 loops as needed for additional payers).

Sending the Claim to the Third Destination Payer:

2000B/2010BB	Third (usually the tertiary) payer
2320/2330	Primary payer
2320/2330	Secondary payer (repeat 2320/2330 loops as needed for additional payers.)

1.4.2.1.2 Coordination of Benefits — Service Line Level

Loop ID-2430 is an optional loop that can occur one or more times for each service line. As each payer adjudicates the service lines, occurrences may be added to this loop to explain how the payer adjudicated the service line.

Loop ID-2430 contains the following:

- ID of the payer who adjudicated the service line
- amount paid for the service line
- procedure code upon which adjudication of the service line was based. This code may be different than the submitted procedure code. (This procedure code also can be used for unbundling or bundling service lines.)
- paid units of service
- service line level adjustments
- adjudication date

To enable accurate matching of billed service lines with paid service lines, it is required that the payer return the original billed procedure code(s) and/or modifiers in the 835 if they are different from those used to pay the line. In addition, if a provider includes line item control numbers at the 2400 level (REF01 = 6R) then payers are required to return this in the corresponding 835.

1.4.2.2 Coordination of Benefits — Correction Detail

In electronic coordination of benefits, it occasionally happens that a claim is paid in error by the primary payer, and the error is discovered and corrected only after the claim was sent (with the payment information from the primary payer incorporated) to the secondary payer. When a claim is paid in error, the incorrect payment (835) is reversed out and the claim is re-paid. If a provider has a claim that involves coordination of benefits between several payers and the primary (or other) payer made a correction on a claim by reversing and resending the data, the implementation guide developers recommend that the entity sending the secondary claim send the corrected payment information to the secondary payer. Only segments specific to COB are included in the following examples.

Example
(This example is included in the *Health Care Claim Payment/Advice (835-004010) Implementation Guide* also.)

Original Claim/Remittance Advice:
In the original Preferred Provider Organization (PPO) payment, the reported charges are as follows:

Submitted charges:	$100.00
Adjustments	
Disallowed amount	$ 20.00
Co-insurance	$ 16.00

Deductible	$ 24.00
Payment amount	$ 40.00

Original 835:
In the original payment (835), the information is as follows:

CLP*1234567890*1*100*40*40*12~

1234567890 = Provider's claim identification number
1 = Paid as primary
100 = Amount billed
40 = Amount paid
40 = Patient responsibility
12 = PPO

CAS*PR*1*242*16~**

PR = Patient Responsibility adjustment reason group code
1 = Claim adjustment reason code — Deductible
24 = Amount of deductible
2 = Claim adjustment reason code — Coinsurance
16 = Amount of co-insurance

CAS*CO*45*20~

CO = Contractual Obligation adjustment reason group code
45 = Claim adjustment reason code — Charges exceed your contracted/legislated fee arrangement
20 = Amount of adjustment

Original secondary 837:
The 837is sent to the secondary as follows:

CLM05-3 uses code 1 - ORIGINAL, because this is the first time the secondary payer received this claim.

CAS*PR*1*242*16~**

PR = Patient Responsibility adjustment reason group code
1 = Claim adjustment reason code — Deductible
24 = Amount of deductible
2 = Claim adjustment reason code — Coinsurance
16 = Amount of co-insurance

CAS*CO*45*20~

CO = Contractual Obligation adjustment reason group code
45 = Claim adjustment reason code — Charges exceed your contracted/legislated fee arrangement
20 = Amount of adjustment

AMT*D*40~

D = Payer Amount Paid code
40 = Amount

AMT*F2*40~

F2 = Patient Responsibility code
40 = Amount

1.4.2.2.1 Reversal and Correction Method of COB

Corrected Remittance Advice and Claim:
The primary payer finds an error in the original claim adjudication that requires a

correction. In this case, the disallowed amount should have been $40.00 instead of the original $20.00. The co-insurance amount should have been $12.00 instead of $16.00, and the deductible amount remained the same.

The reversal and correction method reverses the original payment, restoring the patient accounting system to the pre-posting balance for this patient. The payer sends an 835 showing the reversal of the original claim (reversal 835) and then sends the corrected claim payment (corrected 835) to the provider to post to the account. It is anticipated that the provider has the ability to post these reversals electronically, without any human intervention.

The secondary payer also should be able to handle corrections electronically. The provider does not need to send the information from the reversal 835 to the secondary payer. The provider must send the information from the corrected 835 to the secondary payer. The secondary payer handles the information from the corrected 835 in the manner that best suits the secondary payer's specific accounting system.

In the 835, reversing the original claim payment is accomplished with code 22, Reversal of Previous Payment, in CLP02; code CR, Corrections and Reversals, in CAS01; and appropriate adjustments. All original charge, payment, and adjustment amounts are negated.

Reversal 835:

CLP*1234567890*22*-100*-4012~**

1234567890 = Provider's claim identification number
22 = Reversal of Previous Payment code
-100 = Reversal of original billed amount
-40 = Reversal of original paid amount
12 = PPO provider code

CAS*CR*1*-242*-16**45*-20~**

CR = Correction and Reversals adjustment reason group code
1 = Claim adjustment reason code — Deductible
-24 = Amount of deductible
2 = Claim adjustment reason code — Coinsurance
-16 = Amount of co-insurance
45 = Claim adjustment reason code — Charges exceed your contracted/legislated fee arrangement
-20 = Amount of adjustment

Corrected 835:
The corrected payment information is then sent in a subsequent 835.

CLP*1234567890*1*100*24*36*12~

1234567890 = Provider's claim identification number
1 = Paid as primary
100 = Amount billed
24 = Amount paid
36 = Patient responsibility
12 = PPO

CAS*PR*1*242*12~**

PR = Patient Responsibility adjustment reason group code
1 = Claim adjustment reason code — Deductible
24 = Amount of deductible

2 = Claim adjustment reason code — Coinsurance
12 = Amount of co-insurance

CAS*CO*45*40~

CO = Contractual Obligation adjustment reason group code
45 = Claim adjustment reason code — Charges exceed your contracted/legislated fee arrangement
40 = Amount of adjustment

Corrected secondary 837:
The reversal information is sent to the secondary payer in an 837. The corrected 837 COB payment information is sent as follows: CLM05-3 uses code 7 - RESUBMISSION, to indicate that this claim is not a duplicate.

CAS*PR*1*242*12~**

PR = Patient Responsibility adjustment reason group code
1 = Claim adjustment reason code — Deductible
24 = Amount of deductible
2 = Claim adjustment reason code — Coinsurance
12 = Amount of co-insurance

CAS*CO*45*40~

CO = Contractual Obligation adjustment reason group code
45 = Claim adjustment reason code — Charges exceed your contracted/legislated fee arrangement
40 = Amount of adjustment

AMT*D*24~

D = Payer Amount Paid code
24 = Amount

AMT*F2*36~

F2 = Patient Responsibility code
36 = Amount

1.4.3 Service Line Procedure Code Bundling and Unbundling

This explanation of bundling and unbundling is not applicable to the building of initial claims to primary payers. However, it is applicable to secondary claims that must contain the results of the primary payer's processing.

Procedure code bundling or unbundling occurs when a payer believes that the actual services performed and reported for payment in a claim can be represented by a different group of procedure codes.

Bundling occurs when two or more reported procedure codes are paid under only one procedure code. Unbundling occurs when one submitted procedure code is paid and reported back as two or more procedure codes. In the interest of standardization, payers should perform bundling or unbundling in a consistent manner when including their explanation of benefits on a claim.

See the 004010 835 implementation guide for an explanation on how bundling and unbundling are handled in that transaction.

Bundling:

In a COB situation, it may be necessary to show payment on bundled lines. When showing bundled service lines, the health care claim must report all of the originally submitted service lines. The first bundled procedure should include the new bundled procedure code in the SVD (Service Line Adjudication) segment (SVD03). The other procedure or procedures that are bundled into the same line should be reported as originally submitted with the following:

- an SVD segment with zero payment (SVD02),
- a pointer to the new bundled procedure code (SVD06, data element 554 (Assigned Number) is the bundled service line number that refers to either the line item control number (REF01 = 6R) submitted by the provider in the 837 (one/line) or the LX assigned number of the service line into which this service line was bundled if no line item control number is assigned),
- a CAS segment with a claim adjustment reason code of 97 (payment is included in the allowance for the basic service), and
- an adjustment amount equal to the submitted charge.

The Adjustment Group in the CAS01 should be either CO (Contractual Obligation) or PI (Payer Initiated), depending upon the provider/payer relationship.

Bundling Example
Dr. Smith submits procedure code A and B for $100.00 each to his PPO as primary coverage. Each procedure was performed on the same date of service. The PPO's adjudication system screens the submitted procedures and notes that procedure C covers the services rendered by Dr. Smith on that single date of service. The PPO's maximum allowed amount for procedure C is $120.00. The patient's co-insurance amount for procedure C is $20.00. The patient has not met the $50.00 deductible.

The following example includes only segments specific to bundling.

Claim Level (Loop ID-2320)

CAS*PR*1*50~

PR = Patient's Responsibility
1 = Adjustment reason - Deductible amount
50 = Amount of adjustment

Service Line Level (Loop ID-2430)

LX*1~

1 = Service line 1

SV1*HC:A:100*UN*1***N~**

HC = HCPCS qualifier
A = HCPCS procedure code
100 = Submitted charge
UN = Units
1 = Number of units
N = Not an emergency

SVD* PAYER ID*70*HC:C1~**

PAYER ID = ID of the payer who adjudicated this service line
70 = Payer amount paid
HC = HCPCS qualifier
C = HCPCS procedure code
1 = Paid units of service

CAS*PR*2*20~

PR = Patient Responsibility
2 = Adjustment reason - Coinsurance amount
20 = Amount of adjustment

LX*2~

2 = Service line 2

SV1*HC:B*100*UN*1***N~**

HC = HCPCS qualifier
B = HCPCS procedure code
100 = Submitted charge
UN = Units
1 = Number of units
N = Not an emergency

SVD* PAYER ID*0*HC:C1*1~**

PAYER ID = ID of the payer who adjudicated this service line
0 = Payer amount paid
HC = HCPCS qualifier
C = HCPCS procedure code
1 = Paid units of service
1 = Service line this line was bundled into

CAS*CO*97*100~

CO = Contractual Obligation
97 = Adjustment reason - Payment is included in the allowance for the basic service/procedure.
100 = Amount of adjustment

Bundling with COB Example

Here's an example of how to combine bundling with COB:
Dr. Smith submits procedure code A and B for $100.00 each to his PPO as primary coverage. Each procedure was performed on the same date of service. The original 837 submitted by Dr. Smith contains this information. Only segments specific to bundling are included in the example.

Original 837

LX*1~ (Loop 2400)

1 = Service line 1

SV1*HC:A*100*UN*1N~**

HC = HCPCS qualifier
A = HCPCS code
100 = Submitted charge
UN = Units code
1 = Units billed
N = Not an emergency code

REF*6R*2J01K~

6R = Line item control number code
2J01K = Control number for this line

LX*2~ (Loop 2400)

2 = Service line 2

SV1*HC:B*100*UN*1N~**

HC = HCPCS qualifier
B = HCPCS code
100 = Submitted charge
UN = Units code
1 = Units billed
N = Not an emergency code

REF*6R*2J02K~

6R = Line item control number
2J02K = Control number for this line

The PPO's adjudication system screens the submitted procedures and notes that procedure C covers the services rendered by Dr. Smith on that single date of service. The PPO's maximum allowed amount for procedure C is $120.00. The patient's co-insurance amount for procedure C is $20.00. The patient has not met the $50.00 deductible. The following example includes only segments specific to bundling. The key number to automate tracking of bundled lines is the line item control number assigned to each service line by the provider.

Claim Level (Loop ID-2320)

CAS*PR*1*50~

PR = Patient's Responsibility
1 = Adjustment reason - Deductible amount
50 = Amount of adjustment

Service Line Level (Loop ID-2400)

SV1*HC:A*100*UN*1N~**

HC = HCPCS qualifier
A = HCPCS code
100 = Submitted charge
UN = Units code
1 = Units billed
N = Not an emergency code

REF*6R*2J01K~

6R = Line item control number
2J01K = Control number for this line

SVD*PAYER ID*70*HC:C1~ (Loop 2430)**

Payer ID = ID of the payer who adjudicated this service line
70 = Payer amount paid
HC = HCPCS qualifier
C = HCPCS code for bundled procedure
1 = Paid units of service
2J01K = Line item control number

CAS*PR*2*20~

PR = Patient Responsibility
2 = Adjustment reason — Co-insurance amount
20 = Amount of adjustment

LX*2~ (Loop 2400)

2 = Service line 2

SV1*HC:B*100*UN*1N~**

HC = HCPCS qualifier
B = HCPCS code
100 = Submitted charge
UN = Units code
1 = Units billed
N = Not an emergency code

REF*6R*2J02K~

6R = Line item control number code
2J02K = Control number for this line

SVD*PAYER ID*0*HC:C*1*2J01K~ (Loop 2430)

Payer ID = ID of the payer who adjudicated this service line
0 = Payer amount paid
HC = HCPCS qualifier
C = HCPCS code for bundled procedure
1 = Units paid
2J01K = Service line into which this service line was bundled

CAS*CO*97*100~

CO = Contractual obligations qualifier
97 = Adjustment reason - Payment is included in the allowance for the basic service/procedure
100 = Amount of adjustment

Bundling with more than two payers in a COB situation where there is bundling and more than two payers show all claim level adjustments for each payer in 2320 and 2330 loop as follows:

2330 Loop (for payer A)
SBR* identifies the other subscriber for payer A identified in 2330B
CAS* identifies all the claim level adjustments for payer A

2330A Loop
NM1*identifies other subscriber for payer A

2330B Loop
NM1* identifies payer A

2320 Loop (for payer B)
SBR* identifies the other subscriber for payer B identified in 2330B loop
CAS* identifies all the claim level adjustments for payer B

2330A Loop
NM1*identifies other subscriber for payer B

2330B Loop
NM1* identifies payer B

2320 Loop (for payer C)
SBR* identifies the other subscriber for payer C identified in 2330B loop
CAS* identifies all the claim level adjustments for payer C

2330A Loop
NM1*identifies other subscriber for payer C

2330B Loop
NM1* identifies payer C

Repeat as necessary up to a maximum of 10 times. Any one claim can carry up to a total of 11 payers (10 carried at the COB level and 1 carried up at the top 2010BB loop).

Once all the claim level payers and adjustments have been identified, run the 2400 loop once for each original billed service line. Use 2430 loops to show line level adjustment by each payer.

2400 Loop

LX*1~

SV1* original data from provider

2430 Loop (for payer A)
SVD*A* their data for this line (the original billed procedure code plus the code A paid on)
CAS* payer A's data for this line (repeat CAS as necessary)
DTP* A's adjudication date for this line.

2430 Loop (for payer B)
SVD*B* their data for this line (the original billed procedure code plus the code B paid on)
CAS* payer B's data for this line (repeat CAS as necessary)
DTP* B's adjudication date for this line.

2430 Loop (for payer C, only used if 837 is being sent to payer D)
SVD*C* their data for this line (the original billed procedure code plus the code C paid on)
CAS* payer C's data for this line (repeat CAS as necessary)
DTP* C's adjudication date for this line.

2400 Loop

LX*2~

SV1* original data from provider for line 2

2430 Loop (for payer A)
SVD*A* their data for this line (the original billed procedure code plus the code A paid on)
CAS* payer A's data for this line (repeat CAS as necessary)
DTP* A's adjudication date for this line.

2430 Loop (for payer B)
SVD*B* their data for this line (the original billed procedure code plus the code B paid on)
CAS* payer B's data for this line (repeat CAS as necessary)
DTP* B's adjudication date for this line.

2430 Loop (for payer C, only used if 837 is being sent to payer D)
SVD*C* their data for this line (the original billed procedure code plus the code C paid on)
CAS* payer C's data for this line (repeat CAS as necessary)
DTP* C's adjudication date for this line.

Etc.

Unbundling with COB

When unbundling, the original service line detail should be followed by occurrences of the SVD loop, once for each unbundled procedure code.

Unbundling Example

The same PPO provider submits a one service claim. The billed service procedure code is A, with a submitted charge of $200.00. The payer unbundled this into two services - B and C - each with an allowed amount of $60.00. There is no deductible or co-insurance amount.

Claim Level (Loop ID-2320)
Only segments specific to unbundling are included in the following example.

CAS*OA*93*0~

OA = Other adjustments qualifier
93 = Adjustment reason - No claim level adjustments.
0 = Amount of adjustment

Service Line Level (Loop ID-2400):

LX*1~

1 = Service line 1

SV1*HC:A*200*UN*1N~**

HC = HCPCS qualifier
A = HCPCS code
200 = Submitted charge
UN = Units code
1 = Units billed
N = Not an emergency code

REF*6R*JR001426789~

6R = Line item control number code
JR001426789 = Control number for this service line

Service Line Adjudication Information: (Loop ID-2430)

SVD*PAYER ID*60*HC:B1~**

Payer ID = ID of the payer who adjudicated this service line
60 = Payer amount paid
HC = HCPCS qualifier
B = Unbundled HCPCS code

CAS*CO*45*35~

CO = Contractual obligations qualifier
45 = Adjustment reason — Charges exceed your contracted/legislated fee arrangement
35 = Amount of adjustment

SVD*PAYER ID*60*HC:C

Payer ID = ID of the payer who adjudicated this service line
60 = Payer amount paid
HC = HCPCS qualifier
C = Unbundled HCPCS code

CAS*CO*45*45~

CO = Contractual obligations qualifier
45 = Adjustment reason — Charges exceed your contracted/legislated fee arrangement
45 = Amount of adjustment

1.4.4 Payer-to-Payer COB

See the final HIPAA rules for specifics on payer to payer COB. With the exception of Medicaid and Medicare crossover claims, most payers (with some notable exceptions) only accept COB claims from providers. According to the information available to X12N, the most extensively documented payer-to-payer COB transactions are Medicare to Medicaid/Medicare Secondary Payers. X12N has made every effort to make this implementation guide compatible with the data requirements set out by Medicare for their payer-to-payer transactions as defined in the Medicare NSF COB implementation guide version 3.01. The list of NSF elements specific and unique to COB is given below (in alphabetical order). NSF elements that HCFA no longer considers necessary for COB are so indicated.

Element Name	NSF Field	837 Crosswalk
Approved amount - Claim level	FA0-51.0	2320 - AMT
Approved amount - Line level	FA0-51.0	2400 - AMT
Balance bill limiting charge - Claim	FA0-54.0	2320 - CAS
Balance bill limiting charge - Line	FA0-54.0	2420 - CAS
Beneficiary adjustment amount	DA3-26.0	2320 - CAS
Beneficiary liability amount	FA0-53.0	2320 - CAS
Blood units paid	EA0-51.0	No longer used
Blood units remaining	EA0-52.0	No longer used
Claim adjustment indicator	DA3-24.0	2330B - REF
Limit charge percent	FA0-55.0	Calculated from CAS
Original approved amount	DA3-27.0	Obtained from original claim
Original paid amount	DA3-28.0	Obtained from original claim
Original payor claim control number	DA3-29.0	2330B - REF
Paid amount	FA0-52.0	2320 AMT, 2430 SVD
Performing provider assignment indicator	FA0-59.0	2300 - CLM07
Performing provider phone	FA0-56.0	No longer used
Performing provider tax ID	FA0-58.0	NM109/REF02 of provider loops
Performing provider tax type	FA0-57.0	NM108/REF01 of provider loops
Provider adjustment amount	DA3-25.0	2320, 2430 - CAS

Type of units indicator	FA0-50.0	2400 - SV103, 2400-CR106

Crosswalks involving the CAS segment must be calculated by subtracting the adjustment given in the CAS from the amount billed for the service line or claim (billed - adjustment = paid) or other similar computation. Crosswalks for 'original' amounts are obtained by comparing the amounts received on the original COB claim with that received in the adjusted COB claim.

1.4.5 Crosswalking COB Data Elements

This section has been added to the 837 Health Care Claims professional implementation guide in the event that a trading partner wishes to automate their COB process. Trading partners who may be interested in automating the COB process include payers and providers or their representatives. Refer to final HIPAA rules for information about any mandates for payer-to-payer coordination of benefits (COB) in an electronic format. With the exception of Medicaid and Medicare crossover claims, most payers (with some notable exceptions) only accept COB claims from providers. Although it is possible to do COB in the 4010 version of the 837 it is somewhat awkward (which the workgroup intends to study and remedy if necessary in the future). The purpose of the discussion below is to clarify exactly which data must be moved around within the 837 to facilitate an automation of COB. Either payers or providers can elect to use this strategy.

For the purposes of this discussion there are two types of payers in the 837 (1) the destination payer, i.e., that payer receiving the claim who is defined in the 2010BB loop, and (2) any 'other' payers, i.e., those defined in the 2330B loop(s). The destination payer or the 'other' payers may be the primary, secondary or any other position payer in terms of when they are paying on the claim - the payment position is not particularly important in discussing how to manage the 837 in a COB situation. For this discussion, it is only important to distinguish between the destination payer and any other payer contained in the claim. In a COB situation each payer in the claim takes a turn at being the destination payer. As the destination payer changes, the information that is identified with that payer must stay associated with them. The same is true of all the 'other' payers, who will each, in turn, become the destination payer as the claim is forwarded to them. It is the purpose of the example detailed below to demonstrate exactly how payer specific information stays associated with the correct payer as the destination payer rotates through the various COB payers.

Business Model:

The destination payer is defined as the payer that is described in the 2010BB loop. All the information contained in the 2300, 2310, 2400 and 2420 loops (not other sub-loops — just those specific loops) is specific to the destination payer. Information specific to other payers is contained in the 2320, 2330 and 2430 loops. Data that may be specific to a payer are shown in Table 1 below. The table details where this data is carried for the destination payer and where it is carried for any other payers who might be included in the claim for the professional implementation guide.

Example:

A claim is filed which involves three payers A, B, and C. In any 837 one payer is always the destination payer (the payer receiving the claim); the two 'other' pay-

ers in this example are carried in the 2320/2330 loops. In this example, the claim is first sent to payer A; payers B and C are carried in the 2320/2330 loops. In Table 1 the information specific to the destination payer is carried in the elements indicated in the second column (Destination Payer Location). Information specific to the non-destination payers is carried in the elements listed in the third column (Other Payer Location).

TABLE 1.
Which elements are specific to the destination and 'other' payers in the 837.

Data Element Name	Destination Payer Location Loop - Segment Element	Other Payer Location Loop - Segment Element
Subscriber Last/Org Name	2010BA | NM103	2330A | NM103
Subscriber First Name	2010BA | NM104	2330A | NM104
Subscriber Middle Name	2010BA | NM105	2330A | NM105
Subscriber Suffix Name	2010BA | NM107	2330A | NM107
Subscriber Identification Number	2010BA | NM108/09	2330A | NM108/09
Subscriber Street Address (1)	2010BA | N301	2330A | N301
Subscriber Street Address (2)	2010BA | N302	2330A | N302
Subscriber City	2010BA | N401	2330A | N401
Subscriber State	2010BA | N402	2330A | N402
Subscriber ZIP Code	2010BA | N403	2330A | N403
Payer Name	2010BB | NM103	2330B | NM103
Payer ID	2010BB | NM108/09	2330B | NM108/09
Patient Identification Number	2010CA | NM108/09	2330C | NM108/09
Relationship of subscriber to patient [2]	2000B | SBR02	2320 | SBR02
Assignment of Benefits Indicator	2300 - CLM08	2320 | OI03
Patient's Signature Source Code	2300 - CLM10	2320 | OI04
Release of Information	2300 - CLM09	2320 | OI06
Prior Authorization or Referral Number - claim level	2300 | REF01/02	2330C | REF01/02 of Prior Auth/Referral REF.
Provider identification number(s) - claim level	2310A-E | REF01/02	2330D-H | REF01/02 of other Payer Provider Identifiers.
Payer specific amounts	NO ELEMENTS[1]	All AMTs in the 2320 loop are specific to the payer identified in the 2330B loop of that iteration of the 2320 loop.
Prior Auth/Referral Number - line level	2400 | REF01/02	2420G | REF01/02 of Prior Authorization or Referral REF

Provider identification number(s) line level	2420A-G | REF01/02	Not Crosswalked

[1]All payer specific amounts apply only to payers who have already adjudicated the claim. The destination payer has yet to adjudicate the claim so there are no payer specific amounts that apply to the destination payer.

[2]As the subscriber information changes it may be necessary to change the value in 2000C PAT01 - Relationship of Patient to the Subscriber.

Once payer A has adjudicated the claim, whoever submits the claim to the second payer (B) then needs to move the information specific to payer A into the "other payer location" elements (column 3). Payer B's information is moved to the "destination payer location" (column 2). Payer C's information remains in the "other payer location" (column 3). Table 2 illustrates how the various payers take turns being the destination and 'other' payers.

TABLE 2.
Distinguishing the destination payer from the 'other' payer(s)

Destination Payer	'Other' Payer
When Payer A is the Destination Payer, then	Payer B & C are the 'Other' Payers
When Payer B is the Destination Payer, then	Payer C & A are the 'Other' Payers
When Payer C is the Destination Payer, then	Payer B & A are the 'Other' Payers

Once payer B has adjudicated the claim, whoever submits the claim to the third payer (C) then needs to move the information specific to payer B back into the "other payer location" elements. Payer C's information is moved to the "destination payer location" elements. Payer A's information remains in the "other payer location" elements.

1.5 Property and Casualty

To ensure timely processing, specific information needs to be included when submitting bills to Property and Casualty payers (e.g. Automobile, Homeowner's, or Workers' Compensation insurers and related entities). Section 4.2 of this Implementation Guide explains these requirements.

2 Data Overview

The data overview introduces the 837 transaction set structure and describes the positioning of business data within the structure. The implementation guide developers recommend familiarity with ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure. For a review, see Appendix A, ASC X12 Nomenclature, and Appendix B, EDI Control Directory.

2.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set — the implementation view and the standard view. The implementation view of the transaction set is presented in Section 2.1, Overall Data Architecture. See figure 3, 837 Transaction Set Listing, for the implementation view. Figure 4 displays only the segments described in this implementation guide and their designated health care names.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
005	ST	Transaction Set Header	R	1	
010	BHT	Beginning of Hierarchical Transaction	R	1	
015	REF	Transmission Type Identification	R	1	
		...			

Table 2 - Detail, Billing/Pay-to Provider Hierarchical Level

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			**>1**
001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
003	PRV	Billing/Pay-to Provider Information	S	1	
010	CUR	Foreign Currency Information	S	1	
		LOOP ID - 2010A BILLING PROVIDER NAME			**1**
015	NM1	Billing Provider Name	R	1	
020	N2	Additional Billing Provider Name Information	S	1	
025	N3	Billing Provider Address	R	1	
030	N4	Billing Provider City/State/ZIP Code	R	1	
035	REF	Billing Provider Secondary Identification	S	5	
		...			
555	SE	Transaction Set Trailer	S	1	

Figure 3. 837 Transaction Set Listing

The standard view, which is presented in Section 3, Transaction Set, displays all segments available within the transaction set and their assigned ASC X12 names.

The intent of the implementation view is to clarify the segments' purpose and use by restricting the view to display only those segments used with their assigned health care names.

2.2 Loop Labeling and Use

For the user's convenience, the 837 transaction uses two naming conventions for loops. Loops are labeled with a descriptive name as well as with a shorthand label. Loop ID-2000A BILLING/PAY-TO PROVIDER LEVEL contains information about the billing and pay-to providers. The descriptive name - BILLING/PAY-TO PROVIDER LEVEL - informs the user of the overall focus of the loop. The short-hand name - 2000A - gives, at a glance, the position of the loop within the overall transaction. Billing and pay-to providers have their own subloops labeled Loop ID-2010AA BILLING PROVIDER and Loop ID-2010AB PAY-TO PROVIDER. The shorthand labels for these loops are 2010AA and 2010AB because they are subloops of loop 2000A. When a loop is used more than once a letter is appended to it's numeric portion to allow the user to distinguish the various iterations of that loop when using the shorthand name of the loop. For example, loop 2000 has three possible iterations: Billing/Pay-to Provider, Subscriber and Patient. These loops are labeled 2000A, 2000B and 2000C respectively. Because the 2000 loops involve the hierarchical structure, it is required that they be used in order.

The order of equivalent loops is less important. Equivalent subloops do not need to be sent in the same order in which they appear in this implementation guide. In this transaction, subloops are those with a number that does not end in 00 (e.g., Loop ID-

2010, Loop ID-2420, etc.). For example, loop 2310 has five possible uses identified: referring provider, rendering provider, purchased service provider, service facility location, and supervising provider. These loops are labeled 2310A, 2310B, 2310C, 2310D, and 2310E . Each of these 2310 loops is an equivalent loop. Because they do not specify an HL, it is not necessary to use them in any particular order. In a similar fashion, it is acceptable to send subloops 2010BB, 2010BD, 2010BA, and 2010BC in that order as long as they all belong to the same subloop. However, it is not acceptable to send subloop 2330 before loop 2310 because these are not equivalent subloops.

In a similar manner, if a single loop has many iterations (repetitions) of a particular segment all the iterations of that segment are equivalent. For example there are many DTP segments in the 2300 loop. These are equivalent segments. It is not required that Order Date be sent before Initial Treatment date. However, it is required that the DTP segment in the 2300 loop come after the CLM segment because it carried in a different position within the 2300 loop.

Translators should distinguish between equivalent subloops and segments by qualifier codes (e.g., the value carried in NM101 in loops 2010BA, 2010 BB, and 2010BC; the values in the DTP01s in the 2300 loop), not by the position of the subloop or segment in the transaction. The number of times a loop or segment can be repeated is indicated in the detail information on that portion of the transaction.

2.2.1 Required and Situational Loops

Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction.

The usage designator of a loop's beginning segment indicates the usage of the loop. If a loop is used, the first segment of that loop is required even if it is marked Situational. An example of this is the 2010AB - Pay-to Provider loop.

In the 837 Professional Implementation Guide loops that are required on all claims/encounters are the Header, 1000A - Submitter Name, 1000B - Receiver Name, 2000A - Billing/Pay-to Provider Hierarchical Level, 2010AA - Billing Provider Name, 2000B - Subscriber Hierarchical Level, 2010BA -Subscriber Name, 2010BB - Payer Name, 2300 - Claim Level Information, and 2400 Service Line. The use of all other loops is dependent upon the nature of the claim/encounter.

If the usage of the first segment in a loop is marked Required, the loop must occur at least once unless it is nested in a loop that is not being used. An example of this is Loop ID-2330A - Other Subscriber Name. Loop 2330A is required only when Loop ID-2320 - Other Subscriber Information is used, i.e., if the claim involves coordination of benefits information. A parallel situation exists with the Loop ID-2330B - Other Payer Name. A note on the Required initial segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a segment note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. For an example of this see Loop ID-2010AB - Pay-to Provider. In the 2010AB loop, if the loop is used, the initial segment, NM1 - Pay-to Provider Name must be used. Use of the N2 and REF segments are optional, but the N3 and N4 segments are required.

2.3 Data Use by Business Use

The 837 is divided into two levels, or tables. The Header level, Table 1, contains transaction control information. The Detail level, Table 2, contains the detail information for the transaction's business function and is presented in 2.3.2, Table 2 - Detail Information.

2.3.1 Table 1 — Transaction Control Information

Table 1 is named the Header level (see figure 4, Header Level). Table 1 identifies the start of a transaction, the specific transaction set, and the transaction's business purpose. Additionally, when a transaction set uses a hierarchical data structure, a data element in the header BHT01 — the Hierarchical Structure Code — relates the type of business data expected to be found within each level.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
005	**ST**	Transaction Set Header	**R**	**1**	
010	**BHT**	Beginning of Hierarchical Transaction	**R**	**1**	
015	**REF**	Transmission Type Identification	**R**	**1**	
		. . .			

Figure 4. Table 1 — Header Level

2.3.1.1 837 Table 1 — Header Level

The following is a coding example of Table 1 in the 837. Refer to Appendix A, ASC X12 Nomenclature, for descriptions of data element separators (e.g., *) and segment terminators (e.g., ~).

ST*837*0001~

837 = Transaction set identifier code
0001 = Transaction set control number

BHT*0019*00*98766Y*19970315*0001*CH~

0019 = Hierarchical structure code (information source, subscriber, dependent)
00 = Original
98766Y = Submitter's batch control number
19970315 = Date of file creation
0001 = Time of file creation
CH = Chargeable (claims)

REF*87*004010X098~

87 = Functional category
004010X098 = Professional Implementation Guide

The Transaction Set Header (ST) segment identifies the transaction set by using 837 as the data value for the transaction set identifier code data element, ST01. The transaction set originator assigns the unique transaction set control number ST02, shown in the previous example as 0001. In the example, the health care provider is the transaction set originator.

The Beginning of Hierarchical Transaction (BHT) segment indicates that the transaction uses a hierarchical data structure. The value of 0019 in the hierarchi-

cal structure code data element, BHT01, describes the order of the hierarchical levels and the business purpose of each level. See Section 2.3.1.2, Hierarchical Level Data Structure, for additional information about the BHT01 data element.

The BHT segment also contains the transaction set purpose code, BHT02, which indicates **original transaction** by using data value 00. The submitter's business application system generates the following fields: BHT03, originator's reference number; BHT04, date of transaction creation; BHT05, time of transaction creation. BHT02 is used to indicate the status of the transaction batch, i.e., is the batch an original transmission or a reissue (resubmitted) batch. BHT06 is used to indicate the type of billed service being sent: fee-for-service (claim) or encounter or a mixed bag of both.

Because the 837 is multi-functional, it is important for the receiver to know which business purpose is served, so the REF in the Header is used. A data value of 87 in REF 01 indicates the **functional category,** or type, of 837 being sent. Appropriate values for REF02 are as follows: 004010X098 for a Professional 837 transaction, 004010X097 for Dental, and 004010X096 for Institutional.

The Functional Group Header (GS) segment also identifies the business purpose of multi-functional transaction sets. See Appendix A, ASC X12 Nomenclature, for a detailed description of the elements in the GS segment.

2.3.1.2 Hierarchical Level Data Structure

The hierarchical level (HL) structure identifies and relates the participants involved in the transaction. The participants identified in the 837 Professional transaction are generally billing/pay-to provider, subscriber, and patient (when the patient is not the same person as the subscriber). The 0019 value in the BHT hierarchical structure code (BHT01) describes the appearance order of subsequent loops within the transaction set and refers to these participants, respectively, in the following terms:

- information source (billing provider)
- subscriber (can be the patient when the patient is the subscriber)
- dependent (patient, when the patient is not the subscriber)

The term "billing provider" indicates the information source HL. The term "patient" indicates the dependent HL.

2.3.2 Table 2 — Detail Information

Table 2 uses the hierarchical level structure. Each hierarchical level is comprised of a series of loops. Numbers identify the loops. The hierarchical level that identifies the participants and the relationship to other participants is Loop ID-2000. The individual or entity information is contained in Loop ID-2010.

2.3.2.1 HL Segment

The following information illustrates claim/encounter submissions when the patient is the subscriber and when the patient is not the subscriber.

NOTE
Specific claim detail information can be given in either the Subscriber or the Dependent hierarchical level. Because of this, the claim information is said to "float."

Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information is placed at the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber.

Claim/encounter submission when the **patient is the subscriber:**
Billing provider (HL03=20)
  Subscriber (HL03=22)
    Claim level information
    Line level information

Claim/encounter submission when the **patient is not the subscriber:**
Billing provider (HL03=20)
  Subscriber (HL03=22)
    Patient (HL03=23)
      Claim level information
      Line level information

The Billing Provider or Subscriber HLs may contain multiple “child” HLs. A child HL indicates an HL that is nested within (subordinate to) the previous HL. Hierarchical levels may also have a “parent” HL. A parent HL is the HL that is one level out in the nesting structure. An example follows.

Billing provider HL	**Parent HL** to the Subscriber HL
Subscriber HL	**Parent HL** to the Patient HL; **Child HL** to the Billing Provider HL
Patient HL	**Child HL** to the Subscriber HL

For the subscriber HL, the billing provider HL is the parent. The patient HL is the child. The subscriber HL is contained within the billing provider HL. The patient HL is contained within the subscriber HL.

If the billing provider is submitting claims for more than one subscriber, each of whom may or may not have dependents, the HL structure between the transaction set header and trailer (ST–SE) could look like the following:

BILLING PROVIDER
  SUBSCRIBER #1 (Patient #1)
    Claim level information
    Line level information, as needed
SUBSCRIBER #2
  PATIENT #P2.1 (e.g., subscriber #2 spouse)
    Claim level information
    Line level information, as needed
  PATIENT #P2.2 (e.g., subscriber #2 first child)
    Claim level information
    Line level information, as needed
  PATIENT #P2.3 (e.g., subscriber #2 second child)
    Claim level information
    Line level information, as needed
SUBSCRIBER #3 (Patient #3)
  Claim level information
  Line level information, as needed
SUBSCRIBER #4 (Patient #4)
  Claim level information
  Line level information, as needed

PATIENT #P4.1 (e.g., #4 subscriber's first child)
Claim level information
Line level information, as needed

Based on the previous example, the HL structure looks like the following:

HL*120*1~** (indicates the billing provider)

1 = HL sequence number (HL numbering must begin with 1.)
**(blank) = there is no parent HL (characteristic of the billing provider HL)
20 = information source
1 = there is at least one child HL to this HL

HL*2*1*22*0~ (indicates subscriber #1 for whom there are no dependents)

2 = HL sequence number
1 = parent HL
22 = subscriber
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*3*1*22*1~ (indicates subscriber #2 for whom there are dependents)

3 = HL sequence number
1 = parent HL
22 = subscriber
1 = there is at least one child HL to this HL

HL*4*3*23*0~ (indicates patient #P2.1)

4 = HL sequence number
3 = parent HL
23 = patient
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*5*3*23*0~ (indicates patient #P2.2)

5 = HL sequence number
3 = parent HL
23 = dependent
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*6*3*23*0~ (indicates patient #P2.3)

6 = HL sequence number
3 = parent HL
23 = dependent
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*7*1*22*0~ (indicates subscriber #3 for whom there are no dependents)

7 = HL sequence number
1 = parent HL
22 = subscriber
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

HL*8*1*22*1~(indicates subscriber #4 who is a patient in their own right and for whom there are dependents)

8 = HL sequence number
1 = parent HL

22 = subscriber
1 = there is at least one child HL to this HL (claim level data follows for #4 after which comes HL*9)

HL*9*8*23*0~ (indicates patient #P4.1 for subscriber #4)

9 = HL sequence number
8 = parent HL
23 = dependent
0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

If another billing provider is listed in the same ST–SE transaction, it could be listed as follows: HL*100**20*1~.The HL sequence number of 100 indicates that there are 99 previous HL segments, but it is billing provider level HL (HL02 = **(blank)) and is a different entity than the first billing provider listed.

From a review of these examples, the following information is noted:

- HLs are numbered sequentially beginning with 1. The sequential number is found in HL01, which is the first data element in the HL segment. Sequence number must be numeric.
- The second element, HL02, indicates the sequential number of the parent hierarchical level to which this hierarchical level (HL01) is subordinate. The billing provider/information source has no parent. If the data value in HL02 is equal to “**”(blank), it is known that this is the highest hierarchical level for all the contained subordinate levels. The billing provider level is not subordinate to any hierarchical level.
- The data value in data element HL03 describes the hierarchical level entity. For example, when HL03 equals 20, the hierarchical level is the billing provider; when HL03 equals 23, the hierarchical level is the dependent (patient).
- Data element HL04 indicates whether or not subordinate hierarchical levels exist. A value of “1" indicates subsequent hierarchical levels. A value of ”0" or absence of a data value indicates no subordinate hierarchical levels follow. For the subscriber HL, claim data may follow even when HL04=1 (see subscriber #4 in the above example).
- HL’s must be transmitted in order.

2.4 Loop ID-1000

Use of Loop ID-1000 is difficult to accurately define or describe. Originally, Loop ID-1000 was conceived of as an audit trail loop. (The original instructions for Loop ID-1000 directed that anyone who “opened the envelope” of a transaction should include another iteration of Loop ID-1000 so that it would be possible to identify all the entities who had an opportunity to change the data inside the enveloping structure.) The audit trail concept is difficult to implement for a variety of reasons, and the developers of this implementation guide do not recommend using Loop ID-1000 as an audit trail in this transaction. Instead, the developers recommend using Loop ID-1000 to record the transaction submitter and the receiver. However, the submitter and receiver concepts are difficult to define accurately. The transaction submitter and receiver are not necessarily the two entities who may be passing the transaction between them. Given the complexity of transmission pathways, it is critical to define the original submitter and final receiver somewhere in the transmission.

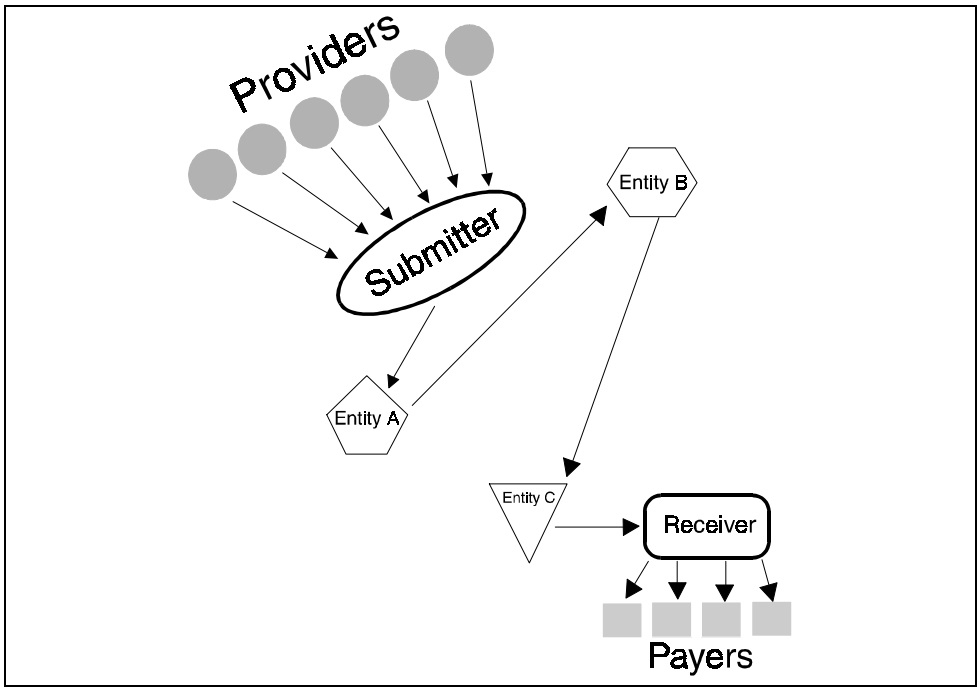


Figure 5. Loop ID-1000 — Example 1

Several figures follow to help clarify the difficulty in defining the terms “submitter” and “receiver.” In figure 5, Loop ID-1000 — Example 1, the submitter is not the service provider. The submitter could be a billing service, an automated clearing house, or another entity who formats the claims into the 837. The original submitter can be thought of as the entity who initially formats the claim data into the ASC X12N transaction and begins the transmission chain, which ultimately ends at the payer. It is possible that the communication between the provider and the submitter is in the form of paper or some other non-standard EDI transaction.

The receiver is more difficult to define. Figure 5, Loop ID-1000 — Example 1, shows that the receiver is not necessarily the destination payer. The receiver is the entity who receives the claim transmission on behalf of perhaps many payer

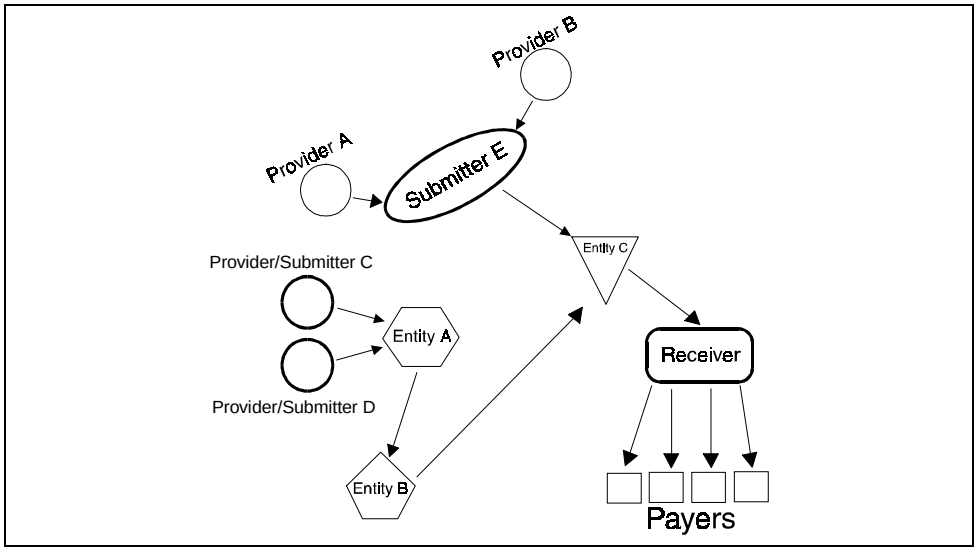


Figure 6. Loop ID-1000 — Example 2

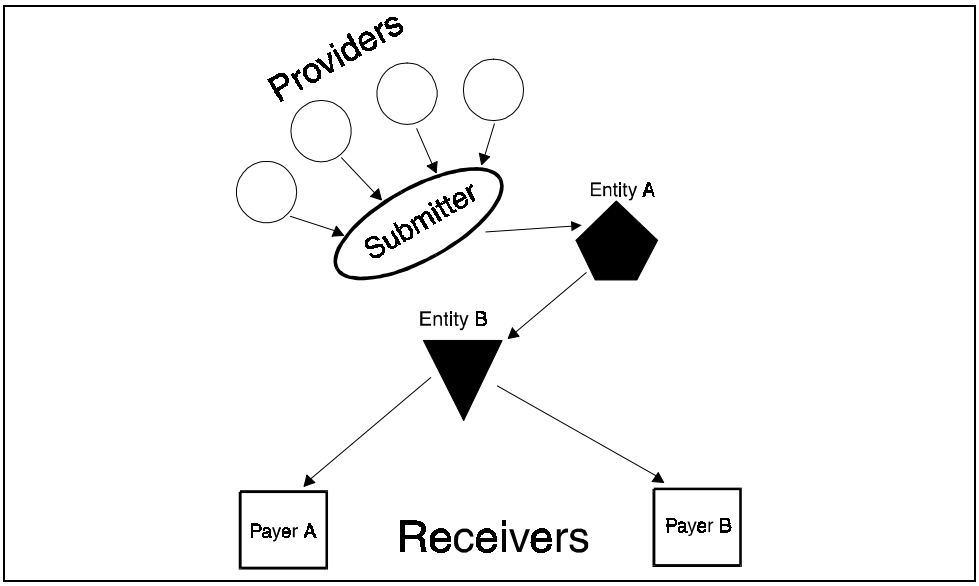


Figure 7. Loop ID-1000 — Example 3

organizations. In figure 6, the receiver can be a Preferred Provider Organization (PPO), a repricer, or any of several other payer-associated entities. These entities can perform a variety of functions for the payer.

Entities A, B, and C can be any of a variety of types of EDI transmission organizations — Value-Added Networks (VANs), Automated Clearing Houses (ACHs), transmission nodes — who may or may not "open the envelope." Their EDI addresses are carried in the Interchange Control Header (ISA) segment of the transmission. (See Appendix B, EDI Control Directory, for an explanation of the ISA segment.) However, the implementation guide developers do not recommend that such entities put information in Loop ID-1000. The claim originator (the submitter) defines, by trading partner agreement, who the claim receiver is. As shown in figure 6, the claim receiver may not be the next transmission entity in the transmission chain. The submitter is the one who completes Loop ID-1000 and identifies the transmission receiver.

It is possible that the provider is the submitter, and the payer the receiver. Figure 6, Loop ID-1000 — Example 2, and figure 7, Loop ID-1000 — Example 3, demonstrate alternate types of transmission pathways where the provider and the payer function as submitter and receiver. In figure 6, Loop ID-1000 — Example 2, providers C and D function as submitters because they format their own claim data into an ASC X12N claim transmission package. Providers A and B use submitter E to perform that function and are therefore, not submitters. In figure 7, payers A and B function as their own transmission receivers.

Because there is not a clear definition of submitter and receiver at this time, the developers of this implementation guide recommend that the submitter and receiver be clearly determined by trading partner agreement.

2.5 The Claim

After the HL structure is defined, the specific claim services are identified in Loop ID-2300. Loop ID-2305 identifies services that are specific to home health care. Loop ID-2310 identifies various providers who may have been involved in the

health care services being reported in the transaction. Loop ID-2320 identifies all other insurance entities (coordination of benefits). Within Loop ID-2320, Loop ID-2330 identifies all the parties associated with the other insurance entities. Loop ID-2400 is required and identifies service line information. Loop ID-2420 identifies any service line providers who are different than the corresponding claim level providers. Loop ID-2430 identifies any service line adjudication information (from a previous payer), and Loop ID-2440 is used to send information from specific forms.

2.6 Interactions with Other Transactions

An overview of transactions that interact with the 837 is presented here.

2.6.1 Functional Acknowledgment (997)

The Functional Acknowledgment (997) transaction is used as the first response to receiving an 837. The 997 informs the 837 submitter that the transmission arrived. In addition, the 997 can be constructed to send information about the syntactical quality of the 837 transmission.

2.6.2 Unsolicited Claim Status (277)

The Unsolicited Claim Status (277) transaction may be used as the second response to receiving an 837. The 277 transmission may be used to indicate to the provider which claims in an 837 batch were received electronically but not yet accepted into the adjudication system, which were accepted into the adjudication system (i.e., which claims passed the front-end edits) and which claims were rejected before entering the adjudication system. Certain information is taken from the 837 and used in, or crosswalked into, the 277 (e.g., the provider's claim identification number, the amount billed, etc.).

This discussion is not intended to imply that the Unsolicited Claim Status (277) transaction is part of HIPAA - it is not. However, this discussion is included in this implementation guide because trading partners may decide to implement the Unsolicited Claim Status (277) transaction as a prudent business decision outside of the HIPAA mandates to automate the front-end accept-reject report process.

2.6.3 Remittance Advice (835)

Information in the Remittance Advice (835) transaction is generated by the payer's adjudication system. However, in a coordination of benefits (COB) situation where the provider is sending an 837 to a secondary payer, information from the 835 may be included in the secondary 837. As shown 1.4.2.2, Coordination of Benefits — Correction Detail, data from specific segments/elements in the 835 is crosswalked directly into the subsequent 837.

2.7 National Uniform Claim Committee

This implementation guide includes information about the National Uniform Claim Committee (NUCC) in Appendix I, National Uniform Claim Committee Recommendations. The NUCC is working to establish a minimal data set for professional claims submission. This work will be published in a separate volume titled

The National Uniform Claim Committee Data Set, NUCC-DS. For additional information about the NUCC data set, contact the NUCC, c/o American Medical Association, 515 North State Street, Chicago, IL 60610

2.8 Limitations to the Size of a Claim/Encounter (837) Transaction

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. Some submitters may have the capability and the desire to transmit enormous 837 transactions with thousands of claims contained in them. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.

2.9 Use of Data Segment and Elements Marked “Situational”

Professional claims span an enormous variety of health care professional specialities and payment situations. Because of this, it is difficult to set a single list of data elements that are required for all types of professional health care claims. To meet the divergent needs of professional claim submitters, many data segments and elements included in this implementation guide are marked “situational.” All situational segments and elements now have notes attached specifying when they should be used. To the greatest degree possible, situational segments and elements have had their required use specified. Some elements (e.g., procedure code modifiers) are used at the discretion of the claim submitter - their use is based on the specific health care provided. See the Health Insurance Portability and Accountability Act of 1996 and it’s associated rules for further information about standardized use of this transaction.

3 Transaction Set

NOTE
See Appendix A, ASC X12 Nomenclature, to review the transaction set structure, including descriptions of segments, data elements, levels, and loops.

3.1 Presentation Examples

The ASC X12 standards are generic. For example, multiple trading communities use the same PER segment to specify administrative communication contacts. Each community decides which elements to use and which code values in those elements are applicable. This implementation guide uses a format that depicts both the generalized standard and the trading community-specific implementation.

The transaction set detail is comprised of two main sections with subsections within the main sections.

Transaction Set Listing

- Implementation
- Standard

Segment Detail

- Implementation
- Standard
- Diagram
- Element Summary

The examples in figures 8 through 13 define the presentation of the transaction set that follows.

The following pages provide illustrations, in the same order they appear in the guide, to describe the format.

The examples are drawn from the 835 Health Care Claim Payment/Advice Transaction Set, but all principles apply.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

835 Health Care Claim Payment/Advice

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	010	ST	835 Header	R	1	
54	020	BPR	Financial Information	R	1	
60	040	TRN	Reassociation Key	R	1	
62	050	CUR	Non-US Dollars Currency	S	1	
65	060	REF	Receiver ID	S	1	
66	060	REF	Version Number	S	1	
68	070	DTM	Production Date	S	1	
			PAYER NAME			1
70	080	N1	Payer Name	R	1	
72	100	N3	Payer Address	S	1	
75	110	N4	Payer City, State, Zip	S	1	
76	120	REF	Additional Payer Reference Number	S	1	
78	130	PER	Payer Contact	S	1	
			PAYEE NAME			1
79	080	N1	Payee Name	R	1	
81	100	N3	Payee Address	S	1	
82	110	N4	Payee City, State, Zip	S	1	
84	120	REF	Payee Additional Reference Number	S	>1	

Each segment is assigned an industry specific name. Not used segments do not appear

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 8. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See Appendix A, ASC X12 Nomenclature for a complete description of the standard

835 Health Care Claim Payment/Advice

Functional Group ID: **HP**

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1	
030	NTE	Note/Special Instruction	O	>1	
040	TRN	Trace	O	1	

Figure 9. Transaction Set Key — Standard

IMPLEMENTATION

PAYER NAME ← Industry assigned Segment Name

Industry Usage

Loop: PAYER NAME **Repeat:** 1 ← Industry Loop Repeat

Industry Segment Repeat

Usage: SITUATIONAL ← Industry assigned Loop Name

Repeat: 1

Advisory: Under most circumstances, this segment is expected to be sent.

Industry Notes

Notes: 1. This N1 loop provides the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.

Example

Example: N1*PR*INSURANCE COMPANY OF TIMBUCKTU*NI*88888888~

Figure 10. Segment Key — Implementation

STANDARD

N1 Name ← X12 ID and Name

Level: Header ← X12 Level

Position: 080 ← X12 Position Number

Loop: N1 **Repeat:** 200 ← X12 Loop Information

Requirement: Optional ← X12 Requirement

Max Use: 1 ← X12 Maximum Use

Purpose: To identify a party by type of organization, name and code

Syntax: **1** **R0203**
At least one of N102 or N103 is required.

2 **P0304**
If either N103 or N104 is present, then the other is required.

X12 Syntax Notes

Figure 11. Segment Key — Standard

DIAGRAM

Indicates a Required Element

Element Delimiter

Abbreviated Element Name

Segment Terminator

N1 *	N101 98 Entity ID Code M ID 2/2	*	N102 93 Name X AN 1/35	*	N103 66 ID Code Qualifier X ID 1/2	*	N104 67 ID Code X AN 2/20	*	N105 706 ~~Entity Relat Code~~ O ID 2/2	*	N106 98 ~~Entity ID Code~~ O ID 2/2	~

Segment ID

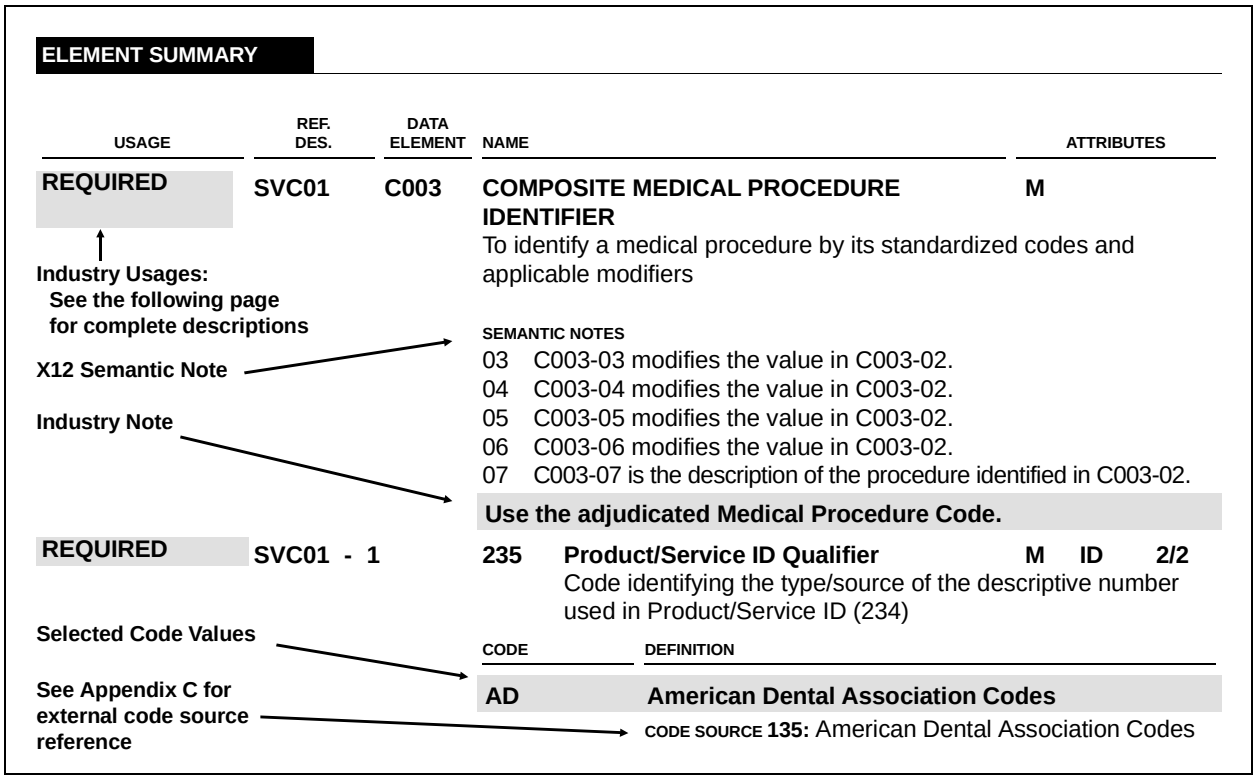
Requirement Designator

Minimum/ Maximum Length

Data Type

Indicates a Not Used Element

Figure 12. Segment Key - Diagram



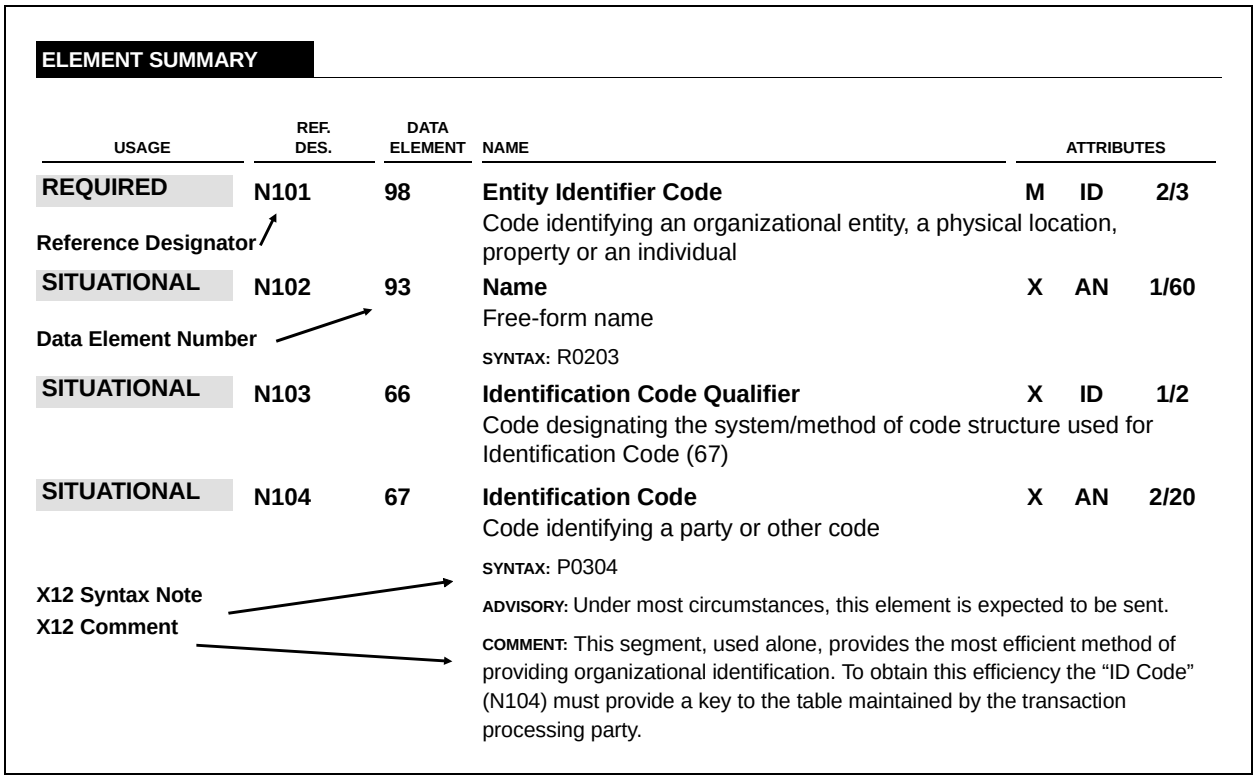


Figure 13. Segment Key — Element Summary

Industry Usages:

Required	This item must be used to be compliant with this implementation guide.
Not Used	This item should not be used when complying with this implementation guide.
Situational	The use of this item varies, depending on data content and business context. The defining rule is generally documented in a syntax or usage note attached to the item.* The item should be used whenever the situation defined in the note is true; otherwise, the item should not be used. **** NOTE*** If no rule appears in the notes, the item should be sent if the data is available to the sender.

Loop Usages:
Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

If the first segment is Required, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the Required first segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is Situational, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the higher level loop is used.

IMPLEMENTATION

837 Health Care Claim: Professional

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.

2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.

3. This standard can, also, be used as a transaction set in support of the coordination of benefits claims process. Additional looped segments can be used within both the claim and service line levels to transfer each payer's adjudication information to subsequent payers.

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
62	005	ST	Transaction Set Header	R	1	
63	010	BHT	Beginning of Hierarchical Transaction	R	1	
66	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
67	020	NM1	Submitter Name	R	1	
70	025	N2	Additional Submitter Name Information	S	1	
71	045	PER	Submitter EDI Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
74	020	NM1	Receiver Name	R	1	
76	025	N2	Receiver Additional Name Information	S	1	

Table 2 - Detail, Billing/Pay-to Provider Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
77	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
79	003	PRV	Billing/Pay-to Provider Specialty Information	S	1	
81	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
84	015	NM1	Billing Provider Name	R	1	
87	020	N2	Additional Billing Provider Name Information	S	1	
88	025	N3	Billing Provider Address	R	1	
89	030	N4	Billing Provider City/State/ZIP Code	R	1	
91	035	REF	Billing Provider Secondary Identification	S	8	
94	035	REF	Credit/Debit Card Billing Information	S	8	
96	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
99	015	NM1	Pay-to Provider Name	S	1	
102	020	N2	Additional Pay-to Provider Name Information	S	1	

103	025	N3	Pay-to Provider Address	R	1	
104	030	N4	Pay-to Provider City/State/ZIP Code	R	1	
106	035	REF	Pay-to-Provider Secondary Identification	S	5	

Table 2 - Detail, Subscriber Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1
108	001	HL	Subscriber Hierarchical Level	R	1	
110	005	SBR	Subscriber Information	R	1	
114	007	PAT	Patient Information	S	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			1
117	015	NM1	Subscriber Name	R	1	
120	020	N2	Additional Subscriber Name Information	S	1	
121	025	N3	Subscriber Address	S	1	
122	030	N4	Subscriber City/State/ZIP Code	S	1	
124	032	DMG	Subscriber Demographic Information	S	1	
126	035	REF	Subscriber Secondary Identification	S	4	
128	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2010BB PAYER NAME			1
130	015	NM1	Payer Name	R	1	
133	020	N2	Additional Payer Name Information	S	1	
134	025	N3	Payer Address	S	1	
135	030	N4	Payer City/State/ZIP Code	S	1	
137	035	REF	Payer Secondary Identification	S	3	
			LOOP ID - 2010BC RESPONSIBLE PARTY NAME			1
139	015	NM1	Responsible Party Name	S	1	
142	020	N2	Additional Responsible Party Name Information	S	1	
143	025	N3	Responsible Party Address	R	1	
144	030	N4	Responsible Party City/State/ZIP Code	R	1	
			LOOP ID - 2010BD CREDIT/DEBIT CARD HOLDER NAME			1
146	015	NM1	Credit/Debit Card Holder Name	S	1	
149	020	N2	Additional Credit/Debit Card Holder Name Information	S	1	
150	035	REF	Credit/Debit Card Information	S	2	

Table 2 - Detail, Patient Hierarchical Level

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to “float.” Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL			>1
152	001	HL	Patient Hierarchical Level	S	1	
154	007	PAT	Patient Information	R	1	

			LOOP ID - 2010CA PATIENT NAME			**1**
157	**015**	**NM1**	Patient Name	**R**	**1**	
160	**020**	**N2**	Additional Patient Name Information	**S**	**1**	
161	**025**	**N3**	Patient Address	**R**	**1**	
162	**030**	**N4**	Patient City/State/ZIP Code	**R**	**1**	
164	**032**	**DMG**	Patient Demographic Information	**R**	**1**	
166	**035**	**REF**	Patient Secondary Identification	**S**	**5**	
168	**035**	**REF**	Property and Casualty Claim Number	**S**	**1**	
			LOOP ID - 2300 CLAIM INFORMATION			**100**
170	**130**	**CLM**	Claim Information	**R**	**1**	
180	**135**	**DTP**	Date - Order Date	**S**	**1**	
182	**135**	**DTP**	Date - Initial Treatment	**S**	**1**	
184	**135**	**DTP**	Date - Referral Date	**S**	**1**	
186	**135**	**DTP**	Date - Date Last Seen	**S**	**1**	
188	**135**	**DTP**	Date - Onset of Current Illness/Symptom	**S**	**1**	
190	**135**	**DTP**	Date - Acute Manifestation	**S**	**5**	
192	**135**	**DTP**	Date - Similar Illness/Symptom Onset	**S**	**10**	
194	**135**	**DTP**	Date - Accident	**S**	**10**	
196	**135**	**DTP**	Date - Last Menstrual Period	**S**	**1**	
197	**135**	**DTP**	Date - Last X-ray	**S**	**1**	
199	**135**	**DTP**	Date - Estimated Date of Birth	**S**	**1**	
200	**135**	**DTP**	Date - Hearing and Vision Prescription Date	**S**	**1**	
201	**135**	**DTP**	Date - Disability Begin	**S**	**5**	
203	**135**	**DTP**	Date - Disability End	**S**	**5**	
205	**135**	**DTP**	Date - Last Worked	**S**	**1**	
206	**135**	**DTP**	Date - Authorized Return to Work	**S**	**1**	
208	**135**	**DTP**	Date - Admission	**S**	**1**	
210	**135**	**DTP**	Date - Discharge	**S**	**1**	
212	**135**	**DTP**	Date - Assumed and Relinquished Care Dates	**S**	**2**	
214	**155**	**PWK**	Claim Supplemental Information	**S**	**10**	
217	**160**	**CN1**	Contract Information	**S**	**1**	
219	**175**	**AMT**	Credit/Debit Card Maximum Amount	**S**	**1**	
220	**175**	**AMT**	Patient Amount Paid	**S**	**1**	
221	**175**	**AMT**	Total Purchased Service Amount	**S**	**1**	
222	**180**	**REF**	Service Authorization Exception Code	**S**	**1**	
224	**180**	**REF**	Mandatory Medicare (Section 4081) Crossover Indicator	**S**	**1**	
226	**180**	**REF**	Mammography Certification Number	**S**	**1**	
227	**180**	**REF**	Prior Authorization or Referral Number	**S**	**2**	
229	**180**	**REF**	Original Reference Number (ICN/DCN)	**S**	**1**	
231	**180**	**REF**	Clinical Laboratory Improvement Amendment (CLIA) Number	**S**	**3**	
233	**180**	**REF**	Repriced Claim Number	**S**	**1**	
235	**180**	**REF**	Adjusted Repriced Claim Number	**S**	**1**	
236	**180**	**REF**	Investigational Device Exemption Number	**S**	**1**	
238	**180**	**REF**	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries	**S**	**1**	
240	**180**	**REF**	Ambulatory Patient Group (APG)	**S**	**4**	
241	**180**	**REF**	Medical Record Number	**S**	**1**	
242	**180**	**REF**	Demonstration Project Identifier	**S**	**1**	
244	**185**	**K3**	File Information	**S**	**10**	
246	**190**	**NTE**	Claim Note	**S**	**1**	
248	**195**	**CR1**	Ambulance Transport Information	**S**	**1**	
251	**200**	**CR2**	Spinal Manipulation Service Information	**S**	**1**	
257	**220**	**CRC**	Ambulance Certification	**S**	**3**	
260	**220**	**CRC**	Patient Condition Information: Vision	**S**	**3**	
263	**220**	**CRC**	Homebound Indicator	**S**	**1**	

265	231	HI	Health Care Diagnosis Code	S	1	
271	241	HCP	Claim Pricing/Repricing Information	S	1	
			LOOP ID - 2305 HOME HEALTH CARE PLAN INFORMATION			6
276	242	CR7	Home Health Care Plan Information	S	1	
278	243	HSD	Health Care Services Delivery	S	3	
			LOOP ID - 2310A REFERRING PROVIDER NAME			2
282	250	NM1	Referring Provider Name	S	1	
285	255	PRV	Referring Provider Specialty Information	S	1	
287	260	N2	Additional Referring Provider Name Information	S	1	
288	271	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2310B RENDERING PROVIDER NAME			1
290	250	NM1	Rendering Provider Name	S	1	
293	255	PRV	Rendering Provider Specialty Information	R	1	
295	260	N2	Additional Rendering Provider Name Information	S	1	
296	271	REF	Rendering Provider Secondary Identification	S	5	
			LOOP ID - 2310C PURCHASED SERVICE PROVIDER NAME			1
298	250	NM1	Purchased Service Provider Name	S	1	
301	271	REF	Purchased Service Provider Secondary Identification	S	5	
			LOOP ID - 2310D SERVICE FACILITY LOCATION			1
303	250	NM1	Service Facility Location	S	1	
306	260	N2	Additional Service Facility Location Name Information	S	1	
307	265	N3	Service Facility Location Address	R	1	
308	270	N4	Service Facility Location City/State/ZIP	R	1	
310	271	REF	Service Facility Location Secondary Identification	S	5	
			LOOP ID - 2310E SUPERVISING PROVIDER NAME			1
312	250	NM1	Supervising Provider Name	S	1	
315	260	N2	Additional Supervising Provider Name Information	S	1	
316	271	REF	Supervising Provider Secondary Identification	S	5	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			10
318	290	SBR	Other Subscriber Information	S	1	
323	295	CAS	Claim Level Adjustments	S	5	
332	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
333	300	AMT	Coordination of Benefits (COB) Approved Amount	S	1	
334	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	1	
335	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	S	1	
336	300	AMT	Coordination of Benefits (COB) Covered Amount	S	1	
337	300	AMT	Coordination of Benefits (COB) Discount Amount	S	1	
338	300	AMT	Coordination of Benefits (COB) Per Day Limit Amount	S	1	
339	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	1	
340	300	AMT	Coordination of Benefits (COB) Tax Amount	S	1	
341	300	AMT	Coordination of Benefits (COB) Total Claim Before Taxes Amount	S	1	
342	305	DMG	Subscriber Demographic Information	S	1	
344	310	OI	Other Insurance Coverage Information	R	1	
347	320	MOA	Medicare Outpatient Adjudication Information	S	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			1
350	325	NM1	Other Subscriber Name	R	1	
353	330	N2	Additional Other Subscriber Name Information	S	1	
354	332	N3	Other Subscriber Address	S	1	
355	340	N4	Other Subscriber City/State/ZIP Code	S	1	

357	355	REF	Other Subscriber Secondary Identification	S	3	
			LOOP ID - 2330B OTHER PAYER NAME			1
359	325	NM1	Other Payer Name	R	1	
362	330	N2	Additional Other Payer Name Information	S	1	
363	345	PER	Other Payer Contact Information	S	2	
366	345	DTP	Claim Adjudication Date	S	1	
368	355	REF	Other Payer Secondary Identifier	S	2	
370	355	REF	Other Payer Prior Authorization or Referral Number	S	2	
372	355	REF	Other Payer Claim Adjustment Indicator	S	2	
			LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION			1
374	325	NM1	Other Payer Patient Information	S	1	
376	355	REF	Other Payer Patient Identification	S	3	
			LOOP ID - 2330D OTHER PAYER REFERRING PROVIDER			2
378	325	NM1	Other Payer Referring Provider	S	1	
380	355	REF	Other Payer Referring Provider Identification	R	3	
			LOOP ID - 2330E OTHER PAYER RENDERING PROVIDER			1
382	325	NM1	Other Payer Rendering Provider	S	1	
384	355	REF	Other Payer Rendering Provider Secondary Identification	R	3	
			LOOP ID - 2330F OTHER PAYER PURCHASED SERVICE PROVIDER			1
386	325	NM1	Other Payer Purchased Service Provider	S	1	
388	355	REF	Other Payer Purchased Service Provider Identification	R	3	
			LOOP ID - 2330G OTHER PAYER SERVICE FACILITY LOCATION			1
390	325	NM1	Other Payer Service Facility Location	S	1	
392	355	REF	Other Payer Service Facility Location Identification	R	3	
			LOOP ID - 2330H OTHER PAYER SUPERVISING PROVIDER			1
394	325	NM1	Other Payer Supervising Provider	S	1	
396	355	REF	Other Payer Supervising Provider Identification	R	3	
			LOOP ID - 2400 SERVICE LINE			50
398	365	LX	Service Line	R	1	
400	370	SV1	Professional Service	R	1	
408	385	SV4	Prescription Number	S	1	
410	420	PWK	DMERC CMN Indicator	S	1	
412	425	CR1	Ambulance Transport Information	S	1	
415	430	CR2	Spinal Manipulation Service Information	S	5	
421	435	CR3	Durable Medical Equipment Certification	S	1	
423	445	CR5	Home Oxygen Therapy Information	S	1	
427	450	CRC	Ambulance Certification	S	3	
430	450	CRC	Hospice Employee Indicator	S	1	
432	450	CRC	DMERC Condition Indicator	S	2	
435	455	DTP	Date - Service Date	R	1	
437	455	DTP	Date - Certification Revision Date	S	1	
439	455	DTP	Date - Referral Date	S	1	
440	455	DTP	Date - Begin Therapy Date	S	1	
442	455	DTP	Date - Last Certification Date	S	1	
444	455	DTP	Date - Order Date	S	1	
445	455	DTP	Date - Date Last Seen	S	1	
447	455	DTP	Date - Test	S	2	
449	455	DTP	Date - Oxygen Saturation/Arterial Blood Gas Test	S	3	
451	455	DTP	Date - Shipped	S	1	

452	455	DTP	Date - Onset of Current Symptom/Illness	S	1	
454	455	DTP	Date - Last X-ray	S	1	
456	455	DTP	Date - Acute Manifestation	S	1	
458	455	DTP	Date - Initial Treatment	S	1	
460	455	DTP	Date - Similar Illness/Symptom Onset	S	1	
462	460	QTY	Anesthesia Modifying Units	S	5	
464	462	MEA	Test Result	S	20	
466	465	CN1	Contract Information	S	1	
468	470	REF	Repriced Line Item Reference Number	S	1	
469	470	REF	Adjusted Repriced Line Item Reference Number	S	1	
470	470	REF	Prior Authorization or Referral Number	S	2	
472	470	REF	Line Item Control Number	S	1	
474	470	REF	Mammography Certification Number	S	1	
475	470	REF	Clinical Laboratory Improvement Amendment (CLIA) Identification	S	1	
477	470	REF	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	S	1	
478	470	REF	Immunization Batch Number	S	1	
479	470	REF	Ambulatory Patient Group (APG)	S	4	
480	470	REF	Oxygen Flow Rate	S	1	
482	470	REF	Universal Product Number (UPN)	S	1	
484	475	AMT	Sales Tax Amount	S	1	
485	475	AMT	Approved Amount	S	1	
486	475	AMT	Postage Claimed Amount	S	1	
487	480	K3	File Information	S	10	
488	485	NTE	Line Note	S	1	
489	488	PS1	Purchased Service Information	S	1	
491	491	HSD	Health Care Services Delivery	S	1	
495	492	HCP	Line Pricing/Repricing Information	S	1	
			LOOP ID - 2420A RENDERING PROVIDER NAME			**1**
501	500	NM1	Rendering Provider Name	S	1	
504	505	PRV	Rendering Provider Specialty Information	R	1	
506	510	N2	Additional Rendering Provider Name Information	S	1	
507	525	REF	Rendering Provider Secondary Identification	S	5	
			LOOP ID - 2420B PURCHASED SERVICE PROVIDER NAME			**1**
509	500	NM1	Purchased Service Provider Name	S	1	
512	525	REF	Purchased Service Provider Secondary Identification	S	5	
			LOOP ID - 2420C SERVICE FACILITY LOCATION			**1**
514	500	NM1	Service Facility Location	S	1	
517	510	N2	Additional Service Facility Location Name Information	S	1	
518	514	N3	Service Facility Location Address	R	1	
519	520	N4	Service Facility Location City/State/ZIP	R	1	
521	525	REF	Service Facility Location Secondary Identification	S	5	
			LOOP ID - 2420D SUPERVISING PROVIDER NAME			**1**
523	500	NM1	Supervising Provider Name	S	1	
526	510	N2	Additional Supervising Provider Name Information	S	1	
527	525	REF	Supervising Provider Secondary Identification	S	5	
			LOOP ID - 2420E ORDERING PROVIDER NAME			**1**
529	500	NM1	Ordering Provider Name	S	1	
532	510	N2	Additional Ordering Provider Name Information	S	1	
533	514	N3	Ordering Provider Address	S	1	
534	520	N4	Ordering Provider City/State/ZIP Code	S	1	

536	525	REF	Ordering Provider Secondary Identification	S	5	
538	530	PER	Ordering Provider Contact Information	S	1	
			LOOP ID - 2420F REFERRING PROVIDER NAME			2
541	500	NM1	Referring Provider Name	S	1	
544	505	PRV	Referring Provider Specialty Information	S	1	
546	510	N2	Additional Referring Provider Name Information	S	1	
547	525	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2420G OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER			4
549	500	NM1	Other Payer Prior Authorization or Referral Number	S	1	
552	525	REF	Other Payer Prior Authorization or Referral Number	R	2	
			LOOP ID - 2430 LINE ADJUDICATION INFORMATION			25
554	540	SVD	Line Adjudication Information	S	1	
558	545	CAS	Line Adjustment	S	99	
566	550	DTP	Line Adjudication Date	R	1	
			LOOP ID - 2440 FORM IDENTIFICATION CODE			5
567	551	LQ	Form Identification Code	S	1	
569	552	FRM	Supporting Documentation	R	99	
572	555	SE	Transaction Set Trailer	R	1	

STANDARD

837 Health Care Claim

Functional Group ID: HC

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
005	ST	Transaction Set Header	M	1	
010	BHT	Beginning of Hierarchical Transaction	M	1	
015	REF	Reference Identification	O	3	
		LOOP ID - 1000			10
020	NM1	Individual or Organizational Name	O	1	
025	N2	Additional Name Information	O	2	
030	N3	Address Information	O	2	
035	N4	Geographic Location	O	1	
040	REF	Reference Identification	O	2	
045	PER	Administrative Communications Contact	O	2	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
001	HL	Hierarchical Level	M	1	
003	PRV	Provider Information	O	1	
005	SBR	Subscriber Information	O	1	
007	PAT	Patient Information	O	1	
009	DTP	Date or Time or Period	O	5	
010	CUR	Currency	O	1	
		LOOP ID - 2010			10
015	NM1	Individual or Organizational Name	O	1	
020	N2	Additional Name Information	O	2	

025	N3	Address Information	O	2	
030	N4	Geographic Location	O	1	
032	DMG	Demographic Information	O	1	
035	REF	Reference Identification	O	20	
040	PER	Administrative Communications Contact	O	2	
		LOOP ID - 2300			**100**
130	CLM	Health Claim	O	1	
135	DTP	Date or Time or Period	O	150	
140	CL1	Claim Codes	O	1	
145	DN1	Orthodontic Information	O	1	
150	DN2	Tooth Summary	O	35	
155	PWK	Paperwork	O	10	
160	CN1	Contract Information	O	1	
165	DSB	Disability Information	O	1	
170	UR	Peer Review Organization or Utilization Review	O	1	
175	AMT	Monetary Amount	O	40	
180	REF	Reference Identification	O	30	
185	K3	File Information	O	10	
190	NTE	Note/Special Instruction	O	20	
195	CR1	Ambulance Certification	O	1	
200	CR2	Chiropractic Certification	O	1	
205	CR3	Durable Medical Equipment Certification	O	1	
210	CR4	Enteral or Parenteral Therapy Certification	O	3	
215	CR5	Oxygen Therapy Certification	O	1	
216	CR6	Home Health Care Certification	O	1	
219	CR8	Pacemaker Certification	O	1	
220	CRC	Conditions Indicator	O	100	
231	HI	Health Care Information Codes	O	25	
240	QTY	Quantity	O	10	
241	HCP	Health Care Pricing	O	1	
		LOOP ID - 2305			**6**
242	CR7	Home Health Treatment Plan Certification	O	1	
243	HSD	Health Care Services Delivery	O	12	
		LOOP ID - 2310			**9**
250	NM1	Individual or Organizational Name	O	1	
255	PRV	Provider Information	O	1	
260	N2	Additional Name Information	O	2	
265	N3	Address Information	O	2	
270	N4	Geographic Location	O	1	
271	REF	Reference Identification	O	20	
275	PER	Administrative Communications Contact	O	2	
		LOOP ID - 2320			**10**
290	SBR	Subscriber Information	O	1	
295	CAS	Claims Adjustment	O	99	
300	AMT	Monetary Amount	O	15	
305	DMG	Demographic Information	O	1	
310	OI	Other Health Insurance Information	O	1	
315	MIA	Medicare Inpatient Adjudication	O	1	
320	MOA	Medicare Outpatient Adjudication	O	1	
		LOOP ID - 2330			**10**
325	NM1	Individual or Organizational Name	O	1	
330	N2	Additional Name Information	O	2	
332	N3	Address Information	O	2	
340	N4	Geographic Location	O	1	
345	PER	Administrative Communications Contact	O	2	

350	DTP	Date or Time or Period	O	9	
355	REF	Reference Identification	O	3	
		LOOP ID - 2400			>1
365	LX	Assigned Number	O	1	
370	SV1	Professional Service	O	1	
375	SV2	Institutional Service	O	1	
380	SV3	Dental Service	O	1	
382	TOO	Tooth Identification	O	32	
385	SV4	Drug Service	O	1	
400	SV5	Durable Medical Equipment Service	O	1	
405	SV6	Anesthesia Service	O	1	
410	SV7	Drug Adjudication	O	1	
415	HI	Health Care Information Codes	O	25	
420	PWK	Paperwork	O	10	
425	CR1	Ambulance Certification	O	1	
430	CR2	Chiropractic Certification	O	5	
435	CR3	Durable Medical Equipment Certification	O	1	
440	CR4	Enteral or Parenteral Therapy Certification	O	3	
445	CR5	Oxygen Therapy Certification	O	1	
450	CRC	Conditions Indicator	O	3	
455	DTP	Date or Time or Period	O	15	
460	QTY	Quantity	O	5	
462	MEA	Measurements	O	20	
465	CN1	Contract Information	O	1	
470	REF	Reference Identification	O	30	
475	AMT	Monetary Amount	O	15	
480	K3	File Information	O	10	
485	NTE	Note/Special Instruction	O	10	
488	PS1	Purchase Service	O	1	
490	IMM	Immunization Status Code	O	>1	
491	HSD	Health Care Services Delivery	O	1	
492	HCP	Health Care Pricing	O	1	
		LOOP ID - 2410			>1
494	LIN	Item Identification	O	1	
495	CTP	Pricing Information	O	1	
496	REF	Reference Identification	O	1	
		LOOP ID - 2420			10
500	NM1	Individual or Organizational Name	O	1	
505	PRV	Provider Information	O	1	
510	N2	Additional Name Information	O	2	
514	N3	Address Information	O	2	
520	N4	Geographic Location	O	1	
525	REF	Reference Identification	O	20	
530	PER	Administrative Communications Contact	O	2	
		LOOP ID - 2430			>1
540	SVD	Service Line Adjudication	O	1	
545	CAS	Claims Adjustment	O	99	
550	DTP	Date or Time or Period	O	9	
		LOOP ID - 2440			>1
551	LQ	Industry Code	O	1	
552	FRM	Supporting Documentation	M	99	
555	SE	Transaction Set Trailer	M	1	

NOTES:

1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.

2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

2/195 The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

2/250 Loop 2310 contains information about the rendering, referring, or attending provider.

2/290 Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.

2/325 Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

2/365 Loop 2400 contains Service Line information.

2/425 The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

2/494 Loop 2410 contains compound drug components, quantities and prices.

2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

2/540 SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.

2/551 Loop 2440 provides certificate of medical necessity information for the procedure identified in SV101 in position 2/370.

2/552 FRM segment provides question numbers and responses for the questions on the medical necessity information form identified in LQ position 551.

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **ST*837*987654~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 005

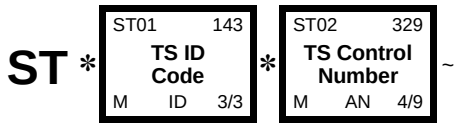
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **The only valid value within this transaction set for ST01 is 837.** **837 Health Care Claim** **REQUIRED**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set ***ALIAS:*** ***Transaction Set Control Number*** **The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.**	**M AN 4/9**

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. The second example denotes the case where the entire transaction set contains ENCOUNTERS.**

Example: **BHT*0019*00*0123*19970618*0932*CH~**

Example: **BHT*0019*00*44445*19970213*0345*RP~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 010

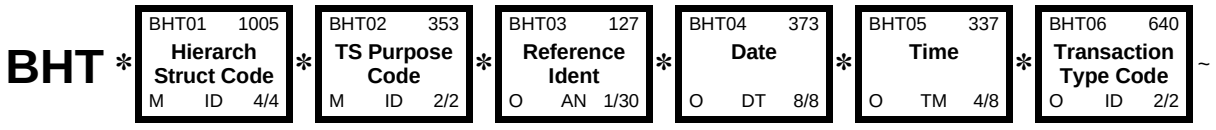
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**BHT01**	**1005**	**Hierarchical Structure Code** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	**M ID 4/4**

CODE	DEFINITION
0019	**Information Source, Subscriber, Dependent**

REQUIRED **BHT02** **353** **Transaction Set Purpose Code** **M ID 2/2**
Code identifying purpose of transaction set

ALIAS: ***Transaction Set Purpose Code***

NSF Reference:

AA0-23.0

BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status.

ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original.

REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.

CODE	DEFINITION
00	**Original**
18	**Reissue**

REQUIRED **BHT03** **127** **Reference Identification** **O AN 1/30**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Originator Application Transaction Identifier***

SEMANTIC: BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.

NSF Reference:

AA0-05.0

The inventory file number of the tape or transmission assigned by the submitter's system. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.

REQUIRED **BHT04** **373** **Date** **O DT 8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Transaction Set Creation Date***

SEMANTIC: BHT04 is the date the transaction was created within the business application system.

NSF Reference:

AA0-15.0

Identifies the date that the submitter created the file.

REQUIRED **BHT05** **337** **Time** **O** **TM** **4/8**

Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)

INDUSTRY: ***Transaction Set Creation Time***

SEMANTIC: BHT05 is the time the transaction was created within the business application system.

NSF Reference:

AA0-16.0

Use this time to identify the time of day that the submitter created the file.

REQUIRED **BHT06** **640** **Transaction Type Code** **O** **ID** **2/2**

Code specifying the type of transaction

INDUSTRY: ***Claim or Encounter Identifier***

ALIAS: ***Claim or Encounter Indicator***

Although this element is required, submitters are not necessarily required to accurately batch claims and encounters at this level. Generally CH is used for claims and RP is used for encounters. However, if an ST-SE envelope contains both claims and encounters use CH. Some trading partner agreements may specify using only one code.

CODE	DEFINITION
CH	**Chargeable** **Use this code when the transaction contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction contains claims or encounters, or if the transaction contains a mix of claims and encounters, the developers of this implementation guide recommend using code CH.**
RP	**Reporting** **Use RP when the entire ST-SE envelope contains encounters.** **Use RP when the transaction is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.**

IMPLEMENTATION

TRANSMISSION TYPE IDENTIFICATION

Usage: **REQUIRED**

Repeat: **1**

Example: **REF*87*004010X098D~**

STANDARD

REF Reference Identification

Level: Header

Position: 015

Loop: ____

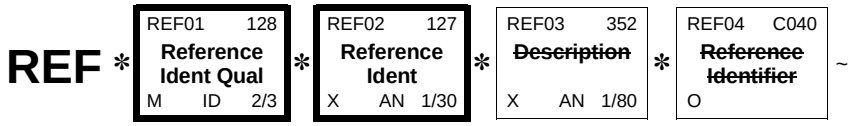
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **87 Functional Category**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Transmission Type Code*** SYNTAX: R0203 **When piloting the transaction set, this value is 004010X098D. When sending the transaction set in a production mode, this value is 004010X098.**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

SUBMITTER NAME

Loop: **1000A — SUBMITTER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **The example in this NM1 and the subsequent N2 demonstrate how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.**
2. **See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.**
3. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*41*2*CRAMMER, DOLE, PALMER, AND JOHANSON*****46*W7933THU~**

STANDARD

NM1 Individual or Organizational Name

Level: Header

Position: 020

Loop: 1000 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

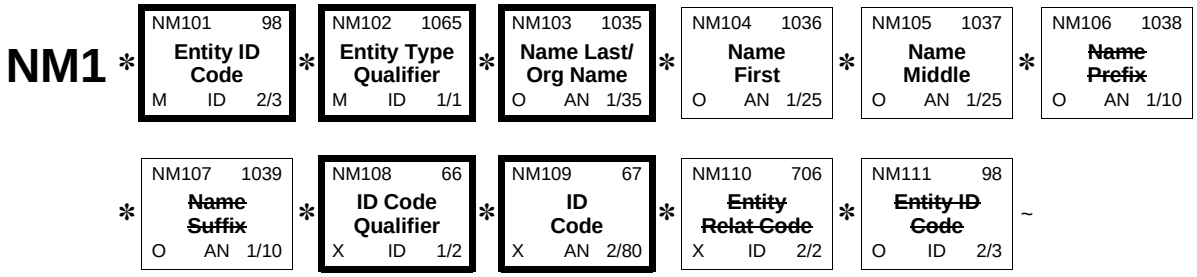
Set Notes:

1. Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: 41 — DEFINITION: Submitter	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Submitter Last or Organization Name*** *ALIAS:* ***Submitter Name*** **NSF Reference:** **AA0-06.0**	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY:* ***Submitter First Name*** *ALIAS:* ***Submitter Name*** **Required if NM102=1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Submitter Middle Name*** *ALIAS:* ***Submitter Name*** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: 46 — DEFINITION: Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement.	X ID 1/2

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Submitter Identifier*** *ALIAS:* ***Submitter Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **AA0-02.0, ZA0-02.0**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL SUBMITTER NAME INFORMATION

Loop: **1000A — SUBMITTER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*N ASSOCIATES, INC~**

STANDARD

N2 Additional Name Information

Level: Header

Position: 025

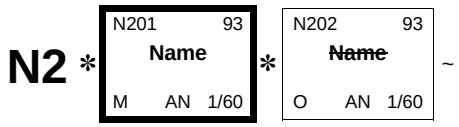
Loop: 1000

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name	**M**	**AN**	**1/60**
			INDUSTRY: ***Additional Submitter Name***			
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SUBMITTER EDI CONTACT INFORMATION

Loop: **1000A — SUBMITTER NAME**

Usage: **REQUIRED**

Repeat: **2**

Notes:

1. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g., (534) 224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

2. **The contact information in this segment should point to the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization.**

3. **There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.**

Example: **PER*IC*JANE DOE*TE*9005555555~**

STANDARD

PER Administrative Communications Contact

Level: Header

Position: 045

Loop: 1000

Requirement: Optional

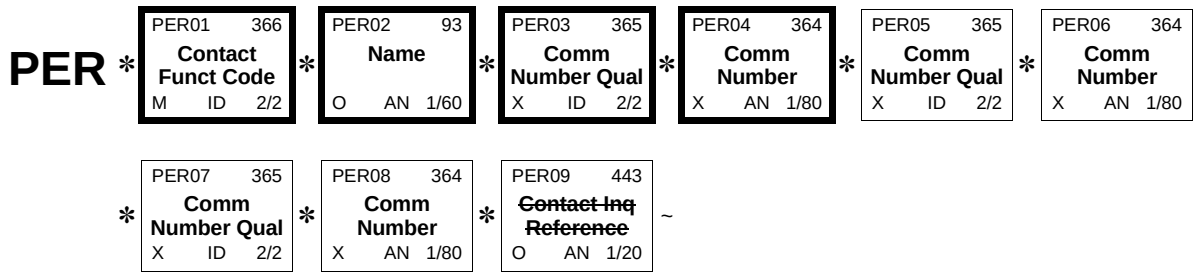
Max Use: 2

Purpose: To identify a person or office to whom administrative communications should be directed

Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.
2. **P0506**
   If either PER05 or PER06 is present, then the other is required.
3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			CODE: **IC** — DEFINITION: **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Submitter Contact Name*** **NSF Reference:** **AA0-13.0** **Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).**	**O AN 1/60**
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304	**X ID 2/2**
			CODE: **ED** — DEFINITION: **Electronic Data Interchange Access Number**	
			CODE: **EM** — DEFINITION: **Electronic Mail**	
			CODE: **FX** — DEFINITION: **Facsimile**	
			CODE: **TE** — DEFINITION: **Telephone**	
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0304 **NSF Reference:** **AA0-14.0**	**X AN 1/80**

SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Used at the discretion of the submitter.**	**X**	**ID**	**2/2**

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **Used at the discretion of the submitter.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Used at the discretion of the submitter.**	**X**	**ID**	**2/2**

CODE	DEFINITION
ED	**Electronic Data Interchange Access Number**
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708 **Used at the discretion of the submitter.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

RECEIVER NAME

Loop: **1000B — RECEIVER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*40*2*UNION MUTUAL OF OREGON*****46*11122333~**

STANDARD

NM1 Individual or Organizational Name

Level: Header

Position: 020

Loop: 1000 **Repeat:** 10

Requirement: Optional

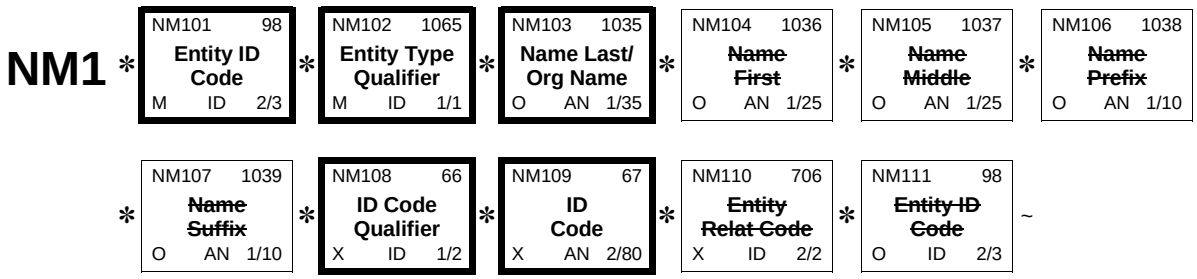
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:
1. Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: 40 — DEFINITION: Receiver	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 2 — DEFINITION: Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Receiver Name***	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: 46 — DEFINITION: Electronic Transmitter Identification Number (ETIN)	X ID 1/2
REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code *INDUSTRY: **Receiver Primary Identifier*** *ALIAS: **Receiver Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **AA0-17.0, ZA0-04.0**	X AN 2/80
NOT USED	NM110	706	**Entity Relationship Code**	X ID 2/2
NOT USED	NM111	98	**Entity Identifier Code**	O ID 2/3

IMPLEMENTATION

RECEIVER ADDITIONAL NAME INFORMATION

Loop: **1000B — RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2✻ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Header

Position: 025

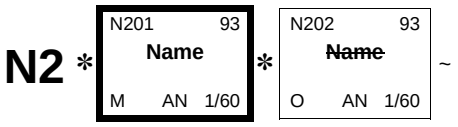
Loop: 1000

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Receiver Additional Name*** *ALIAS:* ***Receiver Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL

Loop: **2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL Repeat: >1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.**

2. **The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims.**

3. **The Billing/Pay-to Provider HL may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.**

4. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

5. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops, there is an implied maximum of 5000.**

6. **If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.**

Example: **HL*1**20*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

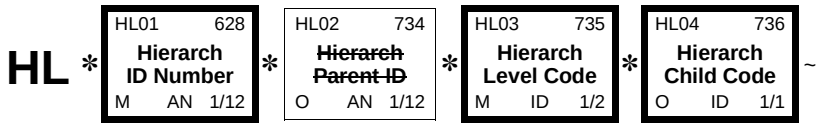
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. **HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.**	**M AN 1/12**
NOT USED	**HL02**	**734**	**Hierarchical Parent ID Number**	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure **COMMENT:** HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **CODE** **DEFINITION** **20** **Information Source**	**M ID 1/2**
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described **COMMENT:** HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. **CODE** **DEFINITION** **1** **Additional Subordinate HL Data Segment in This Hierarchical Structure.**	**O ID 1/1**

IMPLEMENTATION

BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION

Loop: **2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the Rendering Provider is the same entity as the Billing Provider and/or the Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.**
2. **This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*BI*ZZ*203BA050N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 003

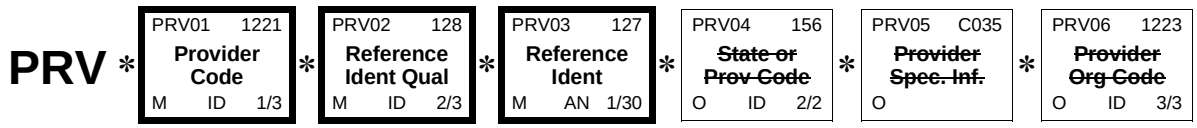
Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**

CODE	DEFINITION
BI	**Billing**
PT	**Pay-To**

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN**	**1/30**

INDUSTRY: ***Provider Taxonomy Code***

ALIAS: ***Provider Specialty Code***

NSF Reference:

BA0-22.0

NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

FOREIGN CURRENCY INFORMATION

Loop: **2000A — BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The CUR segment is required if financial amounts submitted in this ST-SE envelop are for services provided in a currency that is NOT normally used by the receiver for processing claims. For example, claims submitted by United States (U.S.) providers to U.S. receivers are assumed to be in U.S. dollars. Claims submitted by Canadian providers to Canadian receivers are assumed to be in Canadian dollars. Claims submitted by Canadian providers to U.S. receivers are assumed to be in Canadian dollars. In that case the CUR would be used to indicate that the billed amounts are in Canadian dollars.**

   In cases where COB is involved, adjudicated adjustments and amounts must also be in the currency indicated here.

Example: **CUR*85*CAN~**

STANDARD

CUR Currency

Level: Detail

Position: 010

Loop: 2000

Requirement: Optional

Max Use: 1

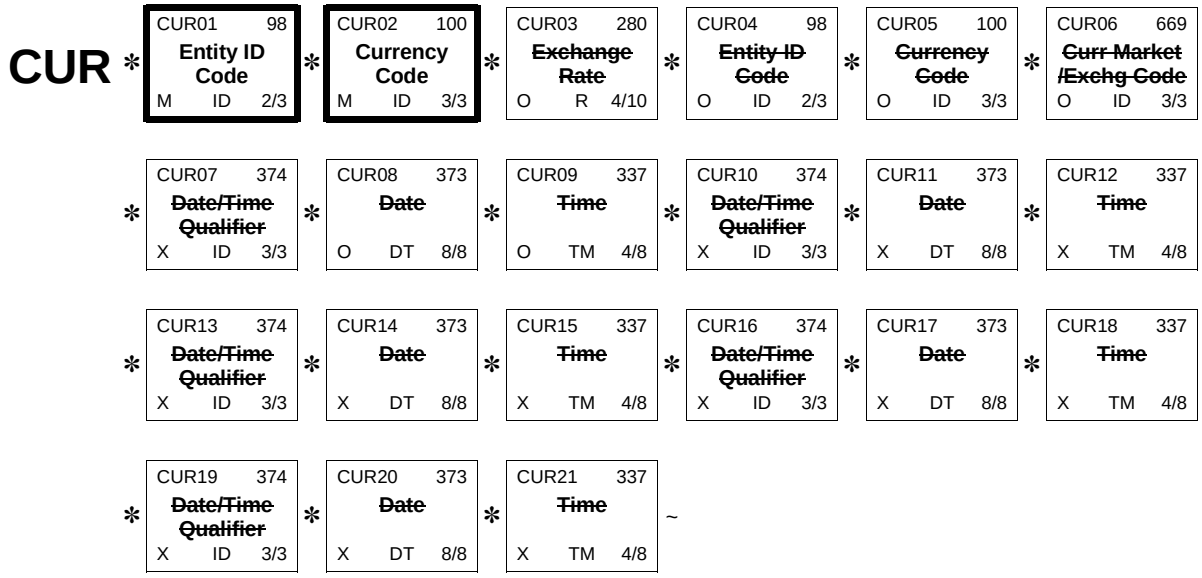
Purpose: To specify the currency (dollars, pounds, francs, etc.) used in a transaction

Syntax:

1. **C0807**
   If CUR08 is present, then CUR07 is required.
2. **C0907**
   If CUR09 is present, then CUR07 is required.
3. **L101112**
   If CUR10 is present, then at least one of CUR11 or CUR12 are required.
4. **C1110**
   If CUR11 is present, then CUR10 is required.
5. **C1210**
   If CUR12 is present, then CUR10 is required.
6. **L131415**
   If CUR13 is present, then at least one of CUR14 or CUR15 are required.
7. **C1413**
   If CUR14 is present, then CUR13 is required.

8. **C1513**
   If CUR15 is present, then CUR13 is required.
9. **L161718**
   If CUR16 is present, then at least one of CUR17 or CUR18 are required.
10. **C1716**
    If CUR17 is present, then CUR16 is required.
11. **C1816**
    If CUR18 is present, then CUR16 is required.
12. **L192021**
    If CUR19 is present, then at least one of CUR20 or CUR21 are required.
13. **C2019**
    If CUR20 is present, then CUR19 is required.
14. **C2119**
    If CUR21 is present, then CUR19 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CUR01**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION **85** / **Billing Provider**	**M ID 2/3**
REQUIRED	**CUR02**	**100**	**Currency Code** Code (Standard ISO) for country in whose currency the charges are specified **CODE SOURCE 5:** Countries, Currencies and Funds	**M ID 3/3**
NOT USED	**CUR03**	**280**	**Exchange Rate**	**O R 4/10**

NOT USED	CUR04	98	Entity Identifier Code	O	ID	2/3
NOT USED	CUR05	100	Currency Code	O	ID	3/3
NOT USED	CUR06	669	Currency Market/Exchange Code	O	ID	3/3
NOT USED	CUR07	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR08	373	Date	O	DT	8/8
NOT USED	CUR09	337	Time	O	TM	4/8
NOT USED	CUR10	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR11	373	Date	X	DT	8/8
NOT USED	CUR12	337	Time	X	TM	4/8
NOT USED	CUR13	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR14	373	Date	X	DT	8/8
NOT USED	CUR15	337	Time	X	TM	4/8
NOT USED	CUR16	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR17	373	Date	X	DT	8/8
NOT USED	CUR18	337	Time	X	TM	4/8
NOT USED	CUR19	374	Date/Time Qualifier	X	ID	3/3
NOT USED	CUR20	373	Date	X	DT	8/8
NOT USED	CUR21	337	Time	X	TM	4/8

IMPLEMENTATION

BILLING PROVIDER NAME

Loop: 2010AA — BILLING PROVIDER NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

Notes:

1. **Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.**

2. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: NM1*85*2*CRAMMER, DOLE, PALMER, AND JOHNANSE***24*111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

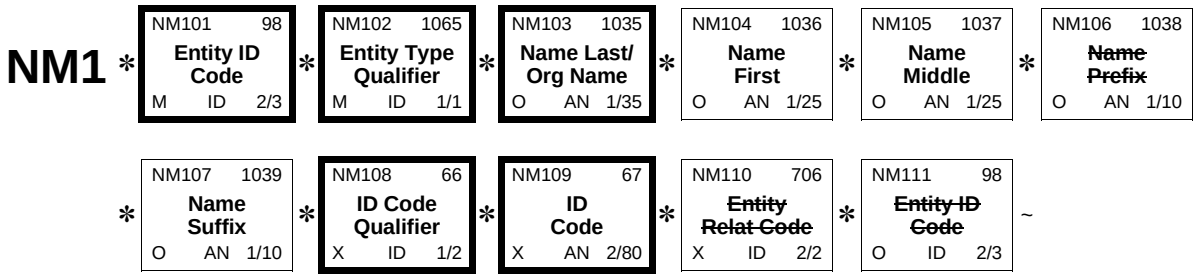
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: **85** — DEFINITION: **Billing Provider** **Use this code to indicate billing provider, billing submitter, and encounter reporting entity.**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE: **1** — DEFINITION: **Person** CODE: **2** — DEFINITION: **Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Billing Provider Last or Organizational Name*** *ALIAS:* ***Billing Provider Name*** **NSF Reference:** **BA0-18.0 or BA0-19.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Billing Provider First Name*** *ALIAS:* ***Billing Provider Name*** **NSF Reference:** **BA0-20.0** **Required if NM102=1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Billing Provider Middle Name*** *ALIAS:* ***Billing Provider Name*** **NSF Reference:** **BA0-21.0** **Required if NM102=1 and the middle name/initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Billing Provider Name Suffix***

ALIAS: ***Billing Provider Name***

Required if known.

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Billing Provider Identifier***

ALIAS: ***Billing Provider Primary Identification Number***

SYNTAX: P0809

NSF Reference:

BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL BILLING PROVIDER NAME INFORMATION

Loop: **2010AA — BILLING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*N ASSOCIATES, INC~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

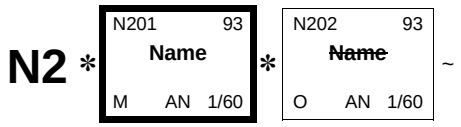
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name	**M**	**AN**	**1/60**
			INDUSTRY: ***Billing Provider Additional Name***			
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

BILLING PROVIDER ADDRESS

Loop: **2010AA — BILLING PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N3*225 MAIN STREET*BARKLEY BUILDING~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

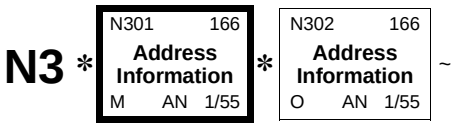
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Billing Provider Address Line*** *ALIAS:* ***Billing Provider Address 1*** **NSF Reference:** **BA1-07.0, BA1-13.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Billing Provider Address Line*** *ALIAS:* ***Billing Provider Address 2*** **NSF Reference:** **BA1-08.0, BA1-14.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

BILLING PROVIDER CITY/STATE/ZIP CODE

Loop: **2010AA — BILLING PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N4*CENTERVILLE*PA*17111~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

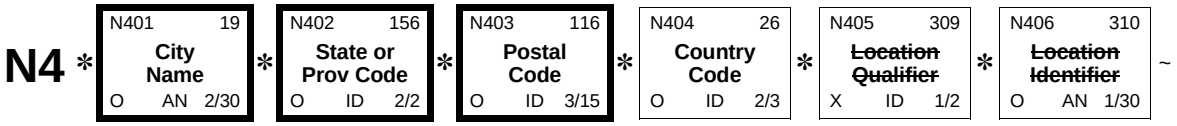
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Billing Provider City Name*** *ALIAS:* ***Billing Provider's City*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **BA1-09.0, BA1-15.0**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Billing Provider State or Province Code*** *ALIAS:* ***Billing Provider's State*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **NSF Reference:** **BA1-10.0, BA1-16.0**	**O**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Billing Provider Postal Zone or ZIP Code*** *ALIAS:* ***Billing Provider's Zip Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **BA1-11.0, BA1-17.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Billing Provider Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

BILLING PROVIDER SECONDARY IDENTIFICATION

Loop: **2010AA — BILLING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **8**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/9 in this loop.**
2. **If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.**
3. **If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.**

Example: **REF*1G*98765~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

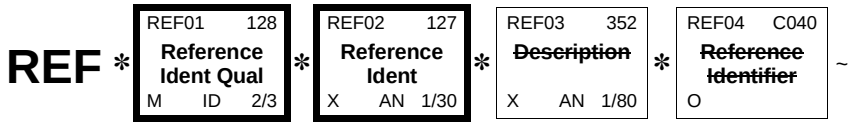
Max Use: 20

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M ID 2/3

CODE	DEFINITION
0B	State License Number
1A	Blue Cross Provider Number
1B	Blue Shield Provider Number
1C	Medicare Provider Number
1D	Medicaid Provider Number
1G	Provider UPIN Number
1H	CHAMPUS Identification Number
1J	Facility ID Number
B3	Preferred Provider Organization Number
BQ	Health Maintenance Organization Code Number
EI	Employer's Identification Number
FH	Clinic Number
G2	Provider Commercial Number
G5	Provider Site Number
LU	Location Number
SY	Social Security Number The social security number may not be used for Medicare.
U3	Unique Supplier Identification Number (USIN)
X5	State Industrial Accident Provider Number

REQUIRED	REF02	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Billing Provider Additional Identifier*** *ALIAS:* ***Billing Provider Secondary Identification Number*** SYNTAX: R0203 **NSF Reference:** **CA0-28.0, BA0-02.0, BA1-02.0, YA0-06.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, BA0-08.0, YA0-02.0**	X AN 1/30
NOT USED	REF03	352	**Description**	X AN 1/80

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

CREDIT/DEBIT CARD BILLING INFORMATION

Loop: **2010AA — BILLING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **8**

Notes:

1. **See Appendix G for use of this segment.**
2. **The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.**

Example: **REF*8U*1112223333~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

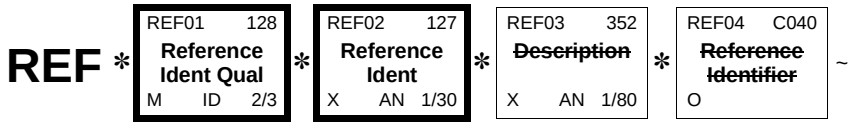
Max Use: 20

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
06	**System Number**
8U	**Bank Assigned Security Identifier**
EM	**Electronic Payment Reference Number**
IJ	**Standard Industry Classification (SIC) Code**

			LU	**Location Number**			
			RB	**Rate code number**			
			ST	**Store Number**			
			TT	**Terminal Code**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Billing Provider Credit Card Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

BILLING PROVIDER CONTACT INFORMATION

Loop: **2010AA — BILLING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Required if this information is different that that contained in the Loop 1000A - Submitter PER segment.**

2. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g., (534) 224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

3. **There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.**

Example: **PER*IC*JIM*TE*8007775555~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 040

Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To identify a person or office to whom administrative communications should be directed

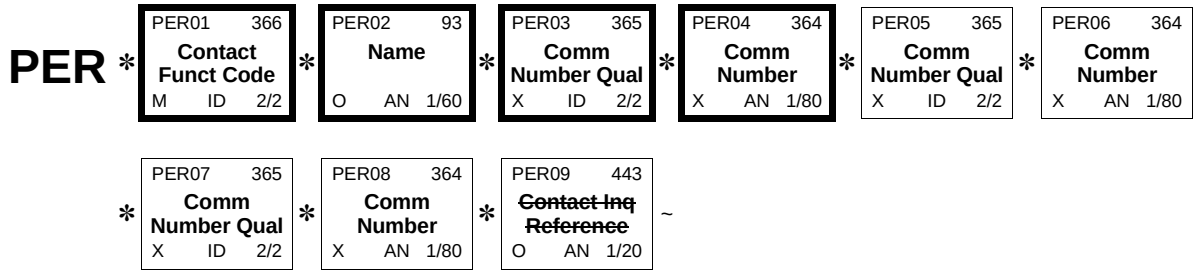
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			CODE: **IC** — DEFINITION: **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name	**O AN 1/60**
			INDUSTRY: ***Billing Provider Contact Name***	
			Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X ID 2/2**
			SYNTAX: P0304	
			CODE: **EM** — DEFINITION: **Electronic Mail**	
			CODE: **FX** — DEFINITION: **Facsimile**	
			CODE: **TE** — DEFINITION: **Telephone**	
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X AN 1/80**
			SYNTAX: P0304	
			NSF Reference:	
			BA1-12.0, BA1-18.0	
SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X ID 2/2**
			SYNTAX: P0506	
			Used at the discretion of the billing provider.	
			CODE: **EM** — DEFINITION: **Electronic Mail**	

			EX **Telephone Extension**			
			FX **Facsimile**			
			TE **Telephone**			
SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506	**X**	**AN**	**1/80**
			Used at the discretion of the billing provider.			
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708	**X**	**ID**	**2/2**
			Used at the discretion of the billing provider.			
			CODE DEFINITION			
			EM **Electronic Mail**			
			EX **Telephone Extension**			
			FX **Facsimile**			
			TE **Telephone**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708	**X**	**AN**	**1/80**
			Used at the discretion of the billing provider.			
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

PAY-TO PROVIDER NAME

Loop: **2010AB — PAY-TO PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the Pay-to Provider is a different entity than the Billing Provider.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*87*1*CRAMMER*JOSEPH****XX*09876543~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

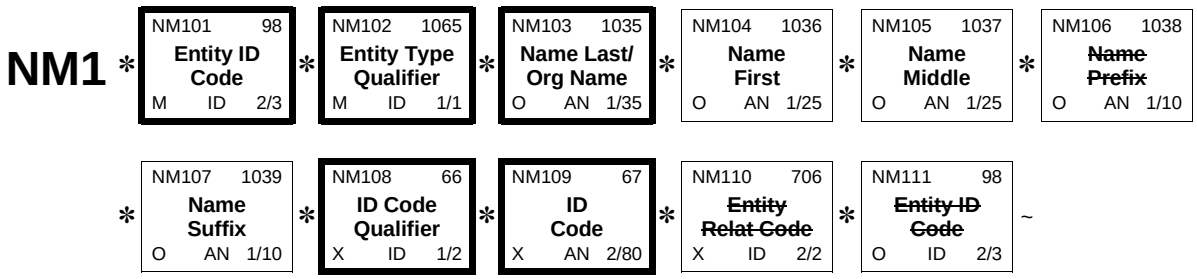
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: 87 — DEFINITION: Pay-to Provider	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person If Person is used and if the pay-to provider is the same person as the rendering provider, it is not necessary to use the Rendering Provider NM1 loop at the claim loop (Loop ID-2300). CODE: 2 — DEFINITION: Non-Person Entity If Non-Person Entity is used then the rendering provider NM1 loop (Loop ID-2310B) must be used when appropriate to identify the person who rendered the services.	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: ***Pay-to Provider Last or Organizational Name*** **NSF Reference:** **BA0-18.0 or BA0-19.0**	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name INDUSTRY: ***Pay-to Provider First Name*** **NSF Reference:** **BA0-20.0** **Required if NM102=1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial INDUSTRY: ***Pay-to Provider Middle Name*** **NSF Reference:** **BA0-21.0** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Pay-to Provider Name Suffix***

Required if known.

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for Medicare.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Pay-to Provider Identifier***

ALIAS: ***Pay-to Provider Primary Identification Number***

SYNTAX: P0809

NSF Reference:

BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL PAY-TO PROVIDER NAME INFORMATION

Loop: **2010AB — PAY-TO PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

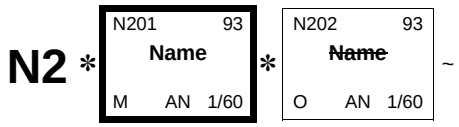
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name	**M**	**AN**	**1/60**
			INDUSTRY: ***Pay-to Provider Additional Name***			
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

PAY-TO PROVIDER ADDRESS

Loop: **2010AB — PAY-TO PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N3*225 MAIN STREET*BARKLEY BUILDING~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

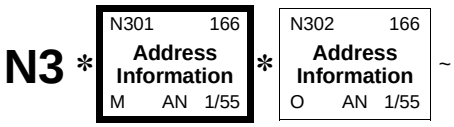
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Pay-to Provider Address Line*** *ALIAS:* ***Pay-to Provider Address 1*** **NSF Reference:** **BA1-13.0, BA1-07.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Pay-to Provider Address Line*** *ALIAS:* ***Pay-to Provider Address 2*** **NSF Reference:** **BA1-14.0, BA1-08.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

PAY-TO PROVIDER CITY/STATE/ZIP CODE

Loop: **2010AB — PAY-TO PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N4*CENTERVILLE*PA*17111~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

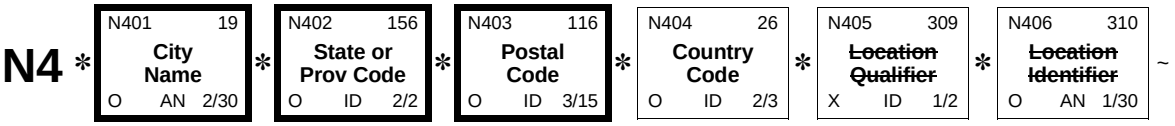
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Pay-to Provider City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **BA1-15.0, BA1-09.0**	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Pay-to Provider State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **NSF Reference:** **BA1-16.0, BA1-10.0**	**O ID 2/2**

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Pay-to Provider Postal Zone or ZIP Code*** *ALIAS:* ***Pay-to Provider Zip Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **BA1-17.0, BA1-11.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Pay-to Provider Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PAY-TO-PROVIDER SECONDARY IDENTIFICATION

Loop: **2010AB — PAY-TO PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

2. **If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 5 times.**

Example: **REF*1G*98765~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

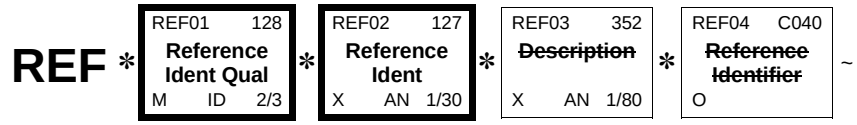
Max Use: 20

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**

			1B	**Blue Shield Provider Number**			
			1C	**Medicare Provider Number**			
			1D	**Medicaid Provider Number**			
			1G	**Provider UPIN Number**			
			1H	**CHAMPUS Identification Number**			
			1J	**Facility ID Number**			
			B3	**Preferred Provider Organization Number**			
			BQ	**Health Maintenance Organization Code Number**			
			EI	**Employer's Identification Number**			
			FH	**Clinic Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			U3	**Unique Supplier Identification Number (USIN)**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Pay-to Provider Identifier*** *ALIAS:* ***Pay-to Provider Additional Identifier*** SYNTAX: R0203 **NSF Reference:** **BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SUBSCRIBER HIERARCHICAL LEVEL

Loop: **2000B — SUBSCRIBER HIERARCHICAL LEVEL Repeat: >1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.**

2. **The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BB), and responsible party (Loop ID-2010BC). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BD). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.**

3. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

4. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Subscriber Hierarchical Level loops, there is an implied maximum of 5000.**

Example: **HL*2*1*22*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

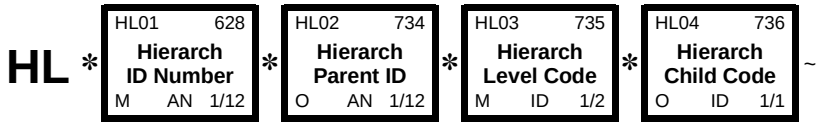
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M ID 1/2**

CODE	DEFINITION
22	**Subscriber**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. **The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0) or when HL04 has subordinate levels indicated (HL04 = 1).** **In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims. The second case (HL04 = 1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04 = 1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) would then be run and the 2300 loop for the dependent/patient would be run after that HL. HL04=1 would also be used when a claim/encounter for a only a dependent is being sent.**	**O ID 1/1**

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**
1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

SUBSCRIBER INFORMATION

Loop: **2000B — SUBSCRIBER HIERARCHICAL LEVEL**

Usage: **REQUIRED**

Repeat: **1**

Example: **SBR*P**GRP01020102******MB~**

STANDARD

SBR Subscriber Information

Level: Detail

Position: 005

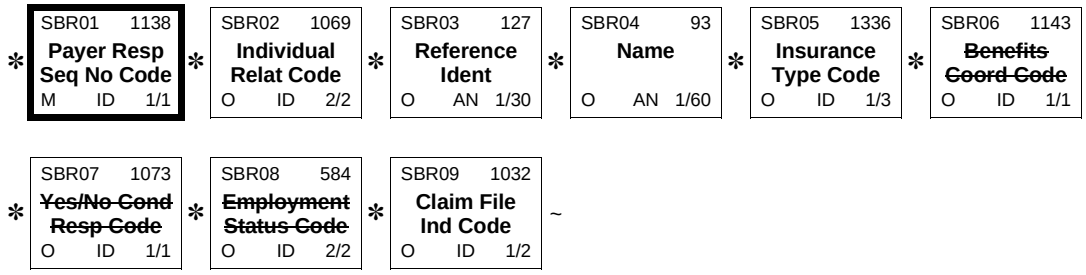
Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim *ALIAS:* ***Payer Responsibility Sequence Number Code*** **NSF Reference:** **DA1-02.0, DA0-02.0, DA2-02.0**	**M ID 1/1**

CODE	DEFINITION
P	**Primary**
S	**Secondary**
T	**Tertiary** **Use to indicate 'payer of last resort'.**

SITUATIONAL **SBR02** **1069** **Individual Relationship Code** **O** **ID** **2/2**
Code indicating the relationship between two individuals or entities

ALIAS: ***Relationship Code***

SEMANTIC: SBR02 specifies the relationship to the person insured.

NSF Reference:

DA0-17.0

Required when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element.

CODE	DEFINITION
18	**Self**

SITUATIONAL **SBR03** **127** **Reference Identification** **O** **AN** **1/30**
Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

INDUSTRY: ***Insured Group or Policy Number***

ALIAS: ***Group or Policy Number***

SEMANTIC: SBR03 is policy or group number.

NSF Reference:

DA0-10.0

Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).

SITUATIONAL **SBR04** **93** **Name** **O** **AN** **1/60**
Free-form name

INDUSTRY: ***Insured Group Name***

ALIAS: ***Group or Plan Name***

SEMANTIC: SBR04 is plan name.

NSF Reference:

DA0-11.0

Required if the subscriber's payer identification includes a Group or Plan Name.

SITUATIONAL **SBR05** **1336** **Insurance Type Code** **O** **ID** **1/3**
Code identifying the type of insurance policy within a specific insurance program

ALIAS: ***Insurance type code***

NSF Reference:

DA0-06.0

Required when the destination payer (Loop 2010BB) is Medicare and Medicare is not the primary payer (SBR01 equals "S" or "T").

CODE	DEFINITION
12	**Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan**

13	Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan
14	Medicare Secondary, No-fault Insurance including Auto is Primary
15	Medicare Secondary Worker's Compensation
16	Medicare Secondary Public Health Service (PHS)or Other Federal Agency
41	Medicare Secondary Black Lung
42	Medicare Secondary Veteran's Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Insurance is Primary

NOT USED	SBR06	1143	Coordination of Benefits Code	O	ID	1/1
NOT USED	SBR07	1073	Yes/No Condition or Response Code	O	ID	1/1
NOT USED	SBR08	584	Employment Status Code	O	ID	2/2
SITUATIONAL	SBR09	1032	Claim Filing Indicator Code Code identifying type of claim	O	ID	1/2

ALIAS: ***Claim Filing Indicator Code***

Required prior to mandated used of PlanID. Not used after PlanID is mandated.

CODE	DEFINITION
09	Self-pay
10	Central Certification NSF Reference: CA0-23.0 (K), DA0-05.0 (K)
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield NSF Reference: CA0-23.0 (G), DA0-05.0 (G), CA0-23.0 (P), DA0-05.0 (P)

CH	**Champus** NSF Reference: **CA0-23.0 (H), DA0-05.0 (H)**
CI	**Commercial Insurance Co.** NSF Reference: **CA0-23.0 (F), DA0-05.0 (F)**
DS	**Disability**
HM	**Health Maintenance Organization** NSF Reference: **CA0-23.0 (I), DA0-05.0 (I)**
LI	**Liability**
LM	**Liability Medical**
MB	**Medicare Part B** NSF Reference: **CA0-23.0 (C), DA0-05.0 (C)**
MC	**Medicaid** NSF Reference: **CA0-23.0 (D), DA0-05.0 (D)**
OF	**Other Federal Program** NSF Reference: **CA0-23.0 (E), DA0-05.0 (E)**
TV	**Title V** NSF Reference: **DA0-05.0 (T)**
VA	**Veteran Administration Plan** **Refers to Veteran's Affairs Plan.** NSF Reference: **DA0-05.0 (V)**
WC	**Workers' Compensation Health Claim** NSF Reference: **CA0-23.0 (B), DA0-05.0 (B)**
ZZ	**Mutually Defined** **Unknown** NSF Reference: **CA0-23.0 (Z), DA0-05.0 (Z)**

IMPLEMENTATION

PATIENT INFORMATION

Loop: **2000B — SUBSCRIBER HIERARCHICAL LEVEL**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if the subscriber is the same person as the patient (Loop ID-2000B SBR02=18), and information in this PAT segment (date of death, and/or patient weight) is necessary to file the claim/encounter (see PAT05, 06, 07, and 08).**

Example: **PAT*****D8*19970314*01*146~**

STANDARD

PAT Patient Information

Level: Detail

Position: 007

Loop: 2000

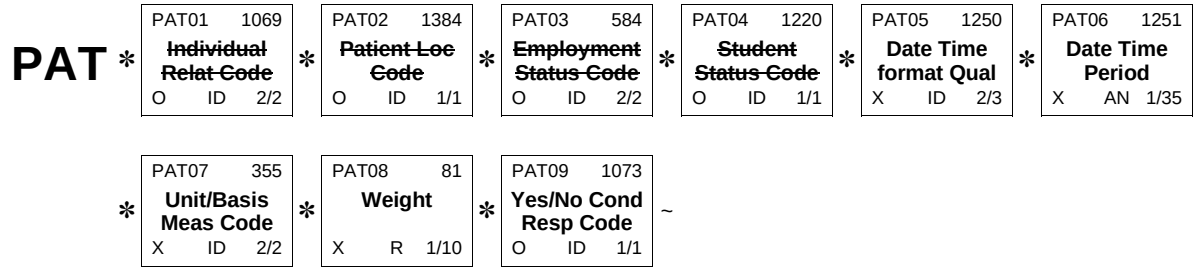
Requirement: Optional

Max Use: 1

Purpose: To supply patient information

Syntax:
1. **P0506**
   If either PAT05 or PAT06 is present, then the other is required.
2. **P0708**
   If either PAT07 or PAT08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
NOT USED	PAT01	1069	Individual Relationship Code	O	ID	2/2
NOT USED	PAT02	1384	Patient Location Code	O	ID	1/1
NOT USED	PAT03	584	Employment Status Code	O	ID	2/2
NOT USED	PAT04	1220	Student Status Code	O	ID	1/1

SITUATIONAL **PAT05** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

SYNTAX: P0506

Required if patient is known to be deceased.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

SITUATIONAL **PAT06** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Insured Individual Death Date***

ALIAS: ***Date of Death***

SYNTAX: P0506

SEMANTIC: PAT06 is the date of death.

NSF Reference:

CA0-21.0

Required if patient is known to be deceased.

SITUATIONAL **PAT07** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0708

Required on claims/encounters for delivery services (newborn's birthweight).

CODE	DEFINITION
GR	**Gram** **This data element is used when the patient's age is less than 29 days old.**

SITUATIONAL **PAT08** **81** **Weight** **X** **R** **1/10**
Numeric value of weight

INDUSTRY: ***Patient Weight***

SYNTAX: P0708

SEMANTIC: PAT08 is the patient's weight.

NSF Reference:

FA0-44.0, GU0-17.0

This data element is used when the patient's age is less than 29 days. Required on (1) claims/encounters for delivery services (newborn's birthweight) and (2) claims/encounters involving EPO (epoetin) for patients on dialysis and Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02.

SITUATIONAL	**PAT09**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Pregnancy Indicator***

SEMANTIC: PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant; code "N" indicates the patient is not pregnant.

Required when required by state law (e.g., Indiana Medicaid). The "Y" code indicates the patient/subscriber is pregnant. If PAT09 is not used it indicates that the patient/subscriber is not pregnant.

CODE	DEFINITION
Y	**Yes**

IMPLEMENTATION

SUBSCRIBER NAME

Loop: **2010BA — SUBSCRIBER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.**
2. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*IL*1*DOE*JOHN*T**JR*MI*123456~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

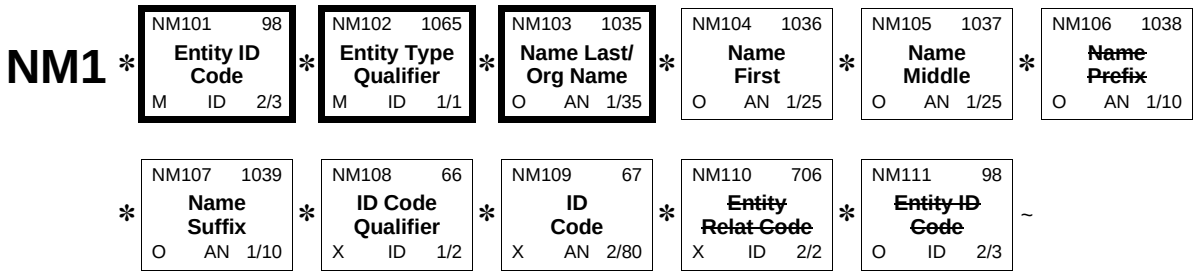
Set Notes:

1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: IL — DEFINITION: Insured or Subscriber	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Subscriber Last Name*** **NSF Reference:** **CA0-04.0, DA0-19.0**	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY:* ***Subscriber First Name*** **NSF Reference:** **CA0-05.0, DA0-20.0** **Required if NM102=1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Subscriber Middle Name*** **NSF Reference:** **CA0-06.0, DA0-21.0** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Subscriber Name Suffix*** *ALIAS:* ***Subscriber Generation*** **NSF Reference:** **CA0-07.0, DA0-22.0** **Required if known.** **Examples: I, II, III, IV, Jr, Sr**	O AN 1/10

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Required if NM102 = 1 (person)

CODE	DEFINITION
MI	**Member Identification Number** **The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.** **MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State).** **In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: ***Subscriber Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **DA0-18.0, CA1-05.0, CA1-06.0** **Required if NM102 = 1 (person)**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL SUBSCRIBER NAME INFORMATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

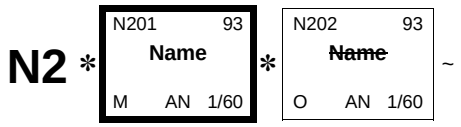
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Subscriber Supplemental Description*** *ALIAS:* ***Subscriber's Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).**

Example: **N3*125 CITY AVENUE~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

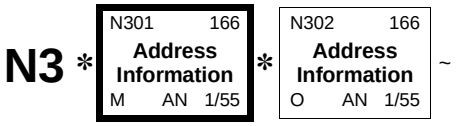
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Subscriber Address Line*** *ALIAS:* ***Subscriber Address 1*** **NSF Reference:** **CA0-11.0, DA2-04.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Subscriber Address Line*** *ALIAS:* ***Subscriber Address 2*** **NSF Reference:** **CA0-12.0, DA2-05.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).**

Example: **N4*CENTERVILLE*PA*17111~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

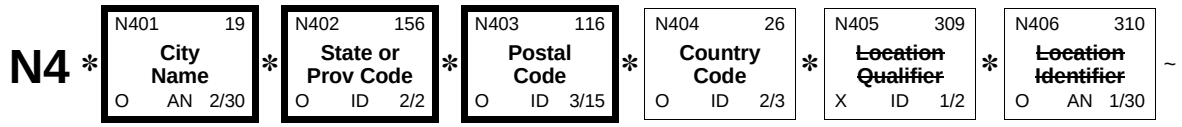
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Subscriber City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **DA2-06.0, CA0-13.0**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Subscriber State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **NSF Reference:** **CA0-14.0, DA2-07.0**	**O**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Subscriber Postal Zone or ZIP Code*** *ALIAS:* ***Subscriber Zip Code*** **CODE SOURCE 51:** ZIP Code **NSF Reference:** **CA0-15.0, DA2-08.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Subscriber Country Code*** **CODE SOURCE 5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).**

Example: **DMG*D8*19330706*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 032

Loop: 2010

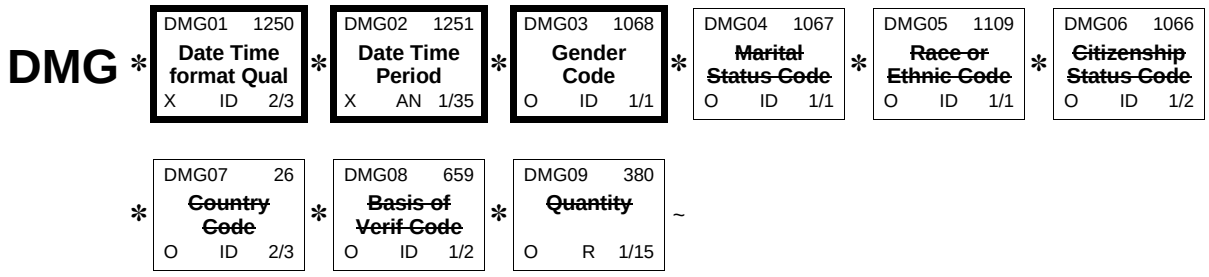
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

Syntax: **1. P0102**
If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102 CODE / DEFINITION **D8** / **Date Expressed in Format CCYYMMDD**	**X ID 2/3**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Subscriber Birth Date*** *ALIAS:* ***Date of Birth - Patient*** SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth. **NSF Reference:** **CA0-08.0, DA0-24.0**	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Subscriber Gender Code*** *ALIAS:* ***Gender - Patient*** **NSF Reference:** **CA0-09.0, DA0-23.0**	**O**	**ID**	**1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

IMPLEMENTATION

SUBSCRIBER SECONDARY IDENTIFICATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **4**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*SY*528446666~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

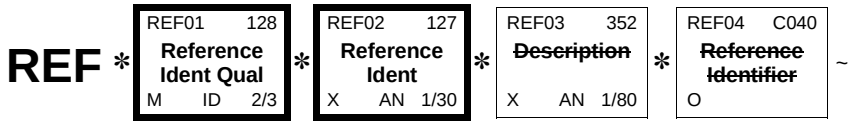
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = M1 do not use this code.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**

			IG	**Insurance Policy Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Subscriber Supplemental Identifier*** **SYNTAX:** R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place.**

2. **This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.**

Example: **REF*Y4*4445555~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

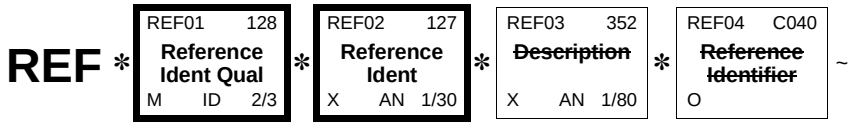
Max Use: 20

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
Y4	**Agency Claim Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier ***INDUSTRY:*** ***Property Casualty Claim Number*** **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

PAYER NAME

Loop: **2010BB — PAYER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **This is the destination payer.**
2. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*PR*2*UNION MUTUAL OF OREGON*****PI*11122333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

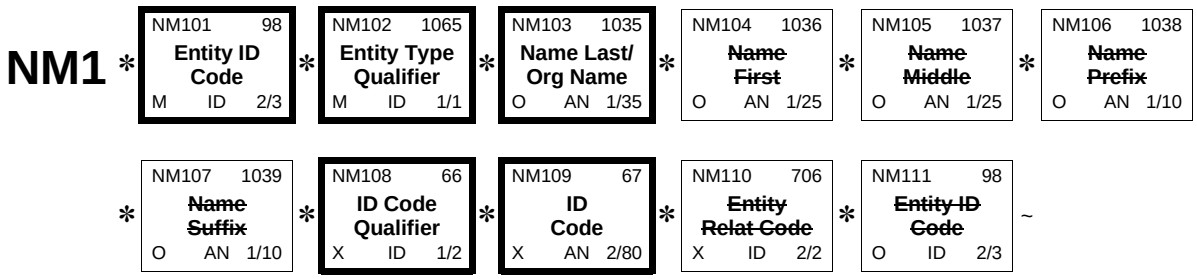
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	M ID 2/3
			CODE: **PR** — DEFINITION: **Payer**	
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE: **2** — DEFINITION: **Non-Person Entity**	
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Payer Name*** **NSF Reference:** **DA0-09.0**	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	X ID 1/2
			CODE: **PI** — DEFINITION: **Payor Identification**	
			CODE: **XV** — DEFINITION: **Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***	
			CODE SOURCE **540:** Health Care Financing Administration National PlanID	
REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payer Identifier*** *ALIAS:* ***Payer Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **DA0-07.0**	X AN 2/80
NOT USED	NM110	706	**Entity Relationship Code**	X ID 2/2

NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

IMPLEMENTATION

ADDITIONAL PAYER NAME INFORMATION

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

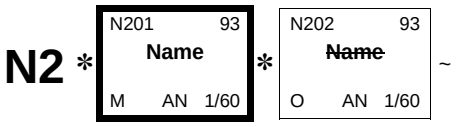
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Payer Additional Name*** *ALIAS:* ***Payer Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

PAYER ADDRESS

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).**

Example: **N3*225 MAIN STREET*BARKLEY BUILDING~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

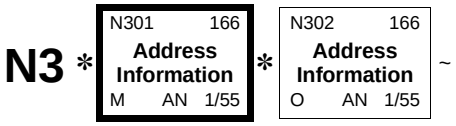
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Payer Address Line*** *ALIAS:* ***Payer Address 1*** **NSF Reference:** **DA1-04.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Payer Address Line*** *ALIAS:* ***Payer Address 2*** **NSF Reference:** **DA1-05.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

PAYER CITY/STATE/ZIP CODE

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).**

Example: **N4*CENTERVILLE*PA*17111~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

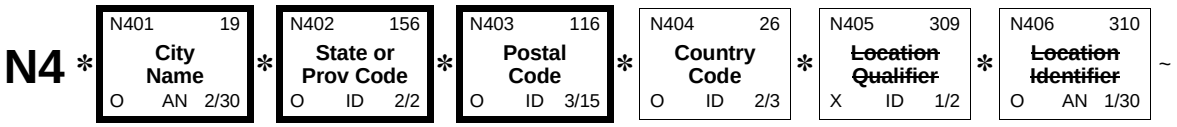
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Payer City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **DA1-06.0**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Payer State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **NSF Reference:** **DA1-07.0**	**O**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Payer Postal Zone or ZIP Code*** *ALIAS:* ***Payer Zip Code*** **CODE SOURCE 51:** ZIP Code **NSF Reference:** **DA1-08.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Payer Country Code*** **CODE SOURCE 5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PAYER SECONDARY IDENTIFICATION

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. Required if additional identification numbers other than the primary identification number in NM108/09 in this loop are necessary to adjudicate the claim/encounter.**

Example: **REF*FY*435261708~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

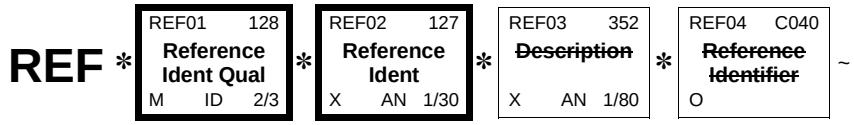
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
2U	**Payer Identification Number** **Used to identify any payer.**
FY	**Claim Office Number**
NF	**National Association of Insurance Commissioners (NAIC) Code**
	CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code
TJ	**Federal Taxpayer's Identification Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Additional Identifier*** SYNTAX: R0203 **NSF Reference:** **DA0-08.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

RESPONSIBLE PARTY NAME

Loop: **2010BC — RESPONSIBLE PARTY NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **In general terms, the responsible party is someone who is not the subscriber/patient but who has financial responsibility for the bill.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

3. **Required for Medicare claims where there is a representative but the provider of medical services has neither the responsible party's signature nor the patient's signature on file.**

   When a Medicare beneficiary is unable to execute a request for payment because of a mental or physical condition, the request may be executed on the beneficiary's behalf by a legal guardian, representative payee, relative, friend, an employee of the institution providing care, or an employee of a governmental agency providing assistance. In this circumstance, unless the requester is a representative payee for the beneficiary, the claim must show the signature and address of the requester with an attached statement explaining the relationship between the requester and the beneficiary, and why the beneficiary can't sign. This information must be on the claim unless it is on file with the provider.

Example: **NM1*QD*1*JONES*LISA~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

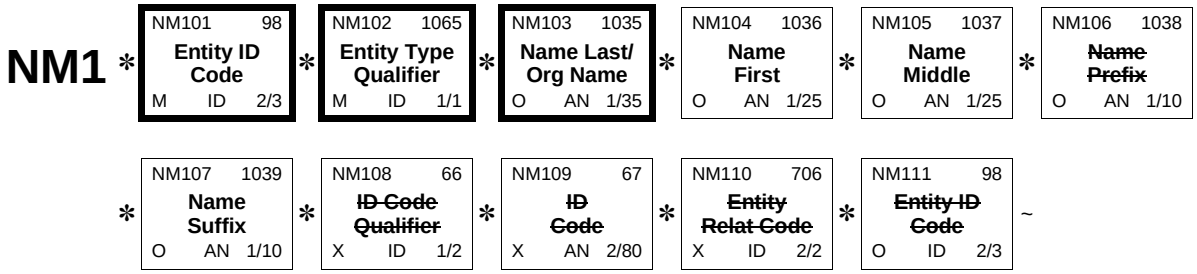
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **NSF Reference:** **CA0-25.0** CODE: **QD** — DEFINITION: **Responsible Party**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE: **1** — DEFINITION: **Person** CODE: **2** — DEFINITION: **Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* Responsible Party Last or Organization Name*** **NSF Reference:** **CB0-04.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:* Responsible Party First Name*** **NSF Reference:** **CB0-05.0** **Required if NM102=1 (person).**	**O AN 1/25**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Responsible Party Middle Name*** **NSF Reference:** **CB0-06.0** **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Responsible Party Suffix Name*** *ALIAS:* ***Responsible Party Generation*** **Required if known.**	**O**	**AN**	**1/10**
NOT USED	**NM108**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**
NOT USED	**NM109**	**67**	**Identification Code**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL RESPONSIBLE PARTY NAME INFORMATION

Loop: **2010BC — RESPONSIBLE PARTY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

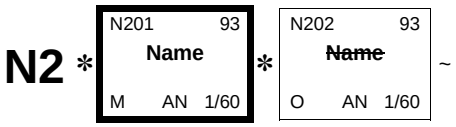
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Responsible Party Additional Name*** *ALIAS:* ***Responsible Party Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RESPONSIBLE PARTY ADDRESS

Loop: **2010BC — RESPONSIBLE PARTY NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N3*123 MAIN STREET~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

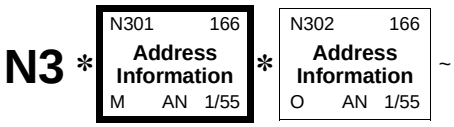
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Responsible Party Address Line*** *ALIAS:* ***Responsible Party Address 1*** **NSF Reference:** **CB0-07.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Responsible Party Address Line*** *ALIAS:* ***Responsible Party Address 2*** **NSF Reference:** **CB0-08.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

RESPONSIBLE PARTY CITY/STATE/ZIP CODE

Loop: **2010BC — RESPONSIBLE PARTY NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N4*ANY TOWN*TX*75123~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

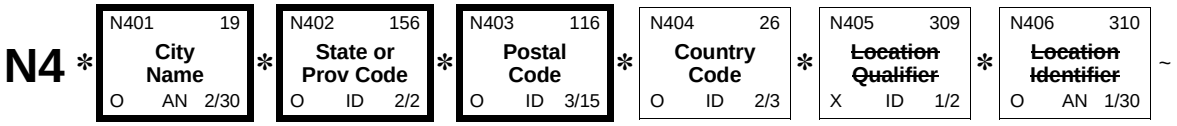
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Responsible Party City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **CB0-09.0**	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Responsible Party State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **NSF Reference:** **CB0-10.0**	**O ID 2/2**

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Responsible Party Postal Zone or ZIP Code*** *ALIAS:* ***Responsible Party Zip Code*** **CODE SOURCE 51:** ZIP Code **NSF Reference:** **CB0-11.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Responsible Party Country Code*** **CODE SOURCE 5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

CREDIT/DEBIT CARD HOLDER NAME

Loop: 2010BD — CREDIT/DEBIT CARD HOLDER NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **It is not intended that credit/debit card information be conveyed to a health care payer. Trading partners are responsible for ensuring that no federal or state privacy regulations are violated if credit/debit card information is carried in the transmission.**

2. **The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.**

Example: NM1*AO*1*SMITH*JANE*L*MI*000000000000000000~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

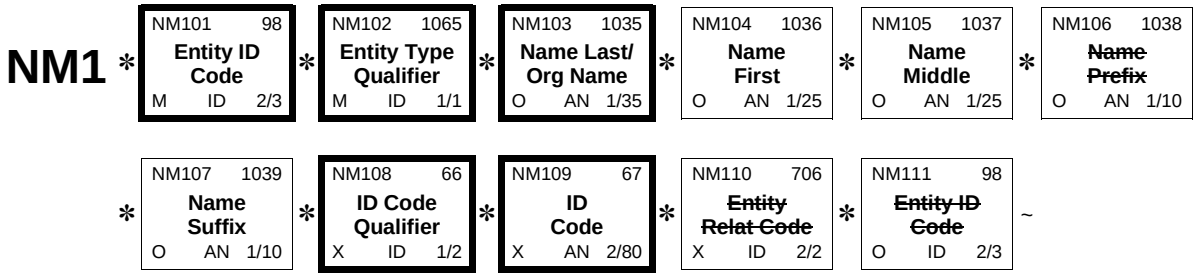
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: **AO** — DEFINITION: **Account Of**	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: **1** — DEFINITION: **Person** CODE: **2** — DEFINITION: **Non-Person Entity**	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Credit or Debit Card Holder Last or Organizational Name*** *ALIAS: **Credit/Debit Card Holder Name***	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY: **Credit or Debit Card Holder First Name*** *ALIAS: **Credit/Debit Card Holder Name*** **Required if NM102=1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Credit or Debit Card Holder Middle Name*** *ALIAS: **Credit/Debit Card Holder Name*** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY: **Credit or Debit Card Holder Name Suffix*** *ALIAS: **Credit/Debit Card Holder Name*** **Required if known.**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: **MI** — DEFINITION: **Member Identification Number**	X ID 1/2

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Credit or Debit Card Number*** *ALIAS:* ***Credit/Debit Card Number*** SYNTAX: P0809	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL CREDIT/DEBIT CARD HOLDER NAME INFORMATION

Loop: **2010BD — CREDIT/DEBIT CARD HOLDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

2. **The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.**

Example: **N2*ADDITIONAL NAME~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

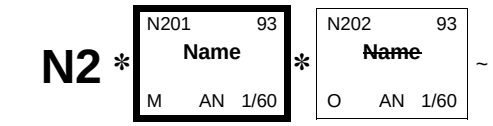
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Credit or Debit Card Holder Additional Name*** *ALIAS:* ***Credit-Debit Card Holder Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

CREDIT/DEBIT CARD INFORMATION

Loop: **2010BD — CREDIT/DEBIT CARD HOLDER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:
1. **The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.**

Example: **REF*BB*111222333334~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

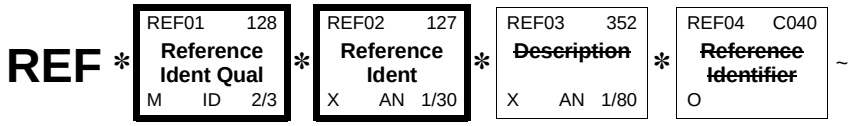
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **AB** — **Acceptable Source Purchaser ID** **BB** — **Authorization Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Credit or Debit Card Authorization Number*** SYNTAX: R0203	**X AN 1/30**

NOT USED	REF03	352	Description	X	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O		

IMPLEMENTATION

PATIENT HIERARCHICAL LEVEL

Loop: **2000C — PATIENT HIERARCHICAL LEVEL Repeat: >1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This HL is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

3. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Patient Hierarchical Level loops, there is an implied maximum of 5000.**

Example: **HL*3*2*23*0~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

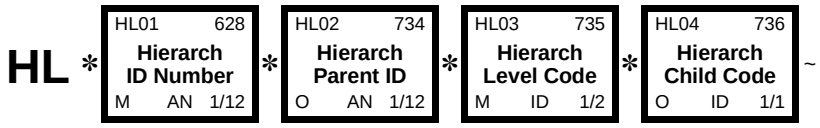
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

Purpose: To identify dependencies among and the content of hierarchically related groups of data segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	**M ID 1/2**

CODE	DEFINITION
23	**Dependent** **The code DEPENDENT is meant to convey that the information in this HL applies to the patient when the subscriber and the patient are not the same person.**

REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	**O ID 1/1**

CODE	DEFINITION
0	**No Subordinate HL Segment in This Hierarchical Structure.**

IMPLEMENTATION

PATIENT INFORMATION

Loop: **2000C — PATIENT HIERARCHICAL LEVEL**

Usage: **REQUIRED**

Repeat: **1**

Example: **PAT*01*****01*145~**

STANDARD

PAT Patient Information

Level: Detail

Position: 007

Loop: 2000

Requirement: Optional

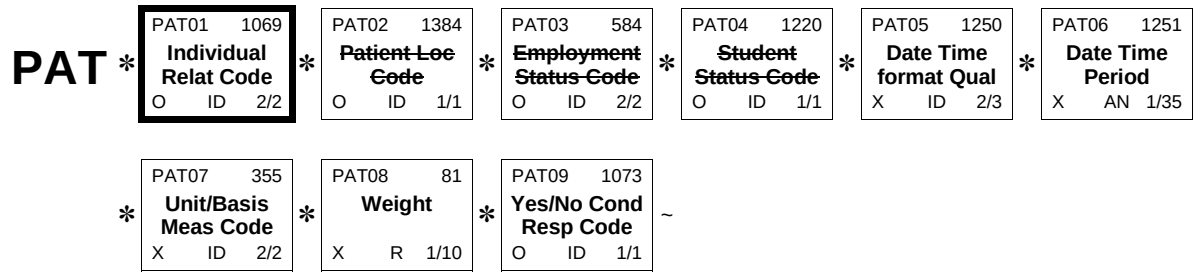
Max Use: 1

Purpose: To supply patient information

Syntax:

1. **P0506**
   If either PAT05 or PAT06 is present, then the other is required.
2. **P0708**
   If either PAT07 or PAT08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PAT01**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities *ALIAS:* ***Patients Relationship to Insured*** **NSF Reference:** **DA0-17.0**	**O ID 2/2**

CODE	DEFINITION
01	**Spouse**
04	**Grandfather or Grandmother**

05	Grandson or Granddaughter
07	Nephew or Niece
09	Adopted Child
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
G8	Other Relationship

NOT USED	PAT02	1384	Patient Location Code	O	ID	1/1
NOT USED	PAT03	584	Employment Status Code	O	ID	2/2
NOT USED	PAT04	1220	Student Status Code	O	ID	1/1
SITUATIONAL	PAT05	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X	ID	2/3

SYNTAX: P0506

Required if patient is known to be deceased.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD

SITUATIONAL **PAT06** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Patient Death Date***

ALIAS: ***Date of Death***

SYNTAX: P0506

SEMANTIC: PAT06 is the date of death.

NSF Reference:

CA0-21.0

Required if patient is known to be deceased.

SITUATIONAL **PAT07** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0708

Required on claims/encounters for delivery services (newborn's birthweight).

CODE	DEFINITION
GR	**Gram** **This data element is used when the patient's age is less than 29 days old.**

SITUATIONAL **PAT08** **81** **Weight** **X** **R** **1/10**
Numeric value of weight

INDUSTRY: ***Patient Weight***

SYNTAX: P0708

SEMANTIC: PAT08 is the patient's weight.

NSF Reference:

FA0-44.0, GU0-17.0

Required on claims/encounters where the patient's age is less than 29 days.

SITUATIONAL **PAT09** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Pregnancy Indicator***

SEMANTIC: PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant; code "N" indicates the patient is not pregnant.

Required when required by state law (e.g., Indiana Medicaid). The "Y" code indicates that the patient is pregnant. If PAT09 is not used it means the patient is not pregnant.

CODE	DEFINITION
Y	**Yes**

IMPLEMENTATION

PATIENT NAME

Loop: **2010CA — PATIENT NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*DOE*SALLY*J***MI*SJD11111~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

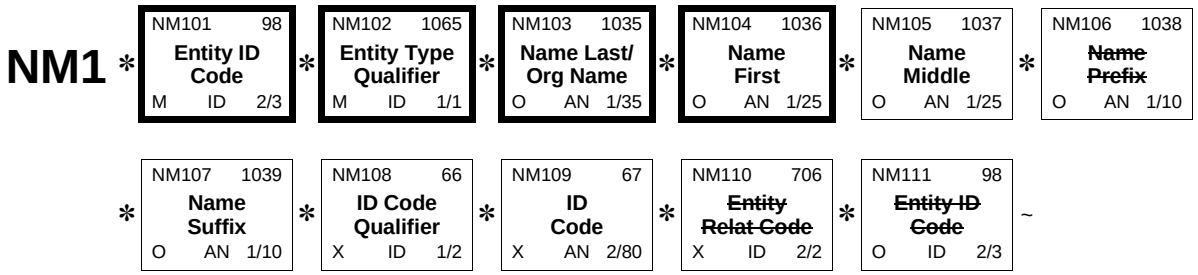
Set Notes:

1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**

CODE	DEFINITION
QC	**Patient**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**O**	**AN**	**1/35**

INDUSTRY: ***Patient Last Name***

NSF Reference:

CA0-04.0

REQUIRED	**NM104**	**1036**	**Name First** Individual first name	**O**	**AN**	**1/25**

INDUSTRY: ***Patient First Name***

NSF Reference:

CA0-05.0

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Patient Middle Name***

ALIAS: ***Patient Middle Initial***

NSF Reference:

CA0-06.0

Required if NM102=1 and the middle name/initial of the person is known.

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Patient Name Suffix***

ALIAS: ***Patient Generation***

NSF Reference:

CA0-07.0

Required if known.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if the patient identifier is different than the subscriber identifier.**	**X**	**ID**	**1/2**

CODE	DEFINITION
MI	**Member Identification Number** **The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: ***Patient Primary Identifier*** ALIAS: ***Patient's Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **DA0-18.0** **Required if the patient identifier is different than the subscriber identifier.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL PATIENT NAME INFORMATION

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

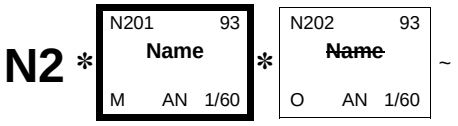
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Patient Additional Name*** *ALIAS:* ***Patient Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

PATIENT ADDRESS

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N3*RFD 10*100 COUNTRY LANE~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

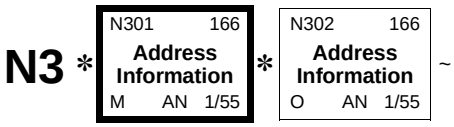
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Patient Address Line*** *ALIAS:* ***Patient Address 1*** **NSF Reference:** **CA0-11.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Patient Address Line*** *ALIAS:* ***Patient Address 2*** **NSF Reference:** **CA0-12.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

PATIENT CITY/STATE/ZIP CODE

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **N4*CORNFIELD TOWNSHIP*IA*99999~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

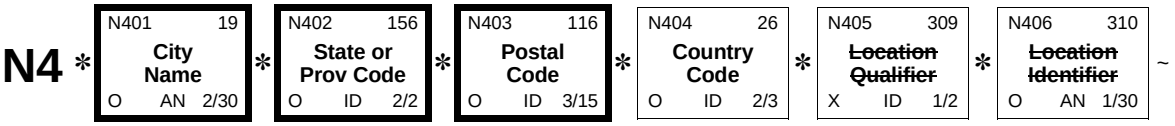
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Patient City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **CA0-13.0**	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Patient State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **NSF Reference:** **CA0-14.0**	**O ID 2/2**

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Patient Postal Zone or ZIP Code*** *ALIAS:* ***Patient Zip Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **CA0-15.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Patient Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PATIENT DEMOGRAPHIC INFORMATION

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

Example: **DMG*D8*19530101*F~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 032

Loop: 2010

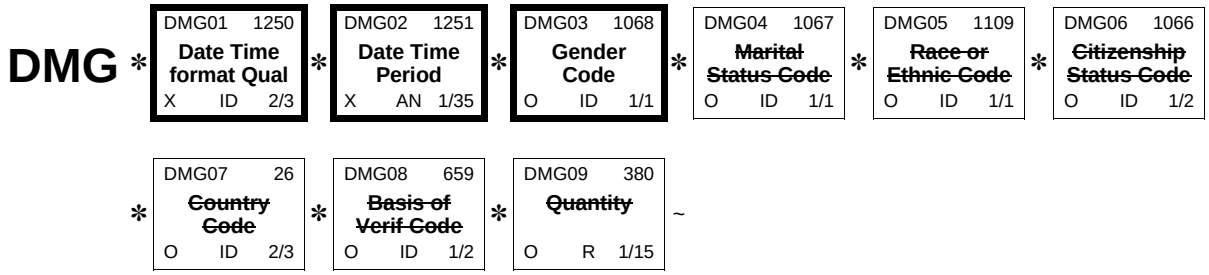
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

Syntax: **1. P0102**
If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SYNTAX:** P0102	**X ID 2/3**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Patient Birth Date***

ALIAS: ***Date of Birth***

SYNTAX: P0102

SEMANTIC: DMG02 is the date of birth.

NSF Reference:

CA0-08.0

REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual	**O**	**ID**	**1/1**

INDUSTRY: ***Patient Gender Code***

ALIAS: ***Gender - Patient***

NSF Reference:

CA0-09.0

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

IMPLEMENTATION

PATIENT SECONDARY IDENTIFICATION

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required if additional identification numbers are necessary to adjudicate the claim/encounter.**

Example: **REF*SY*528779999~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

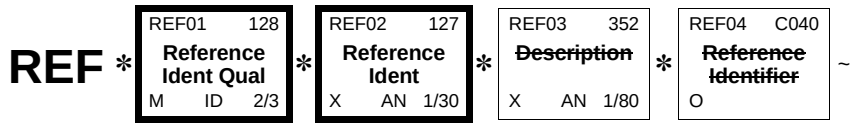
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = M1 do not use this code.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHC/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**
IG	**Insurance Policy Number**

			SY **Social Security Number** **The social security number may not be used for Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Patient Secondary Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place.**

2. **This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.**

Example: **REF*Y4*4445555~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

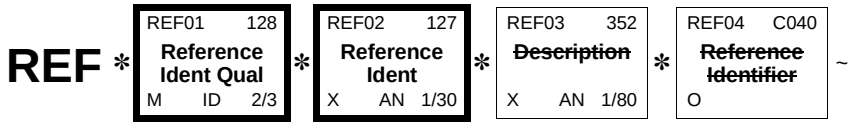
Max Use: 20

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
Y4	**Agency Claim Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Property Casualty Claim Number*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLAIM INFORMATION

Loop: **2300 — CLAIM INFORMATION Repeat: 100**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

2. **The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.**

3. **For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.**

Example: **CLM*A37YH556*500***11::1*Y*A*Y*Y*C~**

STANDARD

CLM Health Claim

Level: Detail

Position: 130

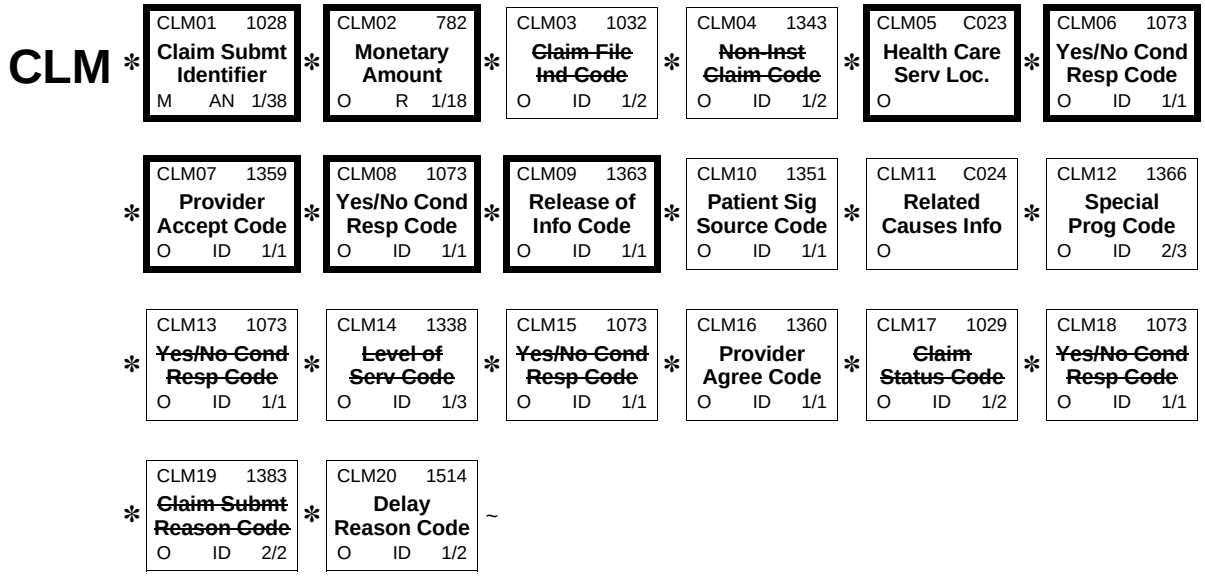
Loop: 2300 **Repeat:** 100

Requirement: Optional

Max Use: 1

Purpose: To specify basic data about the claim

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CLM01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment *INDUSTRY:* ***Patient Account Number*** **NSF Reference:** **CA0-03.0, CB0-03.0, DA0-03.0, DA1-03.0, DA2-03.0, EA0-03.0, EA1-03.0, EA2-03.0, FA0-03.0, FB0-03.0, FB1-03.0, FB2-03.0, FD0-03.0, FE0-03.0, GA0-03.0, GC0-03.0, GX0-03.0, GX2-03.0, XA0-03.0, CA1-03.0, GU0-03.0, HA0-03.0** **The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim.** **The maximum number of characters to be supported for this field is '20'. A provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored nor returned by any 837-receiving system.**	**M AN 1/38**

REQUIRED	**CLM02**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Total Claim Charge Amount***

ALIAS: ***Total Submitted Charges***

SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim.

NSF Reference:

XA0-12.0

For encounter transmissions, zero (0) may be a valid amount.

NOT USED	**CLM03**	**1032**	**Claim Filing Indicator Code**	**O**	**ID**	**1/2**
NOT USED	**CLM04**	**1343**	**Non-Institutional Claim Type Code**	**O**	**ID**	**1/2**
REQUIRED	**CLM05**	**C023**	**HEALTH CARE SERVICE LOCATION INFORMATION** To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered	**O**		

ALIAS: ***Place of Service Code***

NSF Reference:

FA0-07.0

CLM05 applies to all service lines unless it is over written at the line level.

REQUIRED **CLM05 - 1** **1331** **Facility Code Value** **M AN 1/2**
Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

INDUSTRY: ***Facility Type Code***

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- **11 Office**
- **12 Home**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **23 Emergency Room - Hospital**
- **24 Ambulatory Surgical Center**
- **25 Birthing Center**
- **26 Military Treatment Facility**
- **31 Skilled Nursing Facility**
- **32 Nursing Facility**
- **33 Custodial Care Facility**
- **34 Hospice**
- **41 Ambulance - Land**
- **42 Ambulance - Air or Water**
- **51 Inpatient Psychiatric Facility**
- **52 Psychiatric Facility Partial Hospitalization**
- **53 Community Mental Health Center**
- **54 Intermediate Care Facility/Mentally Retarded**
- **55 Residential Substance Abuse Treatment Facility**
- **56 Psychiatric Residential Treatment Center**
- **50 Federally Qualified Health Center**
- **60 Mass Immunization Center**
- **61 Comprehensive Inpatient Rehabilitation Facility**
- **62 Comprehensive Outpatient Rehabilitation Facility**
- **65 End Stage Renal Disease Treatment Facility**
- **71 State or Local Public Health Clinic**
- **72 Rural Health Clinic**
- **81 Independent Laboratory**
- **99 Other Unlisted Facility**

NOT USED **CLM05 - 2** **1332** **Facility Code Qualifier** **O ID 1/2**

REQUIRED **CLM05 - 3** **1325** **Claim Frequency Type Code** **O ID 1/1**
Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type

INDUSTRY: ***Claim Frequency Code***

ALIAS: ***Claim Submission Reason Code***

CODE SOURCE **235:** Claim Frequency Type Code

Code 8 may only be used where permitted by state law (e.g. New York Medicaid). See the NUBC UB92 manual for definitions of these codes.

With the exception of #1 (Original) use 6, 7, and 8 for claims that have already been finalized in the payer's system.

Permissible code values for this subelement:

1 - ORIGINAL (Admit thru Discharge Claim)

6 - CORRECTED (Adjustment of Prior Claim)

7 - REPLACEMENT (Replacement of Prior Claim)

8 - VOID (Void/Cancel of Prior Claim)

REQUIRED **CLM06** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Provider or Supplier Signature Indicator***

ALIAS: ***Provider Signature on File***

SEMANTIC: CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signatue is not on file.

NSF Reference:

EA0-37.0

CODE	DEFINITION
N	**No**
Y	**Yes**

REQUIRED **CLM07** **1359** **Provider Accept Assignment Code** **O** **ID** **1/1**
Code indicating whether the provider accepts assignment

INDUSTRY: ***Medicare Assignment Code***

NSF Reference:

EA0-36.0, FA0-59.0

CLM07 indicates whether the provider accepts Medicare assignment.

The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.

CODE	DEFINITION
A	**Assigned**
B	**Assignment Accepted on Clinical Lab Services Only**
C	**Not Assigned**
P	**Patient Refuses to Assign Benefits**

REQUIRED **CLM08** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Benefits Assignment Certification Indicator***

ALIAS: ***Assignment of Benefits Indicator***

SEMANTIC: CLM08 is assignment of benefits indicator. A “Y” value indicates insured or authorized person authorizes benefits to be assigned to the provider; an “N” value indicates benefits have not been assigned to the provider.

NSF Reference:

DA0-15.0

CODE	DEFINITION
N	**No**
Y	**Yes**

REQUIRED **CLM09** **1363** **Release of Information Code** **O** **ID** **1/1**
Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations

ALIAS: ***Release of Information Code***

NSF Reference:

EA0-13.0

CODE	DEFINITION
A	**Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization**
I	**Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes**
M	**The Provider has Limited or Restricted Ability to Release Data Related to a Claim**
N	**No, Provider is Not Allowed to Release Data**
O	**On file at Payor or at Plan Sponsor**
Y	**Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim**

SITUATIONAL **CLM10** **1351** **Patient Signature Source Code** **O** **ID** **1/1**
Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider

ALIAS: ***Patient Signature Source Code***

NSF Reference:

DA0-16.0

CLM10 is required except in cases where code ''N'' is used in CLM09.

CODE	DEFINITION
B	**Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file**
C	**Signed HCFA-1500 Claim Form on file**
M	**Signed signature authorization form for HCFA-1500 Claim Form block 13 on file**
P	**Signature generated by provider because the patient was not physically present for services**
S	**Signed signature authorization form for HCFA-1500 Claim Form block 12 on file**

SITUATIONAL **CLM11** **C024** **RELATED CAUSES INFORMATION** **O**
To identify one or more related causes and associated state or country information

ALIAS: ***Accident/Employment/Related Causes***

CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0.

If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.

REQUIRED **CLM11 - 1** **1362** **Related-Causes Code** **M** **ID** **2/3**
Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: ***Related Causes Code***

NSF Reference:

EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

CODE	DEFINITION
AA	**Auto Accident**
AB	**Abuse**
AP	**Another Party Responsible**
EM	**Employment**
OA	**Other Accident**

SITUATIONAL **CLM11 - 2** **1362** **Related-Causes Code** **O ID 2/3**
Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: ***Related Causes Code***

NSF Reference:

EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

Used if more than one code applies.

CODE	DEFINITION
AA	**Auto Accident**
AB	**Abuse**
AP	**Another Party Responsible**
EM	**Employment**
OA	**Other Accident**

SITUATIONAL **CLM11 - 3** **1362** **Related-Causes Code** **O ID 2/3**
Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: ***Related Causes Code***

NSF Reference:

EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator

Used if more than one code applies.

CODE	DEFINITION
AA	**Auto Accident**
AB	**Abuse**
AP	**Another Party Responsible**
EM	**Employment**
OA	**Other Accident**

SITUATIONAL **CLM11 - 4** **156** **State or Province Code** **O ID 2/2**
Code (Standard State/Province) as defined by appropriate government agency

INDUSTRY: ***Auto Accident State or Province Code***

CODE SOURCE **22:** States and Outlying Areas of the U.S.

NSF Reference:

EA0-10.0

Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc).

SITUATIONAL	**CLM11 - 5**		**26**	**Country Code** Code identifying the country CODE SOURCE **5:** Countries, Currencies and Funds **Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.**	**O**	**ID**	**2/3**
SITUATIONAL	**CLM12**	**1366**		**Special Program Code** Code indicating the Special Program under which the services rendered to the patient were performed *INDUSTRY:* ***Special Program Indicator*** *ALIAS:* ***Special Program Code*** **NSF Reference:** **EA0-43.0** **Required if the services were rendered under one of the following circumstances/programs/projects.**	**O**	**ID**	**2/3**

CODE	DEFINITION
01	**Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)**
02	**Physically Handicapped Children's Program**
03	**Special Federal Funding**
05	**Disability**
07	**Induced Abortion - Danger to Life**
08	**Induced Abortion - Rape or Incest**
09	**Second Opinion or Surgery**

NOT USED	**CLM13**	**1073**		**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM14**	**1338**		**Level of Service Code**	**O**	**ID**	**1/3**
NOT USED	**CLM15**	**1073**		**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
SITUATIONAL	**CLM16**	**1360**		**Provider Agreement Code** Code indicating the type of agreement under which the provider is submitting this claim *INDUSTRY:* ***Participation Agreement*** **Required if a non-participating (non-par) provider is submitting a participating (par) claim/encounter. Sending the "P" code indicates that a non-par provider is sending a par claim as allowed under certain plans.**	**O**	**ID**	**1/1**

CODE	DEFINITION
P	**Participation Agreement**

NOT USED	**CLM17**	**1029**		**Claim Status Code**	**O**	**ID**	**1/2**
NOT USED	**CLM18**	**1073**		**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM19**	**1383**		**Claim Submission Reason Code**	**O**	**ID**	**2/2**

SITUATIONAL **CLM20** **1514** **Delay Reason Code** **O** **ID** **1/2**
Code indicating the reason why a request was delayed

ALIAS: ***Delay Reason Code***

This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed.

Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.

CODE	DEFINITION
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
6	Delay in Delivery of Custom-made Appliances
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

IMPLEMENTATION

DATE - ORDER DATE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when claim includes an order (i.e., an order for services or supplies is being billed/reported).**
2. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

Example: **DTP*938*D8*19970617~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

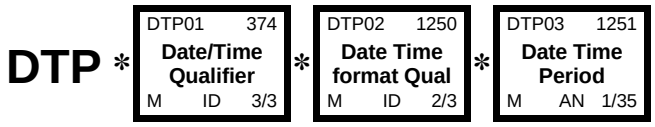
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier***	**M ID 3/3**
			CODE / **DEFINITION** **938** / **Order**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03.	**M ID 2/3**
			CODE / **DEFINITION** **D8** / **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Order Date***

IMPLEMENTATION

DATE - INITIAL TREATMENT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required on all claims involving spinal manipulation.**

Example: **DTP*454*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

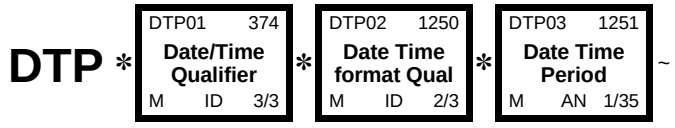
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **454 — Initial Treatment**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Initial Treatment Date***

NSF Reference:

GC0-05.0

IMPLEMENTATION

DATE - REFERRAL DATE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when claim includes a referral.**
2. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

Example: **DTP*330*D8*19970617~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

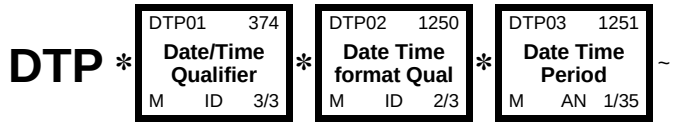
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **330 Referral Date**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Referral Date***

IMPLEMENTATION

DATE - DATE LAST SEEN

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when claims involve services from an independent physical therapist, occupational therapist, or physician services involving routine foot care.**

2. **This is the date that the patient was seen by the attending/supervising physician for the qualifying medical condition related to the services performed.**

Example: **DTP*304*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

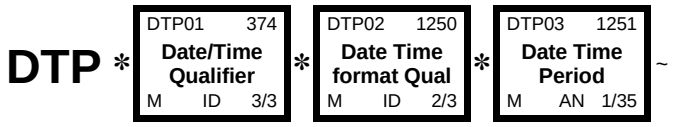
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier**	**M ID 3/3**
			Code specifying type of date or time, or both date and time	
			INDUSTRY: ***Date Time Qualifier***	
			CODE / **DEFINITION**	
			304 — **Latest Visit or Consultation**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier**	**M ID 2/3**
			Code indicating the date format, time format, or date and time format	
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE / **DEFINITION**	
			D8 — **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Last Seen Date***

NSF Reference:

EA0-48.0

IMPLEMENTATION

DATE - ONSET OF CURRENT ILLNESS/SYMPTOM

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required when information is available and if different than the date of service. If not used, claim/service date is assumed to be the date of onset of illness/symptoms.**

Example: **DTP*431*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

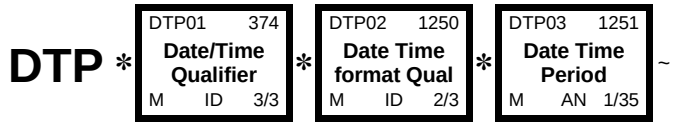
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
431	**Onset of Current Symptoms or Illness**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED **DTP03** **1251** **Date Time Period** **M AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Onset of Current Illness or Injury Date***

NSF Reference:

EA0-07.0

IMPLEMENTATION

DATE - ACUTE MANIFESTATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required when Loop 2300 CR208 = "A" or "M", the claim involves spinal manipulation, and the payer is Medicare.**

Example: **DTP*453*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

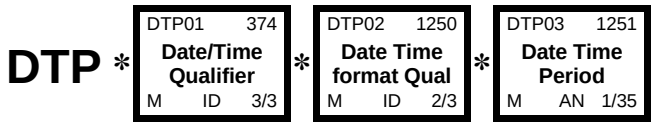
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE / **DEFINITION**	
			453 — **Acute Manifestation of a Chronic Condition**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE / **DEFINITION**	
			D8 — **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Acute Manifestation Date***

NSF Reference:

GC0-12.0

IMPLEMENTATION

DATE - SIMILAR ILLNESS/SYMPTOM ONSET

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required when claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms.**

Example: **DTP*438*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

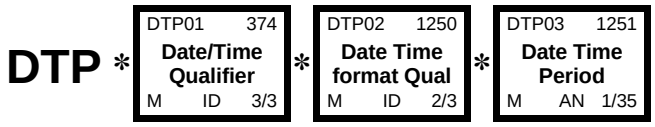
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE / **DEFINITION**	
			438 **Onset of Similar Symptoms or Illness**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE / **DEFINITION**	
			D8 **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Similar Illness or Symptom Date***

NSF Reference:

EA0-16.0

IMPLEMENTATION

DATE - ACCIDENT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes: **1. Required if CLM11-1, CLM11-2, or CLM11-3 = AA, AB, AP or OA.**

Example: **DTP*439*D8*19970114~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

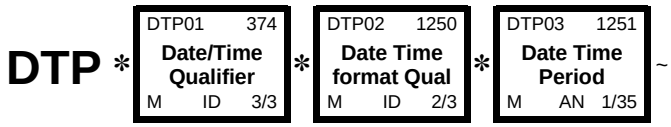
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE / **DEFINITION** **439** — **Accident**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE / **DEFINITION** **D8** — **Date Expressed in Format CCYYMMDD** **DT** — **Date and Time Expressed in Format CCYYMMDDHHMM** **Required if accident hour is known.**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Accident Date***

NSF Reference:

EA0-07.0 - Accident Date, EA0-11.0 Accident Hour (no minutes)

IMPLEMENTATION

DATE - LAST MENSTRUAL PERIOD

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when claim involves pregnancy.**

Example: **DTP*484*D8*19961113~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

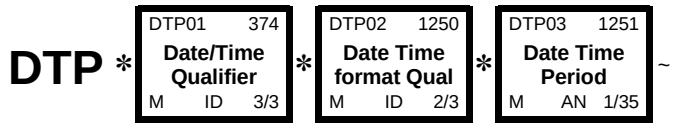
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE: **484** — DEFINITION: **Last Menstrual Period**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE: **D8** — DEFINITION: **Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Last Menstrual Period Date*** **NSF Reference:** **EA0-07.0**	**M AN 1/35**

IMPLEMENTATION

DATE - LAST X-RAY

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required when claim involves spinal manipulation if an x-ray was taken.**

Example: **DTP*455*D8*19970114~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

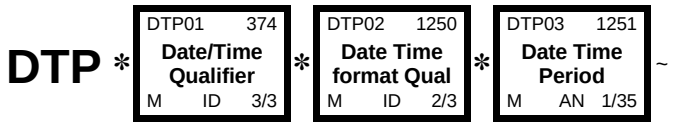
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **455 — Last X-Ray**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Last X-Ray Date***

NSF Reference:

GC0-06.0

IMPLEMENTATION

DATE - ESTIMATED DATE OF BIRTH

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when PAT09 is used.**

Example: **DTP*ABC*D8*19970617~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

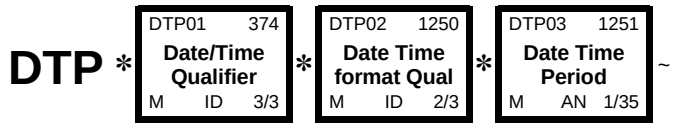
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **ABC** — **Estimated Date of Birth**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Estimated Birth Date*** *ALIAS:* ***Estimated Date of Birth***	**M AN 1/35**

IMPLEMENTATION

DATE - HEARING AND VISION PRESCRIPTION DATE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on claims where a prescription has been written for hearing devices or vision frames and lenses and it is being billed on this claim.**

Example: **DTP*471*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

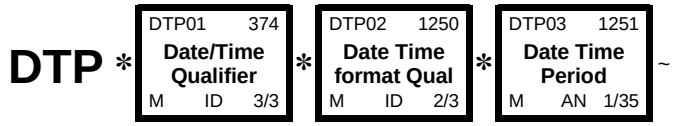
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** M ID 3/3 Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE: **471** — DEFINITION: **Prescription**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** M ID 2/3 Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE: **D8** — DEFINITION: **Date Expressed in Format CCYYMMDD**	
REQUIRED	**DTP03**	**1251**	**Date Time Period** M AN 1/35 Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Prescription Date***	

IMPLEMENTATION

DATE - DISABILITY BEGIN

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required on claims involving disability where, in the opinion of the provider, the patient was or will be unable to perform the duties normally associated with his/her work.**

Example: **DTP*360*D8*19970114~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

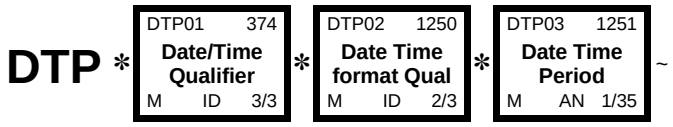
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **360 Disability Begin**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Disability From Date***

NSF Reference:

EA0-18.0

IMPLEMENTATION

DATE - DISABILITY END

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required on claims/encounters involving disability where, in the opinion of the provider, the patient, after having been absent from work for reasons related to the disability, was or will be able to perform the duties normally associated with his/her work.**

Example: **DTP*361*D8*19970613~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

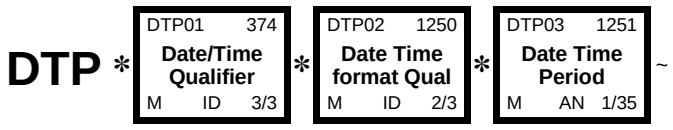
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** **M ID 3/3** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **361** = **Disability End**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** **M ID 2/3** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **D8** = **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Disability To Date***

NSF Reference:

EA0-19.0

IMPLEMENTATION

DATE - LAST WORKED

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on claims where this information is necessary for adjudication of the claim (e.g., workers compensation claims involving absence from work).**

Example: **DTP*297*D8*19970114~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

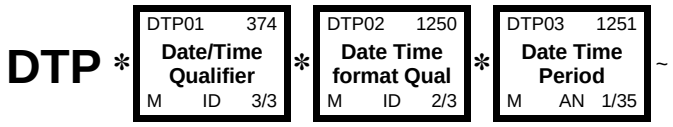
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **297 — Date Last Worked**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Last Worked Date***	**M AN 1/35**

IMPLEMENTATION

DATE - AUTHORIZED RETURN TO WORK

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on claims where this information is necessary for adjudication of the claim (e.g., workers compensation claims involving absence from work).**

Example: **DTP*296*D8*19970620~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

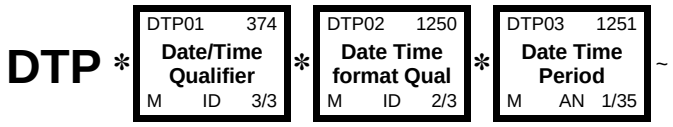
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			296 — Return to Work **This is the date the provider has authorized the patient to return to work.**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			D8 — Date Expressed in Format CCYYMMDD	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Work Return Date***

NSF Reference:

EA1-12.0

IMPLEMENTATION

DATE - ADMISSION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on all ambulance claims/encounters when the patient was known to be admitted to the hospital. Also required on inpatient medical visits claims/encounters.**

Example: **DTP*435*D8*19970114~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

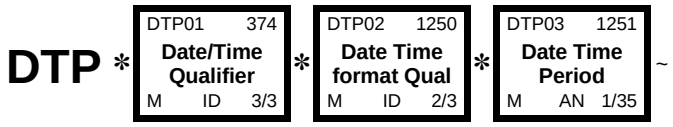
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** M ID 3/3 Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **435 — Admission**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** M ID 2/3 Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **D8 — Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Related Hospitalization Admission Date***

NSF Reference:

GA0-23.0 (for ambulance claims only), EA0-28.0

IMPLEMENTATION

DATE - DISCHARGE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required for inpatient claims when the patient was discharged from the facility and the discharge date is known.**

Example: **DTP*096*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

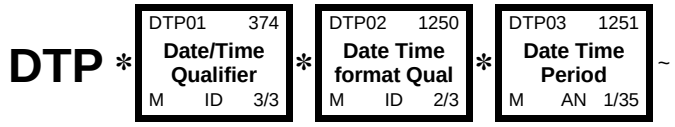
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **096 Discharge**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Related Hospitalization Discharge Date***

NSF Reference:

GA0-22.0 (for Ambulance Claims only), EA0-29.0

IMPLEMENTATION

DATE - ASSUMED AND RELINQUISHED CARE DATES

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Required on Medicare claims to indicate "assumed care date" and "relinquished care date" for situations where providers share post-operative care (global surgery claims). Assumed Care Date is the date care was assumed by another provider during post-operative care. Relinquished Care Date is the date the provider filing this claim ceased post-operative care. See Medicare guidelines for further explanation of these dates.**

2. **Example: Surgeon "A" relinquished post-operative care to Physician "B" five days after surgery. When Surgeon "A" submits a claim/encounter "A" will use code "091 - Report End" to indicate the day the surgeon relinquished care of this patient to Physician "B". When Physician "B" submits a claim/encounter "B" will use code "090 - Report Start" to indicate the date they assumed care of this patient from Surgeon "A".**

Example: **DTP*090*D8*19970214~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

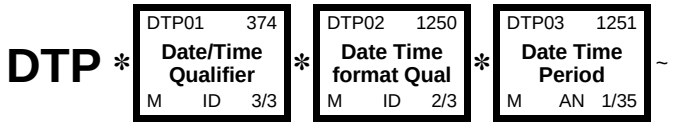
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **090** — **Report Start** **Assumed Care Date - Use code 090 to indicate the date the provider filing this claim assumed care from another provider during post-operative care.** **091** — **Report End** **Relinquished Care Date - Use code 091 to indicate the date the provider filing this claim relinquished post-operative care to another provider.**	M ID 3/3
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	M ID 2/3
REQUIRED	DTP03	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Assumed or Relinquished Care Date*** **NSF Reference:** **EA1-25.0 - Provider Assumed Care Date, HA0-05.0 - Provider Relinquished Care Date**	M AN 1/35

IMPLEMENTATION

CLAIM SUPPLEMENTAL INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope.**

2. **The PWK segment is required to identify attachments that are sent electronically (PWK02 = EL) but are transmitted in another functional group (e.g., 275) rather than by paper. PWK06 is used to identify the attached electronic documentation. The number in PWK06 would be carried in the TRN of the electronic attachment.**

3. **The PWK segment can be used to identify paperwork that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but that is not being sent with the claim. Use code AA in PWK02 to convey this specific use of the PWK segment. See code note under PWK02, code AA.**

Example: **PWK*OB*BM***AC*DMN0012~**

STANDARD

PWK Paperwork

Level: Detail

Position: 155

Loop: 2300

Requirement: Optional

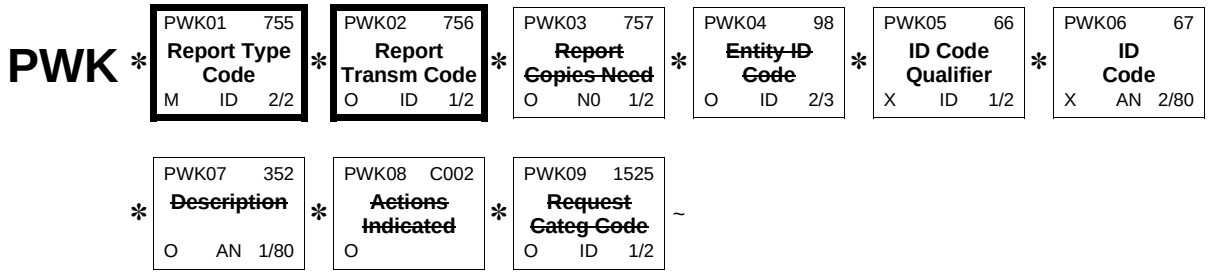
Max Use: 10

Purpose: To identify the type or transmission or both of paperwork or supporting information

Syntax:

1. **P0506**
   If either PWK05 or PWK06 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PWK01	755	**Report Type Code** Code indicating the title or contents of a document, report or supporting item *INDUSTRY:* ***Attachment Report Type Code*** **NSF Reference:** **EA0-41.0**	M ID 2/2

CODE	DEFINITION
77	**Support Data for Verification** **REFERRAL. Use this code to indicate a completed referral form.**
AS	**Admission Summary**
B2	**Prescription**
B3	**Physician Order**
B4	**Referral Form**
CT	**Certification**
DA	**Dental Models**
DG	**Diagnostic Report**
DS	**Discharge Summary**
EB	**Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)**
MT	**Models**
NN	**Nursing Notes**
OB	**Operative Note**
OZ	**Support Data for Claim**
PN	**Physical Therapy Notes**
PO	**Prosthetics or Orthotic Certification**
PZ	**Physical Therapy Certification**
RB	**Radiology Films**
RR	**Radiology Reports**
RT	**Report of Tests and Analysis Report**

REQUIRED	**PWK02**	**756**	**Report Transmission Code** Code defining timing, transmission method or format by which reports are to be sent *INDUSTRY:* ***Attachment Transmission Code***	**O**	**ID**	**1/2**

NSF Reference:

EA0-40.0

CODE	DEFINITION
AA	**Available on Request at Provider Site** **This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.**
BM	**By Mail**
EL	**Electronically Only** **Use to indicate that attachment is being transmitted in a separate X12 functional group.**
EM	**E-Mail**
FX	**By Fax**

NOT USED	**PWK03**	**757**	**Report Copies Needed**	**O**	**N0**	**1/2**
NOT USED	**PWK04**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
SITUATIONAL	**PWK05**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0506 COMMENT: PWK05 and PWK06 may be used to identify the addressee by a code number.	**X**	**ID**	**1/2**

Required if PWK02 = "BM", "EL", "EM" or "FX".

CODE	DEFINITION
AC	**Attachment Control Number**

SITUATIONAL	**PWK06**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Attachment Control Number*** SYNTAX: P0506	**X**	**AN**	**2/80**

Required if PWK02 = "BM", "EL", "EM" or "FX".

NOT USED	**PWK07**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**PWK08**	**C002**	**ACTIONS INDICATED**	**O**		
NOT USED	**PWK09**	**1525**	**Request Category Code**	**O**	**ID**	**1/2**

IMPLEMENTATION

CONTRACT INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The developers of this implementation guide recommend that for non-capitated situations, contract information be maintained in the receiver's files and not be transmitted with each claim whenever possible. It is recommended that submitters always include CN1 for encounters that include only capitated services.**

2. **Required if the provider is contractually obligated to provide contract information on this claim.**

Example: **CN1*02*550~**

STANDARD

CN1 Contract Information

Level: Detail

Position: 160

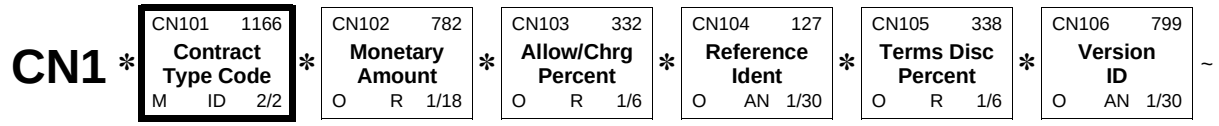
Loop: 2300

Requirement: Optional

Max Use: 1

Purpose: To specify basic data about the contract or contract line item

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CN101**	**1166**	**Contract Type Code** Code identifying a contract type *ALIAS:* ***Contract Type Code***	**M ID 2/2**

CODE	DEFINITION
02	**Per Diem**
03	**Variable Per Diem**
04	**Flat**
05	**Capitated**
06	**Percent**

			09 Other			
SITUATIONAL	**CN102**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Contract Amount*** SEMANTIC: CN102 is the contract amount. **Required if the provider is required by contract to supply this information on the claim.**	**O**	**R**	**1/18**
SITUATIONAL	**CN103**	**332**	**Percent** Percent expressed as a percent *INDUSTRY:* ***Contract Percentage*** *ALIAS:* ***Contract Percent*** SEMANTIC: CN103 is the allowance or charge percent. **Allowance or charge percent** **Required if the provider is required by contract to supply this information on the claim.**	**O**	**R**	**1/6**
SITUATIONAL	**CN104**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Contract Code*** SEMANTIC: CN104 is the contract code. **Required if the provider is required by contract to supply this information on the claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**CN105**	**338**	**Terms Discount Percent** Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date *INDUSTRY:* ***Terms Discount Percentage*** *ALIAS:* ***Terms Discount Percent*** **Required if the provider is required by contract to supply this information on the claim.**	**O**	**R**	**1/6**
SITUATIONAL	**CN106**	**799**	**Version Identifier** Revision level of a particular format, program, technique or algorithm *INDUSTRY:* ***Contract Version Identifier*** SEMANTIC: CN106 is an additional identifying number for the contract. **Required if the provider is required by contract to supply this information on the claim.**	**O**	**AN**	**1/30**

IMPLEMENTATION

CREDIT/DEBIT CARD MAXIMUM AMOUNT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment only for claims that contain credit/debit card information. This segment indicates the maximum amount that can be credited to the account indicated in 2010BD - CREDIT/DEBIT CARD HOLDER NAME.**

2. **The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.**

Example: **AMT*MA*200~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

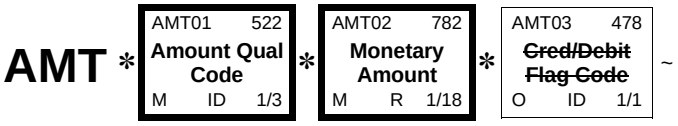
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			MA — Maximum Amount			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Credit or Debit Card Maximum Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PATIENT AMOUNT PAID

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the patient has paid any amount towards the claim.**
2. **Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s).**
3. **The Patient Amount Paid indicated in this segment applies to the entire claim. It is recommended that the Patient Amount Paid AMT segment be used at either the line(s) or claim level but not at both.**

Example: **AMT*F5*152.45~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

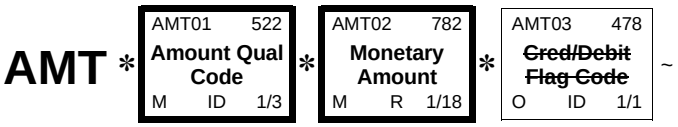
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **F5 — Patient Amount Paid**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Patient Amount Paid*** **NSF Reference:** **XA0-19.0**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

TOTAL PURCHASED SERVICE AMOUNT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if there are purchased service components to this claim.**

Example: **AMT*NE*57.35~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

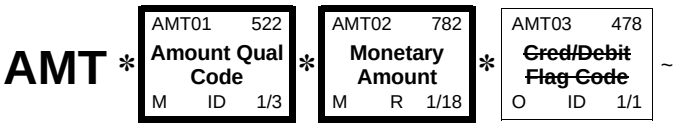
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **NE** — **Net Billed** **Use this code to indicate Total Purchased Service Charges.**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Total Purchased Service Amount*** **NSF Reference:** **EA0-31.0**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

SERVICE AUTHORIZATION EXCEPTION CODE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when providers are required by state law (e.g., New York State Medicaid) to obtain authorization for specific services but, for the reasons listed in REF02, performed the service without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.**

Example: **REF*4N*1~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

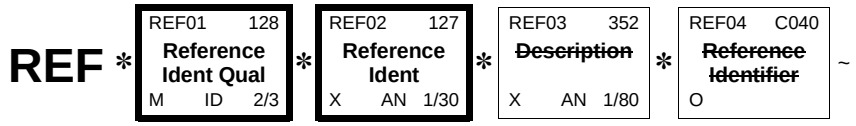
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

CODE	DEFINITION
4N	**Special Payment Reference Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Service Authorization Exception Code*** SYNTAX: R0203 **Allowable values for this element are:** **1 Immediate/Urgent Care** **2 Services Rendered in a Retroactive Period** **3 Emergency Care** **4 Client as Temporary Medicaid** **5 Request from County for Second Opinion to Recipient can Work** **6 Request for Override Pending** **7 Special Handling**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MANDATORY MEDICARE (SECTION 4081) CROSSOVER INDICATOR

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required for Medicare COB crossover claims when Beneficiary Assignment for mandatory Medicare (Section 4081) claim applies. This segment is only completed by Medicare; providers do not use this segment.**
2. **If this segment is not used that means this situation does not apply.**

Example: **REF*F5*N~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

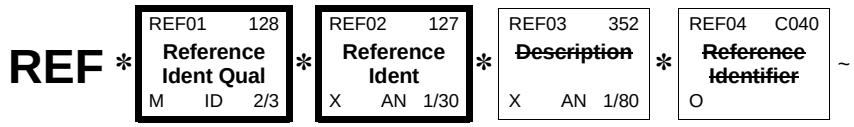
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
F5	**Medicare Version Code**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Medicare Section 4081 Indicator*** SYNTAX: R0203 **NSF Reference:** **DA0-30.0** **The allowed values for this element are:** **Y 4081 (NSF Value 1)** **N Regular crossover (NSF Value 2)**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MAMMOGRAPHY CERTIFICATION NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on Medicare claims for all mammography services.**

Example: **REF*EW*T554~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

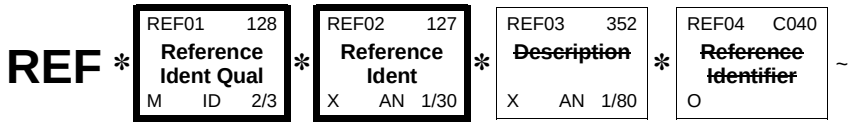
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			EW **Mammography Certification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Mammography Certification Number*** SYNTAX: R0203 **NSF Reference:** **FA0-31.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.**

2. **Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.**

Example: **REF*G1*13579~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

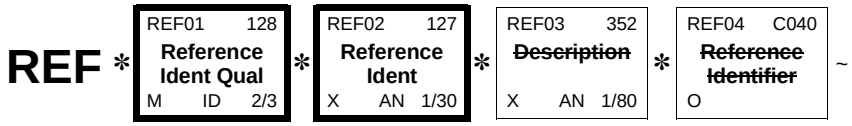
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION 9F — Referral Number G1 — Prior Authorization Number	M	ID	2/3
REQUIRED	REF02	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prior Authorization or Referral Number*** SYNTAX: R0203 **NSF Reference:** **DA0-14.0**	X	AN	1/30
NOT USED	REF03	352	**Description**	X	AN	1/80
NOT USED	REF04	C040	**REFERENCE IDENTIFIER**	O		

IMPLEMENTATION

ORIGINAL REFERENCE NUMBER (ICN/DCN)

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when CLM05-3 (Claim Submission Reason Code) = "6", "7", or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.**

2. **This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and, for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number. In this case the payer is expecting the provider to give them back their (the payer's) claim number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows this is not a duplicate claim.**

   This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.

Example: **REF*F8*R555588~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

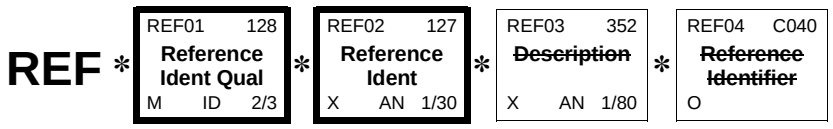
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **F8 Original Reference Number**	**M**	**ID**	**2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Claim Original Reference Number*** *ALIAS:* ***Claim Original Reference Number (ICN/DCN)*** SYNTAX: R0203 **NSF Reference:** **EA0-47.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Required on Medicare and Medicaid claims for any laboratory performing tests covered by the CLIA Act.**
2. **If a CLIA number is indicated at the line level (Loop ID-2400) in addition to the claim level (Loop ID-2300), that would indicate an exception to the CLIA number at the claim level for that individual line.**
3. **In cases where this claim contains both in-house and outsourced laboratory services: For laboratory services preformed by the billing or rendering provider the CLIA number is reported here; for laboratory services which were outsourced, report that CLIA number at the 2400 loop.**

Example: **REF*X4*12D4567890~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

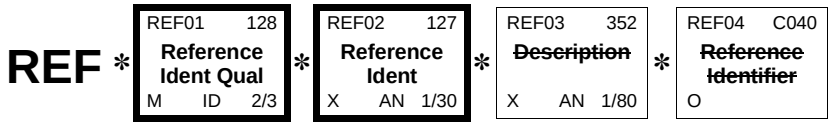
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE: **X4** — DEFINITION: **Clinical Laboratory Improvement Amendment Number**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Clinical Laboratory Improvement Amendment Number*** SYNTAX: R0203 **NSF Reference:** **FA0-34.0**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

REPRICED CLAIM NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**

Example: **REF*9A*RJ55555~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

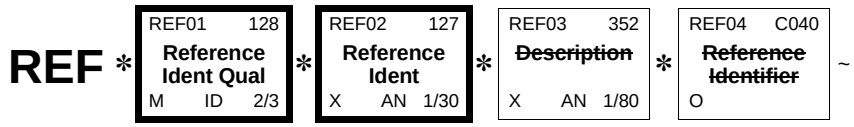
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE: **9A** DEFINITION: **Repriced Claim Reference Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Repriced Claim Reference Number*** SYNTAX: R0203 **NSF Reference:** **FE0-06.0 (TPO Reference Number)**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

ADJUSTED REPRICED CLAIM NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**

Example: **REF*9C*RP44444444~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

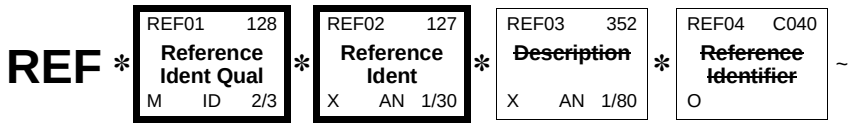
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **9C — Adjusted Repriced Claim Reference Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Adjusted Repriced Claim Reference Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

INVESTIGATIONAL DEVICE EXEMPTION NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when claim involves an FDA assigned investigational device exemption (IDE) number. Only one IDE per claim is to be reported.**

Example: **REF*LX*TG334~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

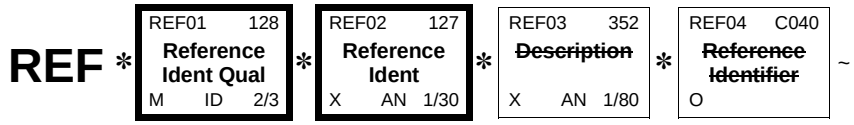
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **LX** — **Qualified Products List**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Investigational Device Exemption Identifier*** SYNTAX: R0203 **NSF Reference:** **EA0-54.0**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

CLAIM IDENTIFICATION NUMBER FOR CLEARING HOUSES AND OTHER TRANSMISSION INTERMEDIARIES

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used only by transmission intermediaries (Automated Clearing Houses, and others) who need to attach their own unique claim number.**

2. **Although this REF is supplied for transmission intermediaries to attach their own unique claim number to a claim/encounter, 837-recipients are not required under HIPAA to return this number in any HIPAA transaction. Trading partners may voluntarily agree to this interaction if they wish.**

Example: **REF*D9*TJ98UU321~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

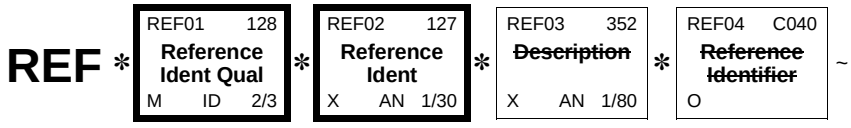
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			Number assigned by clearinghouse/van/etc.			
			CODE / DEFINITION			
			D9 Claim Number			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Clearinghouse Trace Number*** SYNTAX: R0203 **The value carried in this element is limited to a maximum of 20 positions.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

AMBULATORY PATIENT GROUP (APG)

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **4**

Notes: **1. Required if the contractual reimbursement arrangement between provider and payer is based on APG and their contractual arrangement requires that the provider send APG information to the payer on each claim.**

Example: **REF*1S*XXXXX~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

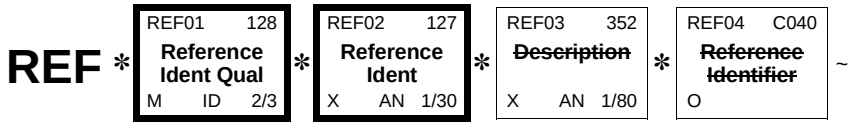
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **1S — Ambulatory Patient Group (APG) Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Ambulatory Patient Group Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

MEDICAL RECORD NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used at discretion of submitter.**

Example: **REF*EA*44444TH56~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

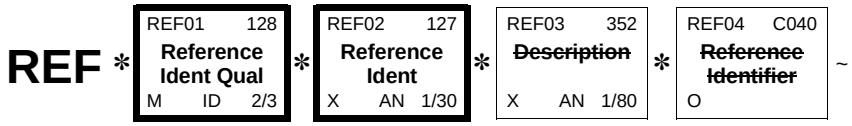
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **EA** **Medical Record Identification Number**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Medical Record Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

DEMONSTRATION PROJECT IDENTIFIER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on claims/encounters where a demonstration project is being billed/reported. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.**

Example: **REF*P4*THJ1222~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

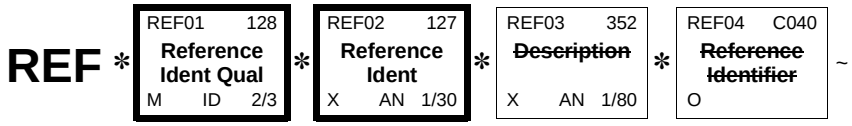
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
P4	**Project Code**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Demonstration Project Identifier*** SYNTAX: R0203 **NSF Reference:** **EA0-43.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

FILE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **At the time of publication K3 segments have no specific use. However, they have been included in this implementation guide to be used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority. This data element can only be required if the specific use is a result of a state law or a regulation issued by a state agency after the publication of this implementation guide, and only if the appropriate national body (X12N, HCPCS, NUBC, NUCC, etc) cannot offer an alternative solution within the current structure of the implementation guide.**

2. **This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement, and X12N determines that there is no method to meet the requirement. Only then may the state require the temporary use of the K3 to meet the requirement. X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee.**

Example: **K3*STATE DATA REQUIREMENT~**

STANDARD

K3 File Information

Level: Detail

Position: 185

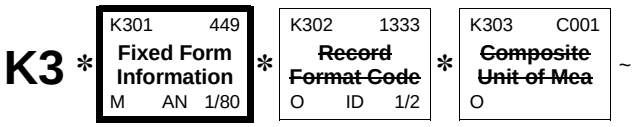
Loop: 2300

Requirement: Optional

Max Use: 10

Purpose: To transmit a fixed-format record or matrix contents

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	K301	449	**Fixed Format Information** Data in fixed format agreed upon by sender and receiver **NSF Reference:** **HA0-05.0**	M	AN	1/80
NOT USED	K302	1333	**Record Format Code**	O	ID	1/2
NOT USED	K303	C001	**COMPOSITE UNIT OF MEASURE**	O		

IMPLEMENTATION

CLAIM NOTE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400. Information is considered to be overridden when the value in NTE01 in Loop ID-2400 is the same as the value in NTE01 in Loop ID-2300.**

   The developers of this implementation guide discourage using narrative information within the 837. Trading partners who require narrative information with claims are encouraged to codify that information within the ASC X12 environment.

2. **Required when: (1) State regulations mandate information not identified elsewhere within the claim set; or (2) in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.**

Example: **NTE*ADD*SURGERY WAS UNUSUALLY LONG BECAUSE [FILL IN REASON]~**

STANDARD

NTE Note/Special Instruction

Level: Detail

Position: 190

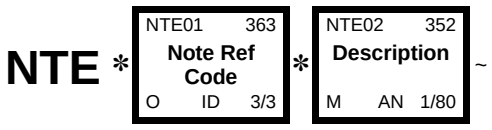
Loop: 2300

Requirement: Optional

Max Use: 20

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NTE01	363	**Note Reference Code** Code identifying the functional area or purpose for which the note applies	O ID 3/3
			CODE / DEFINITION ADD — Additional Information CER — Certification Narrative DCP — Goals, Rehabilitation Potential, or Discharge Plans DGN — Diagnosis Description PMT — Payment TPO — Third Party Organization Notes	
REQUIRED	NTE02	352	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Claim Note Text*** **NSF Reference:** **HA0-05.0**	M AN 1/80

IMPLEMENTATION

AMBULANCE TRANSPORT INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **The CR1 segment in Loop ID-2300 applies to the entire claim unless an exception is reported in the CR1 segment in Loop ID-2400.**
2. **Required on all claims involving ambulance services.**

Example: **CR1*LB*140*I*A*DH*12****UNCONSCIOUS~**

STANDARD

CR1 Ambulance Certification

Level: Detail

Position: 195

Loop: 2300

Requirement: Optional

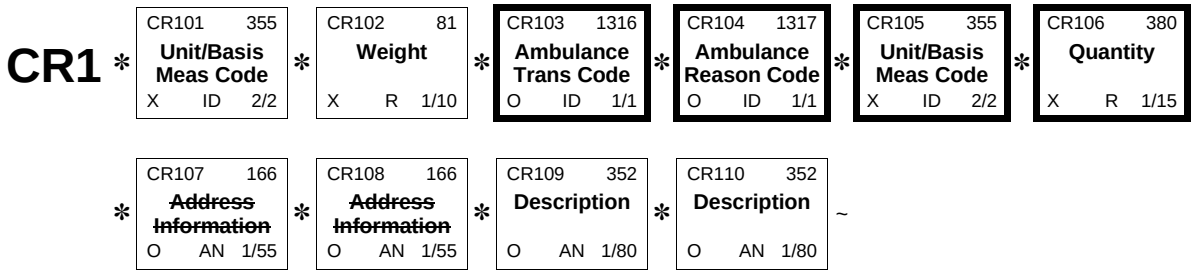
Max Use: 1

Purpose: To supply information related to the ambulance service rendered to a patient

Set Notes:
1. The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

Syntax:
1. **P0102**
   If either CR101 or CR102 is present, then the other is required.
2. **P0506**
   If either CR105 or CR106 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	CR101	355	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken SYNTAX: P0102 **Required if needed to justify extra ambulance services.** CODE / DEFINITION **LB** Pound	X ID 2/2
SITUATIONAL	CR102	81	**Weight** Numeric value of weight *INDUSTRY:* ***Patient Weight*** SYNTAX: P0102 SEMANTIC: CR102 is the weight of the patient at time of transport. **NSF Reference:** **GA0-05.0** **Required if needed to justify extra ambulance services.**	X R 1/10
REQUIRED	CR103	1316	**Ambulance Transport Code** Code indicating the type of ambulance transport *ALIAS:* ***Ambulance Transport Code*** **NSF Reference:** **GA0-07.0** CODE / DEFINITION **I** Initial Trip **R** Return Trip **T** Transfer Trip **X** Round Trip	O ID 1/1
REQUIRED	CR104	1317	**Ambulance Transport Reason Code** Code indicating the reason for ambulance transport *ALIAS:* ***Ambulance Transport Reason Code*** **NSF Reference:** **GA0-15.0** CODE / DEFINITION **A** Patient was transported to nearest facility for care of symptoms, complaints, or both Can be used to indicate that the patient was transferred to a residential facility. **B** Patient was transported for the benefit of a preferred physician	O ID 1/1

			C	**Patient was transported for the nearness of family members**			
			D	**Patient was transported for the care of a specialist or for availability of specialized equipment**			
			E	**Patient Transferred to Rehabilitation Facility**			
REQUIRED	**CR105**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **SYNTAX:** P0506 **CODE** / **DEFINITION** **DH** / **Miles**		**X**	**ID**	**2/2**
REQUIRED	**CR106**	**380**	**Quantity** Numeric value of quantity ***INDUSTRY:*** ***Transport Distance*** **SYNTAX:** P0506 **SEMANTIC:** CR106 is the distance traveled during transport. **NSF Reference:** **GA0-17.0, FA0-50.0** **NSF crosswalk to FA0-50.0 is used only in Medicare payer-to-payer COB situations.**		**X**	**R**	**1/15**
NOT USED	**CR107**	**166**	**Address Information**		**O**	**AN**	**1/55**
NOT USED	**CR108**	**166**	**Address Information**		**O**	**AN**	**1/55**
SITUATIONAL	**CR109**	**352**	**Description** A free-form description to clarify the related data elements and their content ***INDUSTRY:*** ***Round Trip Purpose Description*** **SEMANTIC:** CR109 is the purpose for the round trip ambulance service. **NSF Reference:** **GA0-20.0** **Required if CR103 (Ambulance Transport Code) = "X - Round Trip"; otherwise not used.**		**O**	**AN**	**1/80**
SITUATIONAL	**CR110**	**352**	**Description** A free-form description to clarify the related data elements and their content ***INDUSTRY:*** ***Stretcher Purpose Description*** **SEMANTIC:** CR110 is the purpose for the usage of a stretcher during ambulance service. **NSF Reference:** **GA0-21.0** **Required if needed to justify usage of stretcher.**		**O**	**AN**	**1/80**

IMPLEMENTATION

SPINAL MANIPULATION SERVICE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The CR2 segment in Loop ID-2300 applies to the entire claim unless overridden by the presence of a CR2 segment in Loop ID-2400.**
2. **Required on all claims involving spinal manipulation. Such claims could originate with chiropractors, physical therapists, DOs, and many other types of health care providers.**

Example: **CR2*3*5*C4*C6*MO*2*2*M*Y***Y~**

STANDARD

CR2 Chiropractic Certification

Level: Detail

Position: 200

Loop: 2300

Requirement: Optional

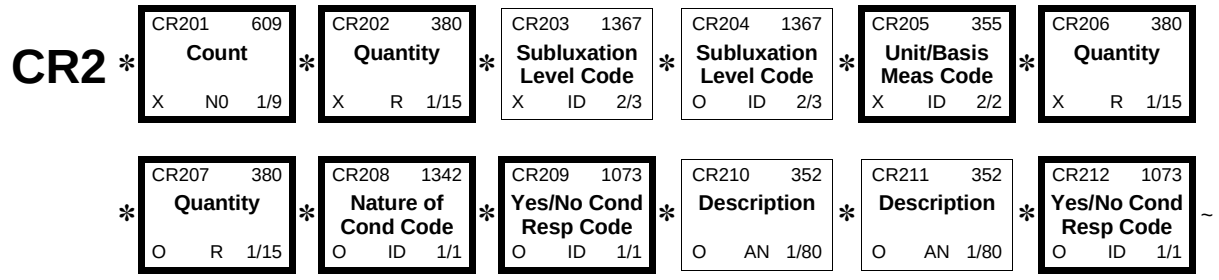
Max Use: 1

Purpose: To supply information related to the chiropractic service rendered to a patient

Syntax:

1. **P0102**
   If either CR201 or CR202 is present, then the other is required.
2. **C0403**
   If CR204 is present, then CR203 is required.
3. **P0506**
   If either CR205 or CR206 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**CR201**	**609**	**Count** Occurence counter *INDUSTRY:* ***Treatment Series Number*** *ALIAS:* ***Treatment Number. Spinal Manipulation*** **SYNTAX:** P0102 **SEMANTIC:** CR201 is the number this treatment is in the series. **NSF Reference:** **GC0-07.0**	**X**	**N0**	**1/9**
REQUIRED	**CR202**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Treatment Count*** *ALIAS:* ***Treatment Series Total. Spinal Manipulation*** **SYNTAX:** P0102 **SEMANTIC:** CR202 is the total number of treatments in the series. **NSF Reference:** **GC0-07.0**	**X**	**R**	**1/15**
SITUATIONAL	**CR203**	**1367**	**Subluxation Level Code** Code identifying the specific level of subluxation *ALIAS:* ***Subluxation Level Code*** **SYNTAX:** C0403 **COMMENT:** When both CR203 and CR204 are present, CR203 is the beginning level of subluxation and CR204 is the ending level of subluxation. **NSF Reference:** **GC0-08.0** **Required if subluxation is involved in the claim.**	**X**	**ID**	**2/3**

CODE	DEFINITION
C1	**Cervical 1**
C2	**Cervical 2**
C3	**Cervical 3**
C4	**Cervical 4**
C5	**Cervical 5**
C6	**Cervical 6**
C7	**Cervical 7**
CO	**Coccyx**
IL	**Ilium**
L1	**Lumbar 1**

L2	Lumbar 2
L3	Lumbar 3
L4	Lumbar 4
L5	Lumbar 5
OC	Occiput
SA	Sacrum
T1	Thoracic 1
T10	Thoracic 10
T11	Thoracic 11
T12	Thoracic 12
T2	Thoracic 2
T3	Thoracic 3
T4	Thoracic 4
T5	Thoracic 5
T6	Thoracic 6
T7	Thoracic 7
T8	Thoracic 8
T9	Thoracic 9

SITUATIONAL **CR204** **1367** **Subluxation Level Code** **O** **ID** **2/3**
Code identifying the specific level of subluxation

ALIAS: ***Subluxation Level Code***

SYNTAX: C0403

NSF Reference:

GC0-08.0

Required if additional subluxation is involved in claim to indicate a range (i.e., subluxation from CR203 to CR204).

CODE	DEFINITION
C1	Cervical 1
C2	Cervical 2
C3	Cervical 3
C4	Cervical 4
C5	Cervical 5
C6	Cervical 6
C7	Cervical 7

CO	Coccyx
IL	Ilium
L1	Lumbar 1
L2	Lumbar 2
L3	Lumbar 3
L4	Lumbar 4
L5	Lumbar 5
OC	Occiput
SA	Sacrum
T1	Thoracic 1
T10	Thoracic 10
T11	Thoracic 11
T12	Thoracic 12
T2	Thoracic 2
T3	Thoracic 3
T4	Thoracic 4
T5	Thoracic 5
T6	Thoracic 6
T7	Thoracic 7
T8	Thoracic 8
T9	Thoracic 9

REQUIRED **CR205** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0506

CODE	DEFINITION
DA	Days
MO	Months
WK	Week
YR	Years

REQUIRED	**CR206**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Treatment Period Count***

ALIAS: ***Treatment Series Period. Spinal Manipulation***

SYNTAX: P0506

SEMANTIC: CR206 is the time period involved in the treatment series.

NSF Reference:

GC0-09.0

REQUIRED	**CR207**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Monthly Treatment Count***

ALIAS: ***Treatment Number in Month. Spinal Manipulation***

SEMANTIC: CR207 is the number of treatments rendered in the month of service.

NSF Reference:

GC0-10.0

REQUIRED	**CR208**	**1342**	**Nature of Condition Code** Code indicating the nature of a patient's condition	**O**	**ID**	**1/1**

INDUSTRY: ***Patient Condition Code***

ALIAS: ***Nature of Condition Code. Spinal Manipulation***

NSF Reference:

GC0-11.0

CODE	DEFINITION
A	**Acute Condition**
C	**Chronic Condition**
D	**Non-acute**
E	**Non-Life Threatening**
F	**Routine**
G	**Symptomatic**
M	**Acute Manifestation of a Chronic Condition**

REQUIRED	**CR209**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Complication Indicator***

ALIAS: ***Complication Indicator. Spinal Manipulation***

SEMANTIC: CR209 is complication indicator. A "Y" value indicates a complicated condition; an "N" value indicates an uncomplicated condition.

NSF Reference:

GC0-13.0

CODE	DEFINITION
N	**No**

			Y **Yes**			
SITUATIONAL	**CR210**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN**	**1/80**

INDUSTRY: ***Patient Condition Description***

ALIAS: ***Patient Condition Description. Spinal Manipulation***

SEMANTIC: CR210 is a description of the patient's condition.

NSF Reference:

GC0-14.0

Used at discretion of submitter.

SITUATIONAL	**CR211**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN**	**1/80**

INDUSTRY: ***Patient Condition Description***

ALIAS: ***Patient Condition Description. Spinal Manipulation***

SEMANTIC: CR211 is an additional description of the patient's condition.

NSF Reference:

GC0-14.0

Used at discretion of submitter.

REQUIRED	**CR212**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***X-ray Availability Indicator***

ALIAS: ***X-ray Availability Indicator. Spinal Manipulation***

SEMANTIC: CR212 is X-rays availability indicator. A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are not maintained and available for carrier review.

NSF Reference:

GC0-15.0

CODE	DEFINITION
N	**No**
Y	**Yes**

IMPLEMENTATION

AMBULANCE CERTIFICATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **The CRC segment in Loop ID-2300 applies to the entire claim unless overridden by a CRC segment at the service line level in Loop ID-2400 with the same value in CRC01.**
2. **Required on ambulance claims/encounters, i.e. when CR1 segment is used.**

Example: **CRC*07*Y*01~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 220

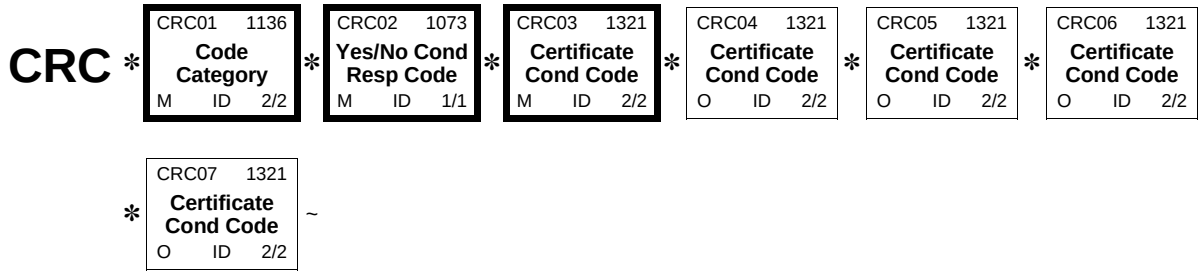
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
07	**Ambulance Certification**

REQUIRED **CRC02** **1073** **Yes/No Condition or Response Code** **M** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Certification Condition Indicator***

ALIAS: ***Certification Condition Code Applies Indicator***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

CODE	DEFINITION
N	**No**
Y	**Yes**

REQUIRED **CRC03** **1321** **Condition Indicator** **M** **ID** **2/2**
Code indicating a condition

INDUSTRY: ***Condition Code***

ALIAS: ***Condition Indicator***

The codes for CRC03 also can be used for CRC04 through CRC07.

CODE	DEFINITION
01	**Patient was admitted to a hospital** NSF Reference: **GA0-06.0**
02	**Patient was bed confined before the ambulance service** NSF Reference: **GA0-08.0**
03	**Patient was bed confined after the ambulance service** NSF Reference: **GA0-09.0**
04	**Patient was moved by stretcher** NSF Reference: **GA0-10.0**
05	**Patient was unconscious or in shock** NSF Reference: **GA0-11.0**
06	**Patient was transported in an emergency situation** NSF Reference: **GA0-12.0**
07	**Patient had to be physically restrained** NSF Reference: **GA0-13.0**
08	**Patient had visible hemorrhaging** NSF Reference: **GA0-14.0**

			09 **Ambulance service was medically necessary** NSF Reference: **GA0-16.0**			
			60 **Transportation Was To the Nearest Facility** NSF Reference: **GA0-24.0**			
SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**

IMPLEMENTATION

PATIENT CONDITION INFORMATION: VISION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. Required on vision claims/encounters involving replacement lenses or frames.**

Example: **CRC*E1*Y*L1~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 220

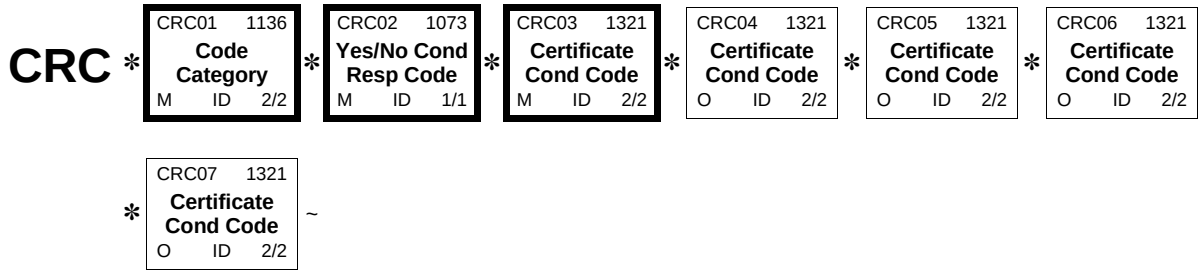
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
E1	**Spectacle Lenses**
E2	**Contact Lenses**
E3	**Spectacle Frames**

REQUIRED	**CRC02**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M**	**ID**	**1/1**

INDUSTRY: ***Certification Condition Indicator***

ALIAS: ***Certification Condition Code Applies Indicator***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

CODE	DEFINITION
N	**No**
Y	**Yes**

REQUIRED	**CRC03**	**1321**	**Condition Indicator** Code indicating a condition	**M**	**ID**	**2/2**

INDUSTRY: ***Condition Code***

ALIAS: ***Condition Indicator***

CODE	DEFINITION
L1	**General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met**
L2	**Replacement Due to Loss or Theft**
L3	**Replacement Due to Breakage or Damage**
L4	**Replacement Due to Patient Preference**
L5	**Replacement Due to Medical Reason**

SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**

INDUSTRY: ***Condition Code***

Use codes listed in CRC03.

Required if additional condition codes are needed.

SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**

INDUSTRY: ***Condition Code***

Use codes listed in CRC03.

Required if additional condition codes are needed.

SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**

INDUSTRY: ***Condition Code***

Use codes listed in CRC03.

Required if additional condition codes are needed.

SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**

INDUSTRY: ***Condition Code***

Use codes listed in CRC03.

Required if additional condition codes are needed.

IMPLEMENTATION

HOMEBOUND INDICATOR

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required for Medicare claims/encounters when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient.**

Example: **CRC*75*Y*IH~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 220

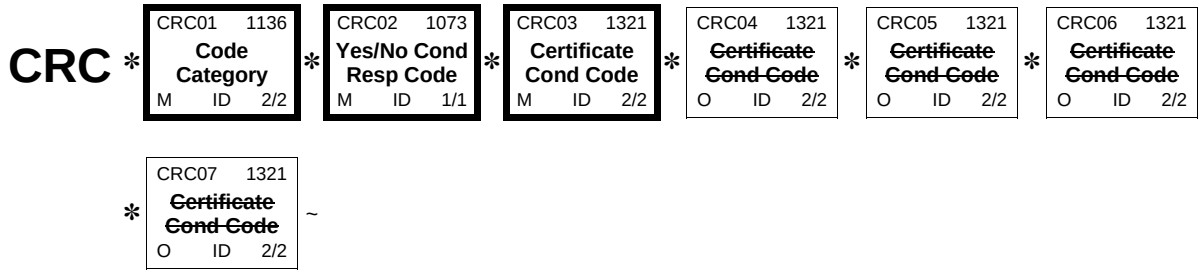
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
75	**Functional Limitations**

REQUIRED	**CRC02**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**M**	**ID**	**1/1**

INDUSTRY: ***Certification Condition Indicator***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A “Y” value indicates the condition codes in CRC03 through CRC07 apply; an “N” value indicates the condition codes in CRC03 through CRC07 do not apply.

CODE	DEFINITION
Y	**Yes**

REQUIRED	**CRC03**	**1321**	**Condition Indicator** Code indicating a condition	**M**	**ID**	**2/2**

INDUSTRY: ***Homebound Indicator***

CODE	DEFINITION
IH	**Independent at Home** NSF Reference: **EA0-50.0**

NOT USED	**CRC04**	**1321**	**Condition Indicator**	**O**	**ID**	**2/2**
NOT USED	**CRC05**	**1321**	**Condition Indicator**	**O**	**ID**	**2/2**
NOT USED	**CRC06**	**1321**	**Condition Indicator**	**O**	**ID**	**2/2**
NOT USED	**CRC07**	**1321**	**Condition Indicator**	**O**	**ID**	**2/2**

IMPLEMENTATION

HEALTH CARE DIAGNOSIS CODE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims).**
2. **Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.**

Example: **HI*BK:8901*BF:87200*BF:5559~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

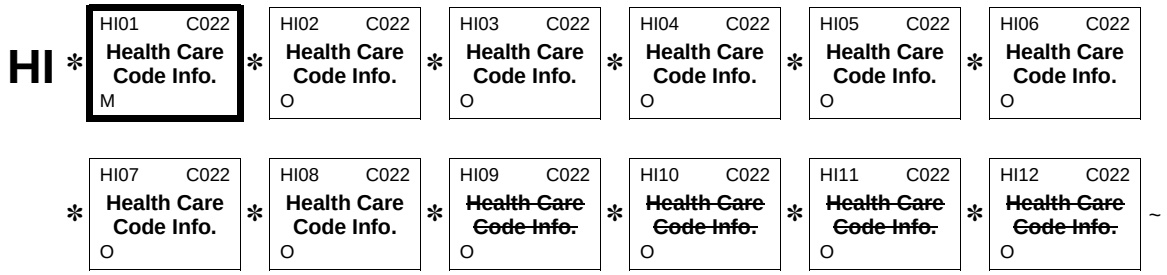
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities *ALIAS:* ***Principal Diagnosis***	**M**

With a few exceptions, it is not recommended to put E codes in HI01. E codes may be put in any other HI element using BF as the qualifier.

The diagnosis listed in this element is assumed to be the principal diagnosis.

REQUIRED	**HI01 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list *INDUSTRY:* ***Diagnosis Type Code***	**M**	**ID**	**1/3**

CODE	DEFINITION
BK	**Principal Diagnosis** **ICD-9 Codes** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Diagnosis Code*** **NSF Reference:** **EA0-32.0, GX0-31.0, GU0-12.0**	**M**	**AN**	**1/30**
NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities *ALIAS:* ***Diagnosis*** **Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.** **Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.**		**O**		
REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list *INDUSTRY:* ***Diagnosis Type Code***	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis** **ICD-9 Codes** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI02 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Diagnosis Code*** **NSF Reference:** **EA0-33.0, GX0-32.0, GU0-13.0**	**M**	**AN**	**1/30**
NOT USED	**HI02 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	HI02 - 6		380	Quantity	O	R	1/15
NOT USED	HI02 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

ALIAS: ***Diagnosis***

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.

REQUIRED	HI03 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

INDUSTRY: ***Diagnosis Type Code***

CODE	DEFINITION
BF	Diagnosis ICD-9 Codes

CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	HI03 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Diagnosis Code***

NSF Reference:

EA0-34.0, GX0-33.0, GU0-14.0

NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI03 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI03 - 6		380	Quantity	O	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

ALIAS: ***Diagnosis***

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.

REQUIRED	**HI04 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list *INDUSTRY:* ***Diagnosis Type Code***	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis** **ICD-9 Codes** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI04 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Diagnosis Code*** **NSF Reference:** **EA0-35.0, GX0-34.0, GU0-15.0**	**M**	**AN**	**1/30**
NOT USED	**HI04 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities *ALIAS:* ***Diagnosis*** **Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.** **Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.**		**O**		
REQUIRED	**HI05 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list *INDUSTRY:* ***Diagnosis Type Code***	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis** **ICD-9 Codes** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI05 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Diagnosis Code***	**M**	**AN**	**1/30**
NOT USED	**HI05 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

ALIAS: ***Diagnosis***

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.

REQUIRED **HI06 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

INDUSTRY: ***Diagnosis Type Code***

CODE	DEFINITION
BF	**Diagnosis ICD-9 Codes**

CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI06 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Diagnosis Code***

NOT USED **HI06 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**

NOT USED **HI06 - 4** **1251** **Date Time Period** **X** **AN** **1/35**

NOT USED **HI06 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI06 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI06 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

ALIAS: ***Diagnosis***

Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.

Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.

REQUIRED **HI07 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

INDUSTRY: ***Diagnosis Type Code***

CODE	DEFINITION
BF	**Diagnosis ICD-9 Codes**

CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI07 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Diagnosis Code***

NOT USED	HI07 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI07 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI07 - 6		380	Quantity	O	R	1/15
NOT USED	HI07 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities *ALIAS:* ***Diagnosis***		O		
			Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.				
			Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.				
REQUIRED	HI08 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list *INDUSTRY:* ***Diagnosis Type Code***	M	ID	1/3
			CODE	DEFINITION			
			BF	**Diagnosis** **ICD-9 Codes** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure			
REQUIRED	HI08 - 2		1271	Industry Code Code indicating a code from a specific industry code list *INDUSTRY:* ***Diagnosis Code***	M	AN	1/30
NOT USED	HI08 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI08 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI08 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI08 - 6		380	Quantity	O	R	1/15
NOT USED	HI08 - 7		799	Version Identifier	O	AN	1/30
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION		O		

IMPLEMENTATION

CLAIM PRICING/REPRICING INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**
2. **For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.**

Example: **HCP*03*100*10*RPO12345~**

STANDARD

HCP Health Care Pricing

Level: Detail

Position: 241

Loop: 2300

Requirement: Optional

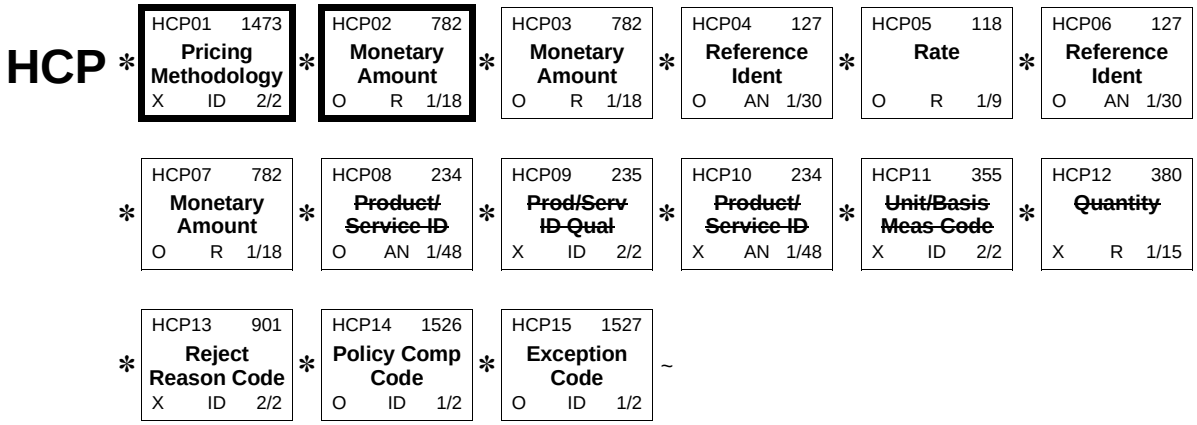
Max Use: 1

Purpose: To specify pricing or repricing information about a health care claim or line item

Syntax:

1. **R0113**
   At least one of HCP01 or HCP13 is required.
2. **P0910**
   If either HCP09 or HCP10 is present, then the other is required.
3. **P1112**
   If either HCP11 or HCP12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HCP01	1473	**Pricing Methodology** Code specifying pricing methodology at which the claim or line item has been priced or repriced *ALIAS:* ***Pricing/repricing methodology*** SYNTAX: R0113 **Trading partners need to agree on the codes to use in this element. There do not appear to be standard definitions for the code elements.**	X ID 2/2
REQUIRED	HCP02	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Repriced Allowed Amount*** *ALIAS:* ***Allowed amount, Pricing*** SEMANTIC: HCP02 is the allowed amount. **Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**	O R 1/18

CODE	DEFINITION
00	Zero Pricing (Not Covered Under Contract)
01	Priced as Billed at 100%
02	Priced at the Standard Fee Schedule
03	Priced at a Contractual Percentage
04	Bundled Pricing
05	Peer Review Pricing
07	Flat Rate Pricing
08	Combination Pricing
09	Maternity Pricing
10	Other Pricing
11	Lower of Cost
12	Ratio of Cost
13	Cost Reimbursed
14	Adjustment Pricing

SITUATIONAL	**HCP03**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Saving Amount***

ALIAS: ***Savings amount, Pricing***

SEMANTIC: HCP03 is the savings amount.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repricing Organization Identifier***

SEMANTIC: HCP04 is the repricing organization identification number.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP05**	**118**	**Rate** Rate expressed in the standard monetary denomination for the currency specified	**O**	**R**	**1/9**

INDUSTRY: ***Repricing Per Diem or Flat Rate Amount***

ALIAS: ***Pricing rate***

SEMANTIC: HCP05 is the pricing rate associated with per diem or flat rate repricing.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repriced Approved Ambulatory Patient Group Code***

ALIAS: ***Approved APG code, Pricing***

SEMANTIC: HCP06 is the approved DRG code.

COMMENT: HCP06, HCP07, HCP08, HCP10, and HCP12 are fields that will contain different values from the original submitted values.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Approved Ambulatory Patient Group Amount***

ALIAS: ***Approved APG amount, Pricing***

SEMANTIC: HCP07 is the approved DRG amount.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

NOT USED	**HCP08**	**234**	**Product/Service ID**	**O**	**AN**	**1/48**
NOT USED	**HCP09**	**235**	**Product/Service ID Qualifier**	**X**	**ID**	**2/2**
NOT USED	**HCP10**	**234**	**Product/Service ID**	**X**	**AN**	**1/48**
NOT USED	**HCP11**	**355**	**Unit or Basis for Measurement Code**	**X**	**ID**	**2/2**
NOT USED	**HCP12**	**380**	**Quantity**	**X**	**R**	**1/15**

SITUATIONAL **HCP13** **901** **Reject Reason Code** **X** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

ALIAS: ***Reject reason code***

SYNTAX: R0113

SEMANTIC: HCP13 is the rejection message returned from the third party organization.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
T1	**Cannot Identify Provider as TPO (Third Party Organization) Participant**
T2	**Cannot Identify Payer as TPO (Third Party Organization) Participant**
T3	**Cannot Identify Insured as TPO (Third Party Organization) Participant**
T4	**Payer Name or Identifier Missing**
T5	**Certification Information Missing**
T6	**Claim does not contain enough information for re-pricing**

SITUATIONAL **HCP14** **1526** **Policy Compliance Code** **O** **ID** **1/2**
Code specifying policy compliance

ALIAS: ***Policy compliance code***

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
1	**Procedure Followed (Compliance)**
2	**Not Followed - Call Not Made (Non-Compliance Call Not Made)**
3	**Not Medically Necessary (Non-Compliance Non-Medically Necessary)**
4	**Not Followed Other (Non-Compliance Other)**
5	**Emergency Admit to Non-Network Hospital**

SITUATIONAL **HCP15** **1527** **Exception Code** **O** **ID** **1/2**

Code specifying the exception reason for consideration of out-of-network health care services

ALIAS: ***Exception code***

SEMANTIC: HCP15 is the exception reason generated by a third party organization.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
1	Non-Network Professional Provider in Network Hospital
2	Emergency Care
3	Services or Specialist not in Network
4	Out-of-Service Area
5	State Mandates
6	Other

IMPLEMENTATION

HOME HEALTH CARE PLAN INFORMATION

Loop: 2305 — HOME HEALTH CARE PLAN INFORMATION Repeat: 6

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required on home health claims/encounters that involve billing/reporting home health visits.

Example: CR7*PT*4*12~

STANDARD

CR7 Home Health Treatment Plan Certification

Level: Detail

Position: 242

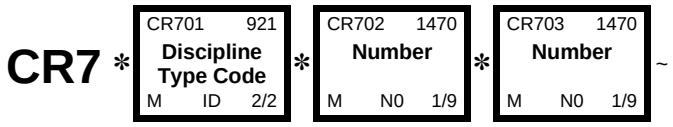
Loop: 2305 **Repeat:** 6

Requirement: Optional

Max Use: 1

Purpose: To supply information related to the home health care plan of treatment and services

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CR701**	**921**	**Discipline Type Code** Code indicating disciplines ordered by a physician *ALIAS:* ***Discipline type code***	**M ID 2/2**

CODE	DEFINITION
AI	**Home Health Aide**
MS	**Medical Social Worker**
OT	**Occupational Therapy**
PT	**Physical Therapy**
SN	**Skilled Nursing**
ST	**Speech Therapy**

REQUIRED	**CR702**	**1470**	**Number** A generic number	**M**	**N0**	**1/9**

INDUSTRY: ***Total Visits Rendered Count***

ALIAS: ***Total visits rendered, home health***

SEMANTIC: CR702 is the total visits on this bill rendered prior to the recertification "to" date.

REQUIRED	**CR703**	**1470**	**Number** A generic number	**M**	**N0**	**1/9**

INDUSTRY: ***Certification Period Projected Visit Count***

ALIAS: ***Total visits projected, home health***

SEMANTIC: CR703 is the total visits projected during this certification period.

IMPLEMENTATION

HEALTH CARE SERVICES DELIVERY

Loop: **2305 — HOME HEALTH CARE PLAN INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment.**

2. **The HSD segment is used to specify the delivery pattern of the health care services. This is how it is used:**

   HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit".
   Between HSD02 and HSD03 verbally insert a "per every."
   HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days."
   Between HSD04 and HSD05 verbally insert a "for."
   HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days."
   The total message reads:

   HSD*VS*1*DA*3*7*21~ = "One visit per every three days for 21 days."

   Another similar data string of HSD*VS*2*DA*4*7*20~ = Two visits per every four days for 20 days.

   An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1***SX*D~ means "1 visit on Wednesday and Thursday morning."**

Example: **HSD*VS*1*DA*1*7*10~ (This indicates ''1 visit every (per) 1 day (daily) for 10 days'')**

Example: **HSD*VS*1*DA****W~ (This indicates ''1 visit per day whenever necessary'')**

STANDARD

HSD Health Care Services Delivery

Level: Detail

Position: 243

Loop: 2305

Requirement: Optional

Max Use: 12

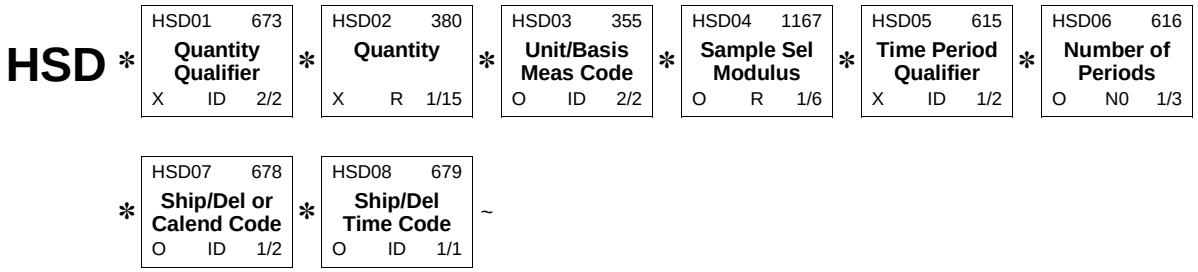
Purpose: To specify the delivery pattern of health care services

Syntax:

1. **P0102**
   If either HSD01 or HSD02 is present, then the other is required.

2. C0605
If HSD06 is present, then HSD05 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**HSD01**	**673**	**Quantity Qualifier** Code specifying the type of quantity *INDUSTRY:* ***Visits*** SYNTAX: P0102 **Required if the order/prescription for the service contains the data.**	**X ID 2/2**
SITUATIONAL	**HSD02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Number of Visits*** SYNTAX: P0102 **Required if the order/prescription for the service contains the data.**	**X R 1/15**
SITUATIONAL	**HSD03**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken *INDUSTRY:* ***Frequency Period*** *ALIAS:* ***Modulus, Unit*** **Required if the order/prescription for the service contains the data.**	**O ID 2/2**

CODE	DEFINITION
VS	**Visits**

CODE	DEFINITION
DA	**Days**
MO	**Months** **Month**
Q1	**Quarter (Time)**
WK	**Week**

SITUATIONAL **HSD04** **1167** **Sample Selection Modulus** **O** **R** **1/6**
To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes

INDUSTRY: ***Frequency Count***

ALIAS: ***Modulus, Amount***

Required if the order/prescription for the service contains the data.

SITUATIONAL **HSD05** **615** **Time Period Qualifier** **X** **ID** **1/2**
Code defining periods

INDUSTRY: ***Duration of Visits Units***

SYNTAX: C0605

Required if the order/prescription for the service contains the data.

CODE	DEFINITION
7	Day
35	Week

SITUATIONAL **HSD06** **616** **Number of Periods** **O** **N0** **1/3**
Total number of periods

INDUSTRY: ***Duration of Visits, Number of Units***

SYNTAX: C0605

Required if the order/prescription for the service contains the data.

SITUATIONAL **HSD07** **678** **Ship/Delivery or Calendar Pattern Code** **O** **ID** **1/2**
Code which specifies the routine shipments, deliveries, or calendar pattern

INDUSTRY: ***Ship, Delivery or Calendar Pattern Code***

ALIAS: ***Pattern Code***

Required if the order/prescription for the service contains the data.

CODE	DEFINITION
1	1st Week of the Month
2	2nd Week of the Month
3	3rd Week of the Month
4	4th Week of the Month
5	5th Week of the Month
6	1st & 3rd Weeks of the Month
7	2nd & 4th Weeks of the Month
A	Monday through Friday
B	Monday through Saturday
C	Monday through Sunday
D	Monday
E	Tuesday

F	Wednesday
G	Thursday
H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
N	As Directed
O	Daily Mon. through Fri.
S	Once Anytime Mon. through Fri.
SA	Sunday, Monday, Thursday, Friday, Saturday
SB	Tuesday through Saturday
SC	Sunday, Wednesday, Thursday, Friday, Saturday
SD	Monday, Wednesday, Thursday, Friday, Saturday
SG	Tuesday through Friday
SL	Monday, Tuesday and Thursday
SP	Monday, Tuesday and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday and Thursday
SZ	Tuesday, Thursday and Friday
W	Whenever Necessary

SITUATIONAL **HSD08** **679** **Ship/Delivery Pattern Time Code** **O** **ID** **1/1**
Code which specifies the time for routine shipments or deliveries

INDUSTRY: ***Delivery Pattern Time Code***

ALIAS: ***Time Code***

Required if the order/prescription for the service contains the data.

CODE	DEFINITION
D	A.M.
E	P.M.
F	As Directed

IMPLEMENTATION

REFERRING PROVIDER NAME

Loop: **2310A — REFERRING PROVIDER NAME Repeat: 2**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.**
3. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
4. **Required if claim involved a referral.**
5. **When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.**

Example: **NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

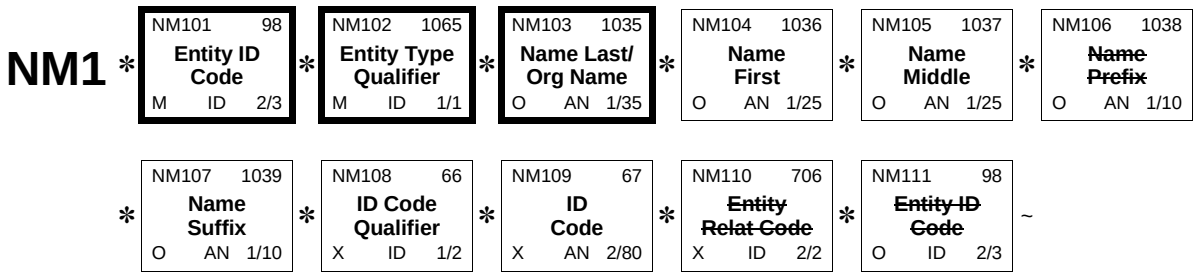
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			The entity identifier in NM101 applies to all segments in this Loop ID-2310.	
			CODE / DEFINITION	
			DN — **Referring Provider** **Use on first iteration of this loop. Use if loop is used only once.**	
			P3 — **Primary Care Provider** **Use only if loop is used twice. Use only on second iteration of this loop.**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE / DEFINITION	
			1 — **Person**	
			2 — **Non-Person Entity**	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Referring Provider Last Name*** **NSF Reference:** **EA0-24.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Referring Provider First Name*** **NSF Reference:** **EA0-25.0**	**O AN 1/25**
			Required if NM102=1 (person).	

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Referring Provider Middle Name*** **NSF Reference:** **EA0-26.0** **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Referring Provider Name Suffix*** *ALIAS:* ***Referring Provider Generation*** **Required if known.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.**	**X**	**ID**	**1/2**

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Referring Provider Identifier*** *ALIAS:* ***Referring Provider Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **EA0-20.0** **Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

REFERRING PROVIDER SPECIALTY INFORMATION

Loop: **2310A — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **Required if required under provider-payer contract.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*RF*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

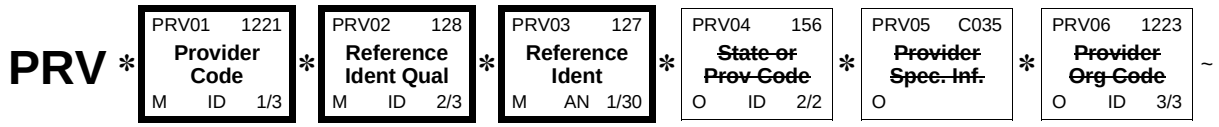
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**

CODE	DEFINITION
RF	**Referring**

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code***	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL REFERRING PROVIDER NAME INFORMATION

Loop: **2310A — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

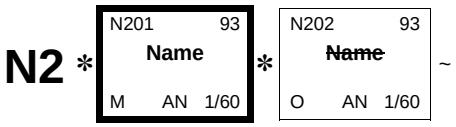
Loop: 2310

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Referring Provider Name Additional Text*** *ALIAS:* ***Referring Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

REFERRING PROVIDER SECONDARY IDENTIFICATION

Loop: **2310A — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required if NM108/09 in this loop is not used or if a secondary number is necessary to identify the provider. Until the NPI is mandated for use, this REF may be required if necessary to adjudicate the claim.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

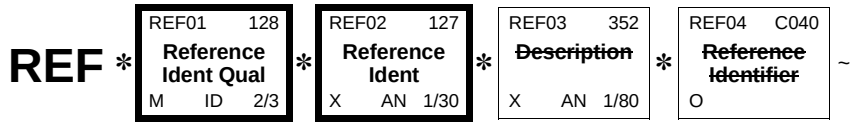
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			SY	**Social Security Number** **The social security number may not be used for Medicare.**		
			X5	**State Industrial Accident Provider Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referring Provider Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **EA0-20.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

RENDERING PROVIDER NAME

Loop: **2310B — RENDERING PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
3. **Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.**
4. **Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a subsitute provider (locum tenans) was used, that person should be entered here.**

Example: **NM1*82*1*BEATTY*GARY*C**SR*XX*12345678~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

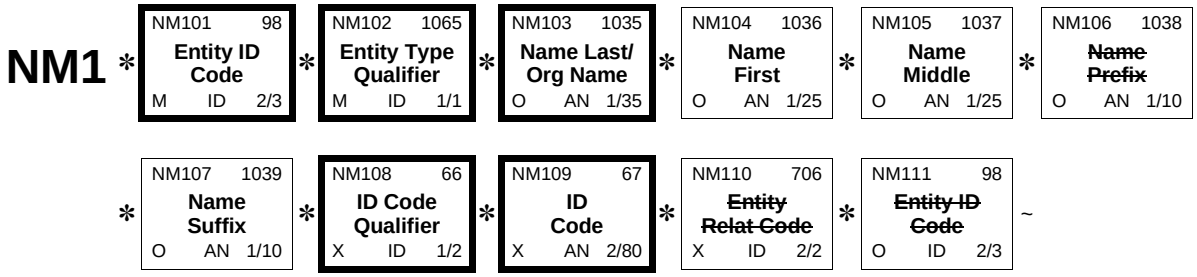
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in this Loop ID-2310.** CODE / DEFINITION **82 Rendering Provider**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1 Person** **2 Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* Rendering Provider Last or Organization Name** ***ALIAS:* Rendering Provider Last Name** **NSF Reference:** **FB1-14.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:* Rendering Provider First Name** **NSF Reference:** **FB1-15.0** **Required if NM102=1 (person).**	**O AN 1/25**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Rendering Provider Middle Name*** **NSF Reference:** **FB1-16.0** **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Rendering Provider Name Suffix*** *ALIAS:* ***Rendering Provider Generation*** **Required if known.**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **NSF Reference:** **FA0-57.0** **FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.**	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Rendering Provider Identifier*** *ALIAS:* ***Rendering Provider Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **FA0-23.0, FA0-58.0** **FA0-58.0 crosswalk is only used in Medicare COB payer-to-payer claims.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

IMPLEMENTATION

RENDERING PROVIDER SPECIALTY INFORMATION

Loop: **2310B — RENDERING PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **PRV02 qualifies PRV03.**

Example: **PRV*PE*ZZ*203BA0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

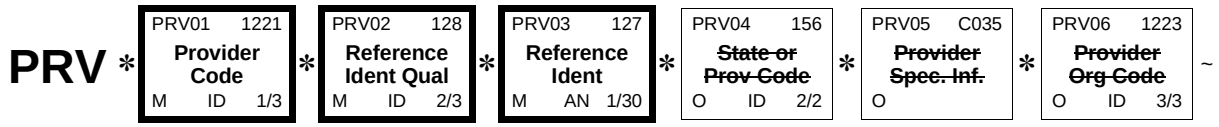
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**
			CODE: **PE** — DEFINITION: **Performing**	

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN**	**1/30**

INDUSTRY: ***Provider Taxonomy Code***

ALIAS: ***Provider Specialty Code***

NSF Reference:

FA0-37.0

NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL RENDERING PROVIDER NAME INFORMATION

Loop: **2310B — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

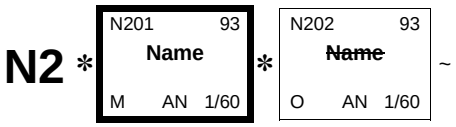
Loop: 2310

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Rendering Provider Name Additional Text*** *ALIAS:* ***Rendering Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RENDERING PROVIDER SECONDARY IDENTIFICATION

Loop: **2310B — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

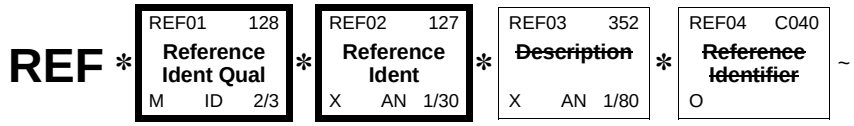
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

NSF Reference:

FA0-57.0

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**

			1G	**Provider UPIN Number**		
			1H	**CHAMPUS Identification Number**		
			EI	**Employer's Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			SY	**Social Security Number** **The social security number may not be used for Medicare.**		
			X5	**State Industrial Accident Provider Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Rendering Provider Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **FA0-58.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

PURCHASED SERVICE PROVIDER NAME

Loop: **2310C — PURCHASED SERVICE PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

3. **Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.**

Example: **NM1*QB*2******FI*111223333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

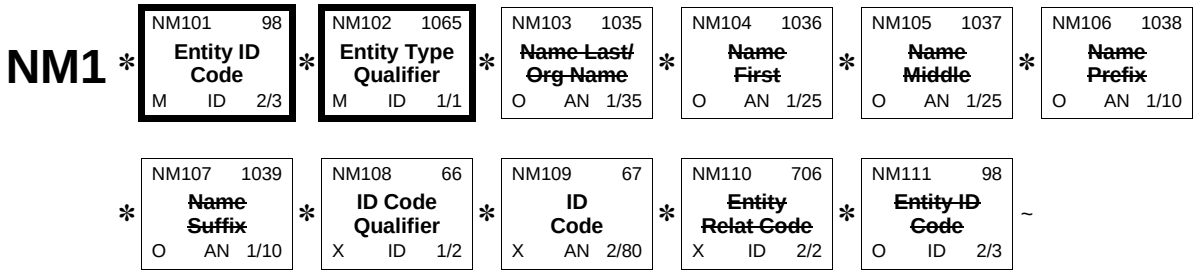
1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION **QB** — **Purchase Service Provider**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** — **Person** **2** — **Non-Person Entity**	**M ID 1/1**
NOT USED	**NM103**	**1035**	**Name Last or Organization Name**	**O AN 1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.** CODE / DEFINITION **24** — **Employer's Identification Number** **34** — **Social Security Number** **XX** — **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***	**X ID 1/2**

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Purchased Service Provider Identifier*** *ALIAS:* ***Purchased Service Provider Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **FB0-11.0** **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

PURCHASED SERVICE PROVIDER SECONDARY IDENTIFICATION

Loop: **2310C — PURCHASED SERVICE PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/9 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

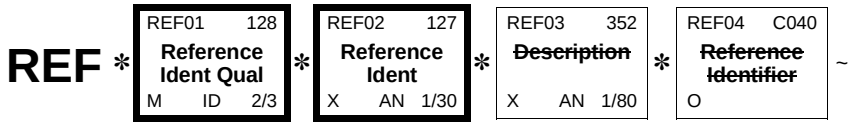
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			U3	**Unique Supplier Identification Number (USIN)**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Purchased Service Provider Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **FB0-11.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE FACILITY LOCATION

Loop: **2310D — SERVICE FACILITY LOCATION Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
3. **This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.**
4. **Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address.**
5. **The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05-1 should indicate that the service occurred in the patient's home.**

Example: **NM1*TL*2*A-OK MOBILE CLINIC*****24*11122333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

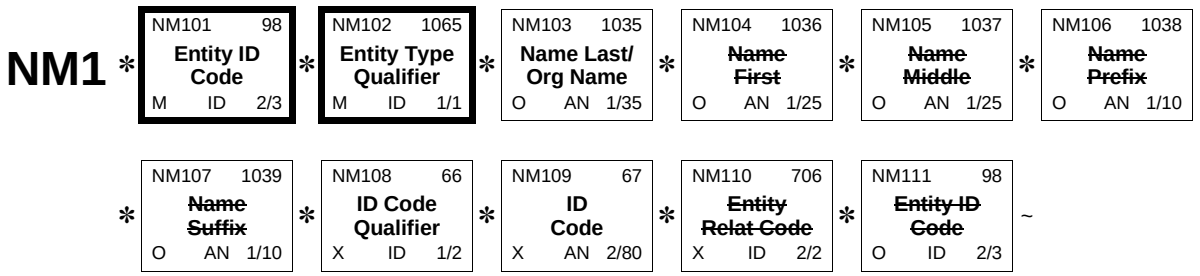
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION **77** — **Service Location** **Use when other codes in this element do not apply.** **FA** — **Facility** **LI** — **Independent Lab** **TL** — **Testing Laboratory**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **2** — **Non-Person Entity**	**M ID 1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* *Laboratory or Facility Name*** ***ALIAS:* *Laboratory/Facility Name*** **NSF Reference:** **EA0-39.0** **Required except when service was rendered in the patient's home.**	**O AN 1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: ***Laboratory or Facility Primary Identifier*** ALIAS: ***Laboratory/Facility Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **EA1-04.0, EA0-53.0**	**X**	**AN**	**2/80**

Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL SERVICE FACILITY LOCATION NAME INFORMATION

Loop: **2310D — SERVICE FACILITY LOCATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

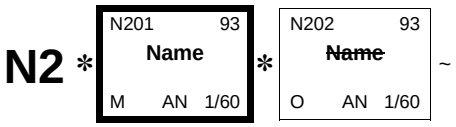
Loop: 2310

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Laboratory or Facility Name Additional Text*** *ALIAS:* ***Laboratory/Facility Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SERVICE FACILITY LOCATION ADDRESS

Loop: **2310D — SERVICE FACILITY LOCATION**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., “crossroad of State Road 34 and 45" or ”Exit near Mile marker 265 on Interstate 80".)**

Example: **N3*123 MAIN STREET~**

STANDARD

N3 Address Information

Level: Detail

Position: 265

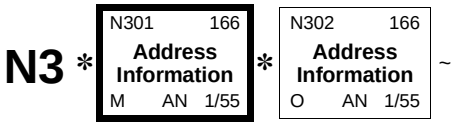
Loop: 2310

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Laboratory or Facility Address Line*** *ALIAS:* ***Laboratory/Facility Address 1*** **NSF Reference:** **EA1-06.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Laboratory or Facility Address Line*** *ALIAS:* ***Laboratory/Facility Address 2*** **NSF Reference:** **EA1-07.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

SERVICE FACILITY LOCATION CITY/STATE/ZIP

Loop: **2310D — SERVICE FACILITY LOCATION**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.**

Example: **N4*ANY TOWN*TX*75123~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 270

Loop: 2310

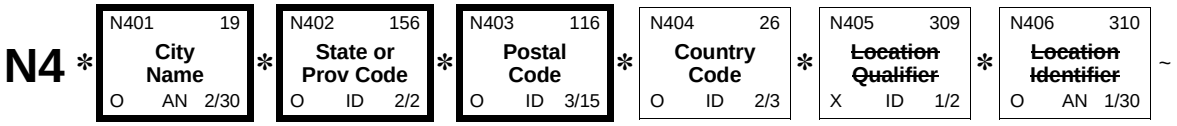
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Laboratory or Facility City Name*** *ALIAS:* ***Laboratory/Facility City*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **EA1-08.0**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Laboratory or Facility State or Province Code*** *ALIAS:* ***Laboratory/Facility State*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **NSF Reference:** **EA1-09.0**	**O**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Laboratory or Facility Postal Zone or ZIP Code*** *ALIAS:* ***Laboratory/Facility Zip Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **EA1-10.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Laboratory/Facility Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

Loop: **2310D — SERVICE FACILITY LOCATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

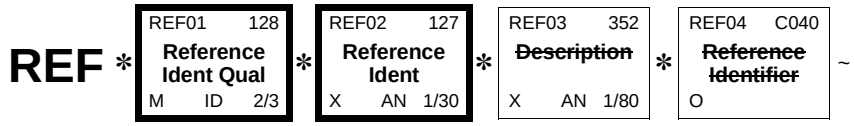
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			TJ	**Federal Taxpayer's Identification Number**		
			X4	**Clinical Laboratory Improvement Amendment Number**		
			X5	**State Industrial Accident Provider Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Laboratory or Facility Secondary Identifier*** *ALIAS:* ***Laboratory/Facility Secondary Identification Number*** SYNTAX: R0203 **NSF Reference:** **EA1-04.0, EA0-53.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SUPERVISING PROVIDER NAME

Loop: **2310E — SUPERVISING PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **Required when the rendering provider is supervised by a physician.**
3. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*DQ*1*KILLIAN*BART*B**II*24*222334444~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

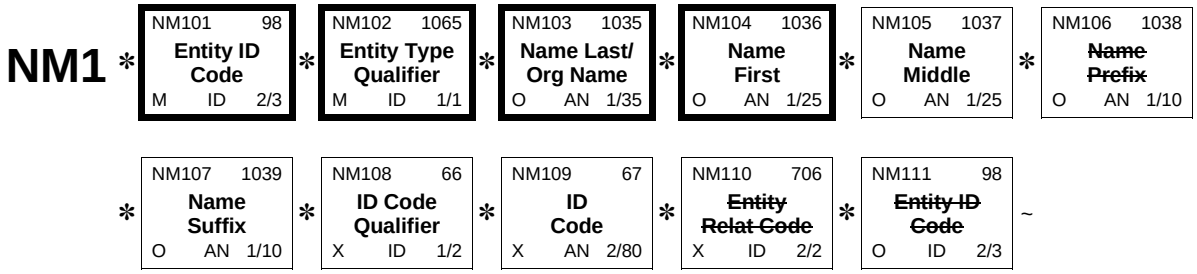
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: DQ — DEFINITION: Supervising Physician	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Supervising Provider Last Name*** **NSF Reference:** **EA1-18.0**	O AN 1/35
REQUIRED	NM104	1036	**Name First** Individual first name *INDUSTRY:* ***Supervising Provider First Name*** **NSF Reference:** **EA1-19.0**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Supervising Provider Middle Name*** **NSF Reference:** **EA1-20.0** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Supervising Provider Name Suffix*** *ALIAS:* ***Supervising Provider Generation*** **Required if known.**	O AN 1/10

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for Medicare.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Supervising Provider Identifier*** *ALIAS:* ***Supervising Provider Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **EA1-16.0**	**X**	**AN**	**2/80**

Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL SUPERVISING PROVIDER NAME INFORMATION

Loop: **2310E — SUPERVISING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

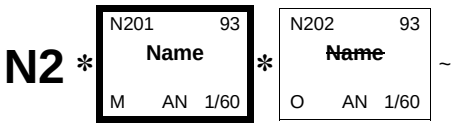
Loop: 2310

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Supervising Provider Name Additional Text*** *ALIAS:* ***Supervising Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SUPERVISING PROVIDER SECONDARY IDENTIFICATION

Loop: **2310E — SUPERVISING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/9 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

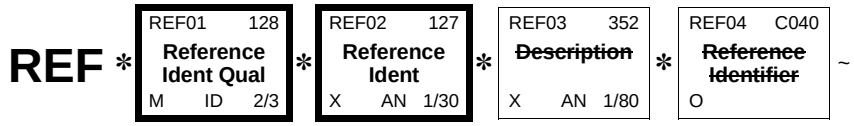
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Supervising Provider Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **EA1-16.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER SUBSCRIBER INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION Repeat: 10**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if other payers are known to potentially be involved in paying on this claim.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

3. **All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 Loop again with it's respective 2330 Loops.**

   See Section 1.4.4 for more information on handling COB.

4. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **SBR*S*01*GR00786**MC****OF~**

STANDARD

SBR Subscriber Information

Level: Detail

Position: 290

Loop: 2320 **Repeat:** 10

Requirement: Optional

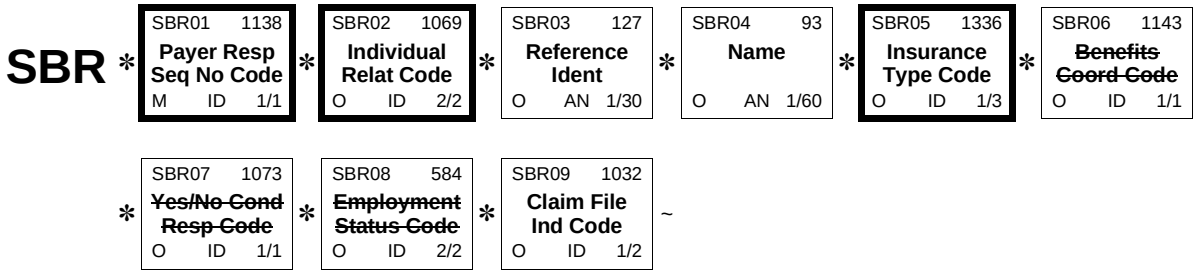
Max Use: 1

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Set Notes:

1. Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim *ALIAS:* ***Payer responsibility sequence number code*** **NSF Reference:** **DA0-02.0, DA1-02.0, DA2-02.0**	**M ID 1/1**

CODE	DEFINITION
P	**Primary**
S	**Secondary**
T	**Tertiary**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities *ALIAS:* ***Individual relationship code*** SEMANTIC: SBR02 specifies the relationship to the person insured. **NSF Reference:** **DA0-17.0**	**O ID 2/2**

CODE	DEFINITION
01	**Spouse**
04	**Grandfather or Grandmother**
05	**Grandson or Granddaughter**
07	**Nephew or Niece**
10	**Foster Child**
15	**Ward**
17	**Stepson or Stepdaughter**
18	**Self**
19	**Child**

			20	**Employee**			
			21	**Unknown**			
			22	**Handicapped Dependent**			
			23	**Sponsored Dependent**			
			24	**Dependent of a Minor Dependent**			
			29	**Significant Other**			
			32	**Mother**			
			33	**Father**			
			36	**Emancipated Minor**			
			39	**Organ Donor**			
			40	**Cadaver Donor**			
			41	**Injured Plaintiff**			
			43	**Child Where Insured Has No Financial Responsibility**			
			53	**Life Partner**			
			G8	**Other Relationship**			
SITUATIONAL	**SBR03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Insured Group or Policy Number*** *ALIAS:* ***Group or Policy Number*** **SEMANTIC:** SBR03 is policy or group number. **NSF Reference:** **DA0-10.0**		**O**	**AN**	**1/30**
			Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).				
SITUATIONAL	**SBR04**	**93**	**Name** Free-form name *INDUSTRY:* ***Other Insured Group Name*** *ALIAS:* ***Group or Plan Name*** **SEMANTIC:** SBR04 is plan name. **NSF Reference:** **DA0-11.0**		**O**	**AN**	**1/60**
			Required if the subscriber's payer identification includes a Group or Plan Name.				

REQUIRED	SBR05	1336	**Insurance Type Code** Code identifying the type of insurance policy within a specific insurance program	O	ID	1/3

ALIAS: ***Insurance type code***

NSF Reference:

DA0-06.0

CODE	DEFINITION
AP	Auto Insurance Policy
C1	Commercial
CP	Medicare Conditionally Primary
GP	Group Policy
HM	Health Maintenance Organization (HMO)
IP	Individual Policy
LD	Long Term Policy
LT	Litigation
MB	Medicare Part B
MC	Medicaid
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PP	Personal Payment (Cash - No Insurance)
SP	Supplemental Policy

NOT USED	SBR06	1143	**Coordination of Benefits Code**	O	ID	1/1
NOT USED	SBR07	1073	**Yes/No Condition or Response Code**	O	ID	1/1
NOT USED	SBR08	584	**Employment Status Code**	O	ID	2/2
SITUATIONAL	SBR09	1032	**Claim Filing Indicator Code** Code identifying type of claim	O	ID	1/2

ALIAS: ***Claim filing indicator code***

NSF Reference:

DA0-05.0

Required prior to mandated used of PlanID. Not used after PlanID is mandated.

CODE	DEFINITION
09	Self-pay
10	Central Certification NSF Reference: CA0-23.0 (K), DA0-05.0 (K)

11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan Refers to Veterans Affairs Plan.
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined Unknown

IMPLEMENTATION

CLAIM LEVEL ADJUSTMENTS

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

Usage: SITUATIONAL

Repeat: 5

Notes:

1. Submitters should use this CAS segment to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged.

2. Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment again.

3. Codes and associated amounts should come from 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment.

4. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information.

5. To locate the claim adjustment group codes (CAS01) and claim adjustment reason codes (CAS02, 05, 08, 11, 14, and 17) see the Washington Publishing Company web site: http://www.wpc-edi.com. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.

6. There several NSF fields which are not directly crosswalked from the 837 to NSF, particularly with respect to payer-to-payer COB situations. Below is a list of some of these NSF fields and some suggestions regarding how to handle them in the 837.

Provider Adjustment Amt (DA3-25.0). This would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level. See the 835 for how to balance the CAS adjustments against the total billed amount.

Beneficiary liability amount (FA0-53.0) This amount would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level when CAS01 = PR (patient responsibility).

Amount paid to Provider (DA1-33.0). This would be calculated through the use of the CAS codes. Please see the detail on the codes and the discussion of how to use them in the 835 implementation guide.

Balance bill limit charge (FA0-54.0). This would equal any CAS adjustment where CAS01=CO and one of the adjustment reason code elements equaled “45".

Beneficiary Adjustment Amt (DA3-26.0) Amount paid to beneficiary (DA1-30.0)). The amount paid to the beneficiary is indicated by the use of CAS code ”100 - Payment made to patient/insured/responsible party."

Original Paid Amount (DA3-28.0): The original paid amount can be calculated from the original COB claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.

Example: **CAS*PR*1*7.93~**

Example: **CAS*OA*93*15.06~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 295

Loop: 2320

Requirement: Optional

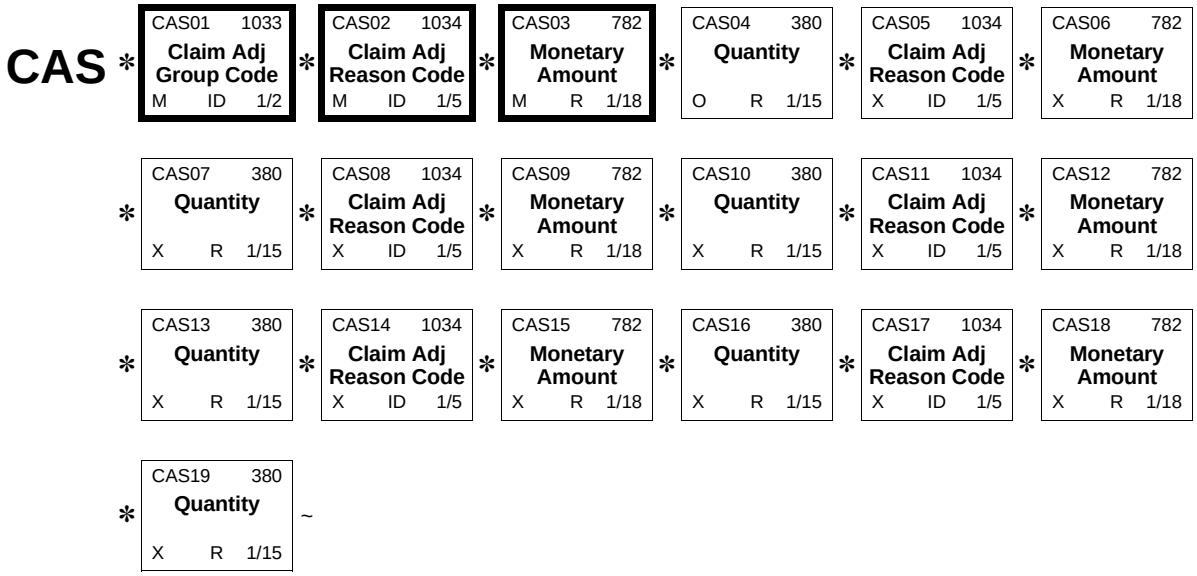
Max Use: 99

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Syntax: **1. L050607**
If CAS05 is present, then at least one of CAS06 or CAS07 are required.

2. **C0605**
   If CAS06 is present, then CAS05 is required.
3. **C0705**
   If CAS07 is present, then CAS05 is required.
4. **L080910**
   If CAS08 is present, then at least one of CAS09 or CAS10 are required.
5. **C0908**
   If CAS09 is present, then CAS08 is required.
6. **C1008**
   If CAS10 is present, then CAS08 is required.
7. **L111213**
   If CAS11 is present, then at least one of CAS12 or CAS13 are required.
8. **C1211**
   If CAS12 is present, then CAS11 is required.
9. **C1311**
   If CAS13 is present, then CAS11 is required.
10. **L141516**
    If CAS14 is present, then at least one of CAS15 or CAS16 are required.
11. **C1514**
    If CAS15 is present, then CAS14 is required.
12. **C1614**
    If CAS16 is present, then CAS14 is required.
13. **L171819**
    If CAS17 is present, then at least one of CAS18 or CAS19 are required.
14. **C1817**
    If CAS18 is present, then CAS17 is required.
15. **C1917**
    If CAS19 is present, then CAS17 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment *ALIAS:* ***Claim Adjustment Group Code***	**M ID 1/2**
REQUIRED	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** *ALIAS:* ***Adjustment Reason Code - Claim Level*** CODE SOURCE **139:** Claim Adjustment Reason Code **NSF Reference:** **DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-16.0, DA1-30.0**	**M ID 1/5**

CODE	DEFINITION
CO	**Contractual Obligations**
CR	**Correction and Reversals**
OA	**Other adjustments**
PI	**Payor Initiated Reductions**
PR	**Patient Responsibility**

REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Claim Level***

SEMANTIC: CAS03 is the amount of adjustment.

COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.

NSF Reference:

DA1-09.0, DA1-10.0, DA1-11.0, DA1-12.0, DA1-13.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0

SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Claim Level***

SEMANTIC: CAS04 is the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Claim Level***

SYNTAX: L050607, C0605, C0705

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-17.0, DA1-30.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Claim Level***

SYNTAX: L050607, C0605

SEMANTIC: CAS06 is the amount of the adjustment.

NSF Reference:

DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS07**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Claim Level***

SYNTAX: L050607, C0705

SEMANTIC: CAS07 is the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS08**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Claim Level***

SYNTAX: L080910, C0908, C1008

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0, DA1-18.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Claim Level***

SYNTAX: L080910, C0908

SEMANTIC: CAS09 is the amount of the adjustment.

NSF Reference:

DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Claim Level***

SYNTAX: L080910, C1008

SEMANTIC: CAS10 is the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Claim Level***

SYNTAX: L111213, C1211, C1311

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Claim Level***

SYNTAX: L111213, C1211

SEMANTIC: CAS12 is the amount of the adjustment.

NSF Reference:

DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Claim Level***

SYNTAX: L111213, C1311

SEMANTIC: CAS13 is the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Claim Level***

SYNTAX: L141516, C1514, C1614

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Claim Level***

SYNTAX: L141516, C1514

SEMANTIC: CAS15 is the amount of the adjustment.

NSF Reference:

DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Claim Level***

SYNTAX: L141516, C1614

SEMANTIC: CAS16 is the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Claim Level***

SYNTAX: L171819, C1817, C1917

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Claim Level***

SYNTAX: L171819, C1817

SEMANTIC: CAS18 is the amount of the adjustment.

NSF Reference:

DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0

Use as needed to show payer adjustment.

SITUATIONAL	**CAS19**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Claim Level***

SYNTAX: L171819, C1917

SEMANTIC: CAS19 is the units of service being adjusted.

Use as needed to show payer adjustment.

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required if claim has been adjudicated by payer identified in this loop. It is acceptable to show "0" amount paid.

Example: AMT*D*411~

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

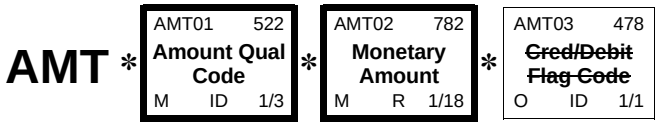
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	AMT01	522	**Amount Qualifier Code** Code to qualify amount	M	ID	1/3
			CODE / DEFINITION			
			D — Payor Amount Paid			
REQUIRED	AMT02	782	**Monetary Amount** Monetary amount	M	R	1/18
			INDUSTRY: ***Payer Paid Amount***			
			This is a crosswalk from CLP04 in 835 when doing COB.			
NOT USED	AMT03	478	**Credit/Debit Flag Code**	O	ID	1/1

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) APPROVED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available.**

2. **The approved amount equals the amount for the total claim that was approved by the payer sending this 837 to another payer.**

Example: **AMT*AAE*500.35~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

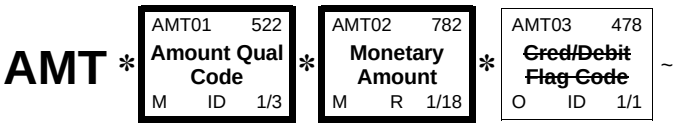
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			AAE Approved Amount			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Approved Amount*** **NSF Reference:** **DA1-37.0**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) ALLOWED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available.**

2. **The allowed amount equals the amount for the total claim that was allowed by the payer sending this 837 to another payer.**

Example: **AMT*B6*519.21~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

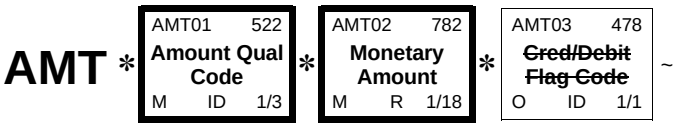
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			B6 Allowed - Actual			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Allowed Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PATIENT RESPONSIBILITY AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1).**

Example: **AMT*F2*15~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

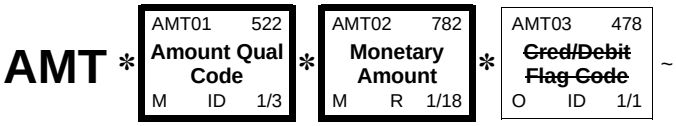
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **F2 — Patient Responsibility - Actual**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Other Payer Patient Responsibility Amount*** **This is a crosswalk from CLP05 in 835 when doing COB.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) COVERED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available.**
2. **The covered amount equals the amount for the total claim that was covered by the payer sending this 837 to another payer.**

Example: **AMT*AU*50~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

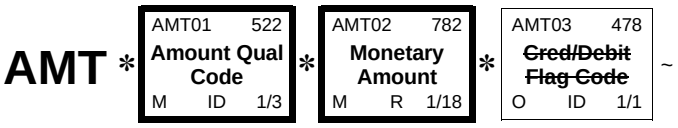
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			AU — Coverage Amount			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Other Payer Covered Amount***			
			This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = AU.			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) DISCOUNT AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.**

Example: **AMT*D8*35~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

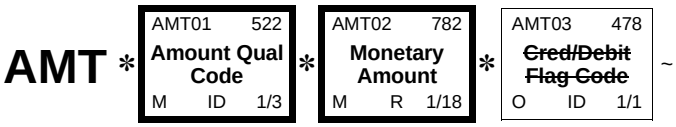
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **D8 — Discount Amount**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Other Payer Discount Amount*** **This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = D8.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PER DAY LIMIT AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.**

Example: **AMT*DY*46~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

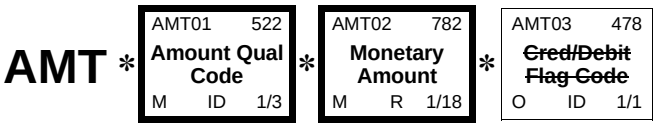
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **DY — Per Day Limit**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Other Payer Per Day Limit Amount*** **This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = DY.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PATIENT PAID AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.**
2. **The amount carried in this segment is the total amount of money paid by the payer to the patient (rather than to the provider) on this claim.**

Example: **AMT*F5*152.45~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

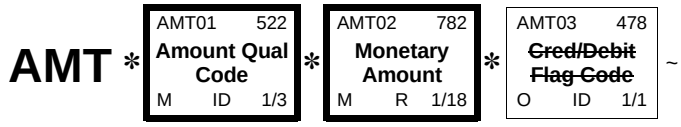
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **F5 — Patient Amount Paid**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Other Payer Patient Paid Amount*** **This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = F5.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TAX AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.**

Example: **AMT*T*45~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

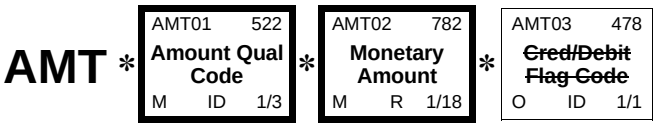
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **T** **Tax**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY: **Other Payer Tax Amount*** **This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = T.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TOTAL CLAIM BEFORE TAXES AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.**

Example: **AMT*T2*456~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

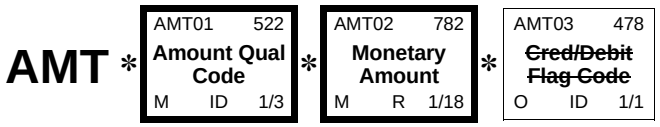
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **T2 — Total Claim Before Taxes**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY: **Other Payer Pre-Tax Claim Total Amount*** **This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = T2.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when 2330A NM102 = 1 (person).**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **DMG*D8*19671105*F~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 305

Loop: 2320

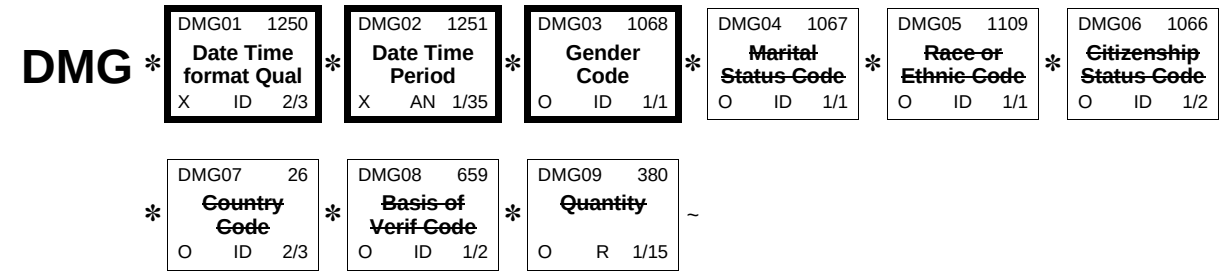
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

Syntax:
1. **P0102**
   If either DMG01 or DMG02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DMG01**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SYNTAX: P0102	**X ID 2/3**

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Other Insured Birth Date*** *ALIAS:* ***Date of Birth - Subscriber*** **SYNTAX:** P0102 **SEMANTIC:** DMG02 is the date of birth. **NSF Reference:** **DA0-24.0**	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Other Insured Gender Code*** *ALIAS:* ***Gender - Subscriber*** **NSF Reference:** **DA0-23.0**	**O**	**ID**	**1/1**

CODE	DEFINITION
F	**Female**
M	**Male**
U	**Unknown**

NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

IMPLEMENTATION

OTHER INSURANCE COVERAGE INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.**

2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **OI✻✻✻Y✻B✻✻Y~**

STANDARD

OI Other Health Insurance Information

Level: Detail

Position: 310

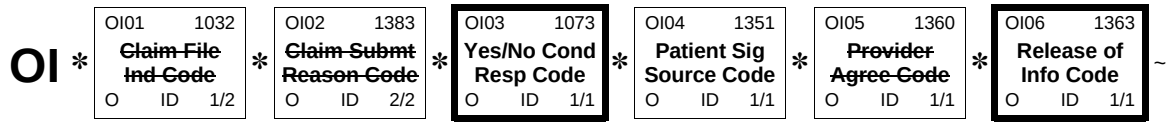
Loop: 2320

Requirement: Optional

Max Use: 1

Purpose: To specify information associated with other health insurance coverage

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
NOT USED	OI01	1032	Claim Filing Indicator Code	O	ID	1/2
NOT USED	OI02	1383	Claim Submission Reason Code	O	ID	2/2

REQUIRED **OI03** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Benefits Assignment Certification Indicator***

ALIAS: ***Assignment of Benefits Indicator***

SEMANTIC: OI03 is the assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

NSF Reference:

DA0-15.0

This is a crosswalk from CLM08 when doing COB.

CODE	DEFINITION
N	**No**
Y	**Yes**

SITUATIONAL **OI04** **1351** **Patient Signature Source Code** **O** **ID** **1/1**
Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider

ALIAS: ***Patient Signature Source Code***

NSF Reference:

DA0-16.0

Required except in cases where ''N'' is used in OI06.

This is a crosswalk from CLM10 when doing COB.

CODE	DEFINITION
B	**Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file**
C	**Signed HCFA-1500 Claim Form on file**
M	**Signed signature authorization form for HCFA-1500 Claim Form block 13 on file**
P	**Signature generated by provider because the patient was not physically present for services**
S	**Signed signature authorization form for HCFA-1500 Claim Form block 12 on file**

NOT USED **OI05** **1360** **Provider Agreement Code** **O** **ID** **1/1**

REQUIRED **OI06** **1363** **Release of Information Code** **O** **ID** **1/1**
Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations

ALIAS: ***Release of Information Code***

This is a crosswalk from CLM09 when doing COB.

CODE	DEFINITION
A	**Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization**

I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes
M	The Provider has Limited or Restricted Ability to Release Data Related to a Claim
N	No, Provider is Not Allowed to Release Data
O	On file at Payor or at Plan Sponsor
Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

IMPLEMENTATION

MEDICARE OUTPATIENT ADJUDICATION INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if returned in the electronic remittance advice (835).**

Example: **MOA***A4~

STANDARD

MOA Medicare Outpatient Adjudication

Level: Detail

Position: 320

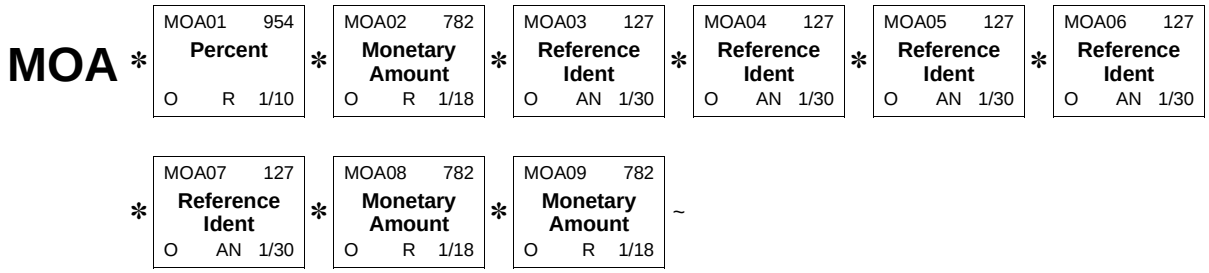
Loop: 2320

Requirement: Optional

Max Use: 1

Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**MOA01**	**954**	**Percent** Percentage expressed as a decimal *INDUSTRY:* ***Reimbursement Rate*** *ALIAS:* ***Outpatient Reimbursement Rate*** **SEMANTIC:** MOA01 is the reimbursement rate. **Required if returned in the electronic remittance advice (835).**	**O R 1/10**

SITUATIONAL	**MOA02**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***HCPCS Payable Amount***

SEMANTIC: MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

ALIAS: ***Remarks Code***

SEMANTIC: MOA03 is the Remittance Remark Code. See Code Source 411.

NSF Reference:

DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

ALIAS: ***Remarks Code***

SEMANTIC: MOA04 is the Remittance Remark Code. See Code Source 411.

NSF Reference:

DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA05**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

ALIAS: ***Remarks Code***

SEMANTIC: MOA05 is the Remittance Remark Code. See Code Source 411.

NSF Reference:

DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

ALIAS: ***Remarks Code***

SEMANTIC: MOA06 is the Remittance Remark Code. See Code Source 411.

NSF Reference:

DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA07**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

ALIAS: ***Remarks Code***

SEMANTIC: MOA07 is the Remittance Remark Code. See Code Source 411.

NSF Reference:

DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA08**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***End Stage Renal Disease Payment Amount***

ALIAS: ***ESRD Paid Amount***

SEMANTIC: MOA08 is the End Stage Renal Disease (ESRD) payment amount.

Required if returned in the electronic remittance advice (835).

SITUATIONAL	**MOA09**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Non-Payable Professional Component Billed Amount***

ALIAS: ***Professional Component***

SEMANTIC: MOA09 is the professional component amount billed but not payable.

Required if returned in the electronic remittance advice (835).

IMPLEMENTATION

OTHER SUBSCRIBER NAME

Loop: 2330A — OTHER SUBSCRIBER NAME Repeat: 1

Usage: REQUIRED

Repeat: 1

Notes:
1. **Submitters are required to send information on all known other subscribers in Loop ID-2330.**
2. **This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: NM1*IL*1*DOE*JOHN*TJR*MI*123456~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

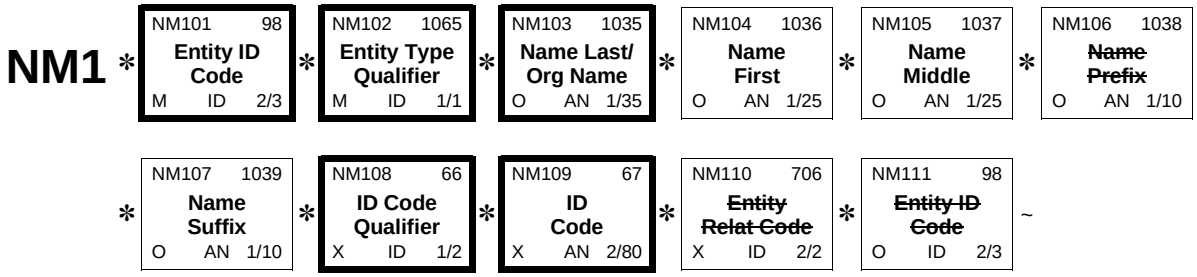
Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:
1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:
1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** M ID 2/3 Code identifying an organizational entity, a physical location, property or an individual CODE: **IL** DEFINITION: **Insured or Subscriber**	
REQUIRED	NM102	1065	**Entity Type Qualifier** M ID 1/1 Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: **1** DEFINITION: **Person** CODE: **2** DEFINITION: **Non-Person Entity**	
REQUIRED	NM103	1035	**Name Last or Organization Name** O AN 1/35 Individual last name or organizational name *INDUSTRY:* ***Other Insured Last Name*** *ALIAS:* ***Subscriber Last Name*** **NSF Reference:** **DA0-19.0**	
SITUATIONAL	NM104	1036	**Name First** O AN 1/25 Individual first name *INDUSTRY:* ***Other Insured First Name*** *ALIAS:* ***Subscriber First Name*** **NSF Reference:** **DA0-20.0** **Required if NM102=1 (person).**	
SITUATIONAL	NM105	1037	**Name Middle** O AN 1/25 Individual middle name or initial *INDUSTRY:* ***Other Insured Middle Name*** *ALIAS:* ***Subscriber Middle Name*** **NSF Reference:** **DA0-21.0** **Required if NM102=1 and the middle name/initial of the person is known.**	
NOT USED	NM106	1038	**Name Prefix** O AN 1/10	

SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Other Insured Name Suffix***

ALIAS: ***Subscriber Generation***

NSF Reference:

DA0-22.0

Required if known.

Examples: I, II, III, IV, Jr, Sr

REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

CODE	DEFINITION
MI	**Member Identification Number** **The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Other Insured Identifier***

ALIAS: ***Other Subscriber Primary Identifier***

SYNTAX: P0809

NSF Reference:

DA0-18.0

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL OTHER SUBSCRIBER NAME INFORMATION

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 330

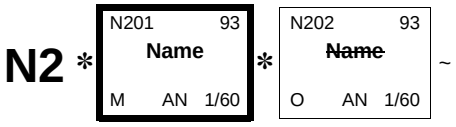
Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Other Insured Additional Name*** *ALIAS:* ***Subscriber Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

OTHER SUBSCRIBER ADDRESS

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when information is available.**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **N3*4320 WASHINGTON ST*SUITE 100~**

STANDARD

N3 Address Information

Level: Detail

Position: 332

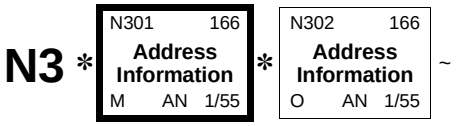
Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Other Insured Address Line*** *ALIAS:* ***Subscriber Address 1*** **NSF Reference:** **DA2-04.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Other Insured Address Line*** *ALIAS:* ***Subscriber Address 2*** **NSF Reference:** **DA2-05.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

OTHER SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when information is available.**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **N4✻PALISADES✻OR✻23119~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 340

Loop: 2330

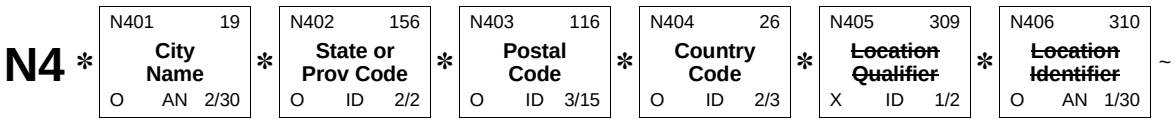
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax:
1. **C0605**
   If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Other Insured City Name*** *ALIAS:* ***Subscriber City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **DA2-06.0** **Required when information is available.**	**O AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Other Insured State Code*** *ALIAS:* ***Subscriber State Code*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **NSF Reference:** **DA2-07.0** **Required when information is available.**	**O**	**ID**	**2/2**
SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Other Insured Postal Zone or ZIP Code*** *ALIAS:* ***Subscriber Zip Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **DA2-08.0** **Required when information is available.**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Subscriber Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

OTHER SUBSCRIBER SECONDARY IDENTIFICATION

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:
1. **Required if additional identification numbers are necessary to adjudicate the claim/encounter.**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*SY*528446666~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

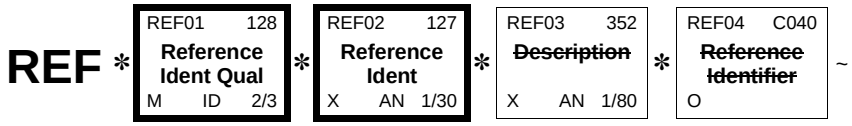
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1W	**Member Identification Number**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHC/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**

			IG	**Insurance Policy Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Insured Additional Identifier*** *ALIAS:* ***Other Subscriber Secondary Identification*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER PAYER NAME

Loop: **2330B — OTHER PAYER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **Submitters are required to send all known information on other payers in this Loop ID-2330.**
2. **This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **NM1*PR*2*UNION MUTUAL OF OREGON*****PI*11122333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

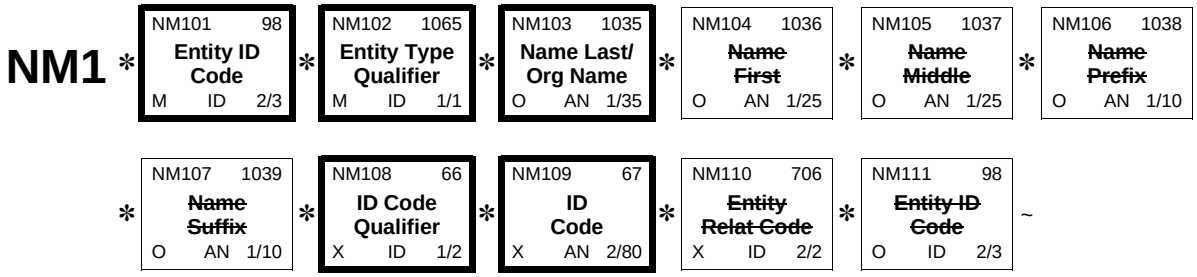
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: PR — DEFINITION: Payer	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 2 — DEFINITION: Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Other Payer Last or Organization Name*** *ALIAS: **Payer Name*** **NSF Reference:** **DA0-09.0**	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: PI — DEFINITION: Payor Identification CODE: XV — DEFINITION: Health Care Financing Administration National PlanID ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.*** CODE SOURCE 540: Health Care Financing Administration National PlanID	X ID 1/2

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Payer Primary Identifier*** *ALIAS:* ***Other Payer Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **DA0-07.0** **This number must be identical to SVD01 (Loop ID-2430) for COB.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL OTHER PAYER NAME INFORMATION

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 330

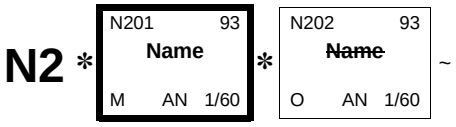
Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Other Payer Additional Name Text*** *ALIAS:* ***Payer Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

OTHER PAYER CONTACT INFORMATION

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **This segment is used only in payer-to-payer COB situations. This segment may be completed by a payer who has adjudicated the claim and is passing it on to a secondary payer. It is not completed by submitting providers.**

2. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g., (534) 224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

3. **There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.**

Example: **PER*IC*SHELLY*TE*5552340000~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 345

Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To identify a person or office to whom administrative communications should be directed

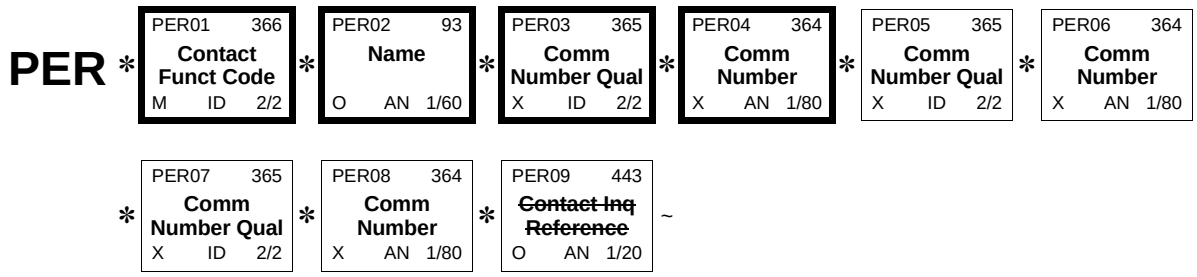
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			CODE / DEFINITION **IC** — **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Other Payer Contact Name***	**O AN 1/60**
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 CODE / DEFINITION **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **FX** — **Facsimile** **TE** — **Telephone**	**X ID 2/2**
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0304	**X AN 1/80**
SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Used at the discretion of the submitter.** CODE / DEFINITION **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **EX** — **Telephone Extension** **FX** — **Facsimile**	**X ID 2/2**

			TE **Telephone**			
SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **Used at the discretion of the submitter.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Used at the discretion of the submitter.**	**X**	**ID**	**2/2**
			CODE DEFINITION			
			ED **Electronic Data Interchange Access Number**			
			EM **Electronic Mail**			
			EX **Telephone Extension**			
			FX **Facsimile**			
			TE **Telephone**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708 **Used at the discretion of the submitter.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

CLAIM ADJUDICATION DATE

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when the payer identified in this iteration of the 2330 loop has previously adjudicated the claim and Loop-ID 2430 (Line Adjudication Information) is not used.**

Example: **DTP*573*D8*19980314~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 345

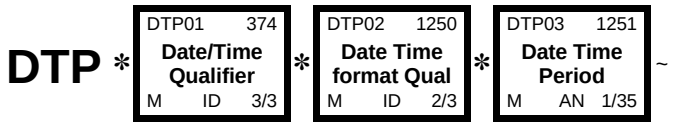
Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **573 — Date Claim Paid**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Adjudication or Payment Date***

NSF Reference:

DA1-27.0

IMPLEMENTATION

OTHER PAYER SECONDARY IDENTIFIER

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**
2. **Used when it is necessary to identify the 'other' payer's claim number in a payer-to-payer COB situation (use code F8). Code F8 is not used by providers.**
3. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**
4. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*FY*435261708~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

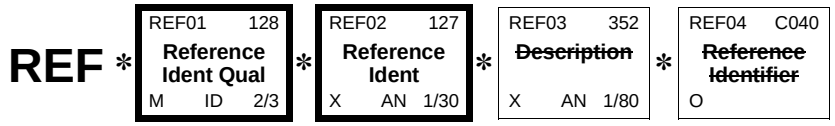
Max Use: 3

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
2U	**Payer Identification Number**

			F8	**Original Reference Number** **Use to indicate the payer's claim number for this claim for the payer identified in this iteration of the 2330B loop.**			
			FY	**Claim Office Number**			
			NF	**National Association of Insurance Commissioners (NAIC) Code** CODE SOURCE **245:** National Association of Insurance Commissioners (NAIC) Code			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **DA3-29.0** **The DA3-29.0 crosswalk is only used in payer-to-payer COB situations.**		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Used when the payer identified in this loop has given a prior authorization or referral number to this claim. This element is primarily used in payer-to-payer COB situations.**
2. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*G1*AB333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

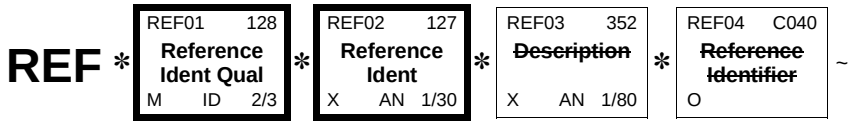
Max Use: 3

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Prior Authorization or Referral Number*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER CLAIM ADJUSTMENT INDICATOR

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Used only in payer-to-payer COB. In that situation, the destination payer is secondary to the payer identified in this loop. Providers/other submitters do not use this segment.**

2. **Required when the payer identified in this loop has previously paid this claim and has indicated so to the destination payer. In this case the payer identified in this loop has readjudicated the claim and is sending the adjusted payment information to the destination payer. This REF segment is used to indicate that this claim is an adjustment of a previously adjudicated claim. If the claim has not been previously adjudicated this REF is not used.**

3. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**

Example: **REF*T4*Y~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

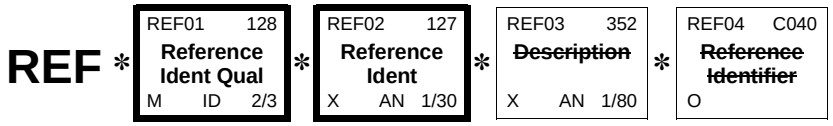
Max Use: 3

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE: **T4** — DEFINITION: **Signal Code**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Claim Adjustment Indicator*** **SYNTAX:** R0203 **NSF Reference:** **DA3-24.0** **Allowable values are "Y" indicating that the payer in this loop has previously adjudicated this claim and sent a record of that adjudication to the destination payer identified in the 2010BB loop. The claim being transmitted in this iteration of the 2300 loop is a re-adjudicated version of that claim.**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

OTHER PAYER PATIENT INFORMATION

Loop: 2330C — OTHER PAYER PATIENT INFORMATION Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Required when it is necessary, in COB situations, to send one or more payer-specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330 loop are those patient ID's which belong to non-destination (COB) payers. The patient ID(s) forr the destination payer are carried in the 2010CA loop NM1 and REF segments. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling non-destination payer patient identifiers and other COB elements.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: NM1*QC*1****MI*6677U801~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

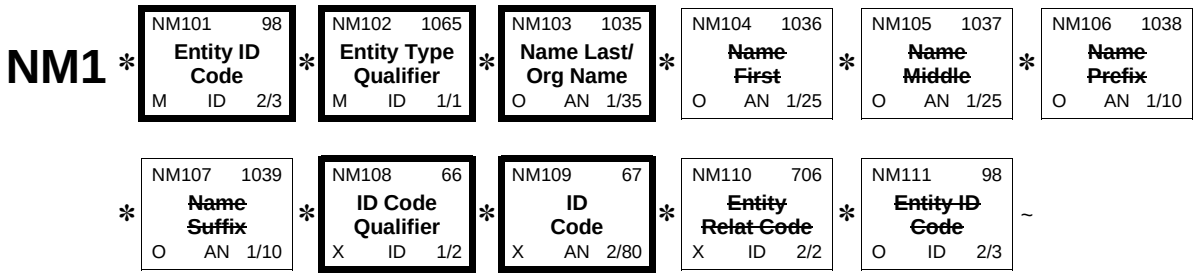
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: QC — DEFINITION: Patient	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Patient Last Name***	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: MI — DEFINITION: Member Identification Number **The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.**	X ID 1/2
REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code *INDUSTRY: **Other Payer Patient Primary Identifier*** *ALIAS: **Patient's Other Payer Primary Identification Number*** SYNTAX: P0809	X AN 2/80
NOT USED	NM110	706	**Entity Relationship Code**	X ID 2/2
NOT USED	NM111	98	**Entity Identifier Code**	O ID 2/3

IMPLEMENTATION

OTHER PAYER PATIENT IDENTIFICATION

Loop: **2330C — OTHER PAYER PATIENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:
1. **Used when a COB payer (listed in 2330B loop) has one or more proprietary patient identification numbers for this claim. The patient (name, DOB, etc) is identified in the 2010BA or 2010CA loop.**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*AZ*B333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

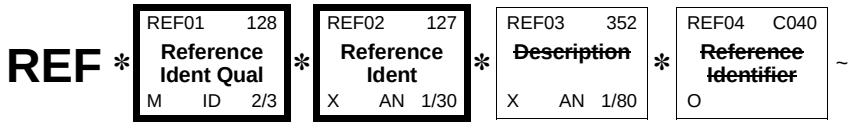
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = M1 do not use this code.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHC/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**

			IG **Insurance Policy Number**			
			SY **Social Security Number** **Do not use for Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Patient Secondary Identifier*** *ALIAS:* ***Patient's Other Payer Secondary Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER REFERRING PROVIDER

Loop: **2330D — OTHER PAYER REFERRING PROVIDER** **Repeat:** **2**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **NM1*DN*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

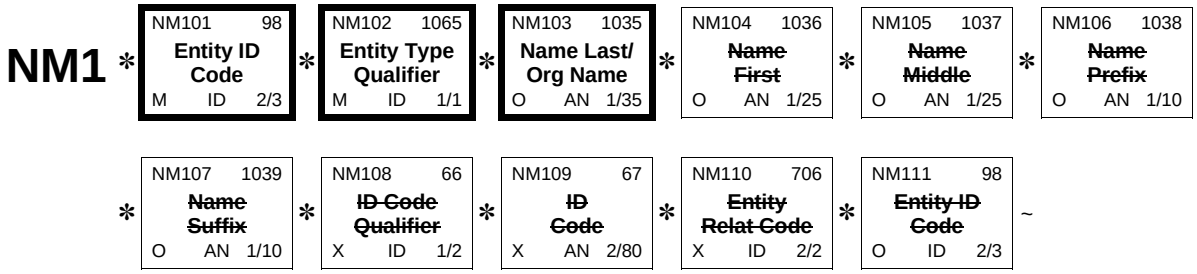
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: DN — Referring Provider. Use on first iteration of this loop. Use if loop is used only once. CODE: P3 — Primary Care Provider. Use only if loop is used twice. Use only on second iteration of this loop.	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — Person CODE: 2 — Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Referring Provider Last Name***	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
NOT USED	NM108	66	**Identification Code Qualifier**	X ID 1/2
NOT USED	NM109	67	**Identification Code**	X AN 2/80
NOT USED	NM110	706	**Entity Relationship Code**	X ID 2/2
NOT USED	NM111	98	**Entity Identifier Code**	O ID 2/3

IMPLEMENTATION

OTHER PAYER REFERRING PROVIDER IDENTIFICATION

Loop: **2330D — OTHER PAYER REFERRING PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes:
1. **Non-destination (COB) payers' provider identification number(s).**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*N5*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

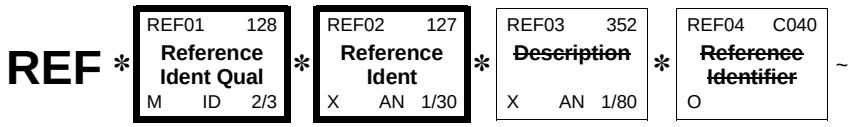
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
EI	**Employer's Identification Number**
G2	**Provider Commercial Number**

			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Referring Provider Identifier*** *ALIAS:* ***Other Payer Referring Provider Identification*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER RENDERING PROVIDER

Loop: **2330E — OTHER PAYER RENDERING PROVIDER** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **NM1*82*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

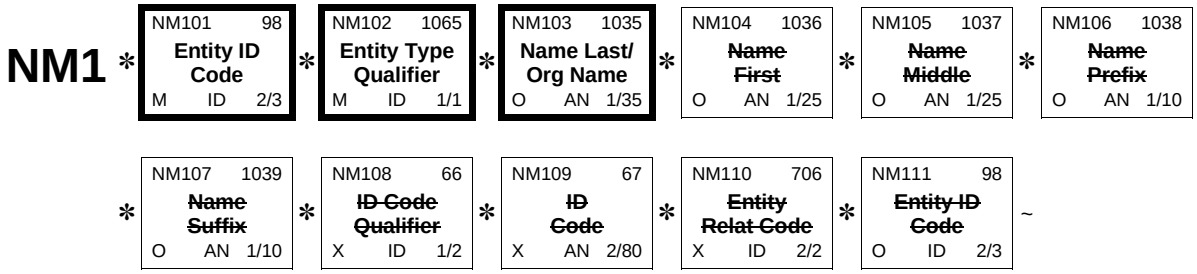
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: 82 — DEFINITION: Rendering Provider	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M	ID	1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Rendering Provider Last or Organization Name***	O	AN	1/35
NOT USED	NM104	1036	**Name First**	O	AN	1/25
NOT USED	NM105	1037	**Name Middle**	O	AN	1/25
NOT USED	NM106	1038	**Name Prefix**	O	AN	1/10
NOT USED	NM107	1039	**Name Suffix**	O	AN	1/10
NOT USED	NM108	66	**Identification Code Qualifier**	X	ID	1/2
NOT USED	NM109	67	**Identification Code**	X	AN	2/80
NOT USED	NM110	706	**Entity Relationship Code**	X	ID	2/2
NOT USED	NM111	98	**Entity Identifier Code**	O	ID	2/3

IMPLEMENTATION

OTHER PAYER RENDERING PROVIDER SECONDARY IDENTIFICATION

Loop: **2330E — OTHER PAYER RENDERING PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes:
1. **Non-destination (COB) payers' provider identification number(s).**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*LU*SLC987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

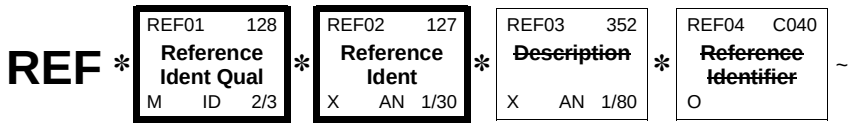
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
EI	**Employer's Identification Number**
G2	**Provider Commercial Number**

			LU **Location Number**			
			N5 **Provider Plan Network Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Rendering Provider Secondary Identifier*** SYNTAX: R0203	**X**	**AN**	**1/30**
			Other Payer Rendering Provider Secondary Identification			
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER PURCHASED SERVICE PROVIDER

Loop: **2330F — OTHER PAYER PURCHASED SERVICE PROVIDER** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
2. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **NM1*QB*2~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

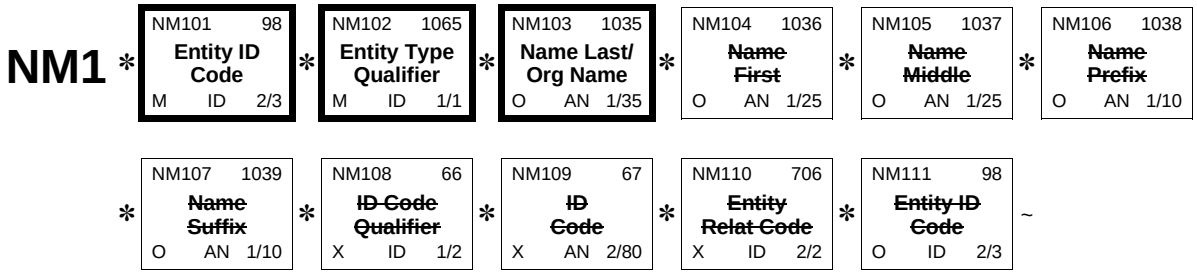
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: QB — DEFINITION: Purchase Service Provider	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M	ID	1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: ***Purchased Service Provider Name***	O	AN	1/35
NOT USED	NM104	1036	**Name First**	O	AN	1/25
NOT USED	NM105	1037	**Name Middle**	O	AN	1/25
NOT USED	NM106	1038	**Name Prefix**	O	AN	1/10
NOT USED	NM107	1039	**Name Suffix**	O	AN	1/10
NOT USED	NM108	66	**Identification Code Qualifier**	X	ID	1/2
NOT USED	NM109	67	**Identification Code**	X	AN	2/80
NOT USED	NM110	706	**Entity Relationship Code**	X	ID	2/2
NOT USED	NM111	98	**Entity Identifier Code**	O	ID	2/3

IMPLEMENTATION

OTHER PAYER PURCHASED SERVICE PROVIDER IDENTIFICATION

Loop: **2330F — OTHER PAYER PURCHASED SERVICE PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes:
1. **Non-destination (COB) payers' provider identification number(s).**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*G2*8893U21~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

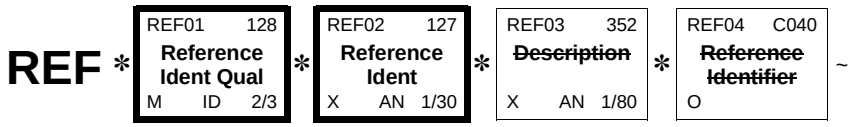
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
EI	**Employer's Identification Number**

			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Purchased Service Provider Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
			Other Payer Purchased Service Provider Identification				
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER PAYER SERVICE FACILITY LOCATION

Loop: 2330G — OTHER PAYER SERVICE FACILITY LOCATION Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
2. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: NM1*TL*2~

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

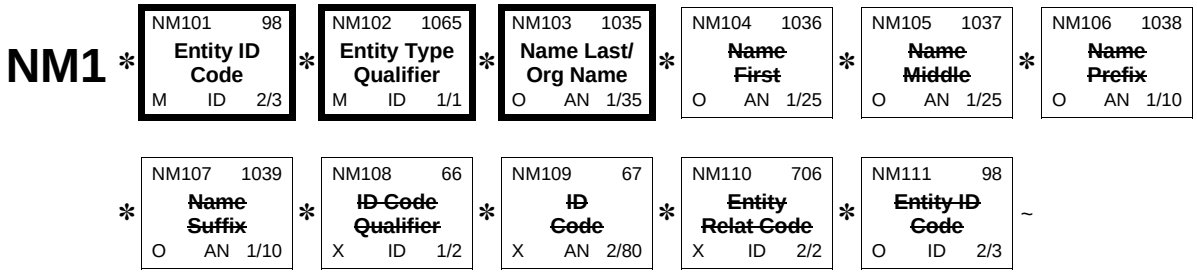
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	M	ID	2/3
			CODE / DEFINITION 77 — Service Location Use when other codes in this element do not apply. FA — Facility LI — Independent Lab TL — Testing Laboratory			
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION 2 — Non-Person Entity	M	ID	1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Service Facility Name***	O	AN	1/35
NOT USED	NM104	1036	**Name First**	O	AN	1/25
NOT USED	NM105	1037	**Name Middle**	O	AN	1/25
NOT USED	NM106	1038	**Name Prefix**	O	AN	1/10
NOT USED	NM107	1039	**Name Suffix**	O	AN	1/10
NOT USED	NM108	66	**Identification Code Qualifier**	X	ID	1/2
NOT USED	NM109	67	**Identification Code**	X	AN	2/80
NOT USED	NM110	706	**Entity Relationship Code**	X	ID	2/2
NOT USED	NM111	98	**Entity Identifier Code**	O	ID	2/3

IMPLEMENTATION

OTHER PAYER SERVICE FACILITY LOCATION IDENTIFICATION

Loop: **2330G — OTHER PAYER SERVICE FACILITY LOCATION**

Usage: **REQUIRED**

Repeat: **3**

Notes:
1. **Non-destination (COB) payers' provider identification number(s).**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*G2*LAB1234~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

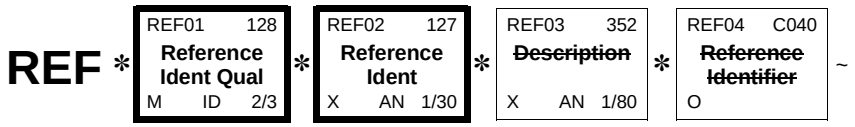
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
G2	**Provider Commercial Number**

			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Service Facility Location Identifier*** *ALIAS:* ***Other Payer Service Facility Location Identification*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER SUPERVISING PROVIDER

Loop: 2330H — OTHER PAYER SUPERVISING PROVIDER Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**
2. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
3. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: NM1*DQ*1~

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

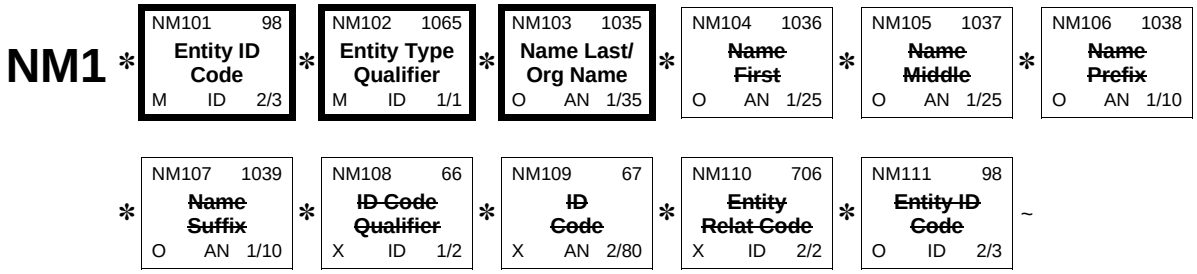
Set Notes:

1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.
2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION DQ — Supervising Physician	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION 1 — Person	M	ID	1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Supervising Provider Last Name***	O	AN	1/35
NOT USED	NM104	1036	**Name First**	O	AN	1/25
NOT USED	NM105	1037	**Name Middle**	O	AN	1/25
NOT USED	NM106	1038	**Name Prefix**	O	AN	1/10
NOT USED	NM107	1039	**Name Suffix**	O	AN	1/10
NOT USED	NM108	66	**Identification Code Qualifier**	X	ID	1/2
NOT USED	NM109	67	**Identification Code**	X	AN	2/80
NOT USED	NM110	706	**Entity Relationship Code**	X	ID	2/2
NOT USED	NM111	98	**Entity Identifier Code**	O	ID	2/3

IMPLEMENTATION

OTHER PAYER SUPERVISING PROVIDER IDENTIFICATION

Loop: **2330H — OTHER PAYER SUPERVISING PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes:
1. **Non-destination (COB) payers' provider identification number(s).**
2. **See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.**

Example: **REF*G2*53334~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

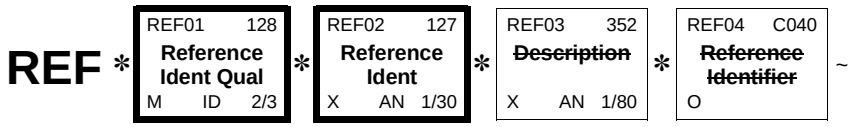
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

Syntax:
1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
EI	**Employer's Identification Number**
G2	**Provider Commercial Number**

			N5 Provider Plan Network Identification Number			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Supervising Provider Identifier*** *ALIAS:* ***Other Payer Supervising Provider Identification*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE LINE

Loop: **2400 — SERVICE LINE Repeat: 50**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.**

2. **The datum in the LX is not usually returned in the 835 (Remittance Advice) transaction. LX01 may be used as a line item control number by the payer in the 835 if a line item control number has not been submitted on the service line. See that REF for more information.**

   LX01 is used to indicate bundling/unbundling in SVC06. See Section 1.4.3 for more information on bundling and unbundling.

3. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.**

Example: **LX*1~**

STANDARD

LX Assigned Number

Level: Detail

Position: 365

Loop: 2400 **Repeat:** >1

Requirement: Optional

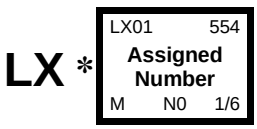
Max Use: 1

Purpose: To reference a line number in a transaction set

Set Notes:

1. Loop 2400 contains Service Line information.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	LX01	554	**Assigned Number** Number assigned for differentiation within a transaction set *ALIAS:* ***Line Counter*** **NSF Reference:** **FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0** **The service line number incremented by 1 for each service line.**	M	N0	1/6

IMPLEMENTATION

PROFESSIONAL SERVICE

Loop: **2400 — SERVICE LINE**

Usage: **REQUIRED**

Repeat: **1**

Example: **SV1*HC:99211:25*12.25*UN*1*11**1:2:3**N~**

STANDARD

SV1 Professional Service

Level: Detail

Position: 370

Loop: 2400

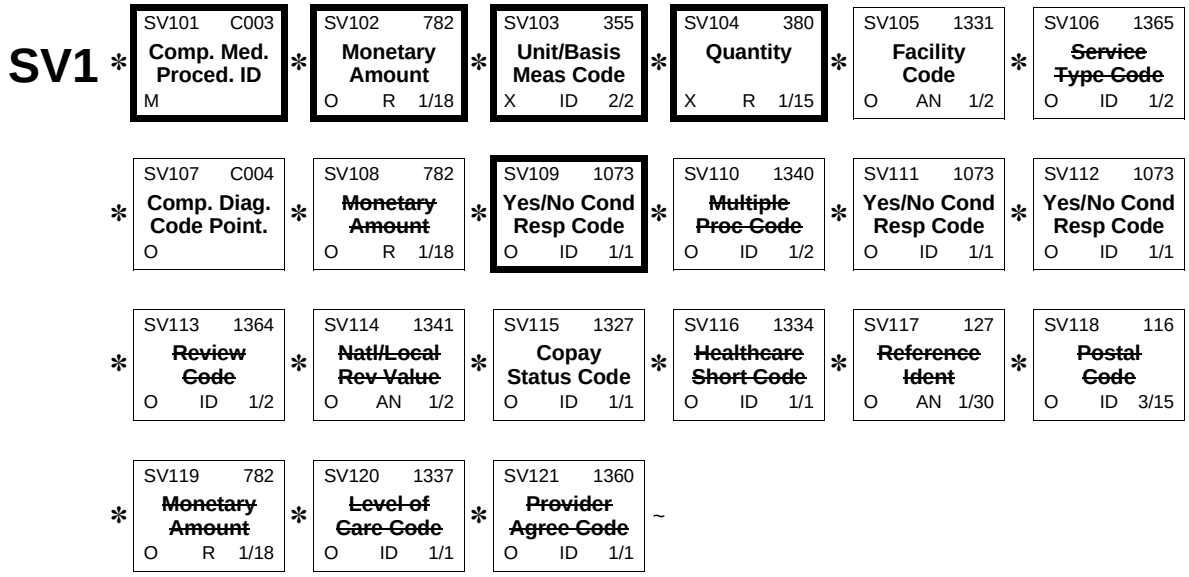
Requirement: Optional

Max Use: 1

Purpose: To specify the claim service detail for a Health Care professional

Syntax: **1. P0304**
If either SV103 or SV104 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SV101**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers *ALIAS:* ***Procedure identifier***	**M**

REQUIRED **SV101 - 1** **235** **Product/Service ID Qualifier** **M ID 2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE **240:** National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE **240:** National Drug Code by Format
ZZ	**Mutually Defined** **Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.**

REQUIRED **SV101 - 2** **234** **Product/Service ID** **M AN 1/48**
Identifying number for a product or service

INDUSTRY: ***Procedure Code***

NSF Reference:

FA0-09.0, FB0-15.0, GU0-07.0

SITUATIONAL **SV101 - 3** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***Procedure Modifier 1***

NSF Reference:

FA0-10.0, GU0-08.0

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

SITUATIONAL **SV101 - 4** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***Procedure Modifier 2***

NSF Reference:

FA0-11.0

Use this modifier for the second procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

SITUATIONAL **SV101 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***Procedure Modifier 3***

NSF Reference:

FA0-12.0

Use this modifier for the third procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

SITUATIONAL **SV101 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***Procedure Modifier 4***

NSF Reference:

FA0-36.0

Use this modifier for the fourth procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

NOT USED **SV101 - 7** **352** **Description** **O AN 1/80**

REQUIRED **SV102** **782** **Monetary Amount** **O R 1/18**
Monetary amount

INDUSTRY: ***Line Item Charge Amount***

ALIAS: ***Submitted charge amount***

SEMANTIC: SV102 is the submitted charge amount.

NSF Reference:

FA0-13.0

For encounter transmissions, zero (0) may be a valid amount.

REQUIRED **SV103** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0304

NSF Reference:

FA0-50.0

FA0-50.0 is only used in Medicare COB payer-to-payer situations.

CODE	DEFINITION
F2	**International Unit** **International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors).**
MJ	**Minutes**
UN	**Unit**

REQUIRED **SV104** **380** **Quantity** **X** **R** **1/15**

Numeric value of quantity

INDUSTRY: ***Service Unit Count***

ALIAS: ***Units or Minutes***

SYNTAX: P0304

NSF Reference:

FA0-18.0, FA0-19.0, FB0-16.0

Note: If a decimal is needed to report units, include it in this element, e.g., “15.6".

SITUATIONAL	**SV105**	**1331**	**Facility Code Value**	**O**	**AN**	**1/2**

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

INDUSTRY: ***Place of Service Code***

ALIAS: ***Place of Service Code***

SEMANTIC: SV105 is the place of service.

NSF Reference:

FA0-07.0, GU0-05.0

Required if value is different than value carried in CLM05-1 in Loop ID-2300.

Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.

- **11 Office**
- **12 Home**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **23 Emergency Room - Hospital**
- **24 Ambulatory Surgical Center**
- **25 Birthing Center**
- **26 Military Treatment Facility**
- **31 Skilled Nursing Facility**
- **32 Nursing Facility**
- **33 Custodial Care Facility**
- **34 Hospice**
- **41 Ambulance - Land**
- **42 Ambulance - Air or Water**
- **50 Federally Qualified Health Center**
- **51 Inpatient Psychiatric Facility**
- **52 Psychiatric Facility Partial Hospitalization**
- **53 Community Mental Health Center**
- **54 Intermediate Care Facility/Mentally Retarded**
- **55 Residential Substance Abuse Treatment Facility**
- **56 Psychiatric Residential Treatment Center**
- **60 Mass Immunization Center**
- **61 Comprehensive Inpatient Rehabilitation Facility**
- **62 Comprehensive Outpatient Rehabilitation Facility**
- **65 End Stage Renal Disease Treatment Facility**
- **71 State or Local Public Health Clinic**
- **72 Rural Health Clinic**
- **81 Independent Laboratory**
- **99 Other Unlisted Facility**

NOT USED	**SV106**	**1365**	**Service Type Code**	**O**	**ID**	**1/2**

SITUATIONAL	**SV107**	**C004**	**COMPOSITE DIAGNOSIS CODE POINTER** To identify one or more diagnosis code pointers		**O**		
			ALIAS: ***Diagnosis Code Pointer***				
			Required if HI segment in Loop ID-2300 is used.				
REQUIRED	**SV107 - 1**		**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service	**M**	**N0**	**1/2**
				NSF Reference:			
				FA0-14.0			
				Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line). Use remaining diagnosis pointers in declining level of importance to service line. Acceptable values are 1 through 8, inclusive.			
SITUATIONAL	**SV107 - 2**		**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service	**O**	**N0**	**1/2**
				NSF Reference:			
				FA0-15.0			
				Use this pointer for the second diagnosis code pointer.			
				Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.			
SITUATIONAL	**SV107 - 3**		**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service	**O**	**N0**	**1/2**
				NSF Reference:			
				FA0-16.0			
				Use this pointer for the third diagnosis code pointer.			
				Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.			
SITUATIONAL	**SV107 - 4**		**1328**	**Diagnosis Code Pointer** A pointer to the claim diagnosis code in the order of importance to this service	**O**	**N0**	**1/2**
				NSF Reference:			
				FA0-17.0			
				Use this pointer for the fourth diagnosis code pointer.			
				Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive.			
NOT USED	**SV108**	**782**	**Monetary Amount**		**O**	**R**	**1/18**

REQUIRED	**SV109**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Emergency Indicator***

SEMANTIC: SV109 is the emergency-related indicator; a "Y" value indicates service provided was emergency related; an "N" value indicates service provided was not emergency related.

NSF Reference:

FA0-20.0

CODE	DEFINITION
N	**No**
Y	**Yes**

NOT USED	**SV110**	**1340**	**Multiple Procedure Code**	**O**	**ID**	**1/2**
SITUATIONAL	**SV111**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***EPSDT Indicator***

SEMANTIC: SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement.

NSF Reference:

FB0-22.0

Required if Medicaid services are the result of a screening referral.

CODE	DEFINITION
Y	**Yes**

SITUATIONAL	**SV112**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Family Planning Indicator***

SEMANTIC: SV112 is the family planning involvement indicator. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement.

NSF Reference:

FB0-23.0

Required if applicable for Medicaid claims.

CODE	DEFINITION
Y	**Yes**

NOT USED	**SV113**	**1364**	**Review Code**	**O**	**ID**	**1/2**
NOT USED	**SV114**	**1341**	**National or Local Assigned Review Value**	**O**	**AN**	**1/2**

SITUATIONAL	**SV115**	**1327**	**Copay Status Code** Code indicating whether or not co-payment requirements were met on a line by line basis *INDUSTRY:* ***Co-Pay Status Code*** *ALIAS:* ***Co-Pay Waiver*** **NSF Reference:** **FB0-21.0** **Required if patient was exempt from co-pay.** CODE / DEFINITION **0 Copay exempt**	**O**	**ID**	**1/1**
NOT USED	**SV116**	**1334**	**Health Care Professional Shortage Area Code**	**O**	**ID**	**1/1**
NOT USED	**SV117**	**127**	**Reference Identification**	**O**	**AN**	**1/30**
NOT USED	**SV118**	**116**	**Postal Code**	**O**	**ID**	**3/15**
NOT USED	**SV119**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**SV120**	**1337**	**Level of Care Code**	**O**	**ID**	**1/1**
NOT USED	**SV121**	**1360**	**Provider Agreement Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PRESCRIPTION NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if dispense of the drug has been done with an assigned Rx number.**

2. **In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.**

Example: **SV4*4466777TJ~**

STANDARD

SV4 Drug Service

Level: Detail

Position: 385

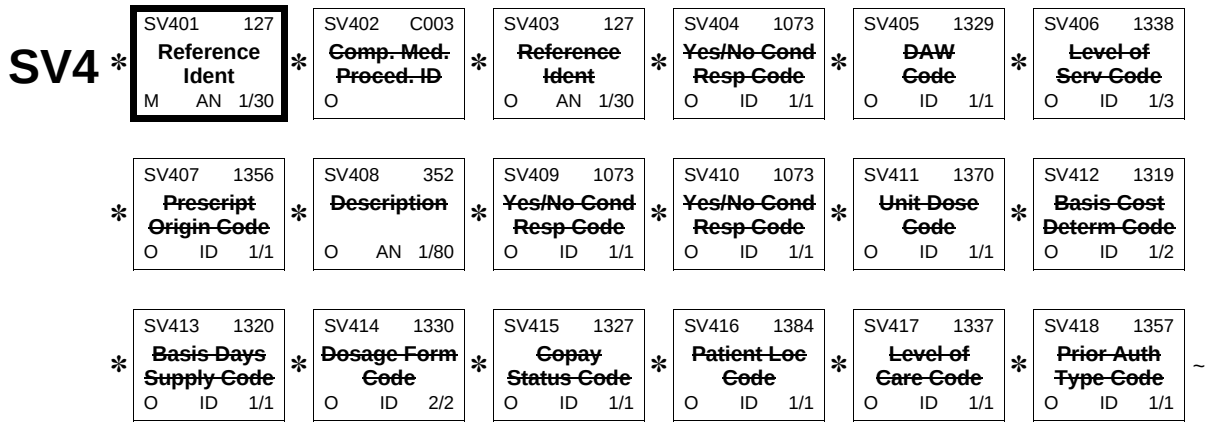
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify the claim service detail for prescription drugs

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**SV401**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prescription Number*** **SEMANTIC:** SV401 is a prescription number.	**M**	**AN**	**1/30**
NOT USED	**SV402**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	**O**		
NOT USED	**SV403**	**127**	**Reference Identification**	**O**	**AN**	**1/30**
NOT USED	**SV404**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV405**	**1329**	**Dispense as Written Code**	**O**	**ID**	**1/1**
NOT USED	**SV406**	**1338**	**Level of Service Code**	**O**	**ID**	**1/3**
NOT USED	**SV407**	**1356**	**Prescription Origin Code**	**O**	**ID**	**1/1**
NOT USED	**SV408**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**SV409**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV410**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV411**	**1370**	**Unit Dose Code**	**O**	**ID**	**1/1**
NOT USED	**SV412**	**1319**	**Basis of Cost Determination Code**	**O**	**ID**	**1/2**
NOT USED	**SV413**	**1320**	**Basis of Days Supply Determination Code**	**O**	**ID**	**1/1**
NOT USED	**SV414**	**1330**	**Dosage Form Code**	**O**	**ID**	**2/2**
NOT USED	**SV415**	**1327**	**Copay Status Code**	**O**	**ID**	**1/1**
NOT USED	**SV416**	**1384**	**Patient Location Code**	**O**	**ID**	**1/1**
NOT USED	**SV417**	**1337**	**Level of Care Code**	**O**	**ID**	**1/1**
NOT USED	**SV418**	**1357**	**Prior Authorization Type Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

DMERC CMN INDICATOR

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on Medicare claims when DMERC CMN is included in this claim.**

Example: **PWK*CT*AB~**

STANDARD

PWK Paperwork

Level: Detail

Position: 420

Loop: 2400

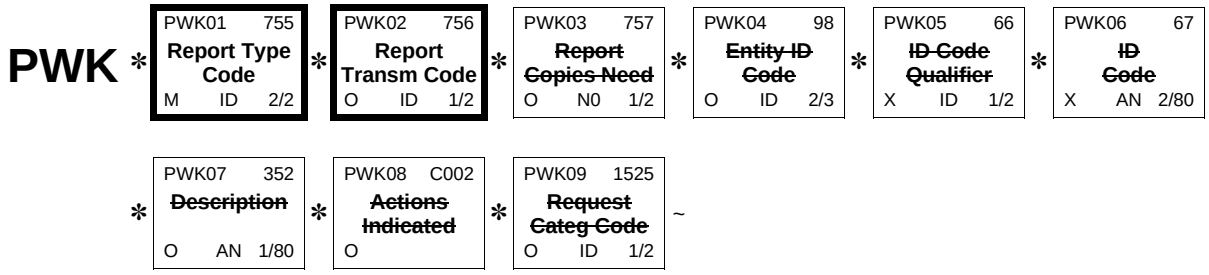
Requirement: Optional

Max Use: 10

Purpose: To identify the type or transmission or both of paperwork or supporting information

Syntax: **1. P0506**
If either PWK05 or PWK06 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PWK01**	**755**	**Report Type Code** Code indicating the title or contents of a document, report or supporting item *INDUSTRY:* ***Attachment Report Type Code*** *ALIAS:* ***DMERC Report Type Code***	**M ID 2/2**

CODE	DEFINITION
CT	**Certification**

REQUIRED	**PWK02**	**756**	**Report Transmission Code** Code defining timing, transmission method or format by which reports are to be sent	**O**	**ID**	**1/2**

INDUSTRY: ***Attachment Transmission Code***

NSF Reference:

EA0-40.0

CODE	DEFINITION
AB	**Previously Submitted to Payer**
AD	**Certification Included in this Claim**
AF	**Narrative Segment Included in this Claim**
AG	**No Documentation is Required**
NS	**Not Specified** **NS = Paperwork is available on request at the provider's site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.**

NOT USED	**PWK03**	**757**	**Report Copies Needed**	**O**	**N0**	**1/2**
NOT USED	**PWK04**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**
NOT USED	**PWK05**	**66**	**Identification Code Qualifier**	**X**	**ID**	**1/2**
NOT USED	**PWK06**	**67**	**Identification Code**	**X**	**AN**	**2/80**
NOT USED	**PWK07**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**PWK08**	**C002**	**ACTIONS INDICATED**	**O**		
NOT USED	**PWK09**	**1525**	**Request Category Code**	**O**	**ID**	**1/2**

IMPLEMENTATION

AMBULANCE TRANSPORT INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required on all ambulance claims if the information is different than in the CR1 at the claim level (Loop ID-2300).**

Example: **CR1*LB*140*I*A*DH*12****UNCONSCIOUS~**

STANDARD

CR1 Ambulance Certification

Level: Detail

Position: 425

Loop: 2400

Requirement: Optional

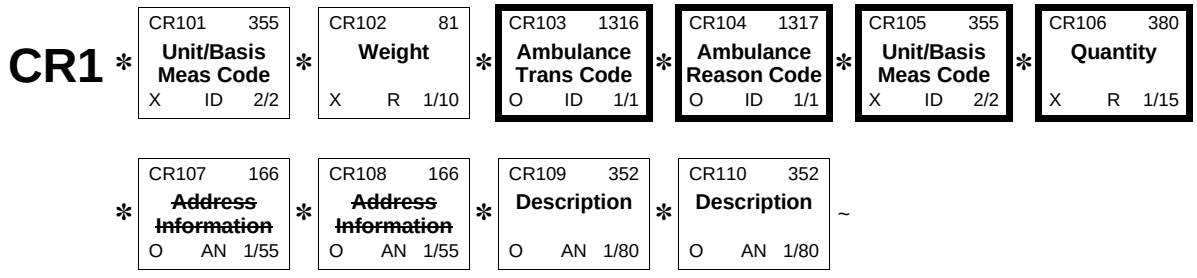
Max Use: 1

Purpose: To supply information related to the ambulance service rendered to a patient

Set Notes:
1. The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

Syntax:
1. **P0102**
   If either CR101 or CR102 is present, then the other is required.
2. **P0506**
   If either CR105 or CR106 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	CR101	355	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken SYNTAX: P0102 **Required if CR102 is present.**	X ID 2/2
			CODE: **LB** — DEFINITION: **Pound**	
SITUATIONAL	CR102	81	**Weight** Numeric value of weight *INDUSTRY:* ***Patient Weight*** SYNTAX: P0102 SEMANTIC: CR102 is the weight of the patient at time of transport. **NSF Reference:** **GA0-05.0** **Required if it is necessary to justify the medical necessity of the level of ambulance services.**	X R 1/10
REQUIRED	CR103	1316	**Ambulance Transport Code** Code indicating the type of ambulance transport *ALIAS:* ***Ambulance transport code*** **NSF Reference:** **GA0-07.0**	O ID 1/1
			CODE: **I** — DEFINITION: **Initial Trip**	
			CODE: **R** — DEFINITION: **Return Trip**	
			CODE: **T** — DEFINITION: **Transfer Trip**	
			CODE: **X** — DEFINITION: **Round Trip**	
REQUIRED	CR104	1317	**Ambulance Transport Reason Code** Code indicating the reason for ambulance transport *ALIAS:* ***Ambulance Transport Reason Code*** **NSF Reference:** **GA0-15.0**	O ID 1/1
			CODE: **A** — DEFINITION: **Patient was transported to nearest facility for care of symptoms, complaints, or both**	
			CODE: **B** — DEFINITION: **Patient was transported for the benefit of a preferred physician**	
			CODE: **C** — DEFINITION: **Patient was transported for the nearness of family members**	

			D	**Patient was transported for the care of a specialist or for availability of specialized equipment**			
			E	**Patient Transferred to Rehabilitation Facility**			
REQUIRED	**CR105**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **SYNTAX:** P0506	**X**	**ID**	**2/2**	
			CODE / **DEFINITION**				
			DH **Miles**				
REQUIRED	**CR106**	**380**	**Quantity** Numeric value of quantity ***INDUSTRY:*** ***Transport Distance*** **SYNTAX:** P0506 **SEMANTIC:** CR106 is the distance traveled during transport. **NSF Reference:** **GA0-17.0, FA0-50.0** **NSF crosswalk to FA0-50.0 is used only in Medicare payer-to-payer COB situations.**	**X**	**R**	**1/15**	
NOT USED	**CR107**	**166**	**Address Information**	**O**	**AN**	**1/55**	
NOT USED	**CR108**	**166**	**Address Information**	**O**	**AN**	**1/55**	
SITUATIONAL	**CR109**	**352**	**Description** A free-form description to clarify the related data elements and their content ***INDUSTRY:*** ***Round Trip Purpose Description*** ***ALIAS:*** ***Transport purpose description*** **SEMANTIC:** CR109 is the purpose for the round trip ambulance service. **NSF Reference:** **GA0-20.0** **Required if CR103 (Ambulance Transport Code) = "X - Round Trip"; otherwise not used.**	**O**	**AN**	**1/80**	
SITUATIONAL	**CR110**	**352**	**Description** A free-form description to clarify the related data elements and their content ***INDUSTRY:*** ***Stretcher Purpose Description*** **SEMANTIC:** CR110 is the purpose for the usage of a stretcher during ambulance service. **NSF Reference:** **GA0-21.0** **Required if needed to justify usage of stretcher.**	**O**	**AN**	**1/80**	

IMPLEMENTATION

SPINAL MANIPULATION SERVICE INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:
1. **Required on all claims involving spinal manipulation if information is different from Loop-ID 2300 CR2 information. Such claims could originate with chiropractors, physical therapists, DOs, and many other types of health care providers.**

Example: **CR2*3*5*C4*C6*MO*2*2*M*Y***Y~**

STANDARD

CR2 Chiropractic Certification

Level: Detail

Position: 430

Loop: 2400

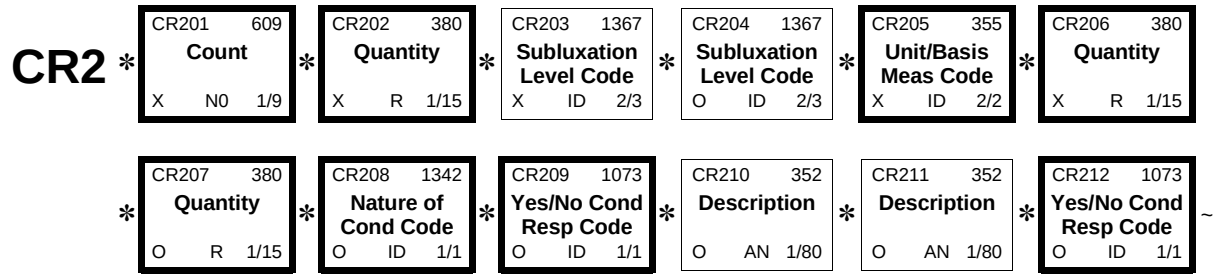
Requirement: Optional

Max Use: 5

Purpose: To supply information related to the chiropractic service rendered to a patient

Syntax:
1. **P0102**
   If either CR201 or CR202 is present, then the other is required.
2. **C0403**
   If CR204 is present, then CR203 is required.
3. **P0506**
   If either CR205 or CR206 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**CR201**	**609**	**Count** Occurence counter *INDUSTRY:* ***Treatment Series Number*** *ALIAS:* ***Treatment Number. Spinal Manipulation*** **SYNTAX:** P0102 **SEMANTIC:** CR201 is the number this treatment is in the series. **NSF Reference:** **GC0-07.0**	**X**	**N0**	**1/9**
REQUIRED	**CR202**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Treatment Count*** *ALIAS:* ***Treatment Series Total. Spinal Manipulation*** **SYNTAX:** P0102 **SEMANTIC:** CR202 is the total number of treatments in the series. **NSF Reference:** **GC0-07.0**	**X**	**R**	**1/15**
SITUATIONAL	**CR203**	**1367**	**Subluxation Level Code** Code identifying the specific level of subluxation *ALIAS:* ***Subluxation Level Code*** **SYNTAX:** C0403 **COMMENT:** When both CR203 and CR204 are present, CR203 is the beginning level of subluxation and CR204 is the ending level of subluxation. **NSF Reference:** **GC0-08.0** **Required if subluxation is involved in claim.**	**X**	**ID**	**2/3**

CODE	DEFINITION
C1	**Cervical 1**
C2	**Cervical 2**
C3	**Cervical 3**
C4	**Cervical 4**
C5	**Cervical 5**
C6	**Cervical 6**
C7	**Cervical 7**
CO	**Coccyx**
IL	**Ilium**
L1	**Lumbar 1**

L2	Lumbar 2
L3	Lumbar 3
L4	Lumbar 4
L5	Lumbar 5
OC	Occiput
SA	Sacrum
T1	Thoracic 1
T10	Thoracic 10
T11	Thoracic 11
T12	Thoracic 12
T2	Thoracic 2
T3	Thoracic 3
T4	Thoracic 4
T5	Thoracic 5
T6	Thoracic 6
T7	Thoracic 7
T8	Thoracic 8
T9	Thoracic 9

SITUATIONAL **CR204** **1367** **Subluxation Level Code** **O** **ID** **2/3**
Code identifying the specific level of subluxation

ALIAS: ***Subluxation Level Code***

SYNTAX: C0403

NSF Reference:

GC0-08.0

Required if additional subluxation is involved in claim to indicate a range (i.e., subluxation from CR203 to CR204).

CODE	DEFINITION
C1	Cervical 1
C2	Cervical 2
C3	Cervical 3
C4	Cervical 4
C5	Cervical 5
C6	Cervical 6
C7	Cervical 7

CO	Coccyx
IL	Ilium
L1	Lumbar 1
L2	Lumbar 2
L3	Lumbar 3
L4	Lumbar 4
L5	Lumbar 5
OC	Occiput
SA	Sacrum
T1	Thoracic 1
T10	Thoracic 10
T11	Thoracic 11
T12	Thoracic 12
T2	Thoracic 2
T3	Thoracic 3
T4	Thoracic 4
T5	Thoracic 5
T6	Thoracic 6
T7	Thoracic 7
T8	Thoracic 8
T9	Thoracic 9

REQUIRED **CR205** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0506

CODE	DEFINITION
DA	Days
MO	Months
WK	Week
YR	Years

REQUIRED	**CR206**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Treatment Period Count***

ALIAS: ***Treatment Series Period. Spinal Manipulation***

SYNTAX: P0506

SEMANTIC: CR206 is the time period involved in the treatment series.

NSF Reference:

GC0-09.0

REQUIRED	**CR207**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Monthly Treatment Count***

ALIAS: ***Treatment Number in Month. Spinal Manipulation***

SEMANTIC: CR207 is the number of treatments rendered in the month of service.

NSF Reference:

GC0-10.0

REQUIRED	**CR208**	**1342**	**Nature of Condition Code** Code indicating the nature of a patient's condition	**O**	**ID**	**1/1**

INDUSTRY: ***Patient Condition Code***

ALIAS: ***Nature of Condition Code. Spinal Manipulation***

NSF Reference:

GC0-11.0

CODE	DEFINITION
A	**Acute Condition**
C	**Chronic Condition**
D	**Non-acute**
E	**Non-Life Threatening**
F	**Routine**
G	**Symptomatic**
M	**Acute Manifestation of a Chronic Condition**

REQUIRED	**CR209**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Complication Indicator***

ALIAS: ***Complication Indicator. Spinal Manipulation***

SEMANTIC: CR209 is complication indicator. A "Y" value indicates a complicated condition; an "N" value indicates an uncomplicated condition.

NSF Reference:

GC0-13.0

CODE	DEFINITION
N	**No**

			Y	**Yes**			

SITUATIONAL	**CR210**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN**	**1/80**

INDUSTRY: ***Patient Condition Description***

ALIAS: ***Patient Condition Description, Chiropractic***

SEMANTIC: CR210 is a description of the patient's condition.

NSF Reference:

GC0-14.0

Used at discretion of submitter.

SITUATIONAL	**CR211**	**352**	**Description** A free-form description to clarify the related data elements and their content	**O**	**AN**	**1/80**

INDUSTRY: ***Patient Condition Description***

ALIAS: ***Patient Condition Description, Chiropractic***

SEMANTIC: CR211 is an additional description of the patient's condition.

NSF Reference:

GC0-14.0

Used at discretion of submitter.

REQUIRED	**CR212**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***X-ray Availability Indicator***

ALIAS: ***X-ray Availability Indicator, Chiropractic***

SEMANTIC: CR212 is X-rays availability indicator. A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are not maintained and available for carrier review.

NSF Reference:

GC0-15.0

CODE	DEFINITION
N	**No**
Y	**Yes**

IMPLEMENTATION

DURABLE MEDICAL EQUIPMENT CERTIFICATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician.**

Example: **CR3*I*MO*6~**

STANDARD

CR3 Durable Medical Equipment Certification

Level: Detail

Position: 435

Loop: 2400

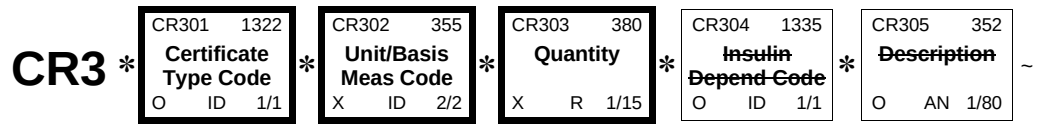
Requirement: Optional

Max Use: 1

Purpose: To supply information regarding a physician's certification for durable medical equipment

Syntax: **1. P0203**
If either CR302 or CR303 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CR301**	**1322**	**Certification Type Code** Code indicating the type of certification	**O ID 1/1**

NSF Reference:

GU0-04.0

CODE	DEFINITION
I	**Initial**
R	**Renewal**
S	**Revised**

REQUIRED	**CR302**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **SYNTAX:** P0203 **SEMANTIC:** CR302 and CR303 specify the time period covered by this certification.	**X**	**ID**	**2/2**

CODE	DEFINITION
MO	**Months**

REQUIRED	**CR303**	**380**	**Quantity** Numeric value of quantity ***INDUSTRY:*** ***Durable Medical Equipment Duration*** ***ALIAS:*** ***DME Duration*** **SYNTAX:** P0203 **NSF Reference:** **GU0-21.0** **Length of time DME equipment is needed.**	**X**	**R**	**1/15**
NOT USED	**CR304**	**1335**	**Insulin Dependent Code**	**O**	**ID**	**1/1**
NOT USED	**CR305**	**352**	**Description**	**O**	**AN**	**1/80**

IMPLEMENTATION

HOME OXYGEN THERAPY INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on all initial, renewal, and revision home oxygen therapy claims.**

Example: **CR5*I*6********56**R*1~**

STANDARD

CR5 Oxygen Therapy Certification

Level: Detail

Position: 445

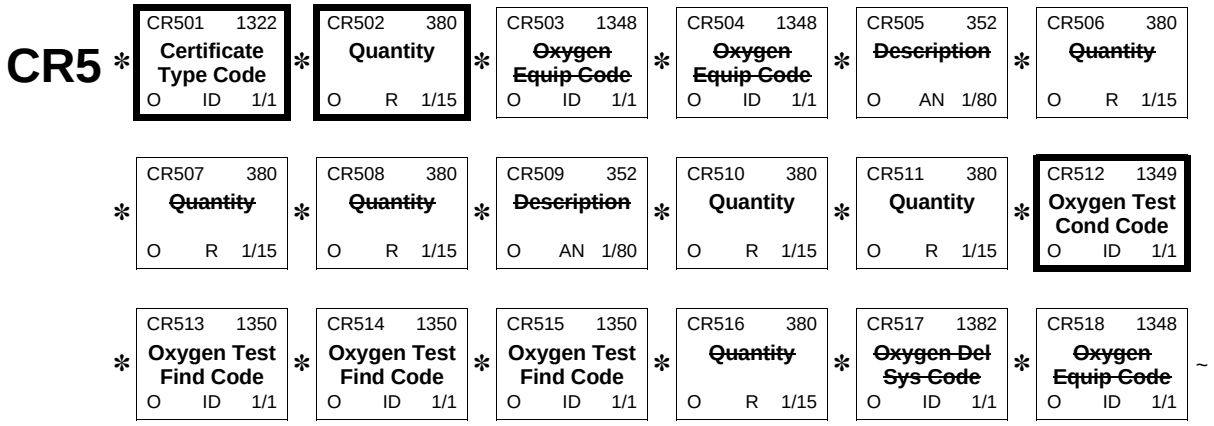
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To supply information regarding certification of medical necessity for home oxygen therapy

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	CR501	1322	**Certification Type Code** Code indicating the type of certification *ALIAS:* ***Certification Type Code. Oxygen Therapy*** **NSF Reference:** **GX0-04.0** CODE / DEFINITION **I** Initial **R** Renewal **S** Revised	O	ID	1/1
REQUIRED	CR502	380	**Quantity** Numeric value of quantity *INDUSTRY:* ***Treatment Period Count*** *ALIAS:* ***Certification Period, Home Oxygen Therapy*** SEMANTIC: CR502 is the number of months covered by this certification. **NSF Reference:** **GX0-06.0**	O	R	1/15
NOT USED	CR503	1348	**Oxygen Equipment Type Code**	O	ID	1/1
NOT USED	CR504	1348	**Oxygen Equipment Type Code**	O	ID	1/1
NOT USED	CR505	352	**Description**	O	AN	1/80
NOT USED	CR506	380	**Quantity**	O	R	1/15
NOT USED	CR507	380	**Quantity**	O	R	1/15
NOT USED	CR508	380	**Quantity**	O	R	1/15
NOT USED	CR509	352	**Description**	O	AN	1/80
SITUATIONAL	CR510	380	**Quantity** Numeric value of quantity *INDUSTRY:* ***Arterial Blood Gas Quantity*** *ALIAS:* ***Arterial Blood Gas*** SEMANTIC: CR510 is the arterial blood gas. **NSF Reference:** **GX0-22.0** **Either CR510 or CR511 is required.** **Required on claims which report arterial blood gas.**	O	R	1/15

SITUATIONAL **CR511** **380** **Quantity** **O** **R** **1/15**
Numeric value of quantity

INDUSTRY: ***Oxygen Saturation Quantity***

ALIAS: ***Oxygen Saturation***

SEMANTIC: CR511 is the oxygen saturation.

NSF Reference:

GX0-23.0

Either CR510 or CR511 is required.

Required on claims which report oxygen saturation quantity.

REQUIRED **CR512** **1349** **Oxygen Test Condition Code** **O** **ID** **1/1**
Code indicating the conditions under which a patient was tested

ALIAS: ***Oxygen test condition code***

NSF Reference:

GX0-26.0

CODE	DEFINITION
E	**Exercising**
R	**At rest on room air**
S	**Sleeping**

SITUATIONAL **CR513** **1350** **Oxygen Test Findings Code** **O** **ID** **1/1**
Code indicating the findings of oxygen tests performed on a patient

ALIAS: ***Oxygen test finding code***

NSF Reference:

GX0-27.0

Required if patient's arterial PO_2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.

CODE	DEFINITION
1	**Dependent edema suggesting congestive heart failure**

SITUATIONAL **CR514** **1350** **Oxygen Test Findings Code** **O** **ID** **1/1**
Code indicating the findings of oxygen tests performed on a patient

ALIAS: ***Oxygen test finding code***

NSF Reference:

GX0-27.0

Required if patient's arterial PO_2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.

CODE	DEFINITION
2	**"P" Pulmonale on Electrocardiogram (EKG)**

SITUATIONAL	**CR515**	**1350**	**Oxygen Test Findings Code** Code indicating the findings of oxygen tests performed on a patient	**O**	**ID**	**1/1**

ALIAS: ***Oxygen test finding code***

NSF Reference:

GX0-27.0

Required if patient's arterial PO_2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.

CODE	DEFINITION
3	**Erythrocythemia with a hematocrit greater than 56 percent**

NOT USED	**CR516**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**CR517**	**1382**	**Oxygen Delivery System Code**	**O**	**ID**	**1/1**
NOT USED	**CR518**	**1348**	**Oxygen Equipment Type Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

AMBULANCE CERTIFICATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.**

2. **Required on all service lines which bill/report ambulance services if the information is different when CRC01=07 in Loop ID-2300.**

Example: **CRC*07*Y*08~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 450

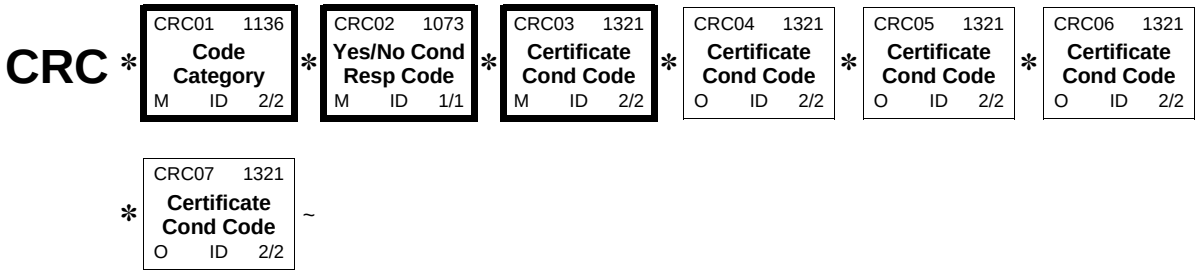
Loop: 2400

Requirement: Optional

Max Use: 3

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
07	**Ambulance Certification**

REQUIRED **CRC02** **1073** **Yes/No Condition or Response Code** **M** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Certification Condition Indicator***

ALIAS: ***Certification Condition Code, Ambulance Certification***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

CODE	DEFINITION
N	**No**
Y	**Yes**

REQUIRED **CRC03** **1321** **Condition Indicator** **M** **ID** **2/2**
Code indicating a condition

INDUSTRY: ***Condition Code***

ALIAS: ***Condition Indicator***

The codes for CRC03 also can be used for CRC04 through CRC07.

CODE	DEFINITION
01	**Patient was admitted to a hospital** NSF Reference: **GA0-06.0**
02	**Patient was bed confined before the ambulance service** NSF Reference: **GA0-08.0**
03	**Patient was bed confined after the ambulance service** NSF Reference: **GA0-09.0**
04	**Patient was moved by stretcher** NSF Reference: **GA0-10.0**
05	**Patient was unconscious or in shock** NSF Reference: **GA0-11.0**
06	**Patient was transported in an emergency situation** NSF Reference: **GA0-12.0**
07	**Patient had to be physically restrained** NSF Reference: **GA0-13.0**
08	**Patient had visible hemorrhaging** NSF Reference: **GA0-14.0**

			09 **Ambulance service was medically necessary** NSF Reference: **GA0-16.0**			
			60 **Transportation Was To the Nearest Facility** NSF Reference: **GA0-24.0**			
SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Condition Code*** *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**

IMPLEMENTATION

HOSPICE EMPLOYEE INDICATOR

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The example shows the method used to indicate whether the rendering provider is an employee of the hospice.**

2. **The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.**

3. **Required on all Medicare claims involving physician services to hospice patients.**

Example: **CRC*70*Y*65~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 450

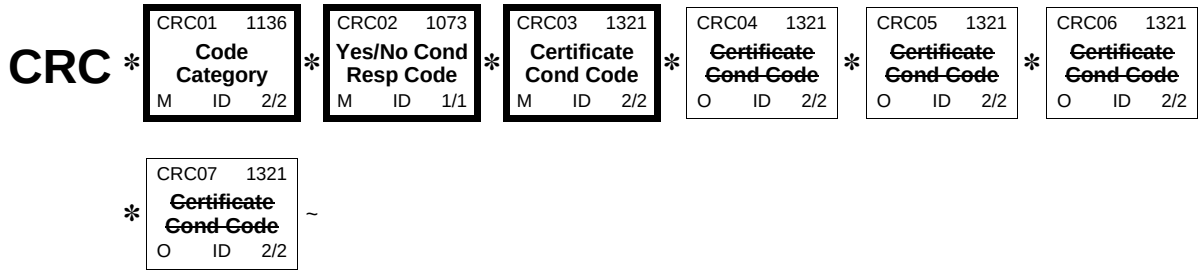
Loop: 2400

Requirement: Optional

Max Use: 3

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	CRC01	1136	**Code Category** Specifies the situation or category to which the code applies SEMANTIC: CRC01 qualifies CRC03 through CRC07. CODE: 70 — DEFINITION: Hospice	M	ID	2/2
REQUIRED	CRC02	1073	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Hospice Employed Provider Indicator*** *ALIAS:* ***Hospice Employee Indicator*** SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply. **NSF Reference:** **FA0-40.0** **A "Y" value indicates the provider is employed by the hospice. A "N" value indicates the provider is not employed by the hospice.** CODE: N — DEFINITION: No CODE: Y — DEFINITION: Yes	M	ID	1/1
REQUIRED	CRC03	1321	**Condition Indicator** Code indicating a condition CODE: 65 — DEFINITION: Open **Use this code as a place holder (element is mandatory) when reporting whether the provider is a hospice employee.**	M	ID	2/2
NOT USED	CRC04	1321	**Condition Indicator**	O	ID	2/2
NOT USED	CRC05	1321	**Condition Indicator**	O	ID	2/2
NOT USED	CRC06	1321	**Condition Indicator**	O	ID	2/2
NOT USED	CRC07	1321	**Condition Indicator**	O	ID	2/2

IMPLEMENTATION

DMERC CONDITION INDICATOR

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Required on all oxygen therapy and DME claims that require a certificate of medical necessity (CMN).**

2. **The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed.**

3. **The first example shows a case where an item billed was not a replacement item.**

Example: **CRC*09*N*ZV~**

Example: **CRC*11*Y*37*38*P1~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 450

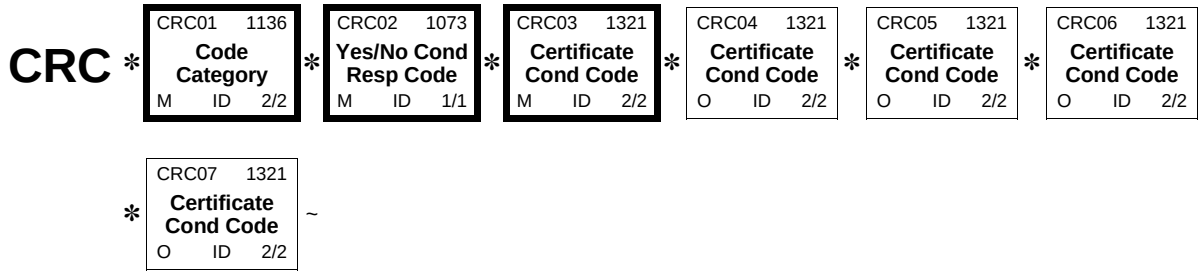
Loop: 2400

Requirement: Optional

Max Use: 3

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** M ID 2/2 Specifies the situation or category to which the code applies **SEMANTIC:** CRC01 qualifies CRC03 through CRC07. **09** = **Durable Medical Equipment Certification** **11** = **Oxygen Therapy Certification**	
REQUIRED	**CRC02**	**1073**	**Yes/No Condition or Response Code** M ID 1/1 Code indicating a Yes or No condition or response *INDUSTRY:* ***Certification Condition Indicator*** *ALIAS:* ***Certification Condition Code Applies Indicator*** **SEMANTIC:** CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply. **N** = **No** **Y** = **Yes**	
REQUIRED	**CRC03**	**1321**	**Condition Indicator** M ID 2/2 Code indicating a condition *ALIAS:* ***Condition Indicator*** **Use "P1" (GX0-20.0) to answer the Medicare Oxygen CMN question: "The test was performed either with the patient in a chronic stable state as an outpatient or within two days prior to discharge from an inpatient facility to home."** **Code ZV was approved by ASC X12 in the version 004011 Data Dictionary but is included in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entities who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this exception code.** **37** = **Oxygen delivery equipment is stationary** NSF Reference: **GX0-05.0** **38** = **Certification signed by the physician is on file at the supplier's office** NSF Reference: **GX0-35.0** **GU0-24.0** **AL** = **Ambulation Limitations** NSF Reference: **GX0-05.0**	

			P1 **Patient was Discharged from the First Facility** NSF Reference: **GX0-20.0**			
			ZV **Replacement Item** NSF Reference: **GU0-06.0**			
SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition *ALIAS:* ***Condition Indicator*** **Required if additional condition codes are needed.** **Use the codes listed in CRC03.**	**O**	**ID**	**2/2**

IMPLEMENTATION

DATE - SERVICE DATE

Loop: 2400 — SERVICE LINE

Usage: REQUIRED

Repeat: 1

Notes:

1. **The total number of DTP segments in the 2400 loop cannot exceed 15.**
2. **In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.**
3. **In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).**

Example: DTP*472*RD8*19970607-19970608~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

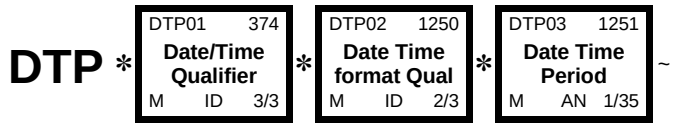
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
472	**Service** **Use RD8 in DTP02 to indicate begin/end or from/to dates.**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **Use RD8 if it is necessary to indicate begin/end dates. Date range indicates drug duration for which the supply of drug be will used by the patient. The difference in dates, including both the begin and end dates, are the days supply of the drug.** **Example: 20000101 - 20000107 (1/1/00 to 1/7/00) is used for a 7 day supply where the first day of the drug used by the patient is 1/1/00. In the event a drug is administered on less than a daily basis (e.g., every other day) the date range would include the entire period during which the drug was supplied, including the last day the drug was used.** **Example: 20000101 - 20000108 (1/1/00 to 1/8/00) is used for an 8 days supply where the prescription is written for Q48 (every 48 hours), four doses of the drug are dispensed and the first dose is used on 1/1/00.**

REQUIRED **DTP03** **1251** **Date Time Period** **M AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Service Date***

NSF Reference:

FA0-05.0, FA0-06.0

IMPLEMENTATION

DATE - CERTIFICATION REVISION DATE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if CR301 (DMERC Certification) = "R" or "S".**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*607*D8*19970519~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

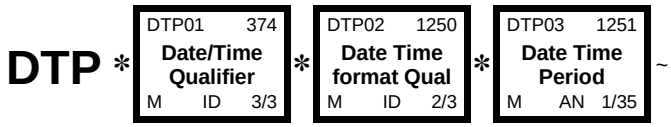
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **607 — Certification Revision**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Certification Revision Date***

NSF Reference:

GU0-20.0, GX0-11.0

IMPLEMENTATION

DATE - REFERRAL DATE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when service line includes a referral.**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*330*D8*19970617~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

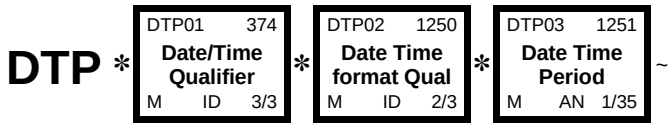
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **330 — Referral Date**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Referral Date***	**M AN 1/35**

IMPLEMENTATION

DATE - BEGIN THERAPY DATE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician.**

2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*463*D8*19970519~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

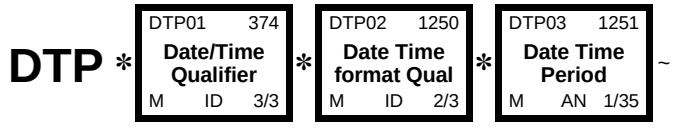
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE **DEFINITION**	
			463 Begin Therapy	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE **DEFINITION**	
			D8 Date Expressed in Format CCYYMMDD	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Begin Therapy Date***

NSF Reference:

GU0-19.0, GX0-10.0

IMPLEMENTATION

DATE - LAST CERTIFICATION DATE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician.**
2. **Required on oxygen therapy certificates of medical necessity (CMN). This is the date the ordering physician signed the CMN.**
3. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*461*D8*19970519~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

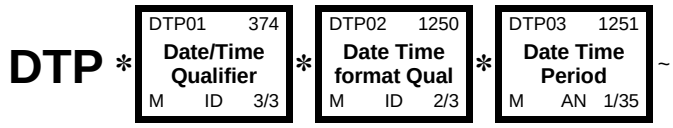
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE / **DEFINITION**	
			461 **Last Certification**	

REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M**	**ID**	**2/3**

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Last Certification Date***

NSF Reference:

GX0-11.0, GU0-22.0

IMPLEMENTATION

DATE - ORDER DATE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when service line includes an order for services or supplies.**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*938*D8*19970617~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

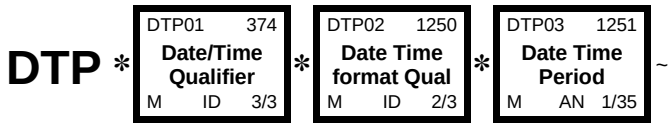
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **938 — Order**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Order Date***	**M AN 1/35**

IMPLEMENTATION

DATE - DATE LAST SEEN

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when claim is from an independent physical therapist, occupational therapist, or physician providing routine footcare if the date last seen by an attending or supervising physician is different from that listed at the claim level (Loop ID-2300).**

2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*304*D8*19970813~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

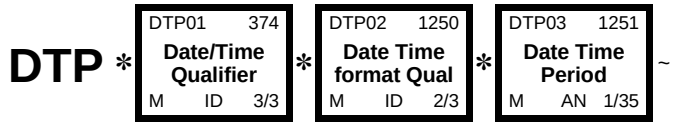
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **304 — Latest Visit or Consultation**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Last Seen Date***

NSF Reference:

EA0-48.0

IMPLEMENTATION

DATE - TEST

Loop: 2400 — SERVICE LINE

Usage: SITUATIONAL

Repeat: 2

Notes:
1. Required on initial EPO claims service lines where test results are being billed/reported.
2. The total number of DTP segments in the 2400 loop cannot exceed 15.

Example: DTP*738*D8*19970615~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

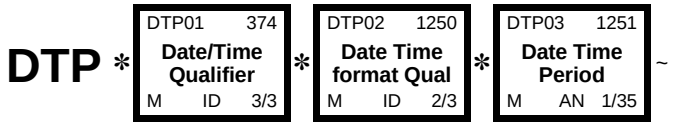
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	M ID 3/3

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
738	Most Recent Hemoglobin or Hematocrit or Both
739	Most Recent Serum Creatine

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	M ID 2/3

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Test Performed Date***

NSF Reference:

FA0-41.0, FA0-46.0

IMPLEMENTATION

DATE - OXYGEN SATURATION/ARTERIAL BLOOD GAS TEST

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:
1. **Required on initial oxygen therapy service line(s) involving certificate of medical necessity (CMN).**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*480*D8*19970615~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

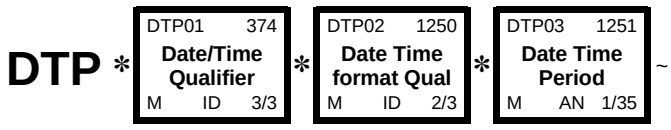
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
119	**Test Performed** **Use for any 4 liter/minute test date. Results for this test date are reported in MEA03 using either the GRA or ZO qualifiers in MEA02.**
480	**Arterial Blood Gas Test** **Do not use to report any 4 liter/minute test date. Results for the arterial blood gas test are reported in CR510.**

			481	**Oxygen Saturation Test** **Do not use to report any 4 liter/minute test date. Results for the oxygen saturation test are reported in CR511.**		
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	**M**	**ID**	**2/3**
			D8	**Date Expressed in Format CCYYMMDD**		
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times INDUSTRY: ***Oxygen Saturation Test Date*** **NSF Reference:** **GX0-19.0, GX0-24.0**	**M**	**AN**	**1/35**

IMPLEMENTATION

DATE - SHIPPED

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when billing/reporting shipped products.**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*011*D8*19970526~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

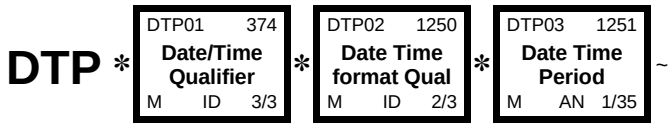
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **011 — Shipped**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Shipped Date***	**M AN 1/35**

IMPLEMENTATION

DATE - ONSET OF CURRENT SYMPTOM/ILLNESS

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if different from that entered at claim level (Loop ID-2300).**
2. **Required on claims involving services to a patient experiencing symptoms similar or identical to previously reported symptoms.**
3. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*431*D8*19971112~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

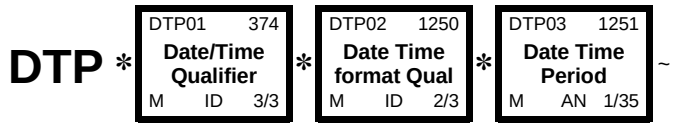
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** M ID 3/3 Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **431** = **Onset of Current Symptoms or Illness**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** M ID 2/3 Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **D8** = **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Onset Date***

NSF Reference:

EA0-07.0, EA0-16.0

IMPLEMENTATION

DATE - LAST X-RAY

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300).**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*455*D8*19970220~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

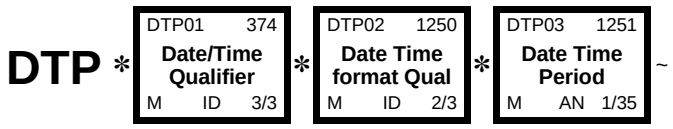
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **455** — **Last X-Ray**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Last X-Ray Date***

NSF Reference:

GC0-06.0

IMPLEMENTATION

DATE - ACUTE MANIFESTATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300).**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*453*D8*19961230~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

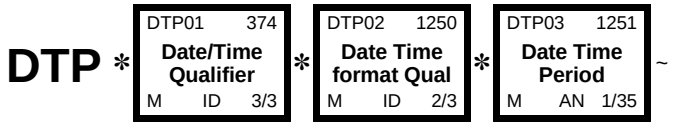
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **453** — **Acute Manifestation of a Chronic Condition**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Acute Manifestation Date***

NSF Reference:

GC0-12.0

IMPLEMENTATION

DATE - INITIAL TREATMENT

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300).**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*454*D8*19970112~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

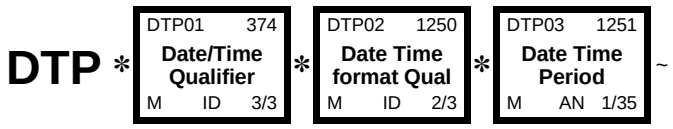
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **454** / **Initial Treatment**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** / **Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Initial Treatment Date***

NSF Reference:

GC0-05.0

IMPLEMENTATION

DATE - SIMILAR ILLNESS/SYMPTOM ONSET

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if line value is different than value given at claim level (Loop ID-2300) and claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms.**
2. **The total number of DTP segments in the 2400 loop cannot exceed 15.**

Example: **DTP*438*D8*19970115~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

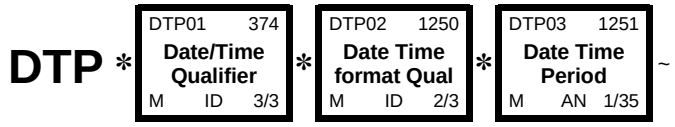
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** M ID 3/3 Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE — DEFINITION **438 — Onset of Similar Symptoms or Illness**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** M ID 2/3 Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE — DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Similar Illness or Symptom Date***

IMPLEMENTATION

ANESTHESIA MODIFYING UNITS

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required on anesthesia service lines if one or more of the extenuating circumstances coded in QTY01 was present at the time of service.**

Example: **QTY*BF*4~**

STANDARD

QTY Quantity

Level: Detail

Position: 460

Loop: 2400

Requirement: Optional

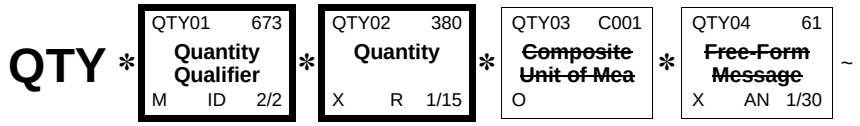
Max Use: 5

Purpose: To specify quantity information

Syntax: **1. R0204**
At least one of QTY02 or QTY04 is required.

2. E0204
Only one of QTY02 or QTY04 may be present.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**M ID 2/2**

CODE	DEFINITION
BF	**Age Modifying Units**
EC	**Use of Extracorporeal Circulation**
EM	**Emergency Modifying Units**
HM	**Use of Hypothermia**
HO	**Use of Hypotension**
HP	**Use of Hyperbaric Pressurization**

			P3	**Physical Status III**			
			P4	**Physical Status IV**			
			P5	**Physical Status V**			
			SG	**Swan-Ganz**			
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Anesthesia Modifying Units*** **SYNTAX:** R0204, E0204		**X**	**R**	**1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**		**O**		
NOT USED	**QTY04**	**61**	**Free-Form Message**		**X**	**AN**	**1/30**

IMPLEMENTATION

TEST RESULT

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **20**

Notes: **1. Required on service lines which bill/report the following: Concentration, Hemoglobin, Hematocrit, Epoetin Starting Dosage, Creatin, and Oxygen.**

Example: **MEA*TR*R1*113.4~**

STANDARD

MEA Measurements

Level: Detail

Position: 462

Loop: 2400

Requirement: Optional

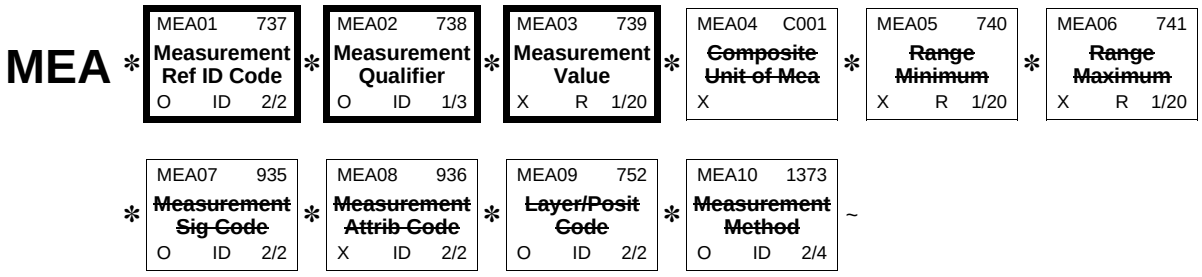
Max Use: 20

Purpose: To specify physical measurements or counts, including dimensions, tolerances, variances, and weights

Syntax:

1. **R03050608**
   At least one of MEA03, MEA05, MEA06 or MEA08 is required.
2. **C0504**
   If MEA05 is present, then MEA04 is required.
3. **C0604**
   If MEA06 is present, then MEA04 is required.
4. **L07030506**
   If MEA07 is present, then at least one of MEA03, MEA05 or MEA06 are required.
5. **E0803**
   Only one of MEA08 or MEA03 may be present.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	MEA01	737	**Measurement Reference ID Code** Code identifying the broad category to which a measurement applies *INDUSTRY:* ***Measurement Reference Identification Code*** *ALIAS:* ***Measurement identifier***	O	ID	2/2
			CODE / DEFINITION OG — Original Starting dosage TR — Test Results			
REQUIRED	MEA02	738	**Measurement Qualifier** Code identifying a specific product or process characteristic to which a measurement applies	O	ID	1/3
			CODE / DEFINITION CON — Concentration GRA — Gas Test Rate HT — Height R1 — Hemoglobin R2 — Hematocrit R3 — Epoetin Starting Dosage R4 — Creatin ZO — Oxygen			
REQUIRED	MEA03	739	**Measurement Value** The value of the measurement *INDUSTRY:* ***Test Results*** SYNTAX: R03050608, L07030506, E0803 **NSF Reference:** **FA0-42.0 - Hemoglobin, FA0-43.0 - Hematocrit, FA0-45.0 - Epoetin Starting Dosage, FA0-47.0 - Creatin, GX0-17.0 - Arterial Blood Gas on 4 liters/minute, GX0-18.0 - Oxygen Saturation on 4 liters/minute, GU0-16.0 - Patient Height**	X	R	1/20
NOT USED	MEA04	C001	**COMPOSITE UNIT OF MEASURE**	X		
NOT USED	MEA05	740	**Range Minimum**	X	R	1/20
NOT USED	MEA06	741	**Range Maximum**	X	R	1/20
NOT USED	MEA07	935	**Measurement Significance Code**	O	ID	2/2
NOT USED	MEA08	936	**Measurement Attribute Code**	X	ID	2/2
NOT USED	MEA09	752	**Surface/Layer/Position Code**	O	ID	2/2
NOT USED	MEA10	1373	**Measurement Method or Device**	O	ID	2/4

IMPLEMENTATION

CONTRACT INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Information contained at this level overwrites CN1 information at the claim level for this specific service line.**

Example: **CN1*04*410.5~**

STANDARD

CN1 Contract Information

Level: Detail

Position: 465

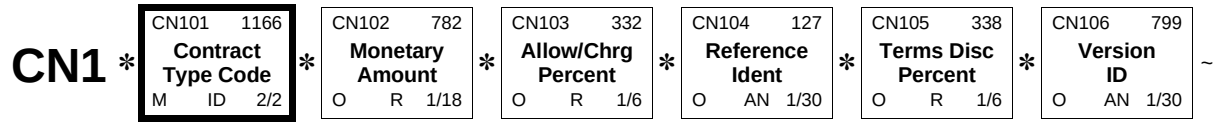
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify basic data about the contract or contract line item

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CN101**	**1166**	**Contract Type Code** Code identifying a contract type *ALIAS:* ***Contract type code***	**M ID 2/2**

The developers of this implementation guide recommend always providing CN101 for capitated encounters.

CODE	DEFINITION
01	**Diagnosis Related Group (DRG)**
02	**Per Diem**
03	**Variable Per Diem**
04	**Flat**
05	**Capitated**
06	**Percent**
09	**Other**

SITUATIONAL	**CN102**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Contract Amount***

SEMANTIC: CN102 is the contract amount.

Required if information is different than that given at claim level (Loop ID-2300).

SITUATIONAL	**CN103**	**332**	**Percent** Percent expressed as a percent	**O**	**R**	**1/6**

INDUSTRY: ***Contract Percentage***

ALIAS: ***Contract Allowance or Charge Percent***

SEMANTIC: CN103 is the allowance or charge percent.

Required if information is different than that given at claim level (Loop ID-2300).

SITUATIONAL	**CN104**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Contract Code***

SEMANTIC: CN104 is the contract code.

Required if information is different than that given at claim level (Loop ID-2300).

SITUATIONAL	**CN105**	**338**	**Terms Discount Percent** Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date	**O**	**R**	**1/6**

INDUSTRY: ***Terms Discount Percentage***

ALIAS: ***Terms discount percent***

Required if information is different than that given at claim level (Loop ID-2300).

SITUATIONAL	**CN106**	**799**	**Version Identifier** Revision level of a particular format, program, technique or algorithm	**O**	**AN**	**1/30**

INDUSTRY: ***Contract Version Identifier***

ALIAS: ***Contract Version***

SEMANTIC: CN106 is an additional identifying number for the contract.

Required if information is different than that given at claim level (Loop ID-2300).

IMPLEMENTATION

REPRICED LINE ITEM REFERENCE NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is intended to be used exclusively by repricing (pricing) organizations who have a need to identify a certain line in their claim submission transmission to their payer organization.**

Example: **REF*9B*444444~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

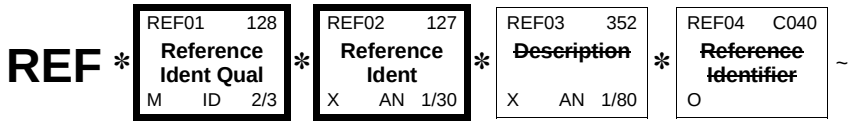
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE: **9B** — DEFINITION: **Repriced Line Item Reference Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Repriced Line Item Reference Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

ADJUSTED REPRICED LINE ITEM REFERENCE NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is intended to be used exclusively by repricing (pricing) organizations who have a need to identify a certain line in their claim submission transmission to their payer organization.**

Example: **REF*9D*444444~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

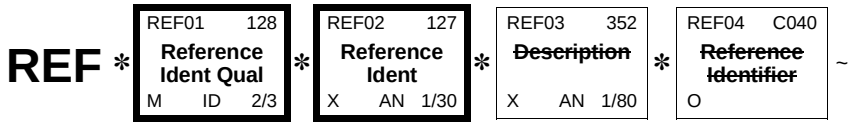
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **9D — Adjusted Repriced Line Item Reference Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Adjusted Repriced Line Item Reference Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim level (Loop-ID 2300).**

Example: **REF*9F*12345678~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

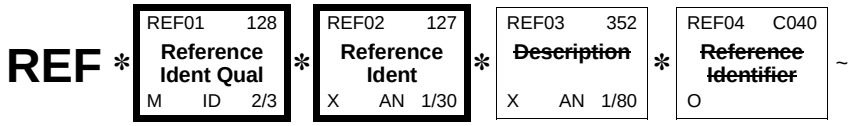
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION	
			9F **Referral Number**	
			G1 **Prior Authorization Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prior Authorization or Referral Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

LINE ITEM CONTROL NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if it is necessary to send a line control or inventory number. Providers are STRONGLY encouraged to routinely send a unique line item control number on all service lines, particularly if the provider automatically posts their remittance advice. Submitting a unique line item control number gives providers the capability to automatically post by service line. The line item control number should be unique within a patient control number (CLM01). Payers are required to return this number in the remittance advice transaction (835) if the providers sends it to them in the 837.**

Example: **REF*6R*54321~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

Requirement: Optional

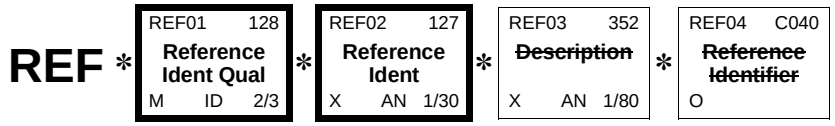
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
6R	**Provider Control Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Line Item Control Number*** SYNTAX: R0203 **NSF Reference:** **FA0-04.0, FB0-04.0, FB1-04.0, FB2-04.0, FD0-04.0, FE0-04.0, HA0-04.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MAMMOGRAPHY CERTIFICATION NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required for Medicare claims for all mammography services.**

Example: **REF*EW*T554~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

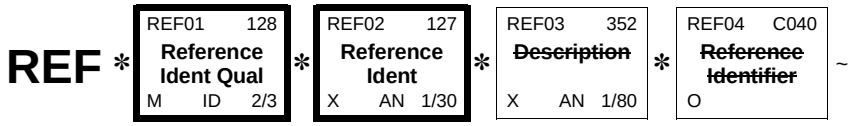
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **EW** **Mammography Certification Number**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Mammography Certification Number*** SYNTAX: R0203 **NSF Reference:** **FA0-31.0**	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) IDENTIFICATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required for all CLIA certified facilities performing CLIA covered laboratory services and if number is different than CLIA number reported at claim level (Loop ID-2300).**

Example: **REF*X4*12D4567890~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

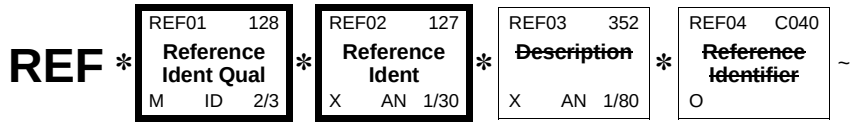
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
X4	**Clinical Laboratory Improvement Amendment Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Clinical Laboratory Improvement Amendment Number*** SYNTAX: R0203 **NSF Reference:** **FA0-34.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

REFERRING CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) FACILITY IDENTIFICATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required for Medicare claims for any laboratory that referred tests to another laboratory covered by the CLIA Act that is billed on this line.**

Example: **REF*F4*34D1234567~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

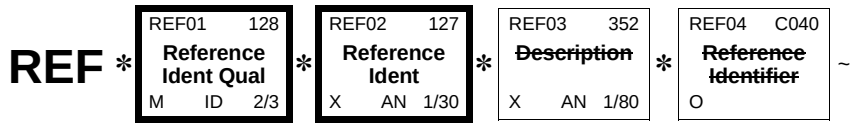
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			F4 Facility Certification Number			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referring CLIA Number*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

IMMUNIZATION BATCH NUMBER

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Use when required by state law for health data reporting.**

Example: **REF*BT*DTP22333444~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

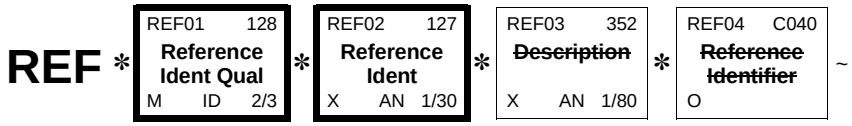
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **BT — Batch Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Immunization Batch Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

AMBULATORY PATIENT GROUP (APG)

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **4**

Notes: **1. Used at discretion of submitter.**

Example: **REF*1S*XXXXX~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

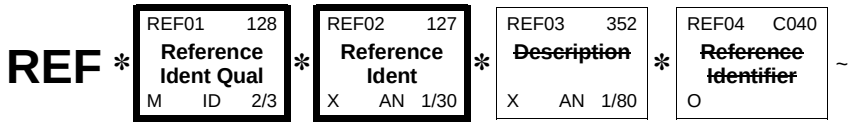
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE — DEFINITION **1S — Ambulatory Patient Group (APG) Number**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Ambulatory Patient Group Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

OXYGEN FLOW RATE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on oxygen therapy certificate of medical necessity (CMN) claim where service line reports oxygen flow rate.**

Example: **REF*TP*002~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

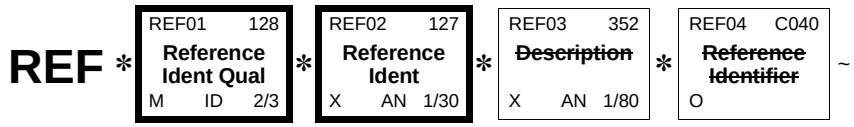
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
TP	**Test Specification Number** **Oxygen Flow Rate**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Oxygen Flow Rate*** SYNTAX: R0203 **NSF Reference:** **GX0-14.0** **Valid values are 1 - 999 liters per minute and X for less than 1 liter per minute.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

UNIVERSAL PRODUCT NUMBER (UPN)

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **X12N has been informed by HCFA that this information will be required on Medicare claims in the near future. It may also be required by some state Medicaids. This segment has been added to the 4010 implementation guide to allow providers to meet the Medicare/Medicaid requirements when they are implemented. When implemented by Medicare/Medicaid, the UPN is required on claim/encounters when an item/supply is being billed/reported that has an associated UPN included in the Health Care Uniform Code Council system or the Health Industry Business Communications Council system. See Appendix C for Code Source 41 and 522.**

Example: **REF*OZ*5737904086~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

Requirement: Optional

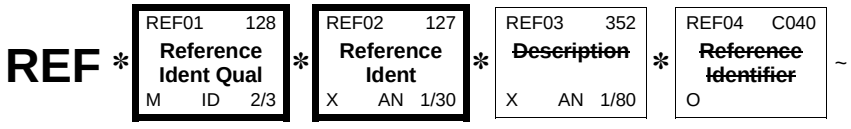
Max Use: 30

Purpose: To specify identifying information

Syntax:

1. **R0203**
   At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			OZ — **Product Number** **Code Source 41** **Use to indicate Health Care Uniform Code Council System. See Appendix C, code source 41.**			
			VP — **Vendor Product Number** **Code Source 522** **Use to indicate Health Industry Business Communications Council system. See Appendix C, code source 522.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Universal Product Number*** SYNTAX: R0203 **NSF Reference:** **FA0-62.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SALES TAX AMOUNT

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if sales tax applies to service line and submitter is required to report that information to the receiver.**

Example: **AMT*T*45~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

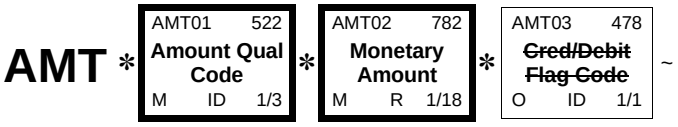
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			T **Tax**			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Sales Tax Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

APPROVED AMOUNT

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available.**

2. **The allowed amount equals the amount for the service line that was approved by the payer sending this 837 to another payer.**

Example: **AMT*AAE*125~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

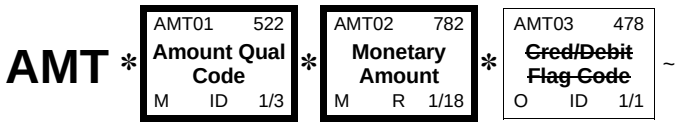
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **AAE** **Approved Amount**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Approved Amount*** **NSF Reference:** **FA0-51.0**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

POSTAGE CLAIMED AMOUNT

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if service line charge (SV102) includes postage amount claimed in this service line.**

Example: **AMT*F4*56.78~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

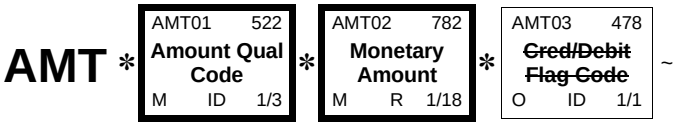
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			F4 Postage Claimed			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Postage Claimed Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

FILE INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement, and X12N determines that there is no method to meet the requirement. Only then may the state require the temporary use of the K3 to meet the requirement. X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee.**

Example: **K3*STATE DATA REQUIREMENT~**

STANDARD

K3 File Information

Level: Detail

Position: 480

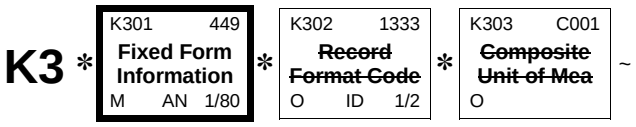
Loop: 2400

Requirement: Optional

Max Use: 10

Purpose: To transmit a fixed-format record or matrix contents

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**K301**	**449**	**Fixed Format Information** Data in fixed format agreed upon by sender and receiver	**M**	**AN**	**1/80**
			NSF Reference:			
			HA0-05.0			
NOT USED	**K302**	**1333**	**Record Format Code**	**O**	**ID**	**1/2**
NOT USED	**K303**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		

IMPLEMENTATION

LINE NOTE

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if submitter used a"not otherwise classified" (NOC) procedure code on this service line (use ADD in NTE01). Otherwise, use at providers discretion.**

Example: **NTE*DCP*PATIENT GOAL TO BE OFF OXYGEN BY END OF MONTH~**

STANDARD

NTE Note/Special Instruction

Level: Detail

Position: 485

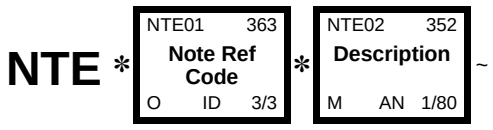
Loop: 2400

Requirement: Optional

Max Use: 10

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NTE01**	**363**	**Note Reference Code** Code identifying the functional area or purpose for which the note applies	**O ID 3/3**
			CODE / **DEFINITION** **ADD** — **Additional Information** **DCP** — **Goals, Rehabilitation Potential, or Discharge Plans** **PMT** — **Payment** **TPO** — **Third Party Organization Notes**	
REQUIRED	**NTE02**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Line Note Text*** **NSF Reference:** **HA0-05.0**	**M AN 1/80**

IMPLEMENTATION

PURCHASED SERVICE INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Using the PS1 segment indicates that services were purchased from another source.**
2. **Required on service lines involving purchased services/tests if different than the information given at the claim level (Loop ID = 2310C).**

Example: **PS1*PN222222*110~**

STANDARD

PS1 Purchase Service

Level: Detail

Position: 488

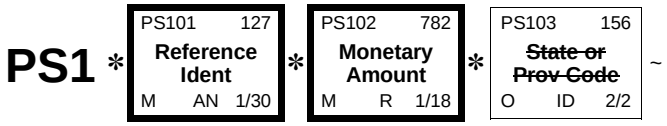
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify the information about services that are purchased

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PS101**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Purchased Service Provider Identifier*** **SEMANTIC:** PS101 is provider identification number. **NSF Reference:** **FB0-11.0**	**M AN 1/30**

REQUIRED	**PS102**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Purchased Service Charge Amount*** **SEMANTIC:** PS102 is cost of the purchased service. **NSF Reference:** **FB0-05.0**	**M**	**R**	**1/18**
NOT USED	**PS103**	**156**	**State or Province Code**	**O**	**ID**	**2/2**

IMPLEMENTATION

HEALTH CARE SERVICES DELIVERY

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The HSD segment is used to specify the delivery pattern of the health care services. This is how it is used:**

   HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit".
   Between HSD02 and HSD03 verbally insert a "per every."
   HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days."
   Between HSD04 and HSD05 verbally insert a "for."
   HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days."
   The total message reads:

   HSD*VS*1*DA*3*7*21~ = "One visit per every three days for 21 days."

   Another similar data string of HSD*VS*2*DA*4*7*20~ = Two visits per every four days for 20 days.

   An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1***SX*D~ means "1 visit on Wednesday and Thursday morning."**

2. **Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment and if information is different than that given at claim level (Loop ID-2300).**

Example: **HSD*VS*1*DA*1*7*10~ (This indicates ''1 visit every (per) 1 day (daily) for 10 days'')**

Example: **HSD*VS*1*DA****W~ (This indicates ''1 visit per day whenever necessary'')**

STANDARD

HSD Health Care Services Delivery

Level: Detail

Position: 491

Loop: 2400

Requirement: Optional

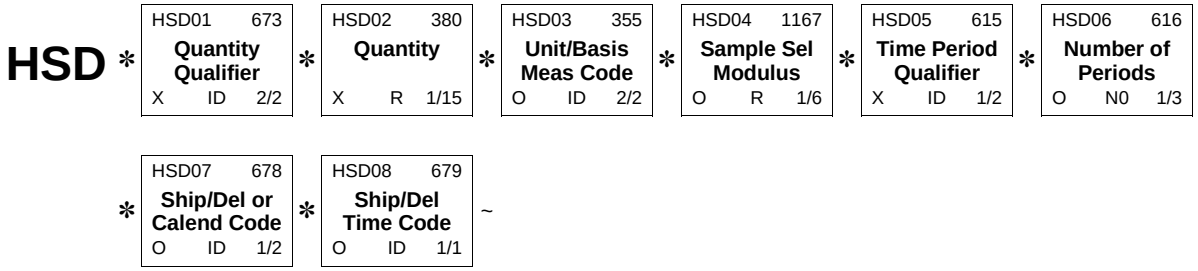
Max Use: 1

Purpose: To specify the delivery pattern of health care services

Syntax: **1. P0102**
If either HSD01 or HSD02 is present, then the other is required.

2. C0605
If HSD06 is present, then HSD05 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**HSD01**	**673**	**Quantity Qualifier** Code specifying the type of quantity *INDUSTRY:* ***Visits*** SYNTAX: P0102 **Required if information is different than that given at claim level (Loop ID-2300).** CODE / DEFINITION **VS** **Visits**	**X ID 2/2**
SITUATIONAL	**HSD02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Number of Visits*** SYNTAX: P0102 **HDS02 qualifies HSD01.** **Required if information is different than that given at claim level (Loop ID-2300).**	**X R 1/15**
SITUATIONAL	**HSD03**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken *INDUSTRY:* ***Frequency Period*** **Required if information is different than that given at claim level (Loop ID-2300).** CODE / DEFINITION **DA** **Days** **MO** **Months** **Month**	**O ID 2/2**

			Q1	**Quarter (Time)**			
			WK	**Week**			
SITUATIONAL	**HSD04**	**1167**	**Sample Selection Modulus** To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes *INDUSTRY:* ***Frequency Count*** **Required if information is different than that given at claim level (Loop ID-2300).**	**O**	**R**	**1/6**	
SITUATIONAL	**HSD05**	**615**	**Time Period Qualifier** Code defining periods *INDUSTRY:* ***Duration of Visits Units*** SYNTAX: C0605 **Required if information is different than that given at claim level (Loop ID-2300).**	**X**	**ID**	**1/2**	
			CODE / DEFINITION				
			7	**Day**			
			34	**Month**			
			35	**Week**			
SITUATIONAL	**HSD06**	**616**	**Number of Periods** Total number of periods *INDUSTRY:* ***Duration of Visits, Number of Units*** SYNTAX: C0605 **Required if information is different than that given at claim level (Loop ID-2300).**	**O**	**N0**	**1/3**	
SITUATIONAL	**HSD07**	**678**	**Ship/Delivery or Calendar Pattern Code** Code which specifies the routine shipments, deliveries, or calendar pattern *INDUSTRY:* ***Ship, Delivery or Calendar Pattern Code*** **Required if information is different than that given at claim level (Loop ID-2300).**	**O**	**ID**	**1/2**	
			CODE / DEFINITION				
			1	**1st Week of the Month**			
			2	**2nd Week of the Month**			
			3	**3rd Week of the Month**			
			4	**4th Week of the Month**			
			5	**5th Week of the Month**			
			6	**1st & 3rd Weeks of the Month**			
			7	**2nd & 4th Weeks of the Month**			
			A	**Monday through Friday**			
			B	**Monday through Saturday**			

C	Monday through Sunday
D	Monday
E	Tuesday
F	Wednesday
G	Thursday
H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
N	As Directed
O	Daily Mon. through Fri.
SA	Sunday, Monday, Thursday, Friday, Saturday
SB	Tuesday through Saturday
SC	Sunday, Wednesday, Thursday, Friday, Saturday
SD	Monday, Wednesday, Thursday, Friday, Saturday
SG	Tuesday through Friday
SL	Monday, Tuesday and Thursday
SP	Monday, Tuesday and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday and Thursday
SZ	Tuesday, Thursday and Friday
W	Whenever Necessary

SITUATIONAL **HSD08** **679** **Ship/Delivery Pattern Time Code** **O** **ID** **1/1**
Code which specifies the time for routine shipments or deliveries

INDUSTRY: ***Delivery Pattern Time Code***

Required if information is different than that given at claim level (Loop ID-2300).

CODE	DEFINITION
D	A.M.
E	P.M.
F	As Directed

IMPLEMENTATION

LINE PRICING/REPRICING INFORMATION

Loop: **2400 — SERVICE LINE**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**

Example: **HCP*03*100*10*RPO12345~**

STANDARD

HCP Health Care Pricing

Level: Detail

Position: 492

Loop: 2400

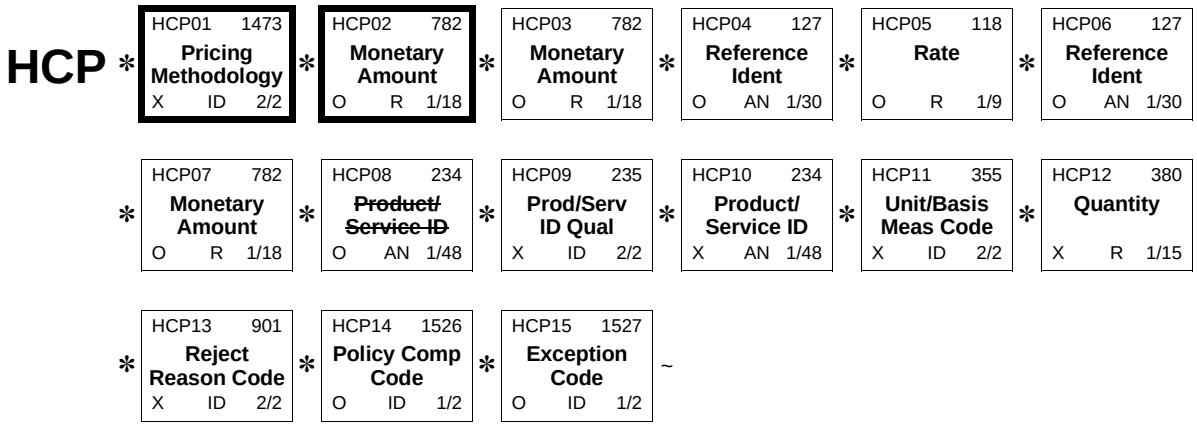
Requirement: Optional

Max Use: 1

Purpose: To specify pricing or repricing information about a health care claim or line item

Syntax:
1. **R0113**
   At least one of HCP01 or HCP13 is required.
2. **P0910**
   If either HCP09 or HCP10 is present, then the other is required.
3. **P1112**
   If either HCP11 or HCP12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HCP01	1473	**Pricing Methodology** Code specifying pricing methodology at which the claim or line item has been priced or repriced *ALIAS:* ***Pricing/repricing methodology*** SYNTAX: R0113 **Trading partners need to agree on the codes to use in this element. There do not appear to be standard definitions for the code elements.** **Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**	X ID 2/2
REQUIRED	HCP02	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Repriced Allowed Amount*** *ALIAS:* ***Pricing/Repricing Allowed Amount*** SEMANTIC: HCP02 is the allowed amount. **Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.**	O R 1/18

CODE	DEFINITION
00	Zero Pricing (Not Covered Under Contract)
01	Priced as Billed at 100%
02	Priced at the Standard Fee Schedule
03	Priced at a Contractual Percentage
04	Bundled Pricing
05	Peer Review Pricing
06	Per Diem Pricing
07	Flat Rate Pricing
08	Combination Pricing
09	Maternity Pricing
10	Other Pricing
11	Lower of Cost
12	Ratio of Cost
13	Cost Reimbursed
14	Adjustment Pricing

SITUATIONAL	**HCP03**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Saving Amount***

ALIAS: ***Pricing/Repricing Savings Amount***

SEMANTIC: HCP03 is the savings amount.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repricing Organization Identifier***

ALIAS: ***Pricing/Repricing Identification Number***

SEMANTIC: HCP04 is the repricing organization identification number.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP05**	**118**	**Rate** Rate expressed in the standard monetary denomination for the currency specified	**O**	**R**	**1/9**

INDUSTRY: ***Repricing Per Diem or Flat Rate Amount***

ALIAS: ***Pricing/Repricing Rate***

SEMANTIC: HCP05 is the pricing rate associated with per diem or flat rate repricing.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repriced Approved Ambulatory Patient Group Code***

ALIAS: ***Approved APG code, Pricing***

SEMANTIC: HCP06 is the approved DRG code.

COMMENT: HCP06, HCP07, HCP08, HCP10, and HCP12 are fields that will contain different values from the original submitted values.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL	**HCP07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Approved Ambulatory Patient Group Amount***

ALIAS: ***Approved APG amount, Pricing***

SEMANTIC: HCP07 is the approved DRG amount.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

NOT USED	**HCP08**	**234**	**Product/Service ID**	**O**	**AN**	**1/48**

SITUATIONAL **HCP09** **235** **Product/Service ID Qualifier** **X** **ID** **2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

SYNTAX: P0910

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
ZZ	**Mutually Defined** **Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.**

SITUATIONAL **HCP10** **234** **Product/Service ID** **X** **AN** **1/48**
Identifying number for a product or service

INDUSTRY: ***Procedure Code***

ALIAS: ***Pricing/Repricing Approved Procedure Code***

SYNTAX: P0910

SEMANTIC: HCP10 is the approved procedure code.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL **HCP11** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P1112

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
DA	**Days**
UN	**Unit**

SITUATIONAL **HCP12** **380** **Quantity** **X** **R** **1/15**
Numeric value of quantity

INDUSTRY: ***Repriced Approved Service Unit Count***

ALIAS: ***Pricing/Repricing Approved Units or Inpatient Days***

SYNTAX: P1112

SEMANTIC: HCP12 is the approved service units or inpatient days.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

SITUATIONAL **HCP13** **901** **Reject Reason Code** **X** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

ALIAS: ***Reject reason code***

SYNTAX: R0113

SEMANTIC: HCP13 is the rejection message returned from the third party organization.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
T1	Cannot Identify Provider as TPO (Third Party Organization) Participant
T2	Cannot Identify Payer as TPO (Third Party Organization) Participant
T3	Cannot Identify Insured as TPO (Third Party Organization) Participant
T4	Payer Name or Identifier Missing
T5	Certification Information Missing
T6	Claim does not contain enough information for re-pricing

SITUATIONAL **HCP14** **1526** **Policy Compliance Code** **O** **ID** **1/2**
Code specifying policy compliance

ALIAS: ***Policy compliance code***

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
1	Procedure Followed (Compliance)
2	Not Followed - Call Not Made (Non-Compliance Call Not Made)
3	Not Medically Necessary (Non-Compliance Non-Medically Necessary)
4	Not Followed Other (Non-Compliance Other)
5	Emergency Admit to Non-Network Hospital

SITUATIONAL **HCP15** **1527** **Exception Code** **O ID 1/2**

Code specifying the exception reason for consideration of out-of-network health care services

ALIAS: ***Exception code***

SEMANTIC: HCP15 is the exception reason generated by a third party organization.

Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.

CODE	DEFINITION
1	Non-Network Professional Provider in Network Hospital
2	Emergency Care
3	Services or Specialist not in Network
4	Out-of-Service Area
5	State Mandates
6	Other

IMPLEMENTATION

RENDERING PROVIDER NAME

Loop: **2420A — RENDERING PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

2. **Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider that what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.**

3. **Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a subsitute provider (locum tenans) was used, that person should be entered here.**

Example: **NM1*82*1*SMITH*JUNE*L***XX*87654321~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

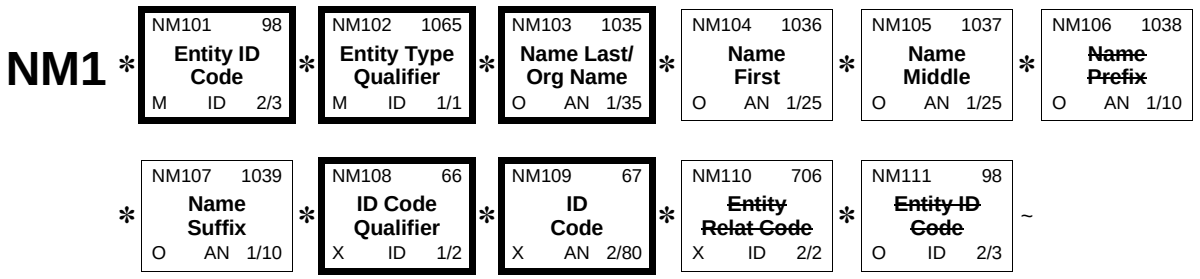
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** CODE / DEFINITION **82 Rendering Provider**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1 Person** **2 Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* Rendering Provider Last or Organization Name** ***ALIAS:* Rendering Provider Last Name** **NSF Reference:** **FB1-14.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:* Rendering Provider First Name** **NSF Reference:** **FB1-15.0** **Required if NM102=1 (person).**	**O AN 1/25**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Rendering Provider Middle Name*** **NSF Reference:** **FB1-16.0** **Required if NM102=1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Rendering Provider Name Suffix*** *ALIAS:* ***Rendering Provider Generation*** **Required if known.**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **NSF Reference:** **FA0-57.0**	**X**	**ID**	**1/2**
			CODE / **DEFINITION** **24** — **Employer's Identification Number** **34** — **Social Security Number** **Social Security Number cannot be used for Medicare claims.** **XX** — **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Rendering Provider Identifier*** *ALIAS:* ***Rendering Provider Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **FA0-23.0, FA0-58.0**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

RENDERING PROVIDER SPECIALTY INFORMATION

Loop: **2420A — RENDERING PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. PRV02 qualifies PRV03.**

Example: **PRV*PE*ZZ*203BA050N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

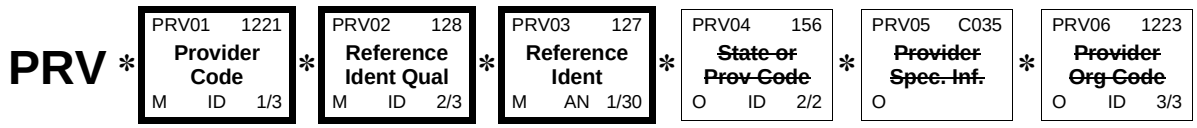
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M**	**ID**	**1/3**
			CODE / DEFINITION **PE** — **Performing**			
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.			
			CODE / DEFINITION **ZZ** — **Mutually Defined** **Health Care Provider Taxonomy Code list**			

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code*** **NSF Reference:** **FA0-37.0**	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL RENDERING PROVIDER NAME INFORMATION

Loop: **2420A — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 510

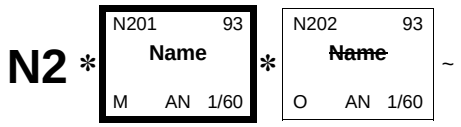
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Rendering Provider Name Additional Text*** *ALIAS:* ***Rendering Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

RENDERING PROVIDER SECONDARY IDENTIFICATION

Loop: **2420A — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

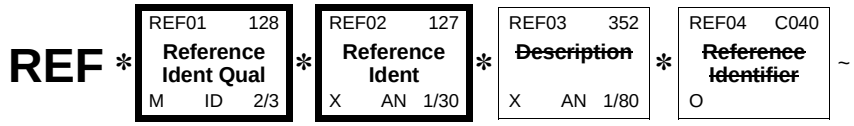
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Rendering Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

PURCHASED SERVICE PROVIDER NAME

Loop: **2420B — PURCHASED SERVICE PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

2. **Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.**

Example: **NM1*QB*2*XYZ HOLTER MONITOR INC*****34*444556666~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

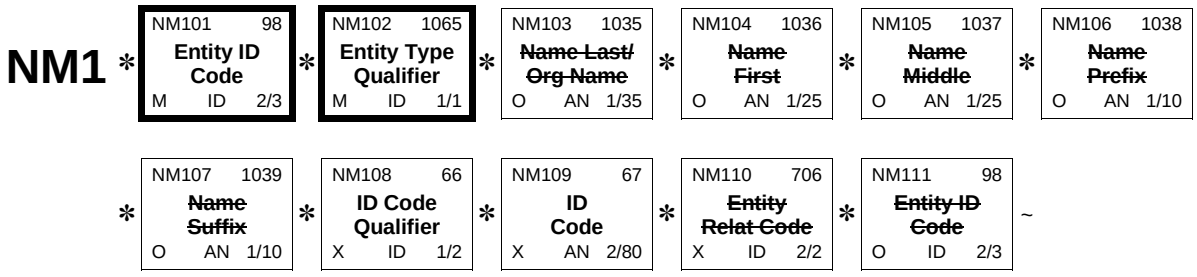
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** CODE / DEFINITION QB – Purchase Service Provider	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION 1 – Person 2 – Non-Person Entity	M ID 1/1
NOT USED	NM103	1035	**Name Last or Organization Name**	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
SITUATIONAL	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.** CODE / DEFINITION 24 – Employer's Identification Number 34 – Social Security Number XX – Health Care Financing Administration National Provider Identifier ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***	X ID 1/2

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Purchased Service Provider Identifier*** *ALIAS:* ***Purchased Service Provider's Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **FB0-11.0** **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

PURCHASED SERVICE PROVIDER SECONDARY IDENTIFICATION

Loop: **2420B — PURCHASED SERVICE PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

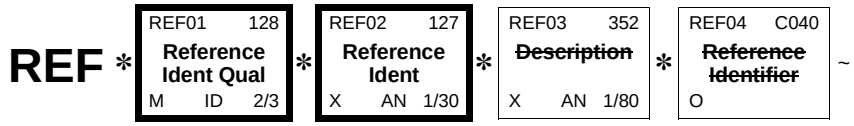
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**		
			EI	**Employer's Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			SY	**Social Security Number** **The social security number may not be used for Medicare.**		
			U3	**Unique Supplier Identification Number (USIN)**		
			X5	**State Industrial Accident Provider Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Purchased Service Provider Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **FB0-11.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE FACILITY LOCATION

Loop: 2420C — SERVICE FACILITY LOCATION Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

2. **Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider), 2010AB (Pay-to Provider), or 2310D Service Facility Location loops. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.**

Example: NM1*TL*2*A-OK MOBILE CLINIC***24*11122333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

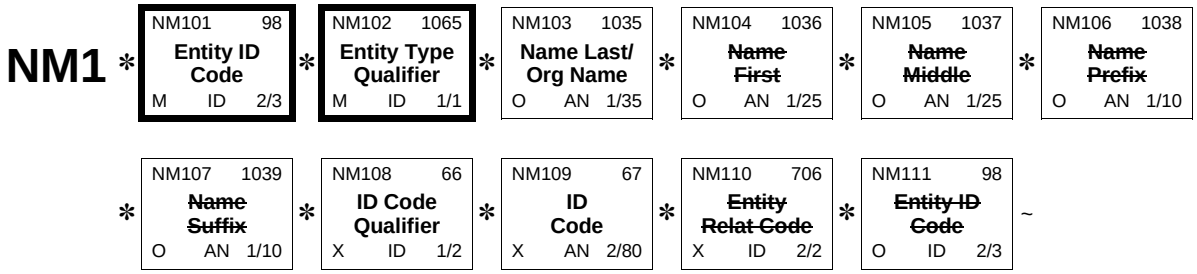
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** **77 Service Location** — **Use when other codes in this element do not apply.** **FA Facility** **LI Independent Lab** **TL Testing Laboratory**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **2 Non-Person Entity**	**M ID 1/1**
SITUATIONAL	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* Laboratory or Facility Name** ***ALIAS:* Service Facility Location Name** **NSF Reference:** **GX0-25.0** **Required except when service was rendered in the patient's home.**	**O AN 1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **Required if either Employer's Identification/Social Security Number (tax ID of service location) or National Provider Identifier is known.** **24 Employer's Identification Number** **34 Social Security Number** — **Do not use for Medicare claims.**	**X ID 1/2**

			XX **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Laboratory or Facility Primary Identifier*** *ALIAS:* ***Service Facility Location Identification Number*** SYNTAX: P0809 **Required if either Employer's Identification/Social Security Number (tax ID of service location) or National Provider Identifier is known.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL SERVICE FACILITY LOCATION NAME INFORMATION

Loop: **2420C — SERVICE FACILITY LOCATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 510

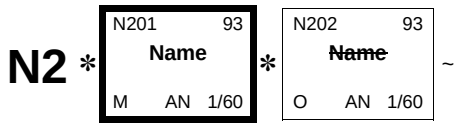
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Laboratory or Facility Name Additional Text*** *ALIAS:* ***Service Facility Location Additional Name***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SERVICE FACILITY LOCATION ADDRESS

Loop: **2420C — SERVICE FACILITY LOCATION**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)**

Example: **N3*2400 HEALTHY WAY~**

STANDARD

N3 Address Information

Level: Detail

Position: 514

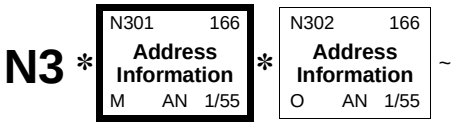
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Laboratory or Facility Address Line*** *ALIAS:* ***Service Facility Location Address 1*** **NSF Reference:** **GX2-04.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Laboratory or Facility Address Line*** *ALIAS:* ***Service Facility Location Address 2*** **NSF Reference:** **GX2-05.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

SERVICE FACILITY LOCATION CITY/STATE/ZIP

Loop: **2420C — SERVICE FACILITY LOCATION**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.**

Example: **N4*HYANNIS*MA*02601~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 520

Loop: 2420

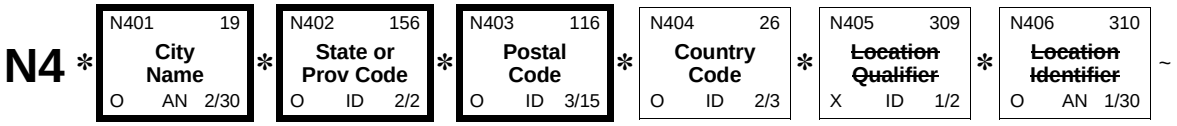
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Laboratory or Facility City Name*** *ALIAS:* ***Service Facility Location City*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **GX2-06.0**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Laboratory or Facility State or Province Code*** *ALIAS:* ***Service Facility Location State*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **NSF Reference:** **GX2-07.0**	**O**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Laboratory or Facility Postal Zone or ZIP Code*** *ALIAS:* ***Service Facility Location ZIP Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **GX2-08.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Service Facility Location Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

Loop: **2420C — SERVICE FACILITY LOCATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

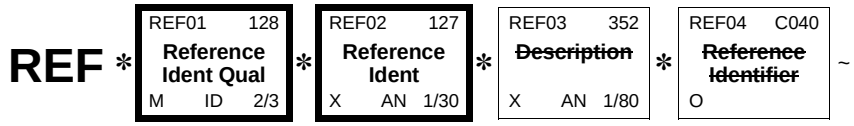
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			TJ	**Federal Taxpayer's Identification Number**			
			X4	**Clinical Laboratory Improvement Amendment Number**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Service Facility Location Secondary Identifier*** *ALIAS:* ***Service Facility Location Secondary Identification Number*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

SUPERVISING PROVIDER NAME

Loop: 2420D — SUPERVISING PROVIDER NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

2. **Required when rendering provider is supervised by a physician and the supervising physician is different than that listed at the claim level for this service line. All paye-specific identifying numbers belong to the destination payer identified in loop 2010BB.**

Example: NM1*DQ*1*KILLIAN*BART*BII*24*222334444~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

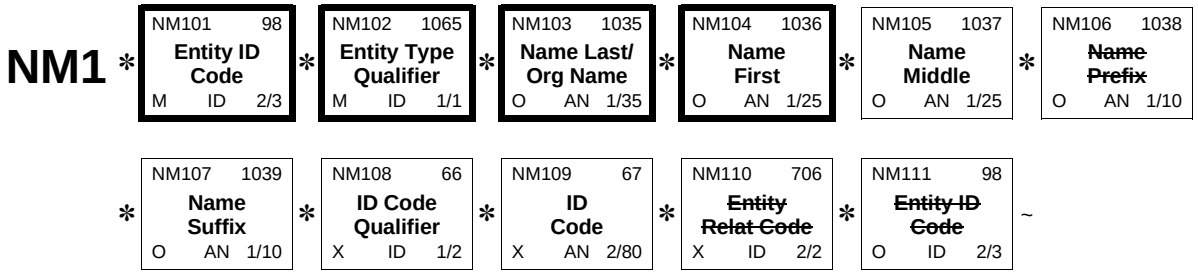
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: DQ — DEFINITION: Supervising Physician	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Supervising Provider Last Name*** **NSF Reference:** **FB1-18.0**	O AN 1/35
REQUIRED	NM104	1036	**Name First** Individual first name *INDUSTRY: **Supervising Provider First Name*** **NSF Reference:** **FB1-19.0**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Supervising Provider Middle Name*** **NSF Reference:** **FB1-20.0** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY: **Supervising Provider Name Suffix*** *ALIAS: **Supervising Provider Generation*** **Required if known.**	O AN 1/10

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Required if either Employer's Identification/Social Security Number (Supervising provider's tax ID) or National Provider Identifier is known.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for Medicare.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Supervising Provider Identifier*** *ALIAS:* ***Supervising Provider's Identification Number*** SYNTAX: P0809 **NSF Reference:** **FB1-21.0**	**X**	**AN**	**2/80**

Required if either Employer's Identification/Social Security Number (Supervising provider's tax ID) or National Provider Identifier is known.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL SUPERVISING PROVIDER NAME INFORMATION

Loop: **2420D — SUPERVISING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 510

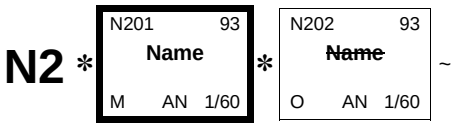
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Supervising Provider Name Additional Text*** *ALIAS:* ***Supervising Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

SUPERVISING PROVIDER SECONDARY IDENTIFICATION

Loop: **2420D — SUPERVISING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

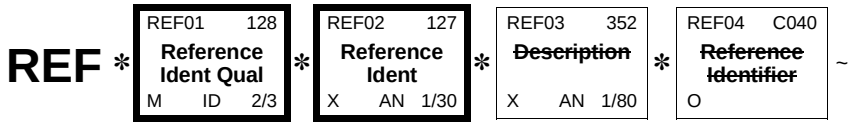
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Supervising Provider Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **FB1-21.0**		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

ORDERING PROVIDER NAME

Loop: **2420E — ORDERING PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

2. **Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. All payer-specific identifiers belong to the destination payer identified in the 2010BB loop.**

Example: **NM1*DK*1*RICHARDSON*TRENT****34*555667778~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

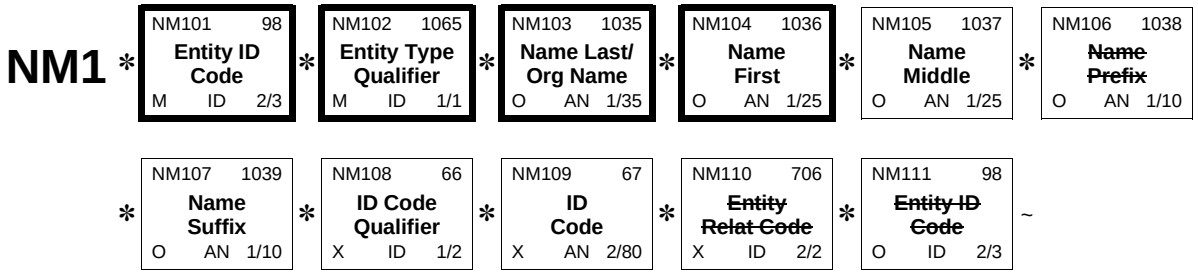
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** CODE: DK — DEFINITION: Ordering Physician	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Ordering Provider Last Name*** **NSF Reference:** **FB1-06.0**	O AN 1/35
REQUIRED	NM104	1036	**Name First** Individual first name *INDUSTRY: **Ordering Provider First Name*** **NSF Reference:** **FB1-07.0**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Ordering Provider Middle Name*** **NSF Reference:** **FB1-08.0** **Required if NM102=1 and the middle name/initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY: **Ordering Provider Name Suffix*** *ALIAS: **Ordering Provider Generation*** **Required if known.**	O AN 1/10

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

Required if either Employer's Identification/Social Security Number (Ordering provider's tax ID) or National Provider Identifier is known.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for Medicare.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Ordering Provider Identifier*** *ALIAS:* ***Ordering Provider Primary Identifier*** SYNTAX: P0809 **NSF Reference:** **FB0-09.0, FB1-09.0, GX0-29.0**	**X**	**AN**	**2/80**

Required if either Employer's Identification/Social Security Number (Ordering provider's tax ID) or National Provider Identifier is known.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL ORDERING PROVIDER NAME INFORMATION

Loop: **2420E — ORDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 510

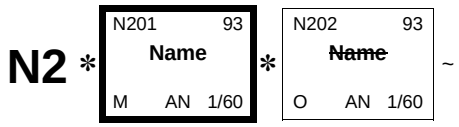
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Ordering Provider Name Additional Text*** *ALIAS:* ***Ordering Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

ORDERING PROVIDER ADDRESS

Loop: **2420E — ORDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.**

Example: **N3*2400 HEALTHY WAY~**

STANDARD

N3 Address Information

Level: Detail

Position: 514

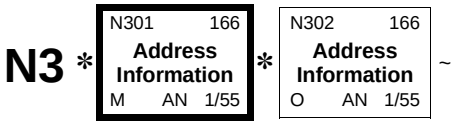
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Ordering Provider Address Line*** *ALIAS:* ***Ordering Provider Address 1*** **NSF Reference:** **FB2-06.0**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Ordering Provider Address Line*** *ALIAS:* ***Ordering Provider Address 2*** **NSF Reference:** **FB2-07.0** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

ORDERING PROVIDER CITY/STATE/ZIP CODE

Loop: **2420E — ORDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.**

Example: **N4*HYANNIS*MA*02601~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 520

Loop: 2420

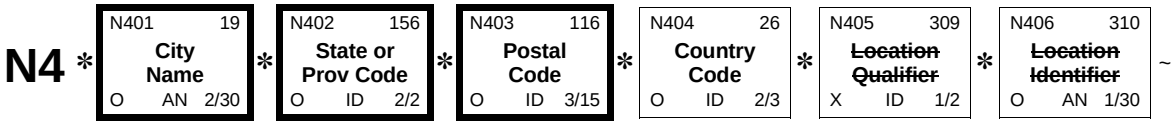
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

Syntax: **1. C0605**
If N406 is present, then N405 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Ordering Provider City Name*** *ALIAS:* ***Ordering Provider City*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **NSF Reference:** **FB2-08.0**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Ordering Provider State Code*** *ALIAS:* ***Ordering Provider State*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **NSF Reference:** **FB0-10.0, FB2-09.0**	**O**	**ID**	**2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Ordering Provider Postal Zone or ZIP Code*** *ALIAS:* ***Ordering Provider Zip Code*** CODE SOURCE **51:** ZIP Code **NSF Reference:** **FB2-10.0**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Ordering Provider Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **Required if the address is out of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

ORDERING PROVIDER SECONDARY IDENTIFICATION

Loop: **2420E — ORDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

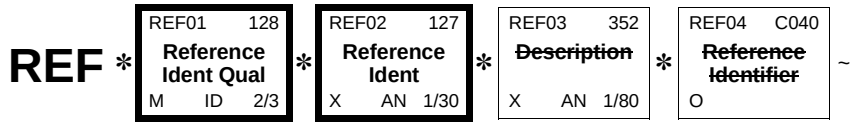
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Ordering Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

ORDERING PROVIDER CONTACT INFORMATION

Loop: **2420E — ORDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g., (534) 224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**

2. **Required when services involving an oxygen therapy certificate of medical necessity (CMN) is being billed/reported on this service line.**

3. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC*JOHN SMITH*TE*2015551212~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 530

Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To identify a person or office to whom administrative communications should be directed

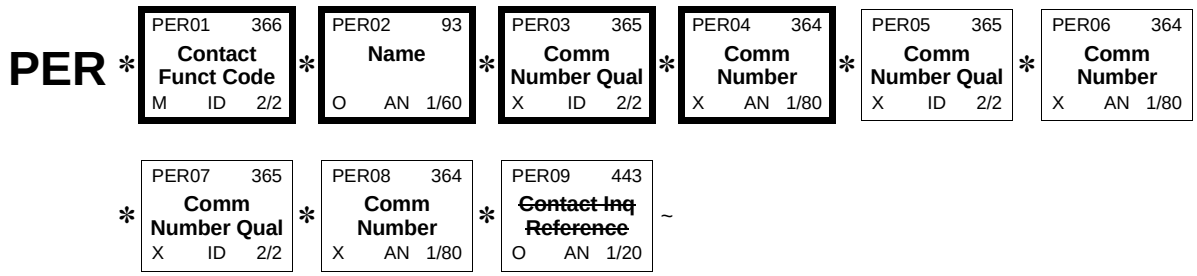
Syntax:

1. **P0304**
   If either PER03 or PER04 is present, then the other is required.

2. **P0506**
   If either PER05 or PER06 is present, then the other is required.

3. **P0708**
   If either PER07 or PER08 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			CODE / DEFINITION **IC** — **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Ordering Provider Contact Name***	**O AN 1/60**
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number **SYNTAX:** P0304 CODE / DEFINITION **EM** — **Electronic Mail** **FX** — **Facsimile** **TE** — **Telephone**	**X ID 2/2**
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable **SYNTAX:** P0304 **NSF Reference:** **GX0-30.0, GU0-23.0**	**X AN 1/80**
SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number **SYNTAX:** P0506 **Used at discretion of submitter.** CODE / DEFINITION **EM** — **Electronic Mail** **EX** — **Telephone Extension** **FX** — **Facsimile** **TE** — **Telephone**	**X ID 2/2**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **Used at discretion of submitter.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Used at discretion of submitter.**	**X**	**ID**	**2/2**
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708 **Used at discretion of submitter.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

IMPLEMENTATION

REFERRING PROVIDER NAME

Loop: **2420F — REFERRING PROVIDER NAME Repeat: 2**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

2. **Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A). All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.**

3. **When there is only one referral on the service line use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this service line. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.**

Example: **NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

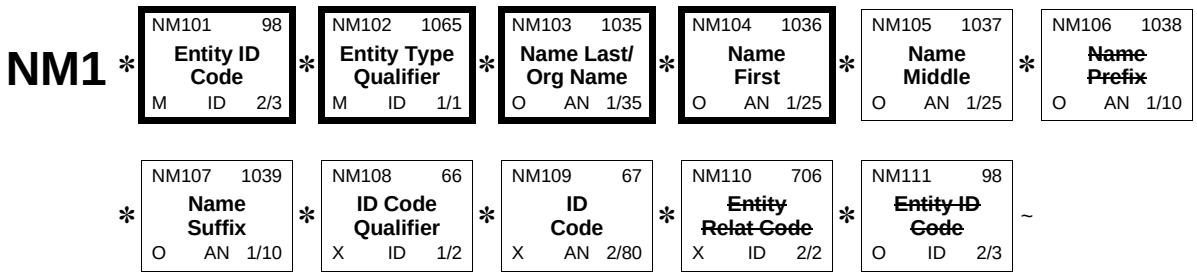
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. **C1110**
   If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			CODE / DEFINITION	
			DN — **Referring Provider** **Use on the first iteration of this loop. Use if loop is used only once.**	
			P3 — **Primary Care Provider** **Use only if loop is used twice. Use only on second iteration of this loop.**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE / DEFINITION	
			1 — **Person**	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Referring Provider Last Name*** **NSF Reference:** **FB1-10.0**	**O AN 1/35**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Referring Provider First Name*** **NSF Reference:** **FB1-11.0**	**O AN 1/25**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O**	**AN**	**1/25**

INDUSTRY: ***Referring Provider Middle Name***

NSF Reference:

FB1-12.0

Required if NM102=1 and the middle name/initial of the person is known.

NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name	**O**	**AN**	**1/10**

INDUSTRY: ***Referring Provider Name Suffix***

ALIAS: ***Referring Provider Generation***

Required if known.

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67)	**X**	**ID**	**1/2**

SYNTAX: P0809

Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.

CODE	DEFINITION
24	**Employer's Identification Number**
34	**Social Security Number** **The social security number may not be used for Medicare.**
XX	**Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Referring Provider Identifier***

ALIAS: ***Referring Provider's Identification Number***

SYNTAX: P0809

NSF Reference:

FB1-13.0, FA0-24.0

Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known.

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

REFERRING PROVIDER SPECIALTY INFORMATION

Loop: **2420F — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if required under provider-payer contract.**
2. **PRV02 qualifies PRV03.**

Example: **PRV*RF*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

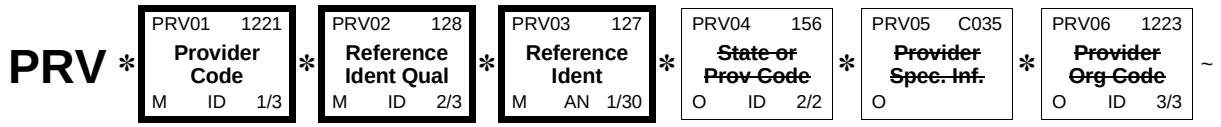
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M ID 1/3**

CODE	DEFINITION
RF	**Referring**

REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**

ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

CODE	DEFINITION
ZZ	**Mutually Defined** **Health Care Provider Taxonomy Code list**

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code***	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL REFERRING PROVIDER NAME INFORMATION

Loop: **2420F — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.**

Example: **N2*ADDITIONAL NAME INFO~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 510

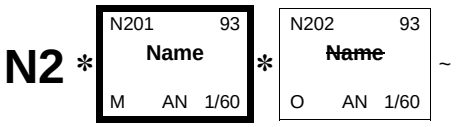
Loop: 2420

Requirement: Optional

Max Use: 2

Purpose: To specify additional names or those longer than 35 characters in length

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name *INDUSTRY:* ***Referring Provider Name Additional Text*** *ALIAS:* ***Referring Provider Additional Name Information***	**M**	**AN**	**1/60**
NOT USED	**N202**	**93**	**Name**	**O**	**AN**	**1/60**

IMPLEMENTATION

REFERRING PROVIDER SECONDARY IDENTIFICATION

Loop: **2420F — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.**

Example: **REF*1D*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

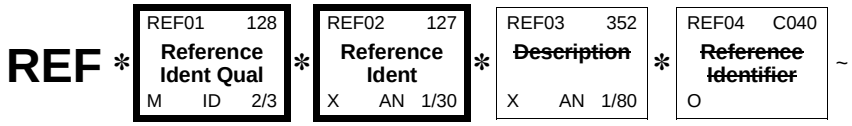
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**

CODE	DEFINITION
0B	**State License Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referring Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2420G — OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER Repeat: 4**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when it is necessary, in COB situations, to send a payer-specific line level referral number or prior authorization number. The payer-specific numbers carried in the REF in this loop belong to the non-destination (COB) payers.**

2. **The strategy in using this loop is to use NM109 to identify which payer the prior authorization/referral number carried in the REF of this loop belongs to. For example, if there are 2 COB payers (non-destination payers) who have additional referral numbers for this service line the data string for the 2420G loop would look like this:**

   NM1*PR*2****PI*PAYER #1 ID~ (This payer ID would be identified in an iteration of loop 2330B in it's own 2320 loop)**
   REF*9F*AAAAAAA~
   NM1*PR*2****PI*PAYER#2 ID~ (This payer ID would also be identified in an interation of loop 2330B in it's own 2320 loop)**
   REF*9F*2BBBBBB~

3. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*PR*2*UNION MUTUAL OF OREGON*****PI*223345~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

Purpose: To supply the full name of an individual or organizational entity

Set Notes:

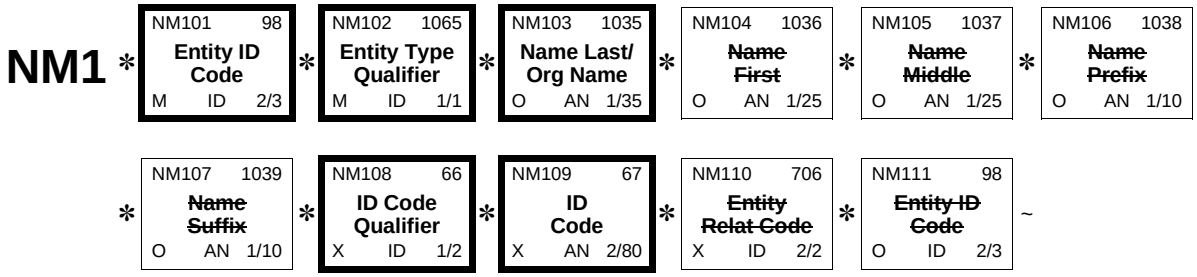
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

1. **P0809**
   If either NM108 or NM109 is present, then the other is required.

2. C1110
If NM111 is present, then NM110 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: **PR** — DEFINITION: **Payer**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE: **2** — DEFINITION: **Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Payer Name***	**O AN 1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O AN 1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 CODE: **PI** — DEFINITION: **Payor Identification** CODE: **XV** — DEFINITION: **Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.*** **CODE SOURCE 540:** Health Care Financing Administration National PlanID	**X ID 1/2**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Payer Identification Number*** *ALIAS:* ***Other Payer Identification*** SYNTAX: P0809 **Must match corresponding Other Payer Identifier in NM109 in 2330B loop(s).**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2420G — OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER**

Usage: **REQUIRED**

Repeat: **2**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*G1*AB333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

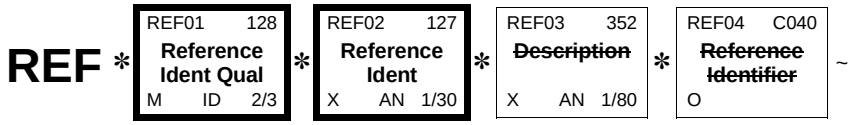
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

Syntax: **1. R0203**
At least one of REF02 or REF03 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **9F — Referral Number** **G1 — Prior Authorization Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Prior Authorization or Referral Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

LINE ADJUDICATION INFORMATION

Loop: **2430 — LINE ADJUDICATION INFORMATION** **Repeat:** **25**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **To show unbundled lines: If, in the original claim, line 3 is unbundled into (for examples) 2 additional lines, then the SVD for line 3 is used 3 times: once for the original adjustment to line 3 and then two more times for the additional unbundled lines. If a line item control number (REF01 = 6R) exists for the line, that number may be used in SVD06 instead of the LX number when a line is unbundled.**

2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

3. **Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.**

Example: **SVD*43*55*HC:84550***3~**

STANDARD

SVD Service Line Adjudication

Level: Detail

Position: 540

Loop: 2430 **Repeat:** >1

Requirement: Optional

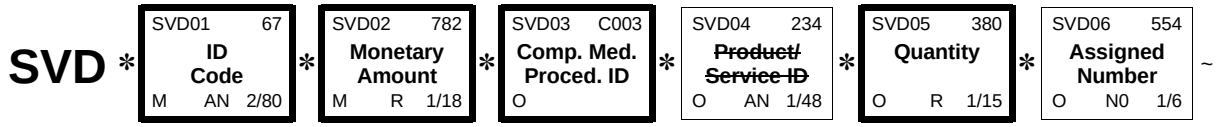
Max Use: 1

Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Set Notes:

1. SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVD01**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Payer Primary Identifier*** *ALIAS:* ***Other Payer identification code*** SEMANTIC: SVD01 is the payer identification code. **This number should match NM109 in Loop ID-2330B identifying Other Payer.**	**M AN 2/80**
REQUIRED	**SVD02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Service Line Paid Amount*** *ALIAS:* ***Paid Amount*** SEMANTIC: SVD02 is the amount paid for this service line. **NSF Reference:** **FA0-52.0** **Zero "0" is an acceptable value for this element.** **The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations.**	**M R 1/18**
REQUIRED	**SVD03**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers *ALIAS:* ***Procedure identifier*** **This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transmission.**	**O**
REQUIRED	**SVD03 - 1**		**235 Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.** CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code** CODE SOURCE **513:** Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format** CODE SOURCE **240:** National Drug Code by Format

			N2	**National Drug Code in 5-3-2 Format** CODE SOURCE **240:** National Drug Code by Format			
			N3	**National Drug Code in 5-4-1 Format** CODE SOURCE **240:** National Drug Code by Format			
			N4	**National Drug Code in 5-4-2 Format** CODE SOURCE **240:** National Drug Code by Format			
			ZZ	**Mutually Defined** **Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.**			
REQUIRED	**SVD03 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code***	**M**	**AN**	**1/48**
SITUATIONAL	**SVD03 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Modifier 1*** **Use this modifier for the first procedure code modifier.** **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Modifier 2*** **Use this modifier for the second procedure code modifier.** **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Modifier 3*** **Use this modifier for the third procedure code modifier.** **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Modifier 4*** **Use this modifier for the fourth procedure code modifier.** **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**

SITUATIONAL	**SVD03 - 7**		**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Procedure Code Description*** **Required if SVC01-7 was returned in the 835 transaction.**	**O**	**AN**	**1/80**
NOT USED	**SVD04**	**234**		**Product/Service ID**	**O**	**AN**	**1/48**
REQUIRED	**SVD05**	**380**		**Quantity** Numeric value of quantity *INDUSTRY:* ***Paid Service Unit Count*** *ALIAS:* ***Paid units of service*** SEMANTIC: SVD05 is the paid units of service. **Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.**	**O**	**R**	**1/15**
SITUATIONAL	**SVD06**	**554**		**Assigned Number** Number assigned for differentiation within a transaction set *INDUSTRY:* ***Bundled or Unbundled Line Number*** *ALIAS:* ***Bundled/Unbundled Line Number*** COMMENT: SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled. **Use the LX from this transaction which points to the bundled/unbundled line.** **Required if payer bundled/unbundled this service line.**	**O**	**N0**	**1/6**

IMPLEMENTATION

LINE ADJUSTMENT

Loop: **2430 — LINE ADJUDICATION INFORMATION**

Usage: **SITUATIONAL**

Repeat: **99**

Notes:

1. **Required if the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.**

2. **Mapping CAS information into a flat file format may involve reading specific Claim Adjustment Reason Codes and then mapping the subsequent Monetary Amount and/or Quantity elements to specific fields in the flat file.**

3. **There are some NSF COB elements which are covered through the use of the CAS segment. Please see the claim level CAS segment for a note on handling those crosswalks at the claim level. Some of that information may apply at the line level. Further information is given below which is more specific to line level issues.**

   Balance bill limiting charge (FA0-54.0). The adjustment for this information would be conveyed in a CAS amount element if the provider billed for more than they were allowed to under contract.

4. **The Claim Adjustment Reason codes are located on the Washington Publishing Company web site http://www.wpc-edi.com.**

Example: **CAS*PR*1*7.93~**

Example: **CAS*OA*93*15.06~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 545

Loop: 2430

Requirement: Optional

Max Use: 99

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Syntax:

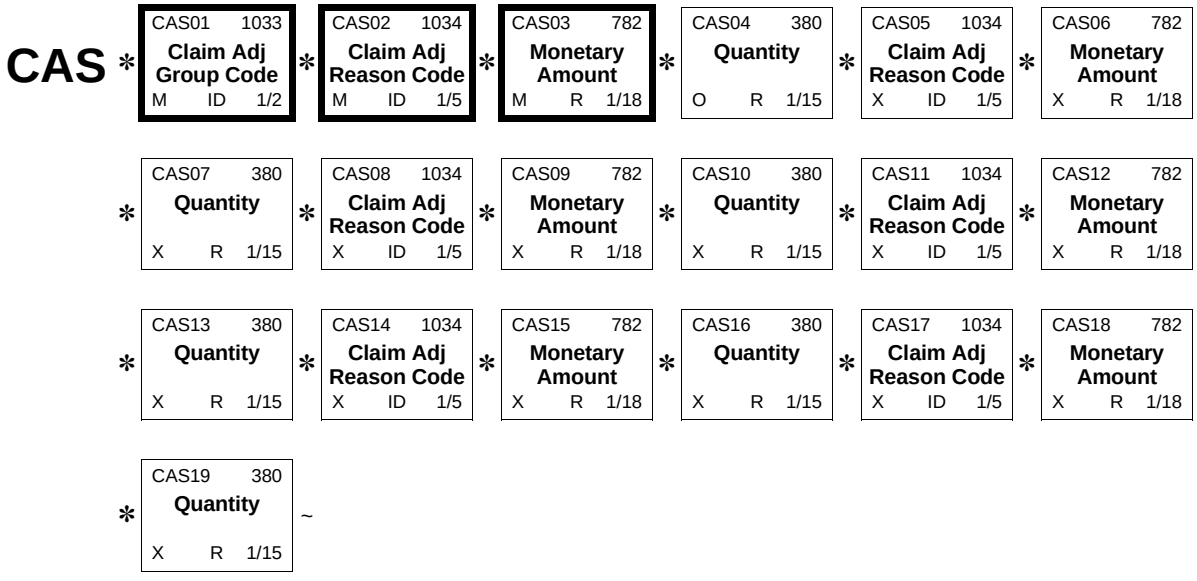
1. **L050607**
   If CAS05 is present, then at least one of CAS06 or CAS07 are required.

2. **C0605**
   If CAS06 is present, then CAS05 is required.

3. **C0705**
   If CAS07 is present, then CAS05 is required.

4. **L080910**
   If CAS08 is present, then at least one of CAS09 or CAS10 are required.
5. **C0908**
   If CAS09 is present, then CAS08 is required.
6. **C1008**
   If CAS10 is present, then CAS08 is required.
7. **L111213**
   If CAS11 is present, then at least one of CAS12 or CAS13 are required.
8. **C1211**
   If CAS12 is present, then CAS11 is required.
9. **C1311**
   If CAS13 is present, then CAS11 is required.
10. **L141516**
    If CAS14 is present, then at least one of CAS15 or CAS16 are required.
11. **C1514**
    If CAS15 is present, then CAS14 is required.
12. **C1614**
    If CAS16 is present, then CAS14 is required.
13. **L171819**
    If CAS17 is present, then at least one of CAS18 or CAS19 are required.
14. **C1817**
    If CAS18 is present, then CAS17 is required.
15. **C1917**
    If CAS19 is present, then CAS17 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment *ALIAS:* ***Adjustment Group Code***	**M**	**ID**	**1/2**

CODE	DEFINITION
CO	**Contractual Obligations**
CR	**Correction and Reversals**
OA	**Other adjustments**
PI	**Payor Initiated Reductions**
PR	**Patient Responsibility**

REQUIRED	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** *ALIAS:* ***Adjustment Reason Code - Line Level*** **CODE SOURCE 139:** Claim Adjustment Reason Code **NSF Reference:** **FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0** **Use the Claim Adjustment Reason Code list (See Appendix C).**	**M**	**ID**	**1/5**
REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** *ALIAS:* ***Adjusted Amount - Line Level*** **SEMANTIC:** CAS03 is the amount of adjustment. **COMMENT:** When the submitted charges are paid in full, the value for CAS03 should be zero. **NSF Reference:** **FA0-27.0, FA0-28.0, FA0-35.0, FA0-48.0, FB0-06.0, FB0-07.0, FB0-08.0, FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0** **Use this amount for the adjustment amount.**	**M**	**R**	**1/18**
SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** *ALIAS:* ***Adjusted Units - Line Level*** **SEMANTIC:** CAS04 is the units of service being adjusted. **Use this quantity for the units of service being adjusted.** **Use as needed to show payer adjustment.**	**O**	**R**	**1/15**

SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L050607, C0605, C0705

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use as needed to show payer adjustment.

Use the Claim Adjustment Reason Code list (See Appendix C).

SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L050607, C0605

SEMANTIC: CAS06 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0

Use this amount for the adjustment amount.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS07**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L050607, C0705

SEMANTIC: CAS07 is the units of service being adjusted.

Use this quantity for the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS08**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L080910, C0908, C1008

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use as needed to show payer adjustment.

Use the Claim Adjustment Reason Code list (See Appendix C).

SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L080910, C0908

SEMANTIC: CAS09 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0

Use this amount for the adjustment amount.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L080910, C1008

SEMANTIC: CAS10 is the units of service being adjusted.

Use this quantity for the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L111213, C1211, C1311

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use as needed to show payer adjustment.

Use the Claim Adjustment Reason Code list (See Appendix C).

SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L111213, C1211

SEMANTIC: CAS12 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0

Use this amount for the adjustment amount.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L111213, C1311

SEMANTIC: CAS13 is the units of service being adjusted.

Use this quantity for the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L141516, C1514, C1614

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use as needed to show payer adjustment.

Use the Claim Adjustment Reason Code list (See Appendix C).

SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L141516, C1514

SEMANTIC: CAS15 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0

Use this amount for the adjustment amount.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L141516, C1614

SEMANTIC: CAS16 is the units of service being adjusted.

Use this quantity for the units of service being adjusted.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L171819, C1817, C1917

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use as needed to show payer adjustment.

Use the Claim Adjustment Reason Code list (See Appendix C).

SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L171819, C1817

SEMANTIC: CAS18 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0

Use this amount for the adjustment amount.

Use as needed to show payer adjustment.

SITUATIONAL	**CAS19**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L171819, C1917

SEMANTIC: CAS19 is the units of service being adjusted.

Use this quantity for the units of service being adjusted.

Use as needed to show payer adjustment.

IMPLEMENTATION

LINE ADJUDICATION DATE

Loop: **2430 — LINE ADJUDICATION INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **DTP*573*D8*19970131~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 550

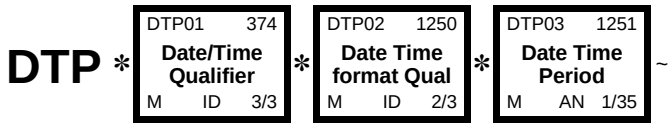
Loop: 2430

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **573** = **Date Claim Paid**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **D8** = **Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Adjudication or Payment Date***	**M AN 1/35**

IMPLEMENTATION

FORM IDENTIFICATION CODE

Loop: **2440 — FORM IDENTIFICATION CODE Repeat: 5**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the provider is required to routinely include supporting documentation (a standardized paper form) in electronic format. An example is for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician. Medicare or other payers may require other supporting documentation for other types of claims (e.g., home health).**

2. **The 2440 loop is designed to allow providers to attach any type of standardized supplemental information to the claim when required to do so by the payer. The LQ segment contains information to identify the form (LQ01) and the specific form number (LQ02). In the example given below, LQ01=UT which identifies the form as a Medicare DMERC CMN form. LQ02=0102A identifies which DMERC CMN form is being used. See Appendix K and the FRM segment for further notes on use of this loop.**

3. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then the LQ and FRM segments are "Required".**

4. **Loop 2440 was approved by ASC X12 in the version 004011 Data Dictionary but is included in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entitles who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this loop.**

Example: **LQ*UT*0102A~**

STANDARD

LQ Industry Code

Level: Detail

Position: 551

Loop: 2440 **Repeat:** >1

Requirement: Optional

Max Use: 1

Purpose: Code to transmit standard industry codes

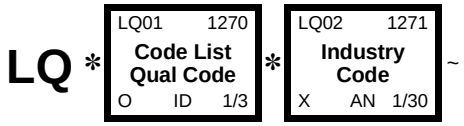
Set Notes:

1. Loop 2440 provides certificate of medical necessity information for the procedure identified in SV101 in position 2/370.

Syntax:

1. **C0102**
   If LQ01 is present, then LQ02 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**LQ01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list *ALIAS:* ***Form Identification Code*** **SYNTAX:** C0102	**O**	**ID**	**1/3**
			CODE / **DEFINITION** **AS** — **Form Type Code** **Use code AS to indicate that a Home Health form is being identified.** **UT** — **Health Care Financing Administration (HCFA) Durable Medical Equipment Regional Carrier (DMERC) Certificate of Medical Necessity (CMN) Forms**			
REQUIRED	**LQ02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Form Identifier*** **SYNTAX:** C0102 **NSF Reference:** **GU0-25.0**	**X**	**AN**	**1/30**

IMPLEMENTATION

SUPPORTING DOCUMENTATION

Loop: **2440 — FORM IDENTIFICATION CODE**

Usage: **REQUIRED**

Repeat: **99**

Notes:

1. **The LQ segment is used to identify the general (LQ01) and specific type (LQ02) for the form being reported in the 2440. The FRM segment is used to answer specific questions on the form identified in the LQ. FRM01 is used to indicate the question being answered. Answers can take one of 4 forms: FRM02 for Yes/No questions, FRM03 for text/uncodified answers, FRM04 for answers which use dates, and FRM05 for answers which are percents. For each FRM01 (question) use a remaining FRM element, choosing the element which has the most appropriate format. One FRM segment is used for each question/answer pair.**

   The example below shows how the FRM can be used to answer all the pertinent questions on DMERC form 0802 (LQ*UT*0802~). See Appendix K - Supporting Documentation Example, for a more detailed explaination of how to use the 2440 Loop.

2. **Loop 2440 was approved by ASC X12 in the version 004011 Data Dictionary but is included in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entitles who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this loop.**

Example:
FRM*1AJ0234~**
FRM*1B500~**
FRM*1C4~**
FRM*4*Y~
FRM*5A5~**
FRM*5B3~**
FRM*8*METHODIST HOSPITAL~
FRM*9*INDIANAPOLIS~
FRM*10INDIANA~**
FRM*11*19971101~**
FRM*12*Y~
FRM*1*N~

STANDARD

FRM Supporting Documentation

Level: Detail

Position: 552

Loop: 2440

Requirement: Mandatory

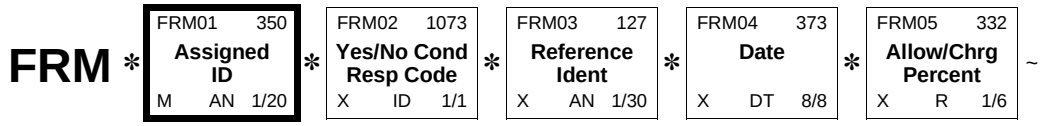
Max Use: 99

Purpose: To specify information in response to a codified questionnaire document.

Set Notes: **1.** FRM segment provides question numbers and responses for the questions on the medical necessity information form identified in LQ position 551.

Syntax: **1. R02030405**
At least one of FRM02, FRM03, FRM04 or FRM05 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**FRM01**	**350**	**Assigned Identification** Alphanumeric characters assigned for differentiation within a transaction set *INDUSTRY:* ***Question Number/Letter*** SEMANTIC: FRM01 is the question number on a questionnaire or codified form.	**M AN 1/20**
SITUATIONAL	**FRM02**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response *INDUSTRY:* ***Question Response*** SYNTAX: R02030405 SEMANTIC: FRM02, FRM03, FRM04 and FRM05 are responses which only have meaning in reference to the question identified in FRM01. **NSF Reference:** **GU0-26.0, GU0-27.0, GU0-28.0, GU0-29.0, GU0-30.0, GU0-31.0, GU0-32.0, GU0-33.0, GU0-34.0, GU0-35.0, GU0-36.0, GU0-37.0, GU0-38.0, GU0-39.0, GU0-40.0, GU0-43.0, GU0-44.0** **FRM02, 03, 04, or 05 is required.** **Used to answer question identified in FRM01 which utilizes a Yes/No response format.**	**X ID 1/1**

CODE	DEFINITION
N	**No**
W	**Not Applicable**
Y	**Yes**

SITUATIONAL	**FRM03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**X**	**AN**	**1/30**

INDUSTRY: ***Question Response***

SYNTAX: R02030405

NSF Reference:

GU0-28.0, GU0-31.0, GU0-33.0, GU0-45.0, GU0-46.0, GU0-47.0, GU0-48.0, GU0-49.0, GU0-50.0, GU0-51.0, GU0-57.0, GU0-58.0, GU0-59.0, GU0-60.0, GU0-61.0, GU0-62.0, GU0-63.0, GU0-64.0, GU0-65.0, GU0-66.0, GU0-67.0, GU0-68.0

FRM02, 03, 04, or 05 is required.

Used to answer question identified in FRM01 which utilizes a text or uncodified response format.

SITUATIONAL	**FRM04**	**373**	**Date** Date expressed as CCYYMMDD	**X**	**DT**	**8/8**

INDUSTRY: ***Question Response***

SYNTAX: R02030405

NSF Reference:

GU0-53.0, GU0-54.0, GU0-55.0, GU0-56.0

FRM02, 03, 04, or 05 is required.

Used to answer question identified in FRM01 which utilizes a date response format.

SITUATIONAL	**FRM05**	**332**	**Percent** Percent expressed as a percent	**X**	**R**	**1/6**

INDUSTRY: ***Question Response***

SYNTAX: R02030405

NSF Reference:

GU0-69.0, GU0-70.0, GU0-71.0

FRM02, 03, 04, or 05 is required.

Used to answer question identified in FRM01 which utilizes a percent response format.

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*211*987654~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 555

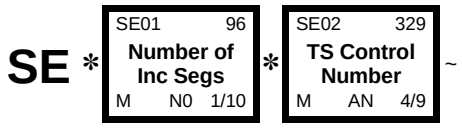
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments *INDUSTRY:* ***Transaction Segment Count*** *ALIAS:* ***Segment Count***	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set *ALIAS:* ***Transaction Set Control Number*** **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.**	**M AN 4/9**

4 EDI Transmission Examples for Different Business Uses

4.1 Professional

4.1.1 Example 1

Patient is the same person as the Subscriber. Payer is an HMO. Encounter is transmitted through a clearinghouse. Submitter is the billing service, receiver is a repricer.

SUBSCRIBER/PATIENT: Ted Smith,
ADDRESS:236 N. Main St., Miami, Fl, 33413,
TELEPHONE NUMBER: 305-555-1111
SEX: M
DOB: 05/01/43
EMPLOYER: ACME Inc.
GROUP #: 12312-A
PAYER ID NUMBER: SSN
SSN: 000-22-1111

DESTINATION PAYER: Alliance Health and Life Insurance Company (AHLIC),
PAYOR ADDRESS: 2345 West Grand Blvd, Detroit, MI 48202. ,
AHLIC #: 741234

RECEIVER: XYZ REPRICER
EDI #: 66783JJT

BILLING PROVIDER/SENDER: Premier Billing Service,
ADDRESS: 234 Seaway St, Miami, FL, 33111
TIN: 587654321,
EDI #: TGJ23
CONTACT PERSON AND PHONE NUMBER: JERRY, 305-555-2222 ext. 231

PAY-TO PROVIDER: Kildare Associates,
PROVIDER ADDRESS: 2345 Ocean Blvd, Miami, Fl 33111.
PROVIDER ID: 99878-ABA
TIN: 581234567

RENDERING PROVIDER: Dr. Ben Kildare/Family Practitioner
AHLIC PROVIDER ID#: 9741234

PATIENT ACCOUNT NUMBER: 2-646-2967
CASE:Patient has sore throat.
DOS=10/03/98. POS=Office, TOS=06 (office visit)/08 (lab)

SERVICES RENDERED: Office visit, intermediate service, established patient, throat culture.
FOLLOW-UP VISIT: DOS=10/10/97 because antibiotics didn't work (pain continues).
SERVICES: Office visit, intermediate service, established patient, mono screening.
CHARGES: Office first visit = $40.00, Lab test for strep = $15.00, lab test for mono = $10.00, Follow-up visit = $35.00. Total charges - $100.00.

ELECTRONIC ROUTE: billing provider(sender) to Clearinghouse to XYW RE-PRICER (receiver) to AHLIC (not shown);
Clearinghouse claim identification number = 17312345600006351.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER** ST TRANSACTION SET HEADER ST*837*0021~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0123*19981015*1023*RP~
3	REF TRANSMISSION TYPE IDENTIFICATION REF*87*004010X098~
4	**1000A SUBMITTER** NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*TGJ23~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*3055552222*EX*231~
6	**1000B RECEIVER** NM1 RECEIVER NAME NM1*40*2*REPRICER XYZ*****46*66783JJT~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP** HL-BILLING PROVIDER HL*1**20*1~
8	**2010AA BILLING PROVIDER** NM1 BILLING PROVIDER NAME NM1*85*2*PREMIER BILLING SERVICE*****MI*587654321~
9	N3 BILLING PROVIDER ADDRESS N3*234 Seaway St~
10	N4 BILLING PROVIDER LOCATION N4*Miami*FL*33111~
11	**2010AB PAY-TO PROVIDER** NM1 PAY-TO PROVIDER NAME NM1*87*2*KILDARE ASSOC*****24*581234567~
12	N3 PAY-TO PROVIDER ADDRESS N3*2345 OCEAN BLVD~
13	N4 PAY-TO PROVIDER CITY N4*MIAMI*FL*33111~
14	**2000B SUBSCRIBER HL LOOP** HL-SUBSCRIBER HL*2*1*22*0~

SEG #	LOOP SEGMENT/ELEMENT STRING
15	SBR SUBSCRIBER INFORMATION SBR*P*18*12312-A******HM~
16	**2010BA SUBSCRIBER** NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*TED****34*000221111~
17	N3 SUBSCRIBER ADDRESS N3*236 N MAIN ST~
18	N4 SUBSCRIBER CITY N4*MIAMI*FL*33413~
19	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*M~
20	**2010BB SUBSCRIBER/PAYER** NM1 PAYER NAME NM1*PR*2*ALLIANCE HEALTH AND LIFE INSURANCE *****PI*741234~
21	N2 PAYER ADDITIONAL NAME INFORMATION N2*COMPANY~
22	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*26462967*100***11::1*Y*A*Y*Y*C~
23	DTP DATE OF ONSET DTP*431*D8*19981003~
24	REF CLEARING HOUSE CLAIM NUMBER (Added by C.H.) REF*D9*17312345600006351~
25	HI HEALTH CARE DIAGNOSIS CODES HI*BK:0340*BF:V7389~
26	**2310B RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN***34*112233334~
27	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~
28	**2310D SERVICE LOCATION** NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
29	N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~
30	N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~

SEG #	LOOP SEGMENT/ELEMENT STRING
31	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*1~
32	SV1 PROFESSIONAL SERVICE
	SV1*HC:99213*40*UN*1***1**N~
33	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19981003~
34	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*2~
35	SV1 PROFESSIONAL SERVICE
	SV1*HC:99214*15*UN*1***1**N~
36	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19981003~
37	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*3~
38	SV1 PROFESSIONAL SERVICE
	SV1*HC:87072*35*UN*1***2**N~
39	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19981003~
40	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*4~
41	SV1 PROFESSIONAL SERVICE
	SV1*HC:86663*10*UN*1***2**N~
42	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19981010~
43	**TRAILER**
	SE TRANSACTION SET TRAILER
	SE*43*0021~

Complete data string:

```
ST*837*0021~BHT*0019*00*0123*19981015*1023*RP~REF*
87*004010X098~NM1*41*2*PREMIER BILLING SERVICE**
***46*TGJ23~PER*IC*JERRY*TE*3055552222*EX*231~NM1*
40*2*REPRICER XYZ*****46*66783JJT~HL*1**20*1~NM1*
85*2*PREMIER BILLING SERVICE*****24*587654321~N3*
234 Seaway St~N4*Miami*FL*33111~NM1*87*2*KILDARE
ASSOC*****24*581234567~N3*2345 OCEAN BLVD~N4*MIAMI
*FL*33111~HL*2*1*22*0~SBR*P*18*12312-A******HM~NM1
*IL*1*SMITH*TED****34*000221111~N3*236 N MAIN ST~
```

```
N4*MIAMI*FL*33413~DMG*D8*19430501*M~NM1*PR*2*
ALLIANCE HEALTH AND LIFE INSURANCE *****PI*741234~
N2*COMPANY~CLM*26462967*100***11::1*Y*A*Y*Y*C~DTP*
431*D8*19981003~REF*D9*17312345600006351~HI*BK:0340
*BF:V7389~NM1*82*1*KILDARE*BEN****34*112233334~PRV
*PE*ZZ*203BF0100Y~ NM1*77*2*KILDARE ASSOCIATES**
***24*581234567~N3*2345 OCEAN BLVD~N4*MIAMI*FL*
33111~LX*1~SV1*HC:99213*40*UN*1***1**N~DTP*472*D8*
19981003~LX*2~SV1*HC:99214*15*UN*1***1**N~DTP*472*
D8*19981003~LX*3~SV1*HC:87072*35*UN*1***2**N~DTP*
472*D8*19981003~LX*4~SV1*HC:86663*10*UN*1***2**N~
DTP*472*D8*19981010~SE*43*0021~
```

4.1.2 Example 2

Patient is a different person than the Subscriber. Payer is commercial health insurance company.

SUBSCRIBER: Jane Smith
PATIENT ADDRESS:236 N. Main St., Miami, Fl, 33413
TELEPHONE NUMBER: 305-555-1111
SEX: F
DOB: 05/01/43
EMPLOYER: ACME Inc.
GROUP #: 2222-SJ
KEY INSURANCE COMPANY ID #: JS00111223333
SSN: 111-22-3333

PATIENT: Ted Smith
PATIENT ADDRESS:236 N. Main St., Miami, Fl, 33413
TELEPHONE NUMBER: 305-555-1111
SEX: M
DOB: 05/01/73
KEY INSURANCE COMPANY ID #: JS01111223333
SSN: 000-22-1111

DESTINATION PAYER: Key Insurance Company
PAYOR ADDRESS: 3333 Ocean St. South Miami, FL 33000

RECEIVER: XYZ REPRICER
EDI #:66783JJT

BILLING PROVIDER/SENDER: Premier Billing Service
TIN: 587654321
ADDRESS: 234 Seaway St, Miami, FL, 33111
EDI #: TGJ23
KEY INSURANCE COMPANY PAYOR ID #: PBS3334

PAY-TO PROVIDER: Kildare Associates,
PROVIDER ADDRESS: 2345 Ocean Blvd, Miami, Fl 33111.,
PROVIDER KEY Insurance Company ID: 99878-ABA,
TIN: 581234567

RENDERING PROVIDER: Dr. Ben Kildare
KEY INSURANCE COMPANY PROVIDER ID#: KA6663
TIN: 999996666

PATIENT ACCOUNT NUMBER: 2-640-3774
CASE:Patient has sore throat.
DOS=10/03/97. POS=Office, TOS=06 (office visit)/08 (lab)
SERVICES RENDERED: Office visit, intermediate service, established patient, throat culture:
FOLLOW-UP VISIT DOS=10/10/97 because antibiotics didnt work (pain continues).
SERVICES: Office visit, intermediate service, established patient, mono screening.
CHARGES: Office first visit = $40.00, Lab test for strep = $15.00, lab test for mono = $10.00, Follow-up visit = $35.00. Total charges - $100.00.

ELECTRONIC ROUTE: billing provider (sender), VAN to XYZ Repricer (receiver) to AHLIC (not shown); VAN claim identification number = 17312345600006351.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER** ST TRANSACTION SET HEADER ST*837*3456~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*244579*19981015*1023*CH~
3	REF TRANSMISSION TYPE IDENTIFICATION REF*87*004010X098~
4	**1000A SUBMITTER** NM1 SUBMITTER NAME NM1*41*2*PREMIER BILLING SERVICE*****46*TGJ23~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*3055552222~
6	**1000B RECEIVER** NM1 RECEIVER NAME NM1*40*2*ABC VALUE ADDED NETWORK*****46*6666VAN~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP** HL - BILLING PROVIDER HL*1**20*1~
8	**2010AA BILLING PROVIDER** NM1 BILLING PROVIDER NAME NM1*85*2*PREMIER BILLING SERVICE*****24*587654321~
9	N3 BILLING PROVIDER ADDRESS N3*234 SEAWAY ST~
10	N4 BILLING PROVIDER LOCATION N4*MIAMI*FL*33111~

SEG #	LOOP SEGMENT/ELEMENT STRING
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*G2*PBS3334~
12	**2010AB PAY-TO PROVIDER** NM1 PAY-TO PROVIDER NAME NM1*87*2*KILDARE ASSOC*****24*581234567~
13	N3 PAY-TO PROVIDER ADDRESS N3*2345 OCEAN BLVD~
14	N4 PAY-TO PROVIDER CITY N4*MAIMI*FL*33111~
15	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION REF*G2*99878-ABA~
16	**2000B SUBSCRIBER HL LOOP** HL - SUBSCRIBER HL*2*1*22*1~
17	SBR SUBSCRIBER INFORMATION SBR*P**2222-SJ******CI~
18	**2010BA SUBSCRIBER** NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****MI*111223333~
19	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~
20	**2010BB PAYER** NM1 PAYER NAME NM1*PR*2*KEY INSURANCE COMPANY*****24*999996666~
21	N3 PAYER ADDRESS N3*3333 OCEAN ST~
22	N4 PAYER CITY/STATE/ZIP CODE N4*SOUTH MIAMI*FL*33000~
23	**2000C PATIENT HL LOOP** HL - PATIENT HL*3*2*23*0~
24	PAT PATIENT INFORMATION PAT*19~
25	**2010CA PATIENT** NM1 PATIENT NAME NM1*QC*1*SMITH*TED****MI*JS01111223333~
26	N3 PATIENT ADDRESS N3*236 N MAIN ST~

SEG #	LOOP SEGMENT/ELEMENT STRING
27	N4 PATIENT CITY/STATE/ZIP N4*MIAMI*FL*33413~
28	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
29	REF PATIENT SECONDARY IDENTIFICATION REF*SY*000221111~
30	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*26463774*100***11::1*Y*A*Y*Y*S~
31	REF CLAIM IDENTIFICATION NUMBER FOR CLEARING HOUSES (added by C.H.) REF*D9*17312345600006351~
32	HI HEALTH CARE DIAGNOSIS CODES HI*BK:0340*BF:V7389~
33	**2310 RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN****24*999996666~
34	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~
35	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*G2*KA6663~
36	**2210D SERVICE LOCATION** NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
37	N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~
38	N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~
39	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*1~
40	SV1 PROFESSIONAL SERVICE SV1*HC:99213*40*UN*1***1**N~
41	DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~
42	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*2~

SEG #	LOOP SEGMENT/ELEMENT STRING
43	SV1 PROFESSIONAL SERVICE SV1*HC:99214*15*UN*1***1**N~
44	DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~
45	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*3~
46	SV1 PROFESSIONAL SERVICE SV1*HC:87072*35*UN*1***2**N~
47	DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~
48	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*4~
49	SV1 PROFESSIONAL SERVICE SV1*HC:86663*10*UN*1***2**N~
50	DTP DATE - SERVICE DATE(S) DTP*472*D8*19981010~
51	**TRAILER** SE TRANSACTION SET TRAILER SE*51*3456~

Complete Data String:

```
ST*837*3456~BHT*0019*00*244579*19981015*1023*CH~
REF*87*004010X098~NM1*41*2*PREMIER BILLING SERVICE
*****46*TGJ23~PER*IC*JERRY*3055552222~NM1*40*2*ABC
VALUE ADDED NETWORK*****46*6666VAN~HL*1**20*1~NM1
*85*2*PREMIER BILLING SERVICE*****24*587654321~N3
*234 SEAWAY ST~N4*MIAMI*FL*33111~REF*G2*PBS3334~
NM1*87*2*KILDARE ASSOC*****24*581234567~N3*2345
OCEAN BLVD~N4*MAIMI*FL*33111~REF*G2*99878-ABA~
HL*2*1*22*1~SBR*P**2222-SJ******CI~NM1*IL*1*SMITH*
JANE****34*11223333~DMG*D8*19430501*F~NM1*PR*2*KEY
INSURANCE COMPANY*****24*999996666~N3*3333 OCEAN
ST~N4*SOUTH MIAMI*FL*33000~HL*3*2*23*0~PAT*19~NM1*
QC*1*SMITH*TED****MI*JS01111223333~N3*236 N MAIN
ST~N4*MIAMI*FL*33413~DMG*D8*19730501*M~REF*SY*
000221111~CLM*26463774*100***11::1*Y*A*Y*Y*S~REF*D9
*17312345600006351~HI*BK:0340*BF:V7389~NM1*82*1*
KILDARE*BEN****24*999996666~PRV*PE*ZZ*203BF0100Y~
REF*G2*KA6663~NM1*77*2*KILDARE ASSOCIATES*****24*
581234567~N3*2345 OCEAN BLVD~N4*MIAMI*FL*33111~
```

```
LX*1~SV1*HC:99213*40*UN*1***1**N~DTP*472*D8*1998100
3~LX*2~SV1*HC:99214*15*UN*1***1**N~DTP*472*D8*19981
003~LX*3~SV1*HC:87072*35*UN*1***2**N~DTP*472*D8*199
81003~LX*4~SV1*HC:86663*10*UN*1***2**N~DTP*472*D8*1
9981010~SE*51*3456~
```

4.1.3 Example 3

Coordination of benefits; patient is not the subscriber; payers are commercial health insurance companies, provider-to payer COB model.

SUBSCRIBER FOR PAYER A: Jane Smith
ADDRESS: 236 N. Main St., Miami, Fl 33413
TELEPHONE NUMBER: 305-555-1111
SEX:F
DOB:05/01/43
EMPLOYER: Acme, Inc.
PAYER A ID NUMBER: JS00111223333
SSN:111-22-3333

SUBSCRIBER FOR PAYER B: Jack Smith
ADDRESS: 236 N. Main St., Miami, Fl 33413
TELEPHONE NUMBER: 305-555-1111
SEX: M
DOB: 10/22/43
EMPLOYER: Telecom of Florida
PAYER B ID NUMBER: T55TY666
SSN: 222-33-4444

PATIENT: Ted Smith
ADDRESS: 236 N. Main St., Miami, Fl 33413
TELEPHONE NUMBER: 305-555-1111
SEX: M
DOB: 05/01/73
PAYER A ID NUMBER: JS01111223333
PAYER B ID NUMBER: T55TY666-01
SSN:000-22-1111

DESTINATION PAYER A: Key Insurance Company
PAYER A ADDRESS: 3333 Ocean St., South Miami, FL, 33000
PAYER A ID NUMBER: (TIN) 999996666

RECEIVER FOR PAYER A: XYZ REPRICER
EDI #: 66783JJT

DESTINATION PAYER B (RECEIVER): Great Prairies Health
PAYER B ADDRESS: 4456 South Shore Blvd., Chicago, IL 44444
PAYER B ID NUMBER: 567890
EDI #: 567890

BILLING PROVIDER/SENDER: Premier Billing Service
ADDRESS: 234 Seaway St, Miami, FL, 33111
PAYER A ID NUMBER: PBS3334
PAYER B ID NUMBER: EJ6666
TIN: 587654321

EDI # FOR RECEIVER A: TGJ23
EDI # FOR PAYER B: 12EEER000-TY

PAY-TO PROVIDER: Kildare Associates,
ADDRESS: 2345 Ocean Blvd, Miami, Fl 33111.
PAYER A ID NUMBER: 99878-ABA

PAYER B ID NUMBER: EX7777
TIN: 581234567

RENDERING PROVIDER: Dr. Ben Kildare
PAYER A ID NUMBER: KA6663
PAYER B ID NUMBER: 88877
TIN: 999996666

PATIENT ACCOUNT NUMBER: 2-640-7789
CASE: Patient came to office for routine hyperlipidemia check. DOS=10/03/97, POS=Office; Patient also complained of hay fever and heart burn.
SERVICES RENDERED: Patient received injection for hyperlipidemia and hay fever.
CHARGES: Patient was charged for office visit ($43.00), and two injections ($15.00 and $21.04).

ELECTRONIC PATH: The billing provider (sender) transmits the claim to Payer A (receiver) (Example 3.a) who adjudicates the claim. Payer A transmits back an 835 to the billing provider. The billing provider then submits a second claim to Payer B (receiver) (Example 3.b).

Example 3.A — Claim to Payer A from Billing Provider

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER** ST TRANSACTION SET HEADER ST*837*0002~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0123*19981015*1023*CH~
3	REF TRANSACTION TYPE IDENTIFICATION REF*87*004010X098~
4	**1000A SUBMITTER** NM1 SUBMITTER NAME NM1*41*2*PREMIER BILLING SERVICE*****46*567890~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*3055552222~
6	**1000B RECEIVER** NM1 RECEIVER NAME NM1*40*2*XYZ REPRICER*****46*66783JJT~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP** HL - BILLING PROVIDER HL*1**20*1~

SEG #	LOOP SEGMENT/ELEMENT STRING
8	**2010AA BILLING PROVIDER**
	NM1 BILLING PROVIDER
	NM1*85*2*PREMIER BILLING
	SERVICE*****24*587654321~
9	N3 BILLING PROVIDER ADDRESS
	N3*1234 SEAWAY ST~
10	N4 BILLING PROVIDER CITY/STATE/ZIP
	N4*MIAMI*FL*33111~
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION
	REF*G2*PBS3334~
12	PER BILLING PROVIDER CONTACT INFORMATION
	PER*IC*CONNIE*TE*3055551234~
13	**2010AB PAY-TO PROVIDER**
	NM1 PAY-TO PROVIDER NAME
	NM1*87*2*KILDARE ASSOC*****24*581234567~
14	N3 PAY-TO PROVIDER ADDRESS
	N3*2345 OCEAN BLVD~
15	N4 PAY-TO PROVIDER CITY/STATE/ZIP
	N4*MIAMI*FL*33111~
16	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION
	REF*G2*99878-ABA~
17	**2000B SUBSCRIBER HL LOOP**
	HL - SUBSCRIBER
	HL*2*1*22*1~
18	SBR SUBSCRIBER INFORMATION
	SBR*P********CI~
19	**2010BA SUBSCRIBER**
	NM1 SUBSCRIBER NAME
	NM1*IL*1*SMITH*JANE****34*111223333~
20	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION
	DMG*D8*19430501*F~
21	REF SUBSCRIBER SECONDARY IDENTIFICATION
	REF*IW*JS00111223333~
22	**2010BB PAYER**
	NM1 PAYER NAME
	NM1*IN*2*KEY INSURANCE
	COMPANY*****24*999996666~
23	N3 PAYER ADDRESS
	N3*3333 OCEAN ST~

SEG #	LOOP SEGMENT/ELEMENT STRING
24	N4 PAYER CITY/STATE/ZIP N4*SOUTH MIAMI*FL*33000~
25	**2000C PATIENT HL LOOP** HL - PATIENT HL*3*1*23*0~
26	PAT PATIENT INFORMATION PAT*02~
27	**2010CA PATIENT** NM1 PATIENT NAME NM1*QC*1*SMITH*TED****MI*JS01111223333~
28	N3 PATIENT ADDRESS N3*236 N MAIN ST~
29	N4 PATIENT CITY/STATE/ZIP N4*MIAMI*FL*33413~
30	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
31	REF PATIENT SECONDARY IDENTIFICATION NUMBER REF*SY*000221111~
32	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y*A*Y*Y*B~
33	HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF:53081~
34	**2310A RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN****24*999996666~
35	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~
36	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*G2*KA6663~
37	**2310D SERVICE FACILITY LOCATION** NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
38	N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~
39	N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~

SEG #	LOOP SEGMENT/ELEMENT STRING
40	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*1~
41	SV1 PROFESSIONAL SERVICE
	SV1*HC:99213*43*UN*1***1:2:3:4**N~
42	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19971003~
43	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*2~
44	SV1 PROFESSIONAL SERVICE
	SV1*HC:90782*15*UN*1***1:2**N~
45	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19971003~
46	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*3~
47	SV1 PROFESSIONAL SERVICE
	SV1*HC:J3301*21.04*UN*1***1:2**N~
48	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19971003~
49	**TRAILER**
	SE TRANSACTION SET TRAILER
	SE*49*0002~

Complete Data String For Example 3.A:

```
ST*837*0002~BHT*0019*00*0123*19981015*1023*CH~
REF*87*004010X098~NM1*41*2*PREMIER BILLING SERV
ICE*****46*567890~PER*IC*JERRY*3055552222~NM1*
40*2*XYZ REPRICER*****46*66783JJT~HL*1**20*1~
NM1*85*2*PREMIER BILLING SERVICE*****24*587654
321~N3*1234 SEAWAY ST~N4*MIAMI*FL*33111~REF*G2
*TGJ23~PER*IC*CONNIE*TE*3055551234~NM1*87*2*KIL
DARE ASSOC*****24*581234567~N3*2345 OCEAN BLVD~
N4*MIAMI*FL*33111~REF*G2*99878ABA~HL*2*1*22*1~SBR
*P********CI~NM1*IL*1*SMITH*JANE****34*111223333~
DMG*D8*19430501*F~REF*IW*JS00111223333~NM1*IN*2*
KEY INSURANCE COMPANY*****24*999996666~N3*3333
OCEAN ST~N4*SOUTH MIAMI*FL*33000~HL*3*1*23*0~ PAT
*02~NM1*QC*1*SMITH*TED****MI*JS01111223333~N3*236
N MAIN ST~N4*MIAMI*FL*33413~DMG*D8*19730501*M~REF*
SY*000221111~CLM*26407789*79.04***11::1*Y*A*Y*Y*B~
```

```
HI*BK:4779*BF:2724*BF:2780*BF:53081~NM1*82*1*KIL
DARE*BEN****24*999996666~PRV*PE*ZZ*203BF0100Y~REF
*G2*KA6663~NM1*77*2*KILDARE ASSOCIATES*****24*
581234567~N3*2345 OCEAN BLVD~N4*MIAMI*FL*33111~
LX*1~SV1*HC:99213*43*UN*1***1:2:3:4**N~DTP*472*
D8*19971003~LX*2~SV1*HC:90782*15*UN*1***1:2**N~
DTP*472*D8*19971003~LX*3~SV1*HC:J3301*21.04*UN*
1***1:2**N~DTP*472*D8*19971003~SE*49*0002~
```

++

Payer A returned an electronic remittance advice (835) to the Billing Provider with the following amounts and Claim Adjustment Reason Codes:

SUBMITTED CHARGES (CLP03): 79.04
AMOUNT PAID (CLP04): 39.15
PATIENT RESPONSIBILITY (CLP05): 36.89

The CAS at the Claim level was:
CAS*PR*1*21.89*3*15~ (INDICATES A $15.00 CO-INSURANCE PAYMENT AND

$21.89 DEDUCTIBLE PAYMENT IS DUE FROM PATIENT).

In addition, Payer A adjusted the office visit charges to $40.00 by contractual agreement. The CAS on line 1 was: CAS*CO*42*3~. Because the other lines did not have adjustments, there are no CAS segments for those lines.

See the Introduction for a discussion on crosswalking 835s to 837s.

++

Example 3.B — Claim to Payer B from Billing Provider

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER**
	ST TRANSACTION SET HEADER
	ST*837*1234~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION
	BHT*0019*00*0123*19981015*1023*CH~
3	REF TRANSMISSION TYPE IDENTIFICATION
	REF*87*004010X098~
4	**1000A SUBMITTER**
	NM1 SUBMITTER
	NM1*41*2*PREMIER BILLING
	SERVICE*****46*12EEER000TY~
5	PER SUBMITTER EDI CONTACT INFORMATION
	PER*IC*JERRY*3055552222~
6	**1000B RECEIVER**
	NM1 RECEIVER
	NM1*40*2*REPRICER XYZ*****46*66783JJT~

SEG #	LOOP SEGMENT/ELEMENT STRING
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP**
	HL - BILLING PROVIDER
	HL*1**20*1~
8	**2010AA BILLING PROVIDER**
	NM1 BILLING PROVIDER
	NM1*85*2*PREMIER BILLING SERVICE*****24*587654321~
9	N3 BILLING PROVIDER ADDRESS
	N3*1234 SEAWAY ST~
10	N4 BILLING PROVIDER CITY
	N4*MIAMI*FL*33111~
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION
	REF*G2*EJ6666~
12	PER BILLING CONTACT INFORMATION
	PER*IC*CONNIE*TE*3055551234~
13	**2010AB PAY-TO PROVIDER**
	NM1 PAY-TO PROVIDER NAME
	NM1*87*2*KILDARE ASSOC*****24*581234567~
14	N3 PAY-TO PROVIDER ADDRESS
	N3*2345 OCEAN BLVD~
15	N4 PAY-TO PROVIDER CITY
	N4*MIAMI*FL*33111~
16	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION
	REF*G2*EX7777~
17	**2000B SUBSCRIBER HL LOOP**
	HL - SUBSCRIBER
	HL*2*1*22*1~
18	SBR SUBSCRIBER INFORMATION
	SBR*S********CI~
19	**2010BA SUBSCRIBER**
	NM1 SUBSCRIBER NAME
	NM1*IL*1*SMITH*JACK****34*222334444~
20	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION
	DMG*D8*19431022*M~
21	REF SUBSCRIBER SECONDARY IDENTIFICATION
	REF*1W*T55TY666~
22	**2010BB PAYER**
	NM1 PAYER NAME
	NM1*IN*2*GREAT PRAIRIES HEALTH*****34*111223333~

SEG #	LOOP SEGMENT/ELEMENT STRING
23	N3 PAYER ADDRESS N3*4456 South Shore Blvd~
24	N4 PAYER CITY/STATE/ZIP CODE N4*Chicago*IL*44444~
25	REF PAYER SECONDARY IDENTIFICATION REF*2U*567890~
26	**2000C PATIENT HL LOOP** HL - PATIENT HL*3*2*23*0~
27	PAT PATIENT INFORMATION PAT*19~
28	**2010CA PATIENT** NM1 PATIENT NAME NM1*QC*1*SMITH*TED****MI*T55TY666-01~
29	N3 PATIENT ADDRESS N3*236 N MAIN ST~
30	N4 PATIENT CITY N4*MIAMI*FL*33413~
31	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
32	REF PATIENT SECONDARY IDENTIFICATION NUMBER REF*SY*000221111~
33	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y*A*Y*Y*B~
34	HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF:53081~
35	**2310A RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN****24*999996666~
36	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~
37	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*G2*88877~
38	**2310D SERVICE FACILITY LOCATION** NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
39	N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~

SEG #	LOOP SEGMENT/ELEMENT STRING
40	N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~
41	**2320 OTHER SUBSCRIBER INFORMATION** SBR OTHER SUBSCRIBER INFORMATION SBR*P*32***CI****CI~
42	CAS CLAIM LEVEL ADJUSTMENTS AND AMOUNTS CAS*PR*1*21.89**3*15~
43	AMT COORDINATION OF BENEFITS - PAYOR PAID AMOUNT AMT*D*42.15~
44	AMT COORDINATION OF BENEFITS - PATIENT RESPONSBILITY AMT*F2*36.89~
45	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~
46	OI OTHER INSURANCE COVERAGE INFORMATION OI***Y*B**Y~
47	**2330A OTHER SUBSCRIBER NAME** NM1 OTHER SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****MI*JS00111223333~
48	N3 OTHER SUBSCRIBER ADDRESS N3*236 N MAIN ST~
49	N4 OTHER SUBSCRIBER CITY N4*MIAMI*FL*33111~
50	**2330B OTHER SUBSCRIBER/PAYER** NM1 OTHER PAYER NAME NM1*IN*2*KEY INSURANCE COMPANY*****24*999996666~
51	**2400 SERVICE LINE** LX*1~
52	SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3:4**N~
53	DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~
54	**2420 LINE ADJUDICATION INFORMATION** SVD LINE ADJUDICATION INFORMATION SVD*111223333*40*HC:99213**1~
55	CAS LINE ADJUSTMENT CAS*CO*42*3~
56	DTP LINE ADJUDICATION DATE DTP*573*D8*19981015~

SEG #	LOOP SEGMENT/ELEMENT STRING
57	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*2~
58	SV1 PROFESSIONAL SERVICE
	SV1*HC:90782*15*UN*1***1:2**N~
59	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19971003~
60	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*3~
61	SV1 PROFESSIONAL SERVICE
	SV1*HC:J3301*21.04*UN*1***1:2**N~
62	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19971003~
63	**TRAILER**
	SE TRANSACTION SET TRAILER
	SE*63*1234~

Complete Data String for Example 3.B:

```
ST*837*1234~BHT*0019*00*0123*19981015*1023*CH~REF*8
7*004010X098~NM1*41*2*PREMIER BILLING SERVICE*****
46*12EEER000TY~PER*IC*JERRY*3055552222~NM1*40*2*RE
PRICER XYZ*****46*66783JJT~HL*1**20*1~NM1*85*2*
PREMIER BILLING SERVICE*****24*587654321~N3*1234
SEAWAY ST~N4*MIAMI*FL*33111~REF*G2*EJ6666~PER*IC*
CONNIE*TE*3055551234~NM1*87*2*KILDARE ASSOC*****
24*581234567~N3*2345 OCEAN BLVD~N4*MIAMI*FL*33111~
REF*G2*EX7777~HL*2*1*22*1~SBR*S********CI~NM1*IL*1
*SMITH*JACK****34*222334444~DMG*D8*19431022*M~REF*
1W*T55TY666~NM1*IN*2*GREAT PRAIRIES HEALTH*****
34*111223333~N3*4456 South Shore Blvd~N4*Chicago
*IL*44444~REF*2U*567890~HL*3*2*23*0~PAT*19~NM1*QC*
1*SMITH*TED****MI*T55TY666-01~N3*236 N MAIN ST~
N4*MIAMI*FL*33413~DMG*D8*19730501*M~REF*SY*0002211
11~CLM*26407789*79.04***11::1*Y*A*Y*Y*B~HI*BK:4779
*BF:2724*BF:2780*BF:53081~NM1*82*1*KILDARE*BEN****
24*999996666~PRV*PE*ZZ*203BF0100Y~REF*G2*88877~SBR
*P*32***CI****CI~CAS*PR*1*21.89**3*15~AMT*D*42.15~
AMT*F2*36.89~DMG*D8*19430501*F~OI***Y*B**Y~NM1*IL*
1*SMITH*JANE****MI*JS00111223333~N3*236 N MAIN ST~
N4*MIAMI*FL*33111~NM1*IN*2*KEY INSURANCE COMPANY
*****24*999996666~ NM1*77*2*KILDARE ASSOCIATES**
```

```
***24*581234567~N3*2345 OCEAN BLVD~N4*MIAMI*FL
*33111~LX*1~SV1*HC:99213*43*UN*1***1:2:3:4**N~DTP*
472*D8*19981003~SVD*111223333*40*HC:99213**1~CAS*C
O*42*3~DTP*573*D8*19981015~LX*2~SV1*HC:90782*15*UN
*1***1:2**N~DTP*472*D8*19971003~LX*3~SV1*HC:J3301*
21.04*UN*1***1:2**N~DTP*472*D8*19971003~SE*63*1234~
```

Example 3.C — Claim to Payer A from Billing Provider in Payer-to-Payer COB Situation (Payer A will pass the claim to Payer B).

If this claim were to go from the Billing Provider to Payer A and then Payer A were to send the claim directly to Payer B, the transaction would then look like this as it comes out of the Billing Provider's translator going to Payer A. In this situation, the Billing Provider must send Payer A all the COB information on Payer B.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER** ST TRANSACTION SET HEADER ST*837*0002~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0123*19981015*1023*CH~
3	REF TRANSACTION TYPE IDENTIFICATION REF*87*004010X098~
4	**1000A SUBMITTER** NM1 SUBMITTER NAME NM1*41*2*PREMIER BILLING SERVICE*****46*567890~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*3055552222~
6	**1000B RECEIVER** NM1 RECEIVER NAME NM1*40*2*XYZ REPRICER*****46*66783JJT~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP** HL - BILLING PROVIDER HL*1**20*1~
8	**2010AA BILLING PROVIDER** NM1 BILLING PROVIDER NM1*85*2*PREMIER BILLING SERVICE*****24*587654321~
9	N3 BILLING PROVIDER ADDRESS N3*1234 SEAWAY ST~
10	N4 BILLING PROVIDER CITY/STATE/ZIP N4*MIAMI*FL*33111~

SEG #	LOOP SEGMENT/ELEMENT STRING
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*G2*PBS3334~
12	PER BILLING PROVIDER CONTACT INFORMATION PER*IC*CONNIE*TE*3055551234~
13	**2010AB PAY-TO PROVIDER** NM1 PAY-TO PROVIDER NAME NM1*87*2*KILDARE ASSOC*****24*581234567~
14	N3 PAY-TO PROVIDER ADDRESS N3*2345 OCEAN BLVD~
15	N4 PAY-TO PROVIDER CITY/STATE/ZIP N4*MIAMI*FL*33111~
16	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION REF*G2*99878-ABA~
17	**2000B SUBSCRIBER HL LOOP** HL - SUBSCRIBER HL*2*1*22*1~
18	SBR SUBSCRIBER INFORMATION SBR*P********CI~
19	**2010BA SUBSCRIBER** NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****34*111223333~
20	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~
21	REF SUBSCRIBER SECONDARY IDENTIFICATION REF*IW*JS00111223333~
22	**2010BB PAYER** NM1 PAYER NAME NM1*IN*2*KEY INSURANCE COMPANY*****24*999996666~
23	N3 PAYER ADDRESS N3*3333 OCEAN ST~
24	N4 PAYER CITY/STATE/ZIP N4*SOUTH MIAMI*FL*33000~
25	**2000C PATIENT HL LOOP** HL - PATIENT HL*3*1*23*0~
26	PAT PATIENT INFORMATION PAT*02~

SEG #	LOOP SEGMENT/ELEMENT STRING
27	**2010CA PATIENT** NM1 PATIENT NAME NM1*QC*1*SMITH*TED****MI*JS01111223333~
28	N3 PATIENT ADDRESS N3*236 N MAIN ST~
29	N4 PATIENT CITY/STATE/ZIP N4*MIAMI*FL*33413~
30	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
31	REF PATIENT SECONDARY IDENTIFICATION NUMBER REF*SY*000221111~
32	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*26407789*79.04***11::1*Y*A*Y*Y*B~
33	HI HEALTH CARE DIAGNOSIS CODES HI*BK:4779*BF:2724*BF:2780*BF:53081~
34	**2310A RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*KILDARE*BEN****24*999996666~
35	PRV RENDERING PROVIDER INFORMATION PRV*PE*S3*203BF0100Y~
36	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*G2*KA6663~
37	**2310D SERVICE FACILITY LOCATION** NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
38	N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~
39	N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~
40	**2320 OTHER SUBSCRIBER INFORMATION** SBR OTHER SUBSCRIBER INFORMATION SBR*P*01***C1****LI~
41	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19431022*M~
42	**2330A OTHER SUBSCRIBER NAME** NM1 OTHER SUBSCRIBER NAME NM1*IL*1*SMITH*JACK***MI*T55TY666~

SEG #	LOOP SEGMENT/ELEMENT STRING
43	N3 OTHER SUBSCRIBER ADDRESS N3*236 N. MAIN ST~
44	N4 OTHER SUBSCRIBER CITY/STATE/ZIP N4*MIAMI*FL*33413~
45	**2330B OTHER PAYER NAME** NM1 OTHER PAYER NAME NM1*PR*2*GREAT PRAIRIES HEALTH****PI*567890~
46	**2330C OTHER PAYER PATIENT INFORMATION** NM1 OTHER PAYER PATIENT INFORMATION NM1*QC*1******MI*T55TY666-01~
47	2330E OTHER PAYER RENDERING PROVIDER NM1 OTHER PAYER RENDERING PROVIDER NM1*82*1~
48	REF OTHER PAYER RENDERING PROVIDER IDENTIFICATION REF*G2*88877~
49	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*1~
50	SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3:4**N~
51	DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~
52	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*2~
53	SV1 PROFESSIONAL SERVICE SV1*HC:90782*15*UN*1***1:2**N~
54	DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~
55	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*3~
56	SV1 PROFESSIONAL SERVICE SV1*HC:J3301*21.04*UN*1***1:2**N~
57	DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~
58	**TRAILER** SE TRANSACTION SET TRAILER SE*58*0002~

Complete Data String for Example 3.C:

```
ST*837*0002~BHT*0019*00*0123*19981015*1023*CH~REF*8
7*004010X098~NM1*41*2*PREMIER BILLING SERVICE
*****46*567890~PER*IC*JERRY*3055552222~NM1*40*2*XY
Z REPRICER*****46*66783JJT~HL*1**20*1~NM1*85*2*
PREMIER BILLING SERVICE*****24*587654321~N3*1234
SEAWAY ST~N4*MIAMI*FL*33111~REF*G2*PBS3334~PER*IC*
CONNIE*TE*3055551234~NM1*87*2*KILDARE ASSOC*****
24*581234567~N3*2345 OCEAN BLVD~N4*MIAMI*FL*33111~
REF*G2*99878-ABA~HL*2*1*22*1~SBR*P********CI~NM1*
IL*1*SMITH*JANE****34*111223333~DMG*D8*19430501*F~
REF*IW*JS00111223333~NM1*IN*2*KEY INSURANCE COMP
ANY*****24*999996666~N3*3333 OCEAN ST~N4*SOUTH MI-
AMI*FL*33000~HL*3*1*23*0~PAT*02~NM1*QC*1*SMITH*TED
****MI*JS01111223333~N3*236 N MAIN ST~N4*MIAMI*FL*
33413~DMG*D8*19730501*M~REF*SY*000221111~CLM*26407
789*79.04***11::1*Y*A*Y*Y*B~HI*BK:4779*BF:2724*BF:
2780*BF:53081~NM1*82*1*KILDARE*BEN****24*999996666
~PRV*PE*S3*203BF0100Y~REF*G2*KA6663~NM1*77*2*KILDA
RE ASSOCIATES*****24*581234567~N3*2345 OCEAN BLVD~
N4*MIAMI*FL*33111~SBR*P*01***C1****LI~DMG*D8*
19431022*M~NM1*IL*1*SMITH*JACK***MI*T55TY666~N3*23
6 N. MAIN ST~N4*MIAMI*FL*33413~NM1*PR*2*GREAT
PRAIRIES HEALTH****PI*567890~NM1*QC*1******MI
*T55TY666-01~NM1*82*1~REF*G2*88877~LX*1~SV1*HC:
99213*43*UN*1***1:2:3:4**N~DTP*472*D8*19971003~LX*
2~SV1*HC:90782*15*UN*1***1:2**N~DTP*472*D8*1997100
3~LX*3~SV1*HC:J3301*21.04*UN*1***1:2**N~DTP*472*D8
*19971003~SE*58*0002~
```

Example 3.D — Payer A sends the claim to Payer B after adjudication.

If Payer A were to then adjudicate the claim and send the claim to Payer B with the payment information, Payer A would send the transaction shown below.

SEG #	LOOP SEGMENT/ELEMENT STRING	
1	**HEADER**	
	ST TRANSACTION SET HEADER	
	ST*837*1234~	
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION	
	BHT*0019*00*0123*19981015*1023*CH~	
3	REF TRANSMISSION TYPE IDENTIFICATION	
	REF*87*004010X098~	

SEG #	LOOP SEGMENT/ELEMENT STRING
4	**1000A SUBMITTER**
	NM1 SUBMITTER
	NM1*41*2*KEY INSURANCE
	COMPANY*****46*999996666~
5	PER SUBMITTER EDI CONTACT INFORMATION
	PER*IC*COB CUSTOMER SERVICE*3031112222~
6	**1000B RECEIVER**
	NM1 RECEIVER
	NM1*40*2*GREAT PRAIRIES
	HEALTH*****46*567890~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP**
	HL - BILLING PROVIDER
	HL*1**20*1~
8	**2010AA BILLING PROVIDER**
	NM1 BILLING PROVIDER
	NM1*85*2*PREMIER BILLING
	SERVICE*****24*587654321~
9	N3 BILLING PROVIDER ADDRESS
	N3*1234 SEAWAY ST~
10	N4 BILLING PROVIDER CITY
	N4*MIAMI*FL*33111~
11	REF BILLING PROVIDER SECONDARY
	IDENTIFICATION
	REF*G2*EJ6666~
12	PER BILLING CONTACT INFORMATION
	PER*IC*CONNIE*TE*3055551234~
13	**2010AB PAY-TO PROVIDER**
	NM1 PAY-TO PROVIDER NAME
	NM1*87*2*KILDARE ASSOC*****24*581234567~
14	N3 PAY-TO PROVIDER ADDRESS
	N3*2345 OCEAN BLVD~
15	N4 PAY-TO PROVIDER CITY
	N4*MIAMI*FL*33111~
16	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION
	REF*G2*EX7777~
17	**2000B SUBSCRIBER HL LOOP**
	HL - SUBSCRIBER
	HL*2*1*22*1~
18	SBR SUBSCRIBER INFORMATION
	SBR*S*******CI~

SEG #	LOOP SEGMENT/ELEMENT STRING
19	**2010BA SUBSCRIBER**
	NM1 SUBSCRIBER NAME
	NM1*IL*1*SMITH*JACK****34*222334444~
20	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION
	DMG*D8*19431022*M~
21	REF SUBSCRIBER SECONDARY IDENTIFICATION
	REF*1W*T55TY666~
22	**2010BB PAYER**
	NM1 PAYER NAME
	NM1*IN*2*GREAT PRAIRIES
	HEALTH*****24*111223333~
23	N3 PAYER ADDRESS
	N3*4456 South Shore Blvd~
24	N4 PAYER CITY/STATE/ZIP CODE
	N4*Chicago*IL*44444~
25	REF PAYER SECONDARY IDENTIFICATION
	REF*2U*567890~
26	**2000C PATIENT HL LOOP**
	HL - PATIENT
	HL*3*2*23*0~
27	PAT PATIENT INFORMATION
	PAT*19~
28	**2010CA PATIENT**
	NM1 PATIENT NAME
	NM1*QC*1*SMITH*TED****MI*T55TY666-01~
29	N3 PATIENT ADDRESS
	N3*236 N MAIN ST~
30	N4 PATIENT CITY
	N4*MIAMI*FL*33413~
31	DMG PATIENT DEMOGRAPHIC INFORMATION
	DMG*D8*19730501*M~
32	REF PATIENT SECONDARY IDENTIFICATION NUMBER
	REF*SY*000221111~
33	**2300 CLAIM**
	CLM CLAIM LEVEL INFORMATION
	CLM*26407789*79.04***11::1*Y*A*Y*Y*B~
34	HI HEALTH CARE DIAGNOSIS CODES
	HI*BK:4779*BF:2724*BF:2780*BF:53081~
35	**2310A RENDERING PROVIDER**
	NM1 RENDERING PROVIDER NAME
	NM1*82*1*KILDARE*BEN****34*999996666~

SEG #	LOOP SEGMENT/ELEMENT STRING
36	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*203BF0100Y~
37	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*G2*88877~
38	**2310D SERVICE FACILITY LOCATION** NM1 SERVICE FACILITY LOCATION NM1*77*2*KILDARE ASSOCIATES*****24*581234567~
39	N3 SERVICE FACILITY ADDRESS N3*2345 OCEAN BLVD~
40	N4 SERVICE FACILITY CITY/STATE/ZIP N4*MIAMI*FL*33111~
41	**2320 OTHER SUBSCRIBER INFORMATION** SBR OTHER SUBSCRIBER INFORMATION SBR*P*32***CI****CI~
42	CAS CLAIM LEVEL ADJUSTMENTS AND AMOUNTS CAS*PR*1*21.89**3*15~
43	AMT COORDINATION OF BENEFITS - PAYOR PAID AMOUNT AMT*D*42.15~
44	AMT COORDINATION OF BENEFITS - PATIENT RESPONSBILITY AMT*F2*36.89~
45	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~
46	OI OTHER INSURANCE COVERAGE INFORMATION OI***Y*B**Y~
47	**2330A OTHER SUBSCRIBER NAME** NM1 OTHER SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****MI*JS00111223333~
48	N3 OTHER SUBSCRIBER ADDRESS N3*236 N MAIN ST~
49	N4 OTHER SUBSCRIBER CITY N4*MIAMI*FL*33111~
50	**2330B OTHER SUBSCRIBER/PAYER** NM1 OTHER PAYER NAME NM1*IN*2*KEY INSURANCE COMPANY*****24*999996666~

SEG #	LOOP SEGMENT/ELEMENT STRING
51	**2330C OTHER PAYER PATIENT INFORMATION** NM1 OTHER PAYER PATIENT INFORMATION NM1*QC*1******MI*JS01111223333~
52	**2330E OTHER PAYER RENDERING PROVIDER** NM1 OTHER PAYER RENDERING PROVIDER NM1*82*1~
53	REF OTHER PAYER RENDERING PROVIDER IDENTIFICATION REF*G2*88877~
54	**2400 SERVICE LINE** LX*1~
55	SV1 PROFESSIONAL SERVICE SV1*HC:99213*43*UN*1***1:2:3:4**N~
56	DTP DATE - SERVICE DATE(S) DTP*472*D8*19981003~
57	**2420 LINE ADJUDICATION INFORMATION** SVD LINE ADJUDICATION INFORMATION SVD*111223333*40*HC:99213**1~
58	CAS LINE ADJUSTMENT CAS*CO*42*3~
59	DTP LINE ADJUDICATION DATE DTP*573*D8*19981015~
60	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*2~
61	SV1 PROFESSIONAL SERVICE SV1*HC:90782*15*UN*1***1:2**N~
62	DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~

SEG #	LOOP SEGMENT/ELEMENT STRING
63	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*3~

SEG #	LOOP SEGMENT/ELEMENT STRING
64	SV1 PROFESSIONAL SERVICE SV1*HC:J3301*21.04*UN*1***1:2**N~
65	DTP DATE - SERVICE DATE(S) DTP*472*D8*19971003~
66	**TRAILER** SE TRANSACTION SET TRAILER SE*66*1234~

Complete Data String for Example 3.D:

```
ST*837*1234~BHT*0019*00*0123*19981015*1023*CH~REF*8
7*004010X098~NM1*41*2*KEY INSURANCE COMPANY*****
46*999996666~PER*IC*COB CUSTOMER SERVICE*30311
12222~NM1*40*2*GREAT PRAIRIES HEALTH*****46*
567890~HL*1**20*1~NM1*85*2*PREMIER BILLING SERV-
ICE*****24*587654321~N3*1234 SEAWAY ST~N4*MIAMI*FL
*33111~REF*G2*EJ6666~PER*IC*CONNIE*TE*3055551234~
NM1*87*2*KILDARE ASSOC*****24*581234567~N3*2345
OCEAN BLVD~N4*MIAMI*FL*33111~REF*G2*EX7777~HL*2*
```

HEADER INFO
- HEADER
  - ST
  - BHT
  - REF
- SUBMITTER (LOOP 1000A)
  - NM1 (BILLING PROVIDER A)
  - PER
- RECEIVER (LOOP 1000B)
  - NM1 (DESTINATION PAYER)

BILLING PROV INFO
- HL - BILLING/PAY-TO PROVIDER (LOOP 2000A)
  - HL
- BILLING PROVIDER (LOOP 2010AA)
  - NM1 (BILLING PROVIDER)
  - N3 (BILLING PROVIDER ADDRESS)
  - N4 (BILLING PROVIDER CITY/STATE/ZIP)

SUBSCRIBER A
- HL - SUBSCRIBER (LOOP 2000B)
  - HL (HL04=1)
  - SBR (INFO FOR SUBSCRIBER A)
- SUBSCRIBER (LOOP 2010BA)
  - NM1 (SUBSCRIBER A NAME & ID)
- PAYER (LOOP 2010BB)
  - NM1 (PAYER NAME & ID)

PATIENT A1
- HL - PATIENT (LOOP 2000C)
  - HL
  - PAT (PATIENT A1 INFO)
- PATIENT (LOOP 2010CA)
  - NM1 (PATIENT A1 NAME & ID)
  - N3 (PATIENT A1 ADDRESS)
  - N4 (PATIENT A1 CITY/STATE/ZIP)
  - DMG (PATIENT A1 DEMOGRAPHIC INFO)
- CLAIM INFORMATION (LOOP 2300)
  - CLM (CLAIM INFO FOR PATIENT A1)

PATIENT A1 CLAIM INFO

DTP (ANY APPROPRIATE DATES TO THIS CLAIM)
AMT (ANY APPROPRIATE AMOUNTS TO THIS CLAIM)
REF (ANY APPROPRIATE REFERENCE NUMBERS TO THIS CLAIM)
HI (ALL DIAGNOSES (up to 8) APPROPRIATE TO THIS CLAIM)
RENDERING PROVIDER (LOOP 2310B)
NM1 (RENDERING PROVIDER NAME & ID)
PRV (RENDERING PROVIDER SPECIALTY)
SERVICE FACILITY LOCATION
NM1 (SERVICE LOCATION NAME & ID)
N3 (SERVICE LOCATION ADDRESS)
N4 (SERVICE LOCATION CITY/STATE/ZIP)
SERVICE LINE (LOOP 2400 - REPEAT AS MANY TIMES AS NECESSARY (up to 50 lines))
LX
SV1 (SERVICE LINE INFO)
DTP (DATE OF SERVICE)
DTP (ANY OTHER DATES APPROPRIATE TO THIS SERVICE LINE)
REF (LINE ITEM CONTROL NUMBER & ANY OTHER REFERENCE NUMBERS APPROPRIATE TO THIS SERVICE LINE)
AMT (ANY AMOUNTS APPROPRIATE TO THIS SERVICE LINE)

PATIENT A2 CLAIM

HL - PATIENT (LOOP 2000C)
HL
PAT (PATIENT A2 INFO)
PATIENT (LOOP 2010CA)
NM1 (PATIENT A2 NAME & ID)
N3 (PATIENT A2 ADDRESS)
N4 (PATIENT A2 CITY/STATE/ZIP)
DMG (PATIENT A2 DEMOGRAPHIC INFO)
CLAIM INFORMATION (LOOP 2300)
CLM (CLAIM INFO FOR PATIENT A2)
DTP (ANY APPROPRIATE DATES TO THIS CLAIM)
AMT (ANY APPROPRIATE AMOUNTS TO THIS CLAIM)
REF (ANY APPROPRIATE REFERENCE NUMBERS TO THIS CLAIM)
HI (ALL DIAGNOSES (up to 8) APPROPRIATE TO THIS CLAIM)
RENDERING PROVIDER (LOOP 2310B)
NM1 (RENDERING PROVIDER NAME & ID)
PRV (RENDERING PROVIDER SPECIALTY)
SERVICE FACILITY LOCATION
NM1 (SERVICE LOCATION NAME & ID)
N3 (SERVICE LOCATION ADDRESS)
N4 (SERVICE LOCATION CITY/STATE/ZIP)
SERVICE LINE (LOOP 2400)
LX
SV1 (SERVICE LINE INFO)
DTP (DATE OF SERVICE)
DTP (ANY OTHER DATES APPROPRIATE TO THIS SERVICE LINE)
REF (LINE ITEM CONTROL NUMBER & ANY OTHER REFERENCE NUMBERS APPROPRIATE TO THIS SERVICE LINE)
AMT (ANY AMOUNTS APPROPRIATE TO THIS SERVICE LINE)

SUBSCRIBER B CLAIM

HL - SUBSCRIBER (LOOP 2000B)
HL (HL04=0)
SBR (INFO FOR SUBSCRIBER B)
SUBSCRIBER (LOOP 2010BA)
NM1 (PATIENT B NAME & ID) (The subscriber is the patient in this case)
N3 (PATIENT B ADDRESS)
N4 (PATIENT B CITY/STATE/ZIP)
PAYER (LOOP 2010BB)
NM1 (PAYER NAME & ID)
CLAIM INFORMATION (LOOP 2300)

CLM (CLAIM INFORMATION FOR PATIENT B)
DTP (ANY APPROPRIATE DATES TO THIS CLAIM)
AMT (ANY APPROPRIATE AMOUNTS TO THIS CLAIM)
REF (ANY APPROPRIATE REFERENCE NUMBERS TO THIS CLAIM)
HI (ALL DIAGNOSES (up to 8) APPROPRIATE TO THIS CLAIM)
RENDERING PROVIDER (LOOP 2310B)
NM1 (RENDERING PROVIDER NAME & ID)
PRV (RENDERING PROVIDER SPECIALTY)
SERVICE FACILITY LOCATION
NM1 (SERVICE LOCATION NAME & ID)
N3 (SERVICE LOCATION ADDRESS)
N4 (SERVICE LOCATION CITY/STATE/ZIP)
SERVICE LINE (LOOP 2400 - REPEAT AS NECESSARY)
LX
SV1 (SERVICE LINE INFO)
DTP (DATE OF SERVICE)
DTP (ANY OTHER DATES APPROPRIATE TO THIS SERVICE LINE)
REF (LINE ITEM CONTROL NUMBER & ANY OTHER REFERENCE NUMBERS APPROPRIATE TO THIS SERVICE LINE)
AMT (ANY AMOUNTS APPROPRIATE TO THIS SERVICE LINE)

SUBSCRIBER C CLAIM

HL - SUBSCRIBER (LOOP 2000B)
HL (HL04=0)
SBR (INFO FOR SUBSCRIBER C)
SUBSCRIBER (LOOP 2010BA)
NM1 (PATIENT C NAME & ID)
N3 (PATIENT C ADDRESS)
N4 (PATIENT C CITY/STATE/ZIP)
PAYER (LOOP 2010BB)
NM1 (PAYER NAME & ID)
CLAIM INFORMATION (LOOP 2300)
CLM (CLAIM INFORMATION FOR PATIENT C)
DTP (ANY APPROPRIATE DATES TO THIS CLAIM)
AMT (ANY APPROPRIATE AMOUNTS TO THIS CLAIM)
REF (ANY APPROPRIATE REFERENCE NUMBERS TO THIS CLAIM)
HI (ALL DIAGNOSES (up to 8) APPROPRIATE TO THIS CLAIM)
REFERRING PROVIDER (LOOP 2310A)
NM1 (REFERRING PROVIDER NAME & ID)
PRV (REFERRING PROVIDER SPECIALTY)
RENDERING PROVIDER (LOOP 2310B)
NM1 (RENDERING PROVIDER NAME & ID)
PRV (RENDERING PROVIDER SPECIALTY)
SERVICE FACILITY LOCATION
NM1 (SERVICE LOCATION NAME & ID)
N3 (SERVICE LOCATION ADDRESS)
N4 (SERVICE LOCATION CITY/STATE/ZIP)
SERVICE LINE (LOOP 2400 - REPEAT AS NECESSARY)
LX
SV1 (SERVICE LINE INFO)
DTP (DATE OF SERVICE)
DTP (ANY OTHER DATES APPROPRIATE TO THIS SERVICE LINE)
REF (LINE ITEM CONTROL NUMBER & ANY OTHER REFERENCE NUMBERS APPROPRIATE TO THIS SERVICE LINE)
AMT (ANY AMOUNTS APPROPRIATE TO THIS SERVICE LINE)
RENDERING PROVIDER - LINE LEVEL (LOOP 2420A) (The rendering provider for this service line is different than that listed for the claim as a whole)
NM1 (RENDERING PROVIDER NAME & ID)
REFERRING PROVIDER - LINE LEVEL (LOOP 2420F) (The referring provider for this service line is different than that listed for the claim as a whole)
NM1 (REFERRING PROVIDER NAME & ID)

PRV (REFERRING PROVIDER SPECIALTY)

SUBSCRIBER D

HL - SUBSCRIBER (LOOP 2000B)
- HL (HL04=0)
- SBR (INFO FOR SUBSCRIBER D)

SUBSCRIBER (LOOP 2010BA)
- NM1 (SUBSCRIBER D NAME & ID)

PAYER (LOOP 2010BB)
- NM1 (PAYER NAME & ID)

PATIENT D1 CLAIM

HL - PATIENT (LOOP 2000C)
- HL
- PAT (PATIENT D1 INFO)

PATIENT (LOOP 2010CA)
- NM1 (PATIENT D1 NAME & ID)
- N3 (PATIENT D1 ADDRESS)
- N4 (PATIENT D1 CITY/STATE/ZIP)
- DMG (PATIENT D1 DEMOGRAPHIC INFO)

CLAIM INFORMATION (LOOP 2300)
- CLM (CLAIM INFORMATION FOR PATIENT D1)
- DTP (ANY APPROPRIATE DATES TO THIS CLAIM)
- AMT (ANY APPROPRIATE AMOUNTS TO THIS CLAIM)
- REF (ANY APPROPRIATE REFERENCE NUMBERS TO THIS CLAIM)
- HI (ALL DIAGNOSES (up to 8) APPROPRIATE TO THIS CLAIM)

SERVICE FACILITY LOCATION
- NM1 (SERVICE LOCATION NAME & ID)
- N3 (SERVICE LOCATION ADDRESS)
- N4 (SERVICE LOCATION CITY/STATE/ZIP)

SERVICE LINE (LOOP 2400 - REPEAT AS NECESSARY)
- LX
- SV1 (SERVICE LINE INFO)
- DTP (DATE OF SERVICE)
- DTP (ANY OTHER DATES APPROPRIATE TO THIS SERVICE LINE)
- REF (LINE ITEM CONTROL NUMBER & ANY OTHER REFERENCE NUMBERS APPROPRIATE TO THIS SERVICE LINE)
- AMT (ANY AMOUNTS APPROPRIATE TO THIS SERVICE LINE)

FORM IDENTIFICATION (LOOP 2440)
- FRM (IDENTIFIES FORM)
- LQ (ANSWERS QUESTIONS, ONE LQ PER QUESTION)

SE (TRANSACTION SET TRAILER)

```
1*22*1~SBR*S********CI~NM1*IL*1*SMITH*JACK****34*2
22334444~DMG*D8*19431022*M~REF*1W*T55TY666~NM1*IN*
2*GREAT PRAIRIES HEALTH*****24*111223333~N3*4456
South Shore Blvd~N4*Chicago*IL*44444~REF*2U*567
890~HL*3*2*23*0~PAT*19~NM1*QC*1*SMITH*TED****MI*T
55TY666-01~N3*236 N MAIN ST~N4*MIAMI*FL*33413~DMG*
D8*19730501*M~REF*SY*000221111~CLM*26407789*79.04
***11::1*Y*A*Y*Y*B~HI*BK:4779*BF:2724*BF:2780*BF:5
3081~NM1*82*1*KILDARE*BEN****34*999996666~PRV*PE*
ZZ*203BF0100Y~REF*G2*88877~NM1*77*2*KILDARE ASSO-
CIATES*****24*581234567~N3*2345 OCEAN BLVD~N4*MI-
AMI*FL*33111~SBR*P*32***CI****CI~CAS*PR*1*21.89**3
*15~AMT*D*42.15~AMT*F2*36.89~DMG*D8*19430501*F~OI*
**Y*B**Y~NM1*IL*1*SMITH*JANE****MI*JS00111223333~N
3*236 N MAIN ST~N4*MIAMI*FL*33111~NM1*IN*2*KEY IN-
SURANCE COMPANY*****24*999996666~NM1*QC*1******MI*
JS01111223333~NM1*82*1~REF*G2*88877~LX*1~SV1*HC:99
213*43*UN*1***1:2:3:4**N~DTP*472*D8*19981003~SVD*1
11223333*40*HC:99213***1~CAS*CO*42*3~DTP*573*D8*19
981015~LX*2~SV1*HC:90782*15*UN*1***1:2**N~DTP*472*
D8*19971003~LX*3~SV1*HC:J3301*21.04*UN*1***1:2**N~
DTP*472*D8*19971003~SE*66*1234~
```

4.1.4 Example 4

Transaction containing several claims from a billing provider who is also the pay-to provider but is not the rendering provider. The various specialty information that may be included in a claim (e.g., CR2, CRC, etc), is not shown.

In this example, the exact detail of the data is not shown. Rather, this example shows the progression of segments with a verbal description of the function of each segment. The purpose of this approach is to give an overall feel for the data string involved in a typical 837 data string.

The billing Provider is the pay-to provider. Several Rendering and Referring providers are involved on the various claims (shown as Rendering A, Rendering B, etc). There is no COB involved in any of these claims.

Subscribers and Patients:

Subscriber A has two dependents (Patient A1 and Patient A2)
Subscriber B has no dependents (Patient B)
Subscriber C has no dependents (Patient C)
    This claim has line level provider information
Subscriber D has one dependent (Patient D1)
    This claim has an attached form

SEGMENT SERIES

4.2 Property and Casualty

Healthcare Bill to Property & Casualty Payer

The requirements for submitting of Healthcare bills to Property & Casualty payers to ensure prompt processing, meet jurisdictional requirements, and avoid potential fines and penalties are presented here.

837 Transaction Set

Bills resulting from accident or occupationally-related injuries and illnesses should be submitted to a Property & Casualty (P&C) payer. Because coverage is triggered by a specific event, certain information is critical for the payment process. Unlike health insurance where each bill is an individual claim, for P&C a bill is a piece of information that needs to be associated with an event. The ensuing P&C claim includes both the bill information as well as the information on the event that caused the injury or illness. Information concerning the event is necessary to associate a medical bill with the P&C claim. P&C is generally governed by State Insurance Regulations, Departments of Labor, Worker's Compensation Boards, or other Jurisdictionally defined entities, which often mandates compliance with Jurisdiction-specific procedures.

The Business Need: Provider to P&C Payer Bill Transmission

- The date of accident/occurrence/onset of symptoms (Date of Loss) is a critical piece of information and should always be transmitted in the "Date - Accident" DTP segment within Loop ID-2300 (Claim loop). This segment triggers the applicability of P&C for consideration of payment for the health care provided.
- A unique identification number, referred to in P&C as a claim number, should be transmitted along with the bill information to expedite the adjudication of the bill for payment. This information can be transmitted in the REF segment of Loop ID-2010BA if the patient is the subscriber or in the REF segment of Loop ID-2010CA if the patient is not the subscriber.
- If no claim number is assigned or available, then the subscribers policy number should be transmitted along with the date of loss. The REF segment of the Subscriber loop (Loop ID-2010BA) should be used to transmit the policy number.
- In the case of a work-related injury or illness, if no claim number or policy number is available, then it is necessary to include the employer's information (at a minimum name, address, and telephone number) in the NM1 segment of the Subscriber loop (Loop ID-2010BA) and the patient's name and Social Security Number in the NM1 segment of the patient loop (Loop ID-2010CA).
- Because most P&C coverage is based upon fee-for-service arrangements, it is necessary to itemize the services provided on a line-by-line basis. Each service line should be transmitted in its own SV1 segment in the Service Line Number loop (Loop ID-2400) for clarity.

4.2.1 Example 1

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company.

Date of Accident: 03/17/97

Subscriber: Graig Norton
Subscriber Address: 72 Fairway Drive, Golfers Haven, FL, 91919
Policy Number: 970925824
Insurance Company: Last Chance Insurance Company
Claim Number: 88-N5223-71

Patient: William Clifton
Patient Address: 1600 Razorback Avenue, Little Rock, AR, 54321
Sex: M
DOB: 10/13/49
SSN: 234-55-7329

Destination Payer/Receiver: Last Chance Insurance Company
Payer Address: 1 Desert Line Road, Reno, NV, 44544
Payer ID: 123456789

Billing Provider/Sender: Presidential Chiropractic
TIN: 222559999
National Provider Identifier: 777BH666
Address: 5 Lumbar Lane, Golfers Haven, FL, 91919
Telephone: 321-555-6677

Pay-To-Provider: Presidential Chiropractic

Rendering Provider: Mack Donald, DC
National Provider Identifier: 999OU812
TIN: 311235689

Referring Provider: THEODORE ZEUSS
National Provider Identifier: 999DS427
Specialty: Family Practice

Patient Account Number: 686868686

CASE: Patient was a guest in Subscriber's home when he fell and injured his low back.
DOS=03/18/97, POS=Office

Diagnosis: 847.2

Services Rendered: Office visit, intermediate service, new patient; x-ray of spine; electrical stimulation; ultrasound; massage; and hot packs.
CHARGES: Office visit = $60.00, x-ray = $75.00, electrical stimulation = $25.00, ultrasound = $25.00, massage = $35.00, hot packs = $25.00.
Total charges = $245.00.

Electronic Route: Billing provider (sender) to payer (receiver) via LAN.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER** ST TRANSACTION SET HEADER ST*837*872391~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0123*19970410*1339*CH~
3	REF TRANSMISSION TYPE IDENTIFICATION REF*87*004010X098~

SEG #	LOOP SEGMENT/ELEMENT STRING
4	**1000A SUBMITTER**
	NM1 SUBMITTER
	NM1*41*2*PRESIDENTIAL CHIROPRACTIC*****46*777BH666~
5	PER SUBMITTER EDI CONTACT INFORMATION
	PER*IC*LARRY*TE*3215556677~
6	**1000B RECEIVER**
	NM1 RECEIVER NAME
	NM1*40*2*LAST CHANCE INSURANCE COMPANY*****46*123456789~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP**
	HL-BILLING PROVIDER
	HL*1**20*1~
8	**2010AA BILLING PROVIDER**
	NM1 BILLING PROVIDER NAME
	NM1*85*2*PRESIDENTIAL CHIROPRACTIC*****XX*777BH666~
9	N3 BILLING PROVIDER ADDRESS
	N3*5 LUMBAR LANE~
10	N4 BILLING PROVIDER LOCATION
	N4*GOLFERS HAVEN*FL*91919~
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION
	REF*EI*222559999~
12	PER BILLING PROVIDER CONTACT INFORMATION
	PER*IC*SUSAN*TE*3215557777~
13	**2000B SUBSCRIBER HL LOOP**
	HL-SUBSCRIBER
	HL*2*1*22*1~
14	SBR SUBSCRIBER INFORMATION
	SBR*P********LM~
15	**2010BA SUBSCRIBER**
	NM1 SUBSCRIBER NAME
	NM1*IL*1*NORTON*GRAIG****MI*970925824~
16	**2010BB SUBSCRIBER/PAYER**
	NM1 PAYER NAME
	NM1*PR*2*LAST CHANCE INSURANCE COMPANY*****XV*123456789~
17	N3 PAYER STREET ADDRESS
	N3*1 DESERT LINE ROAD~
18	N4 PAYER CITY/STATE/ZIP
	N4*RENO*NV*44544~

SEG #	LOOP SEGMENT/ELEMENT STRING
19	**2000C PATIENT HL LOOP** HL-PATIENT HL*3*2*23*0~
20	PAT PATIENT INFORMATION PAT*41~
21	**NM1 2010CA PATIENT NAME** NM1 PATIENT NAME NM1*QC*1*CLIFTON*WILLIAM****34*234557329~
22	N3 PATIENT STREET ADDRESS N3*1600 RAZORBACK AVENUE~
23	N4 PATIENT CITY/STATE/ZIP N4*LITTLE ROCK*AR*54321~
24	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19491013*M~
25	REF PROPERTY AND CASUALTY CLAIM NUMBER REF*Y4*88N522371~
26	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*686868686*245***11::1*Y*A*Y*Y*B*OA~
27	DTP DATE - INITIAL TREATMENT DTP*454*D8*19970318~
28	DTP DATE - ACCIDENT DTP*439*D8*19970317~
29	CR2 SPINAL MANIPULATION SERVICE INFORMATION CR2*1*1***DA*1*1*A*Y***Y~
30	HEALTH CARE DIAGNOSIS CODES HI*BK:8472~
31	**2310A REFERRING PROVIDER** NM1 REFERRING PROVIDER NM1*DN*1*ZEUSS*THEODORE****XX*999DS427~
32	REFERRING PROVIDER SPECIALTY INFORMATION PRV*RF*ZZ*203BF0100Y~
33	**2310B RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*DONALD*MACK****XX*999OU812~
34	PRV RENDERING PROVIDER SPECIALTY INFORMATION PRV*PE*ZZ*111NS0005N~
35	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*EI*311235689~

SEG #	LOOP SEGMENT/ELEMENT STRING
36	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*1~
37	SV1 PROFESSIONAL SERVICE SV1*HC:99204*60*UN*1***1**N~
38	DTP DATE - SERVICE DATE(S) DTP*472*D8*19970318~
39	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*2~
40	SV1 PROFESSIONAL SERVICE SV1*HC:72100*75*UN*1***1**N~
41	DTP DATE - SERVICE DATE(S) DTP*472*D8*19970318~
42	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*3~
43	SV1 PROFESSIONAL SERVICE SV1*HC:97010*25*UN*1***1**N~
44	DTP DATE - SERVICE DATE(S) DTP*472*D8*19970318~
45	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*4~
46	SV1 PROFESSIONAL SERVICE SV1*HC:97014*25*UN*1***1**N~
47	DTP DATE - SERVICE DATE(S) DTP*472*D8*19970318~
48	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*5~
49	SV1 PROFESSIONAL SERVICE SV1*HC:97124*35*UN*1***1**N~
50	DTP DATE - SERVICE DATE(S) DTP*472*D8*19970318~
51	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*6~
52	SV1 PROFESSIONAL SERVICE SV1*HC:97035*25*UN*1***1**N~

SEG #	LOOP SEGMENT/ELEMENT STRING
53	DTP DATE - SERVICE DATE(S) DTP*472*D8*19970318~
54	**TRAILER** SE TRANSACTION SET TRAILER SE*54*872391~

Entire data string:

```
ST*837*872391~BHT*0019*00*0123*19970410*1339*CH~
REF *87*004010X098~NM1*41*2*PRESIDENTIAL CHIRO-
PRACTIC*****46*777BH666~PER*IC*LARRY*TE*321555
6677~NM1*40*2*LAST CHANCE INSURANCE COMPANY*****
46*123456789~HL*1**20*1~NM1*85*2*PRESIDENTIAL CHI-
ROPRACTIC*****XX*777BH666~N3*5 LUMBAR LANE~
N4*GOLFERS HAVEN*FL*91919~REF*EI*222559999~PER*IC*
SUSAN*TE*3215557777~HL*2*1*22*1~SBR*P********LM~
NM1*IL*1*NORTON*GRAIG****MI*970925824~NM1*PR*2*
LAST CHANCE INSURANCE COMPANY*****XV*123456789~N3*
1 DESERT LINE ROAD~N4*RENO*NV*44544~HL*3*2*23*0~
PAT*41~NM1*QC*1*CLIFTON*WILLIAM****34*234557329~
N3*1600 RAZORBACK AVENUE~N4*LITTLE ROCK*AR*54321~
DMG*D8*19491013*M~REF*Y4*88N522371~CLM*686868686*2
45***11::1*Y*A*Y*Y*B*OA~DTP*454*D8*19970318~DTP*43
9*D8*19970317~CR2*1*1***DA*1*1*A*Y***Y~HI*BK:8472~
NM1*DN*1*ZEUSS*THEODORE****XX*999DS427~PRV*RF*ZZ*
203BF0100Y~NM1*82*1*DONALD*MACK****XX*999OU812~
PRV*PE*ZZ*111NS0005N~REF*EI*311235689~LX*1~SV1*HC:
99204*60*UN*1***1**N~DTP*472*D8*19970318~LX*2~SV1*
HC:72100*75*UN*1***1**N~DTP*472*D8*19970318~LX*3~
SV1*HC:97010*25*UN*1***1**N~DTP*472*D8*19970318~LX
*4~SV1*HC:97014*25*UN*1***1**N~DTP*472*D8*19970318
~LX*5~SV1*HC:97124*35*UN*1***1**N~DTP*472*D8*19970
318~LX*6~SV1*HC:97035*25*UN*1***1**N~DTP*472*D8*19
970318~SE*54*872391~
```

4.2.2 Example 2

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company.

Date of Accident: 02/12/97

Subscriber: Jen & Barry's Ice Cream Shoppe
Subscriber Address: 123 Rocky Road, Cherry, VT, 55555

Policy Number: WC-96-2222-L
Insurance Company: Basket & Roberts Insurance Company
Claim Number: W9-1234-99

Patient: Penny Plump
Patient Address: 265 Double Dip Lane, Sugar Cone, VT, 55544
Sex: F
DOB: 02/11/77
SSN: 115-68-3870

Destination Payer/Receiver: Basket & Roberts Insurance Company
Payer Address: 31 Flavor Street, Maple, VT, 55534
Payer ID: 345345345

Billing Provider/Sender: Speedy Billing Service
TIN: 333119999
Address: 1 EDI Way, Walnut, VT, 55333
Contact: Sam Speedy 815-555-4444

Pay-To-Provider: Sam Sweettooth, MD
TIN: 331330001
National Provider Identifier: 777ST123
Proprietary Payer Identifier: 331330001
Address: 837 Professional Drive, Pistachio, VT, 55557
Telephone: 617-555-3210

Rendering Provider: Sam Sweettooth, MD

Service Location: Pistachio Emergency Services
123 Emergency Way, Pistachio, VT 55576
National Provider Identifier: ERP66655

Patient Account Number: 888-22-8888

CASE: Patient is an employee of Subscriber. She slammed her thumb in the freezer case.
DOS=02/12/97, ER Attending Physician
SERVICES RENDERED: ER Professional Component
DOS=02/26/97, POS=Office, TOS=Medical Care & Diagnostic x-ray

Diagnosis: 816.02 (Principle), 354.0 (Additional)

Services Rendered: Office visit, x-ray, splint.
CHARGES: ER visit = $210.00, F/U Office Visit = $120.00, X-ray = $50.00, Splint = $25.00. Total charges = $405.00

Electronic Route: Billing Service (sender), VAN to Payer (receiver).

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER**
	ST TRANSACTION SET HEADER
	ST*837*872401~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION
	BHT*0019*00*0124*19970411*0724*CH~
3	REF TRANSMISSION TYPE IDENTIFICATION
	REF*87*004010X098~

SEG #	LOOP SEGMENT/ELEMENT STRING
4	**1000A SUBMITTER**
	NM1 SUBMITTER
	NM1*41*2*SPEEDY BILLING
	SERVICE*****46*333119999~
5	PER SUBMITTER EDI CONTACT INFORMATION
	PER*IC*SAM SPEEDY*TE*8154445555~
6	**1000B RECEIVER**
	NM1 RECEIVER NAME
	NM1*40*2*BASKET & ROBERTS INSURANCE
	COMPANY*****46*345345345~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP**
	HL-BILLING PROVIDER
	HL*1**20*1~
8	**2010AA BILLING PROVIDER**
	NM1 BILLING PROVIDER NAME
	NM1*85*2*SPEEDY BILLING
	SERVICE*****24*333119999~
9	N3 BILLING PROVIDER ADDRESS
	N3*1 EDI WAY~
10	N4 BILLING PROVIDER LOCATION
	N4*WALNUT*VT*55333~
11	**2010AB PAY-TO PROVIDER**
	NM1 PAY-TO PROVIDER NAME
	NM1*87*1*SWEETTOOTH*SAM****XX*777ST123~
12	N3 PAY-TO PROVIDER ADDRESS
	N3*837 PROFESSIONAL DRIVE~
13	N4 PAY-TO PROVIDER CITY/STATE/ZIP
	N4*PISTACHIO*VT*55557~
14	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION
	REF*EI*331330001~
15	REF PAY-TO PROVIDER SECONDARY IDENTIFICATION
	REF*G2*331330001~
16	**2000B SUBSCRIBER HL LOOP**
	HL-SUBSCRIBER
	HL*2*1*22*1~
17	SBR SUBSCRIBER INFORMATION
	SBR*P********WC~
18	**2010BA SUBSCRIBER**
	NM1 SUBSCRIBER NAME
	NM1*IL*2*JEN & BARRY'S ICE CREAM
	SHOPPE*****MI*WC962222L~

SEG #	LOOP SEGMENT/ELEMENT STRING
19	**2010BB SUBSCRIBER/PAYER** NM1 PAYER NAME NM1*PR*2*BASKET & ROBERTS INSURANCE COMPANY*****XV*345345345~
20	N3 PAYER STREET ADDRESS N3*31 FLAVOR STREET~
21	N4 PAYER CITY/STATE/ZIP N4*MAPLE*VT*55222~
22	**2000C PATIENT HL LOOP** HL-PATIENT HL*3*2*23*0~
23	PAT PATIENT INFORMATION PAT*20~
24	**NM1 2010CA PATIENT NAME** NM1 PATIENT NAME NM1*QC*1*PLUMP*PENNY****34*115683870~
25	N3 PATIENT STREET ADDRESS N3*265 DOUBLE DIP LANE~
26	N4 PATIENT CITY/STATE/ZIP N4*SUGAR CONE*VT*55544~
27	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19770211*F~
28	REF PROPERTY AND CASUALTY CLAIM NUMBER REF*Y4*W9123499~
29	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*888228888*405***11::1*Y*A*Y*Y*B*EM:OA~ 30 DTP DATE - ACCIDENT DTP*439*D8*19970212~
31	DTP DATE - INITIAL TREATMENT DTP*454*D8*19970212~
32	HEALTH CARE DIAGNOSIS CODES HI*BK:81602*BF:354~
33	**2310B RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*SWEETTOOTH*SAM****XX*777ST123~
34	RENDERING PROVIDER SPECIALTY INFORMATION PRV*PE*ZZ*203BE004Y~
35	REF RENDERING PROVIDER SECONDARY IDENTIFICATION REF*EI*331330001~

SEG #	LOOP SEGMENT/ELEMENT STRING
36	**2310D SERVICE FACILITY LOCATION**
	NM1 SERVICE FACILITY LOCATION
	NM1*77*1*PISTACHIO EMERGENCY
	SERVICES****XX* ERP66655~
37	N3 SERVICE FACILITY LOCATION ADDRESS
	N3*123 EMERGENCY WAY~
38	N4 SERVICE FACILITY LOCATION CITY/STATE/ZIP
	N4*PISTACHIO*VT*55556~
39	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*1~
40	SV1 PROFESSIONAL SERVICE
	SV1*HC:99242*120*UN*1***1**Y~
41	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19970226~
42	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*2~
43	SV1 PROFESSIONAL SERVICE
	SV1*HC:A4570*25*UN*1***1**Y~
44	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19970226~
45	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*3~
46	SV1 PROFESSIONAL SERVICE
	SV1*HC:73140*50*UN*1***1**Y~
47	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19970226~
48	**2400 SERVICE LINE**
	LX SERVICE LINE COUNTER
	LX*4~
49	SV1 PROFESSIONAL SERVICE
	SV1*HC:99283*210*UN*1*23**1:2**Y~
50	DTP DATE - SERVICE DATE(S)
	DTP*472*D8*19970212~
51	**TRAILER**
	SE TRANSACTION SET TRAILER
	SE*51*872401~

```
Entire data string:
ST*837*872401~BHT*0019*00*0124*19970411*0724*CH~
REF *87*004010X098~NM1*41*2*SPEEDY BILLING SERVICE
*****46*333119999~PER*IC*SAM SPEEDY*TE*8154445555~
NM1*40*2*BASKET & ROBERTS INSURANCE COMPANY*****
46*345345345~HL*1**20*1~NM1*85*2*SPEEDY BILLING
SERVICE*****24*333119999~N3*1 EDI WAY~N4*WALNUT*VT
*55333~ NM1*87*1*SWEETTOOTH*SAM****XX*777ST123~
N3*837 PROFESSIONAL DRIVE~N4*PISTACHIO*VT*55557~
REF*EI*331330001~REF*G2*331330001~
HL*2*1*22*1~SBR*P********WC~NM1*IL*2*JEN & BARRY'S
 ICE CREAM SHOPPE*****MI*WC962222L~NM1*PR*2*BASKET
 & ROBERTS INSURANCE COMPANY*****XV*345345345~
N3*31 FLAVOR STREET~N4*MAPLE*VT*55222~ HL*3*2*23
*0~PAT*20~NM1*QC*1*PLUMP*PENNY****34*115683870~N3*
265 DOUBLE DIP LANE~N4*SUGAR CONE*VT*55544~DMG*D8*
19770211*F~REF*Y4*W9123499~CLM*888228888*405***11:
:1*Y*A*Y*Y*B*EM:OA~DTP*439*D8*19970212~DTP*454*D8*
19970212~HI*BK:81602*BF:354~NM1*82*1*SWEETTOOTH*
SAM****XX*777ST123~PRV*PE*ZZ*203BE004Y~REF*EI*3313
30001~NM1*77*1*PISTACHIO EMERGENCY SERVICES****XX*
ERP66655~N3*123 EMERGENCY WAY~N4*PISTACHIO*VT*
55556~LX*1~SV1*HC:99242*120*UN*1***1**Y~DTP*472*D8
*19970226~LX*2~SV1*HC:A4570*25*UN*1***1**Y~DTP*472
*D8*19970226~LX*3~SV1*HC:73140*50*UN*1***1**Y~DTP*
472*D8*19970226~LX*4~SV1*HC:99283*210*UN*1*23**1:2
**Y~DTP*472*D8*19970212~SE*51*872401~
```

4.2.3 Example 3

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company.

Date of Accident: 06/17/94

Subscriber: Hal Howling
Subscriber Address: 327 Bronco Drive, Getaway, CA, 99999
Policy Number: B999-777-91G
Insurance Company: Heisman Insurance Company
Claim Number: 32-3232-32

Patient: D.J. Dimpson
Patient Address: 32 Buffalo Run, Rocking Horse, CA, 99666
Sex: M
DOB: 06/01/48
SSN: 567-32-4788

Destination Payer/Receiver: Heisman Insurance Company
Payer Address: 1 Trophy Lane, NYAC, NY, 10032
Payer ID: 999888777

Billing Provider/Sender: Fermann Hand & Foot Clinic
TIN: 579999999
National Provider Identifier: 591PD123
Address: 10 1/2 Shoemaker Street, Cobbler, CA, 99997
Telephone: 212-555-7987

Pay-To-Provider: Fermann Hand & Foot Clinic

Rendering Provider: Bruno Moglie, MD
National Provider Identifier: 687AB861

Patient Account Number: 900-00-0032

CASE: The patient was a passenger in the subscriber's automobile, and the patient reports that his hand was cut when the car was struck in the rear.

Diagnosis: 884.2

Services Rendered: Office visit, Drain Abscess.
DOS=06/20/94, POS=Office, TOS=Medical Care
CHARGES: Office visit = $150.00, Drain Abscess = $35.00. Total charges = $185.00.

Electronic Route: Billing provider (sender) to payer (receiver) via VAN.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	**HEADER** ST TRANSACTION SET HEADER ST*837*872501~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0125*19970411*1524*CH~
3	REF TRANSMISSION TYPE IDENTIFICATION REF*87*004010X098~
4	**1000A SUBMITTER** NM1 SUBMITTER NM1*41*2*FERMANN HAND & FOOT CLINIC*****46*591PD123~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JAN FOOT*TE*8156667777~
6	**1000B RECEIVER** NM1 RECEIVER NAME NM1*40*2*HEISMAN INSURANCE COMPANY*****46*555667777~
7	**2000A BILLING/PAY-TO PROVIDER HL LOOP** HL-BILLING PROVIDER HL*1**20*1~

SEG #	LOOP SEGMENT/ELEMENT STRING
8	**2010AA BILLING PROVIDER** NM1 BILLING PROVIDER NAME NM1*85*2*FERMANN HAND & FOOT CLINIC*****XX*591PD123~
9	N3 BILLING PROVIDER ADDRESS N3*10 1/2 SHOEMAKER STREET~
10	N4 BILLING PROVIDER LOCATION N4*COBBLER*CA*99997~
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*EI*579999999~
12	**2000B SUBSCRIBER HL LOOP** HL-SUBSCRIBER HL*2*1*22*1~
13	SBR SUBSCRIBER INFORMATION SBR*P********AM~
14	**2010BA SUBSCRIBER** NM1 SUBSCRIBER NAME NM1*IL*1*HOWLING*HAL****MI*B99977791G~
15	**2010BB SUBSCRIBER/PAYER** NM1 PAYER NAME NM1*PR*2*HEISMAN INSURANCE COMPANY*****XV*999888777~
16	N3 PAYER STREET ADDRESS N3*1 TROPHY LANE~
17	N4 PAYER CITY/STATE/ZIP N4*NYAC*NY*10032~
18	**2000C PATIENT HL LOOP** HL-PATIENT HL*3*2*23*0~
19	PAT PATIENT INFORMATION PAT*41~
20	**NM1 2010CA PATIENT NAME** NM1 PATIENT NAME NM1*QC*1*DIMPSON*DJ****34*567324788~
21	N3 PATIENT STREET ADDRESS N3*32 BUFFALO RUN~
22	N4 PATIENT CITY/STATE/ZIP N4*ROCKING HORSE*CA*99666~
23	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19480601*M~

SEG #	LOOP SEGMENT/ELEMENT STRING
24	REF PROPERTY AND CASUALTY CLAIM NUMBER REF*Y4*32323232~
25	**2300 CLAIM** CLM CLAIM LEVEL INFORMATION CLM*900000032*185***11::1*Y*A*Y*Y*B*AA~
26	DTP DATE - ACCIDENT DTP*439*D8*19940617~
27	HEALTH CARE DIAGNOSIS CODES HI*BK:8842~
28	**2310B RENDERING PROVIDER** NM1 RENDERING PROVIDER NAME NM1*82*1*MOGLIE*BRUNO****XX*687AB861~
29	PRV RENDERING PROVIDER SPECIALTY INFORMATION PRV*PE*ZZ*203BE004Y~
30	2320D SERVICE FACILITY LOCATION NM1 SERVICE FACILITY LOCATION NM1*77*2*FERMANN HAND & FOOT CLINIC*****XX*591PD123~
31	N3 SERVICE FACILITY LOCATION ADDRESS N3*10 1/2 SHOEMAKER STREET~
32	N4 SERVICE FACILITY LOCATION CITY/STATE/ZIP N4*COBBLER*CA*99997~
33	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*1~
34	SV1 PROFESSIONAL SERVICE SV1*HC:99201*150*UN*1***1**Y~
35	DTP DATE - SERVICE DATE(S) DTP*472*D8*19940620~
36	**2400 SERVICE LINE** LX SERVICE LINE COUNTER LX*2~
37	SV1 PROFESSIONAL SERVICE SV1*HC:26010*35*UN*1***1**Y~
38	DTP DATE - SERVICE DATE(S) DTP*472*D8*19940620~
39	**TRAILER** SE TRANSACTION SET TRAILER SE*39*872501~

Entire data string:

ST*837*872501~BHT*0019*00*0125*19970411*1524*CH~

```
REF *87*004010X098~NM1*41*2*FERMANN HAND & FOOT
CLINIC*****46*591PD123~PER*IC*JAN FOOT*TE*81566
67777~NM1*40*2*HEISMAN INSURANCE COMPANY*****46*
555667777~HL*1**20*1~NM1*85*2*FERMANN HAND & FOOT
 CLINIC*****XX*591PD123~N3*10 1/2 SHOEMAKER
STREET~N4*COBBLER*CA*99997~REF*EI*579999999~HL*2*
1*22*1~SBR*P********AM~NM1*IL*1*HOWLING*HAL****
MI*B99977791G~NM1*PR*2*HEISMAN INSURANCE COMPANY
*****XV*999888777~N3*1 TROPHY LANE~N4*NYAC*NY*100
32~HL*3*2*23*0~PAT*41~NM1*QC*1*DIMPSON*DJ****34*
567324788~N3*32 BUFFALO RUN~N4*ROCKING HORSE*CA*
99666~DMG*D8*19480601*M~REF*Y4*32323232~CLM*900000
032*185***11::1*Y*A*Y*Y*B*AA~DTP*439*D8*19940617~
HI*BK:8842~NM1*82*1*MOGLIE*BRUNO****XX*687AB861~
PRV*PE*ZZ*203BE004Y~NM1*77*2*FERMANN HAND & FOOT
CLINIC*****XX*591PD123~N3*10 1/2 SHOEMAKER STREET~
N4*COBBLER*CA*99997~LX*1~SV1*HC:99201*150*UN*1***
1**Y~DTP*472*D8*19940620~LX*2~SV1*HC:26010*35*UN*1
***1**Y~DTP*472*D8*19940620~SE*39*872501~
```

A ASC X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

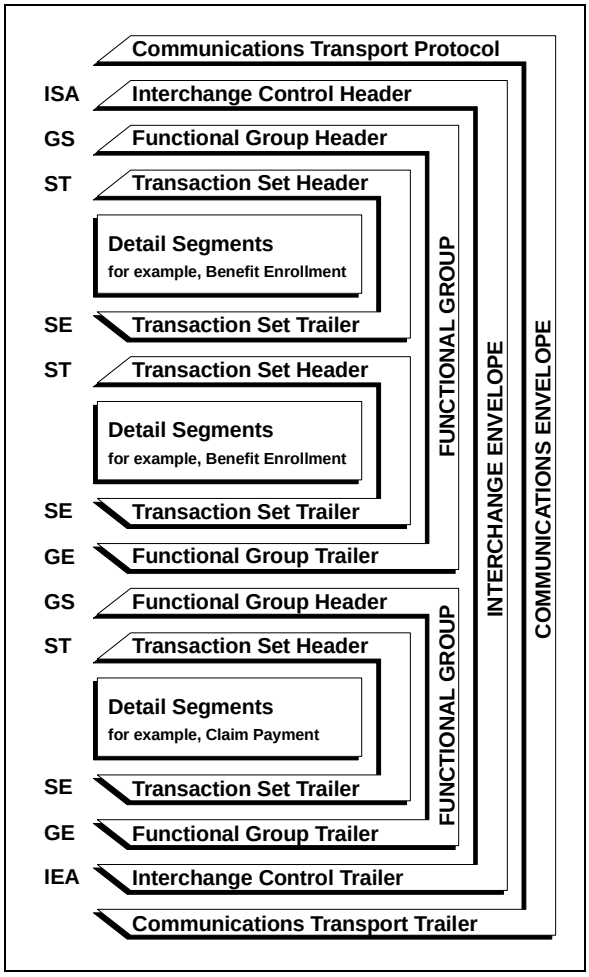


Figure A1. Transmission Control Schematic

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer. Figure A1, Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions and Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. The data element is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in figure A2, Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure A2. Basic Character Set

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in figure A3, Extended Character Set.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

Figure A3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears

in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the matrix A1, Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix A1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in matrix A2, Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix A2. Extended Control Set

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

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, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in matrix A3, Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

Matrix A3. Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element can result in errors in translation programs. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

A.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See A.1.3.8, Condition Designator.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member.

This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 3.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List	

Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table A5. Condition Designator

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number

and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

- **ST** Transaction Set Header, starts a transaction set.
  - **LS** Loop Header, starts a bounded loop of data segments but is not part of the loop.
    - **LS** Loop Header, starts an inner, nested, bounded loop.
    - **LE** Loop Trailer, ends an inner, nested bounded loop.
  - **LE** Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
- **SE** Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See figure A1, Transmission Control Schematic.

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat

an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by ">1."

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See figure A1, Transmission Control Schematic.

A.1.4 Envelopes and Control Structures

A.1.4.1 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products, if these fields are different the interchange will be "suspended" in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written trading partner agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. The ISA12 does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An Interchange Acknowledgment can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a "yes" condition in data element ISA14 would be the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrep-

ancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix B, EDI Control Directory, for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

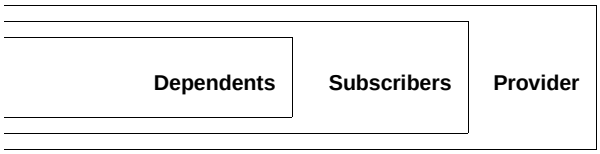
Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. For health care, this unit identification can be used to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be used for debugging purposes during problem resolution. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. Appendix B provides guidance for the value for this data element. The GS08 does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix B, EDI Control Directory, for a complete detailing of the functional group header and trailer.

A.1.4.3 HL Structures

The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide. The following diagram, from transaction set 837, illustrates a typical hierarchy.



Each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims. Each guide states what levels are available, the level's requirement, a repeat value, and whether that level has subordinate levels within a transmission.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although recommended by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

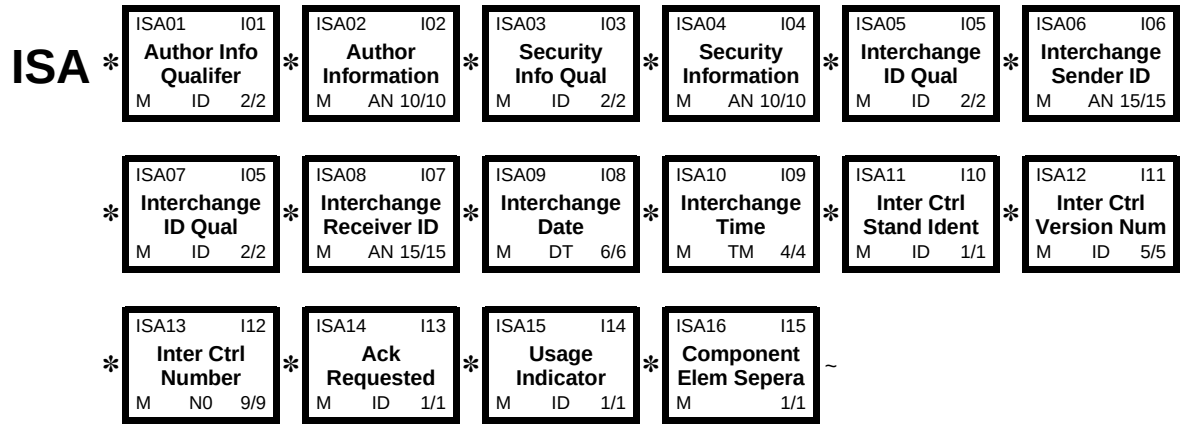
Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID..* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00401* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**
			CODE / **DEFINITION** **00** — **No Authorization Information Present (No Meaningful Information in I02)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.** **03** — **Additional Data Identification**	
REQUIRED	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M ID 2/2**
Code to identify the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M AN 10/10**
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121: Health Industry Identification Number**
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**

			14	**Duns Plus Suffix**		
			20	**Health Industry Number (HIN)**		
				CODE SOURCE **121: Health Industry Identification Number**		
			27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			30	**U.S. Federal Tax Identification Number**		
			33	**National Association of Insurance Commissioners Company Code (NAIC)**		
			ZZ	**Mutually Defined**		
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID**		**M**	**AN**	**15/15**
			Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them				
REQUIRED	**ISA09**	**I08**	**Interchange Date**		**M**	**DT**	**6/6**
			Date of the interchange				
			The date format is YYMMDD.				
REQUIRED	**ISA10**	**I09**	**Interchange Time**		**M**	**TM**	**4/4**
			Time of the interchange				
			The time format is HHMM.				
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier**		**M**	**ID**	**1/1**
			Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer				
			CODE	DEFINITION			
			U	**U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number**		**M**	**ID**	**5/5**
			This version number covers the interchange control segments				
			CODE	DEFINITION			
			00401	**Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number**		**M**	**N0**	**9/9**
			A control number assigned by the interchange sender				
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M ID 1/1**
Code sent by the sender to request an interchange acknowledgment (TA1)

See Section A.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Acknowledgment Requested**
1	**Interchange Acknowledgment Requested**

REQUIRED **ISA15** **I14** **Usage Indicator** **M ID 1/1**
Code to indicate whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M 1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

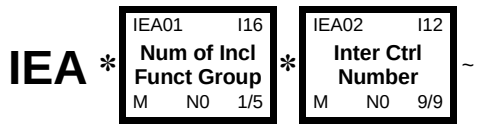
Example: IEA*1*000000905~

STANDARD

IEA Interchange Control Trailer

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

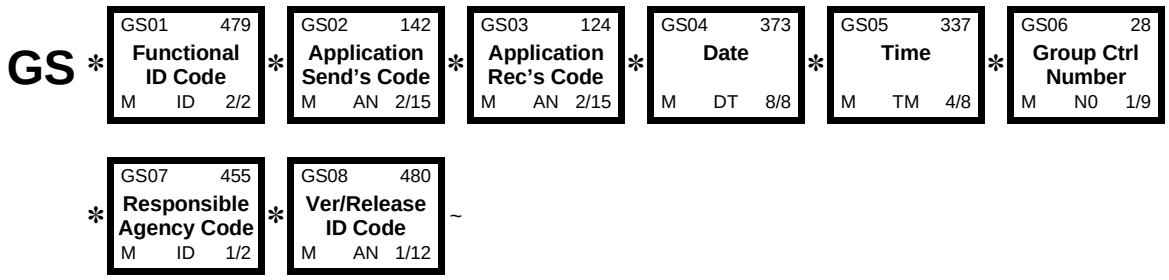
Example: GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X098~

STANDARD

GS Functional Group Header

Purpose: To indicate the beginning of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **CODE** / **DEFINITION** **HC** — **Health Care Claim (837)**	**M ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M DT 8/8**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **SEMANTIC:** GS05 is the group time. **Use this time for the creation time. The recommended format is HHMM.**	**M TM 4/8**

REQUIRED **GS06** **28** **Group Control Number** **M N0 1/9**
Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

REQUIRED **GS07** **455** **Responsible Agency Code** **M ID 1/2**
Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M AN 1/12**
Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE	DEFINITION
004010X098	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

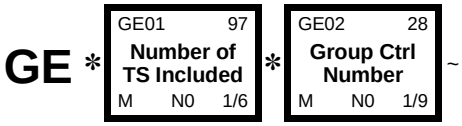
Example: GE*1*1~

STANDARD

GE Functional Group Trailer

Purpose: To indicate the end of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M N0 1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**
2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in this Appendix.**

Example: **TA1*000000905*940101*0100*A*000~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.			
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.			
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M**	**DT**	**6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)			
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M**	**TM**	**4/4**
			This is the time of the original interchange being acknowledged. (HHMM)			

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M ID 1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.
E	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.
R	The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.

REQUIRED **TA105** **I18** **Interchange Note Code** **M ID 3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported.
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Use of the 997 transaction is subject to trading partner agreement or accepted usage and is neither mandated nor prohibited in this Appendix.**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

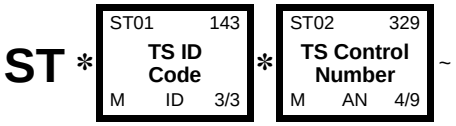
Requirement: Mandatory

Max Use: 1

Purpose: To indicate the start of a transaction set and to assign a control number

Set Notes:
1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE** **DEFINITION** **997** **Functional Acknowledgment**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.** **Use the corresponding value in SE02 for this transaction set.**	**M AN 4/9**

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HC*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

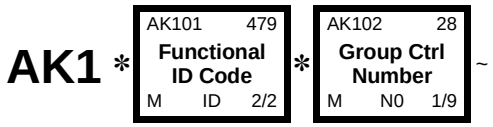
Max Use: 1

Purpose: To start acknowledgment of a functional group

Set Notes:

1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **SEMANTIC:** AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.	**M**	**ID**	**2/2**
			CODE / **DEFINITION** **HC** **Health Care Claim (837)**			
REQUIRED	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.	**M**	**N0**	**1/9**

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **AK2 — TRANSACTION SET RESPONSE HEADER** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when communicating information about a transaction set within the functional group identified in AK1.**

Example: **AK2*837*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

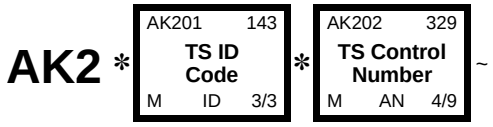
Requirement: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Set Notes:
1. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged. **CODE** / **DEFINITION** **837** **Health Care Claim**	**M**	**ID**	**3/3**
REQUIRED	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **SEMANTIC:** AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.	**M**	**AN**	**4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when there are errors to report in a transaction.**

Example: **AK3*NM1*37*2010BB*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

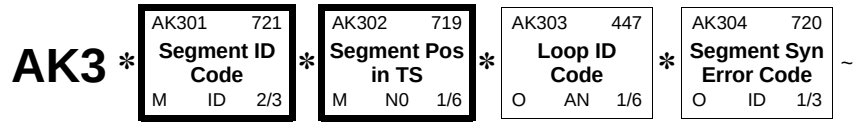
Requirement: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Set Notes: **1.** The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) **CODE SOURCE 77:** X12 Directories **This is the two or three characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

SITUATIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/6**
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Use this code to identify a loop within the transaction set that is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

SITUATIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a segment

This code is required if an error exists.

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **SITUATIONAL**

Repeat: **99**

Notes: **1. Used when there are errors to report in a data element or composite data structure.**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

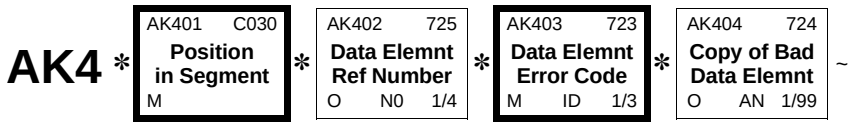
Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
SITUATIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error **Used when an error occurs in a composite data element and the composite data element position can be determined.**	**O N0 1/2**

SITUATIONAL **AK402** **725** **Data Element Reference Number** **O** **N0** **1/4**

Reference number used to locate the data element in the Data Element Dictionary

ADVISORY: Under most circumstances, this element is expected to be sent.

CODE SOURCE 77: X12 Directories

The Data Element Reference Number for this data element is 725. For example, all reference numbers are found with the segment descriptions in this guide.

REQUIRED **AK403** **723** **Data Element Syntax Error Code** **M** **ID** **1/3**

Code indicating the error found after syntax edits of a data element

CODE	DEFINITION
1	Mandatory data element missing
2	Conditional required data element missing.
3	Too many data elements.
4	Data element too short.
5	Data element too long.
6	Invalid character in data element.
7	Invalid code value.
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated

SITUATIONAL **AK404** **724** **Copy of Bad Data Element** **O** **AN** **1/99**

This is a copy of the data element in error

SEMANTIC: In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.

Used to provide copy of erroneous data to the original submitter, but this is not used if the error reported in an invalid character.

IMPLEMENTATION

TRANSACTION SET RESPONSE TRAILER

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **REQUIRED**

Repeat: **1**

Example: **AK5*E*5~**

STANDARD

AK5 Transaction Set Response Trailer

Level: Header

Position: 060

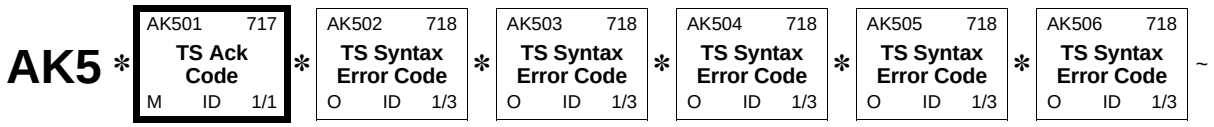
Loop: AK2

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK501**	**717**	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted But Errors Were Noted**
M	**Rejected, Message Authentication Code (MAC) Failed**
R	**Rejected** **ADVISED**
W	**Rejected, Assurance Failed Validity Tests**
X	**Rejected, Content After Decryption Could Not Be Analyzed**

SITUATIONAL **AK502** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

This code is required if an error exists.

CODE	DEFINITION
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment

SITUATIONAL **AK503** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

Use the same codes indicated in AK502.

SITUATIONAL	**AK504**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK505**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK506**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9*A*1*1*1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

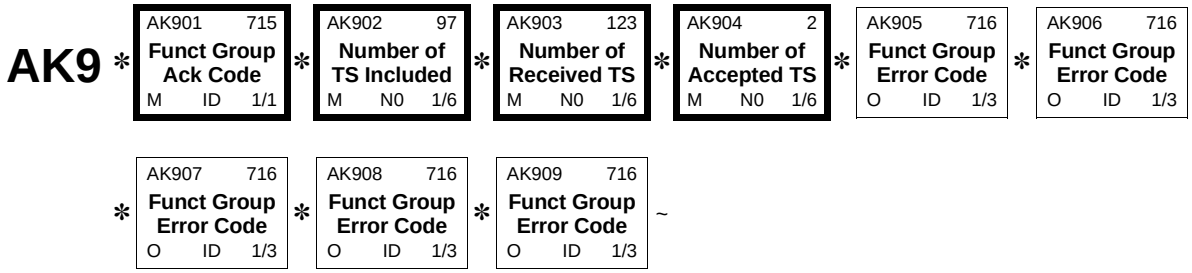
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group COMMENT: If AK901 contains the value “A” or “E”, then the transmitted functional group is accepted.	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted, But Errors Were Noted.**
M	**Rejected, Message Authentication Code (MAC) Failed**

			P	**Partially Accepted, At Least One Transaction Set Was Rejected** **ADVISED**			
			R	**Rejected** **ADVISED**			
			W	**Rejected, Assurance Failed Validity Tests**			
			X	**Rejected, Content After Decryption Could Not Be Analyzed**			
REQUIRED	**AK902**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**	
			This is the value in the original GE01.				
REQUIRED	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0**	**1/6**	
REQUIRED	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0**	**1/6**	
SITUATIONAL	**AK905**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			This code is required if an error exists.				

CODE	DEFINITION
1	**Functional Group Not Supported**
2	**Functional Group Version Not Supported**
3	**Functional Group Trailer Missing**
4	**Group Control Number in the Functional Group Header and Trailer Do Not Agree**
5	**Number of Included Transaction Sets Does Not Match Actual Count**
6	**Group Control Number Violates Syntax**
10	**Authentication Key Name Unknown**
11	**Encryption Key Name Unknown**
12	**Requested Service (Authentication or Encryption) Not Available**
13	**Unknown Security Recipient**
14	**Unknown Security Originator**
15	**Syntax Error in Decrypted Text**
16	**Security Not Supported**
17	**Incorrect Message Length (Encryption Only)**
18	**Message Authentication Code Failed**

			23	**S3E Security End Segment Missing for S3S Security Start Segment**			
			24	**S3S Security Start Segment Missing for S3E End Segment**			
			25	**S4E Security End Segment Missing for S4S Security Start Segment**			
			26	**S4S Security Start Segment Missing for S4E Security End Segment**			
SITUATIONAL	**AK906**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK907**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK908**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK909**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*27*1234~**

STANDARD

SE Transaction Set Trailer

Level: Header

Position: 080

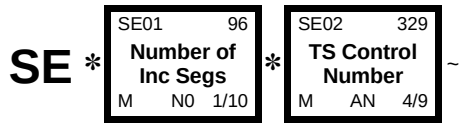
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M AN 4/9**
			The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.	

C External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CH, 26, 100

SOURCE

Codes for Representation of Names of Countries, ISO 3166-(Latest Release)
Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM

American National Standards Institute
11 West 42nd Street, 13th Floor
New York, NY 10036

ABSTRACT

This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entitles in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

Microfiche available from NTIS (same as address above).
The Canadian Post Office lists the following as “official” codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT - Yukon

41 Universal Product Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/8, 235/UA, 235/UB, 235/UC, 235/UD, 235/UE, 235/UI, 235/UN, 235/UP, 559/FD, 88/UP, 438, 766

SOURCE

Publication series on Universal Product Code numbering system and usage.

AVAILABLE FROM

Uniform Code Council, Inc.
8163 Old Yankee Road, Suite J
Dayton, OH 45458

ABSTRACT

U.P.C. is a system of coding products whereby each item/multipack/case is uniquely identified. Codes are formated as an optional digit which identifies the packing variations, one or two high order digit(s) identifying the system (grocery, drug, general merchandise, coupons), 5 digits which identify the manufacturer, 5 digits which identity the item and an optional 1 character check digit.

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

SOURCE

National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM

U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents

P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT

The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HI, 66/21, I05/20, 1270/HI

SOURCE

Health Industry Number Database

AVAILABLE FROM

Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018

ABSTRACT

The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospi-

tals and other provider organizations - the customers of health industry manufacturers and distributors.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Health Care Finance Administration Common Procedural Coding System

AVAILABLE FROM

www.hcfa.gov/medicare/hcpcs.htm
Health Care Financing Administration
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD

SOURCE

International Classification of Diseases, 9th Revision, Clincal Modification (ICD-9-CM)

AVAILABLE FROM

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1034

SOURCE

National Health Care Claim Payment/Advice Committee Bulletins

AVAILABLE FROM

www.wpc-edi.com
Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116

ABSTRACT

Bulletins describe standard codes and messages that detail the reason why an adjustment was made to a health care claim payment by the payer.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1325

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Position 3

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

237 Place of Service from Health Care Financing Administration Claim Form

SIMPLE DATA ELEMENT/CODE REFERENCES

1332/B

SOURCE

Electronic Media Claims National Standard Format

AVAILABLE FROM

www.hcfa.gov/medicare/poscode.htm
Health Care Financing Administration
Center for Health Plans and Providers
7500 Security Blvd.
Baltimore, MD 21244-1850
Contact: Patricia Gill

ABSTRACT

A variety of codes indicating place where service was rendered.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES

235/N1, 235/N2, 235/N3, 235/N4, 1270/NDC, 235/N5, 235/N6

SOURCE

Drug Establishment Registration and Listing Instruction Booklet

AVAILABLE FROM

Federal Drug Listing Branch HFN-315
5600 Fishers Lane
Rockville, MD 20857

ABSTRACT

Publication includes manufacturing and labeling information as well as drug packaging sizes.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/NF

SOURCE

National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM

National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT

Codes that uniquely identify each insurance company.

411 Remittance Remark Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/HE, 1271

SOURCE

Medicare Part A Specification for the ASC X12 835 (7/1/94)
or
Medicare Part B Specification for the ASC X12 835 (7/1/94)
or
National Standard Format Electronic Remittance Advice (Version 001.04)

AVAILABLE FROM

Washington Publishing Company
http://www.wpc-edi.com
or
Health Care Financing Administration (HCFA)
http://www.hcfa.gov/medicare/edi/edi.htm

ABSTRACT

These codes represent non-financial information critical to understanding the adjudication of a health insurance claim.

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

Home Infusion EDI Coalition — affiliated with National Home Infusion Association
205 Daingerfield Road
Alexandria, Virginia 22314
Telephone: 703-549-3740
FAX: 703-683-1484

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

522 Health Industry Labeler Identification Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/LIC

SOURCE

AVAILABLE FROM

Health Industry Business Communications Council
5110 North 40th Street, Suite 240
Phoenix, AZ 85018

ABSTRACT

The HIBCC Labeler Identification Code (LIC) is assigned and maintained by HIBCC. The first character of the code is always alphabetic. The LIC may, at the option of the labeler, identify a labeler to the point of separate subsidiaries and divisions within a parent organization. The LIC is also a key component of the HIBCC LIC Primary Data Symbologies Code 128 and Code 39.

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PlanID Database

AVAILABLE FROM

Health Care Financing Administration
Center for Beneficiary Services
Administration Group
Division of Membership Operations
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

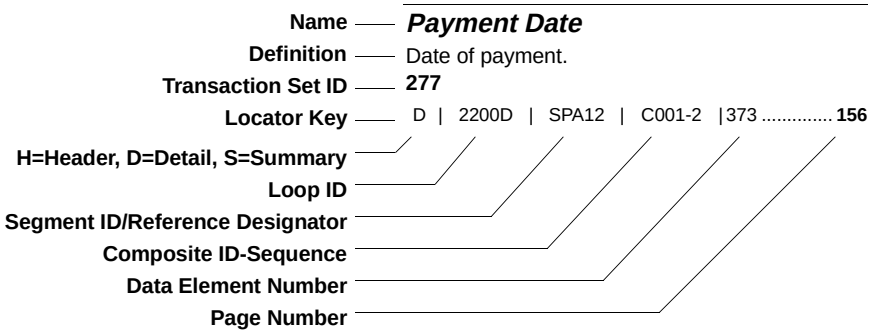
The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

D Change Summary

The ASC X12N 4010 Implementation Guide for the 837 Professional Health Care Claim is based on the 3070 Tutorial. As such, all changes from the 3060 version to the 3070 version are contained in the 3070 Tutorial.

E Data Element Name Index

This appendix contains an alphabetic listing of data elements used in this implementation guide. Consult the Data Element Dictionary for the complete list. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.



Accident Date

Date of the accident related to charges or to the patient's current condition, diagnosis, or treatment referenced in the transaction.

D | 2300 | DTP03 | - | 1251 ..... **195**

Acute Manifestation Date

Date of acute manifestation of patient's condition.

D | 2300 | DTP03 | - | 1251 ..... **191**
D | 2400 | DTP03 | - | 1251 ..... **457**

Additional Submitter Name

Additional name information for the receiver or submitter of the transaction.

H | 1000A | N201 | - | 93 ..... **70**

Adjudication or Payment Date

Date of payment or denial determination by previous payer.

D | 2330B | DTP03 | - | 1251 ..... **367**
D | 2430 | DTP03 | - | 1251 ..... **566**

Adjusted Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify an adjusted claim.

D | 2300 | REF02 | - | 127 ..... **235**

Adjusted Repriced Line Item Reference Number

Identification number of an adjusted repriced line item adjusted from an original amount.

D | 2400 | REF02 | - | 127 ..... **469**

Adjustment Amount

Adjustment amount for the associated reason code.

D | 2320 | CAS03 | - | 782 ..... **327**
D | 2320 | CAS06 | - | 782 ..... **327**
D | 2320 | CAS09 | - | 782 ..... **328**
D | 2320 | CAS12 | - | 782 ..... **329**
D | 2320 | CAS15 | - | 782 ..... **330**
D | 2320 | CAS18 | - | 782 ..... **330**
D | 2430 | CAS03 | - | 782 ..... **560**
D | 2430 | CAS06 | - | 782 ..... **561**
D | 2430 | CAS09 | - | 782 ..... **562**
D | 2430 | CAS12 | - | 782 ..... **563**
D | 2430 | CAS15 | - | 782 ..... **564**
D | 2430 | CAS18 | - | 782 ..... **565**

Adjustment Quantity

Numeric quantity associated with the related reason code for coordination of benefits.

D | 2320 | CAS04 | - | 380 ..... **327**
D | 2320 | CAS07 | - | 380 ..... **328**
D | 2320 | CAS10 | - | 380 ..... **328**
D | 2320 | CAS13 | - | 380 ..... **329**
D | 2320 | CAS16 | - | 380 ..... **330**
D | 2320 | CAS19 | - | 380 ..... **331**
D | 2430 | CAS04 | - | 380 ..... **560**
D | 2430 | CAS07 | - | 380 ..... **561**
D | 2430 | CAS10 | - | 380 ..... **562**
D | 2430 | CAS13 | - | 380 ..... **563**
D | 2430 | CAS16 | - | 380 ..... **564**
D | 2430 | CAS19 | - | 380 ..... **565**

Adjustment Reason Code

Code that indicates the reason for the adjustment.

D | 2320 | CAS02 | - | 1034 ..... **326**
D | 2320 | CAS05 | - | 1034 ..... **327**
D | 2320 | CAS08 | - | 1034 ..... **328**
D | 2320 | CAS11 | - | 1034 ..... **329**
D | 2320 | CAS14 | - | 1034 ..... **329**
D | 2320 | CAS17 | - | 1034 ..... **330**
D | 2430 | CAS02 | - | 1034 ..... **560**

D | 2430 | CAS05 | - | 1034 ..... **561**
D | 2430 | CAS08 | - | 1034 ..... **562**
D | 2430 | CAS11 | - | 1034 ..... **563**
D | 2430 | CAS14 | - | 1034 ..... **564**
D | 2430 | CAS17 | - | 1034 ..... **565**

Allowed Amount

The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.

D | 2320 | AMT02 | - | 782 ..... **334**

Ambulance Transport Code

Code indicating the type of ambulance transport.

D | 2300 | CR103 | - | 1316 ..... **249**
D | 2400 | CR103 | - | 1316 ..... **413**

Ambulance Transport Reason Code

Code indicating the reason for ambulance transport.

D | 2300 | CR104 | - | 1317 ..... **249**
D | 2400 | CR104 | - | 1317 ..... **413**

Ambulatory Patient Group Number

Identifier for Ambulatory Patient Group assigned to the claim.

D | 2300 | REF02 | - | 127 ..... **240**
D | 2400 | REF02 | - | 127 ..... **479**

Amount Qualifier Code

Code to qualify amount.

D | 2300 | AMT01 | - | 522 ..... **219**
D | 2300 | AMT01 | - | 522 ..... **220**
D | 2300 | AMT01 | - | 522 ..... **221**
D | 2320 | AMT01 | - | 522 ..... **332**
D | 2320 | AMT01 | - | 522 ..... **333**
D | 2320 | AMT01 | - | 522 ..... **334**
D | 2320 | AMT01 | - | 522 ..... **335**
D | 2320 | AMT01 | - | 522 ..... **336**
D | 2320 | AMT01 | - | 522 ..... **337**
D | 2320 | AMT01 | - | 522 ..... **338**
D | 2320 | AMT01 | - | 522 ..... **339**
D | 2320 | AMT01 | - | 522 ..... **340**
D | 2320 | AMT01 | - | 522 ..... **341**
D | 2400 | AMT01 | - | 522 ..... **484**
D | 2400 | AMT01 | - | 522 ..... **485**
D | 2400 | AMT01 | - | 522 ..... **486**

Anesthesia Modifying Units

Unit quantity for qualifying extenuating circumstances at time of service.

D | 2400 | QTY02 | - | 380 ..... **463**

Approved Amount

Amount approved.

D | 2320 | AMT02 | - | 782 ..... **333**
D | 2400 | AMT02 | - | 782 ..... **485**

Arterial Blood Gas Quantity

The Arterial Blood Gas test results breathing room air (furnish results of recent hospital tests).

D | 2400 | CR510 | - | 380 ..... **424**

Assigned Number

Number assigned for differentiation within a transaction set.

D | 2400 | LX01 | - | 554 ..... **399**

Assumed or Relinquished Care Date

Date post-operative care was assumed by another provider, or date provider ceased post-operative care.

D | 2300 | DTP03 | - | 1251 ..... **213**

Attachment Control Number

Identification number of attachment related to the claim.

D | 2300 | PWK06 | - | 67 ..... **216**

Attachment Report Type Code

Code to specify the type of attachment that is related to the claim.

D | 2300 | PWK01 | - | 755 ..... **215**
D | 2400 | PWK01 | - | 755 ..... **410**

Attachment Transmission Code

Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.

D | 2300 | PWK02 | - | 756 ..... **216**
D | 2400 | PWK02 | - | 756 ..... **411**

Auto Accident State or Province Code

State or Province where auto accident occurred.

D | 2300 | CLM11 | C024-4 | 156 ..... **177**

Begin Therapy Date

Date therapy begins.

D | 2400 | DTP03 | - | 1251 ..... **441**

Benefits Assignment Certification Indicator

A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

D | 2300 | CLM08 | - | 1073 ..... **175**
D | 2320 | OI03 | - | 1073 ..... **345**

Billing Provider Additional Identifier

Identifies another or additional distinguishing code number associated with the billing provider.

D | 2010AA | REF02 | - | 127 ..... **92**

Billing Provider Additional Name

Additional names or characters for the billing provider or billing entity for the transaction.

D | 2010AA | N201 | - | 93 ..... **87**

Billing Provider Address Line

Address line of the billing provider or billing entity address.

D | 2010AA | N301 | - | 166 ..... **88**
D | 2010AA | N302 | - | 166 ..... **88**

Billing Provider City Name

City of the billing provider or billing entity

D | 2010AA | N401 | - | 19 ..... **89**

Billing Provider Contact Name

Person at billing organization to contact regarding the billing transaction.

D | 2010AA | PER02 | - | 93 ..... **97**

Billing Provider Credit Card Identifier

Identification number for credit card processing for the billing provider or billing entity

D | 2010AA | REF02 | - | 127 ..... **95**

Billing Provider First Name

First name of the billing provider or billing entity

D | 2010AA | NM104 | - | 1036 ..... **85**

Billing Provider Identifier

Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.

D | 2010AA | NM109 | - | 67 ..... **86**

Billing Provider Last or Organizational Name

Last name or organization name of the provider billing or billing entity for services.

D | 2010AA | NM103 | - | 1035 ..... **85**

Billing Provider Middle Name

The middle name of the billing provider or billing entity

D | 2010AA | NM105 | - | 1037 ..... **85**

Billing Provider Name Suffix

Suffix, including generation, for the name of the provider or billing entity submitting the claim.

D | 2010AA | NM107 | - | 1039 ..... **86**

Billing Provider Postal Zone or ZIP Code

Postal zone code or ZIP code for the provider or billing entity billing for services.

D | 2010AA | N403 | - | 116..... **90**

Billing Provider State or Province Code

State or province for provider or billing entity billing for services.

D | 2010AA | N402 | - | 156 ..... **90**

Bundled or Unbundled Line Number

Identification of line item bundled or unbundled by non-destination (COB) payer in payment of benefits.

D | 2430 | SVD06 | - | 554 ..... **557**

Certification Condition Indicator

Code indicating whether or not the condition codes apply to the patient or another entity.

D | 2300 | CRC02 | - | 1073 ..... **258**
D | 2300 | CRC02 | - | 1073 ..... **261**
D | 2300 | CRC02 | - | 1073 ..... **264**
D | 2400 | CRC02 | - | 1073 ..... **428**
D | 2400 | CRC02 | - | 1073 ..... **433**

Certification Period Projected Visit Count

Total visits projected during this certification period.

D | 2305 | CR703 | - | 1470 ..... **277**

Certification Revision Date

Date the certification was revised.

D | 2400 | DTP03 | - | 1251 ..... **438**

Certification Type Code

Code indicating the type of certification

D | 2400 | CR301 | - | 1322 ..... **421**
D | 2400 | CR501 | - | 1322 ..... **424**

Claim Adjustment Group Code

Code identifying the general category of payment adjustment.

D | 2320 | CAS01 | - | 1033 ..... **326**
D | 2430 | CAS01 | - | 1033 ..... **560**

Claim Filing Indicator Code

Code identifying type of claim or expected adjudication process.

D | 2000B | SBR09 | - | 1032 .....**112**
D | 2320 | SBR09 | - | 1032 ..... **321**

Claim Frequency Code

Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.

D	2300	CLM05	C023-3	1325	.....	**173**

Claim Note Text

Narrative text providing additional information related to the claim.

D	2300	NTE02	-	352	.....	**247**

Claim Original Reference Number

Number assigned by a processor to identify a claim.

D	2300	REF02	-	127	.....	**230**

Claim or Encounter Identifier

Code indicating whether the transaction is a claim or reporting encounter information.

H		BHT06	-	640	.....	**65**

Clearinghouse Trace Number

Unique tracking number for the transaction assigned by a clearinghouse.

D	2300	REF02	-	127	.....	**239**

Clinical Laboratory Improvement Amendment Number

The CLIA Certificate of Waiver or the CLIA Certificate of Registration Identification Number assigned to the laboratory testing site that rendered the services on this claim.

D	2300	REF02	-	127	.....	**232**
D	2400	REF02	-	127	.....	**476**

Co-Pay Status Code

A code indicating the status of the co-payment requirements for this service.

D	2400	SV115	-	1327	.....	**407**

Code Category

Specifies the situation or category to which the code applies.

D	2300	CRC01	-	1136	.....	**257**
D	2300	CRC01	-	1136	.....	**260**
D	2300	CRC01	-	1136	.....	**263**
D	2400	CRC01	-	1136	.....	**427**
D	2400	CRC01	-	1136	.....	**431**
D	2400	CRC01	-	1136	.....	**433**

Code List Qualifier Code

Code identifying a specific industry code list.

D	2440	LQ01	-	1270	.....	**568**

Communication Number

Complete communications number including country or area code when applicable

H	1000A	PER04	-	364	.....	**72**
H	1000A	PER06	-	364	.....	**73**
H	1000A	PER08	-	364	.....	**73**
D	2010AA	PER04	-	364	.....	**97**
D	2010AA	PER06	-	364	.....	**98**
D	2010AA	PER08	-	364	.....	**98**
D	2330B	PER04	-	364	.....	**364**
D	2330B	PER06	-	364	.....	**365**
D	2330B	PER08	-	364	.....	**365**
D	2420E	PER04	-	364	.....	**539**
D	2420E	PER06	-	364	.....	**540**
D	2420E	PER08	-	364	.....	**540**

Communication Number Qualifier

Code identifying the type of communication number

H	1000A	PER03	-	365	.....	**72**
H	1000A	PER05	-	365	.....	**73**
H	1000A	PER07	-	365	.....	**73**
D	2010AA	PER03	-	365	.....	**97**
D	2010AA	PER05	-	365	.....	**97**
D	2010AA	PER07	-	365	.....	**98**
D	2330B	PER03	-	365	.....	**364**
D	2330B	PER05	-	365	.....	**364**
D	2330B	PER07	-	365	.....	**365**
D	2420E	PER03	-	365	.....	**539**
D	2420E	PER05	-	365	.....	**539**
D	2420E	PER07	-	365	.....	**540**

Complication Indicator

A code to indicate whether the Patient's condition is Complicated or Uncomplicated.

D	2300	CR209	-	1073	.....	**255**
D	2400	CR209	-	1073	.....	**419**

Condition Code

Code(s) used to identify condition(s) relating to this bill or relating to the patient.

D	2300	CRC03	-	1321	.....	**258**
D	2300	CRC04	-	1321	.....	**259**
D	2300	CRC05	-	1321	.....	**259**
D	2300	CRC06	-	1321	.....	**259**
D	2300	CRC07	-	1321	.....	**259**
D	2300	CRC03	-	1321	.....	**261**
D	2300	CRC04	-	1321	.....	**261**
D	2300	CRC05	-	1321	.....	**261**
D	2300	CRC06	-	1321	.....	**261**
D	2300	CRC07	-	1321	.....	**262**
D	2400	CRC03	-	1321	.....	**428**
D	2400	CRC04	-	1321	.....	**429**
D	2400	CRC05	-	1321	.....	**429**
D	2400	CRC06	-	1321	.....	**429**
D	2400	CRC07	-	1321	.....	**429**

Condition Indicator

Code indicating a condition

D	2400	CRC03	-	1321	.....	**431**
D	2400	CRC03	-	1321	.....	**433**
D	2400	CRC04	-	1321	.....	**434**
D	2400	CRC05	-	1321	.....	**434**
D	2400	CRC06	-	1321	.....	**434**
D	2400	CRC07	-	1321	.....	**434**

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

H	1000A	PER01		-	366	**72**
D	2010AA	PER01		-	366	**97**
D	2330B	PER01		-	366	**364**
D	2420E	PER01		-	366	**539**

Contract Amount

Fixed monetary amount pertaining to the contract

D	2300	CN102		-	782	**218**
D	2400	CN102		-	782	**467**

Contract Code

Code identifying the specific contract, established by the payer.

D	2300	CN104		-	127	**218**
D	2400	CN104		-	127	**467**

Contract Percentage

Percent of charges payable under the contract

D	2300	CN103		-	332	**218**
D	2400	CN103		-	332	**467**

Contract Type Code

Code identifying a contract type

D	2300	CN101		-	1166	**217**
D	2400	CN101		-	1166	**466**

Contract Version Identifier

Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.

D	2300	CN106		-	799	**218**
D	2400	CN106		-	799	**467**

Country Code

Code indicating the geographic location.

D	2010AA	N404		-	26	**90**
D	2010AB	N404		-	26	**105**
D	2010BA	N404		-	26	**123**
D	2010BB	N404		-	26	**136**
D	2010BC	N404		-	26	**145**
D	2010CA	N404		-	26	**163**
D	2300	CLM11		C024-5	26	**178**
D	2310D	N404		-	26	**309**
D	2330A	N404		-	26	**356**
D	2420C	N404		-	26	**520**
D	2420E	N404		-	26	**535**

Credit or Debit Card Authorization Number

Credit/Debit card authorization number used to authorize use of card for payment for billed charges.

D	2010BD	REF02		-	127	**150**

Credit or Debit Card Holder Additional Name

Additional name information for the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BD	N201		-	93	**149**

Credit or Debit Card Holder First Name

First name of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BD	NM104		-	1036	**147**

Credit or Debit Card Holder Last or Organizational Name

Last name or organization name of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BD	NM103		-	1035	**147**

Credit or Debit Card Holder Middle Name

Middle name of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BD	NM105		-	1037	**147**

Credit or Debit Card Holder Name Suffix

Name suffix of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BD	NM107		-	1039	**147**

Credit or Debit Card Maximum Amount

Dollar limit for a credit or debit card

D	2300	AMT02		-	782	**219**

Credit or Debit Card Number

Credit/Debit card number that may be used to pay for billed charges.

D	2010BD	NM109		-	67	**148**

Currency Code

Code for country in whose currency the charges are specified.

D	2000A	CUR02		-	100	**82**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format

D	2000B	PAT05		-	1250	**115**
D	2010BA	DMG01		-	1250	**124**
D	2000C	PAT05		-	1250	**155**

D	2010CA	DMG01	-	1250		**164**
D	2300	DTP02	-	1250		**180**
D	2300	DTP02	-	1250		**182**
D	2300	DTP02	-	1250		**184**
D	2300	DTP02	-	1250		**186**
D	2300	DTP02	-	1250		**189**
D	2300	DTP02	-	1250		**190**
D	2300	DTP02	-	1250		**192**
D	2300	DTP02	-	1250		**194**
D	2300	DTP02	-	1250		**196**
D	2300	DTP02	-	1250		**197**
D	2300	DTP02	-	1250		**199**
D	2300	DTP02	-	1250		**200**
D	2300	DTP02	-	1250		**201**
D	2300	DTP02	-	1250		**203**
D	2300	DTP02	-	1250		**205**
D	2300	DTP02	-	1250		**206**
D	2300	DTP02	-	1250		**208**
D	2300	DTP02	-	1250		**210**
D	2300	DTP02	-	1250		**213**
D	2320	DMG01	-	1250		**342**
D	2330B	DTP02	-	1250		**366**
D	2400	DTP02	-	1250		**436**
D	2400	DTP02	-	1250		**437**
D	2400	DTP02	-	1250		**439**
D	2400	DTP02	-	1250		**440**
D	2400	DTP02	-	1250		**443**
D	2400	DTP02	-	1250		**444**
D	2400	DTP02	-	1250		**445**
D	2400	DTP02	-	1250		**447**
D	2400	DTP02	-	1250		**450**
D	2400	DTP02	-	1250		**451**
D	2400	DTP02	-	1250		**452**
D	2400	DTP02	-	1250		**454**
D	2400	DTP02	-	1250		**456**
D	2400	DTP02	-	1250		**458**
D	2400	DTP02	-	1250		**460**
D	2430	DTP02	-	1250		**566**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

D	2300	DTP01	-	374		**180**
D	2300	DTP01	-	374		**182**
D	2300	DTP01	-	374		**184**
D	2300	DTP01	-	374		**186**
D	2300	DTP01	-	374		**188**
D	2300	DTP01	-	374		**190**
D	2300	DTP01	-	374		**192**
D	2300	DTP01	-	374		**194**
D	2300	DTP01	-	374		**196**
D	2300	DTP01	-	374		**197**
D	2300	DTP01	-	374		**199**
D	2300	DTP01	-	374		**200**
D	2300	DTP01	-	374		**201**
D	2300	DTP01	-	374		**203**
D	2300	DTP01	-	374		**205**
D	2300	DTP01	-	374		**206**
D	2300	DTP01	-	374		**208**
D	2300	DTP01	-	374		**210**
D	2300	DTP01	-	374		**213**
D	2330B	DTP01	-	374		**366**
D	2400	DTP01	-	374		**435**
D	2400	DTP01	-	374		**437**
D	2400	DTP01	-	374		**439**
D	2400	DTP01	-	374		**440**
D	2400	DTP01	-	374		**442**
D	2400	DTP01	-	374		**444**
D	2400	DTP01	-	374		**445**
D	2400	DTP01	-	374		**447**
D	2400	DTP01	-	374		**449**
D	2400	DTP01	-	374		**451**
D	2400	DTP01	-	374		**452**
D	2400	DTP01	-	374		**454**
D	2400	DTP01	-	374		**456**
D	2400	DTP01	-	374		**458**
D	2400	DTP01	-	374		**460**
D	2430	DTP01	-	374		**566**

Delay Reason Code

Code indicating the reason why a request was delayed.

D	2300	CLM20	-	1514		**179**

Delivery Pattern Time Code

Code which specifies the time delivery pattern of the services..

D	2305	HSD08	-	679		**281**
D	2400	HSD08	-	679		**494**

Demonstration Project Identifier

Identification number for a Medicare demonstration project.

D	2300	REF02	-	127		**243**

Diagnosis Code

An ICD-9-CM Diagnosis Code identifying a diagnosed medical condition.

D	2300	HI01	C022-2	1271		**266**
D	2300	HI02	C022-2	1271		**266**
D	2300	HI03	C022-2	1271		**267**
D	2300	HI04	C022-2	1271		**268**
D	2300	HI05	C022-2	1271		**268**
D	2300	HI06	C022-2	1271		**269**
D	2300	HI07	C022-2	1271		**269**
D	2300	HI08	C022-2	1271		**270**

Diagnosis Code Pointer

A pointer to the claim diagnosis code in the order of importance to this service

D	2400	SV107	C004-1	1328		**405**
D	2400	SV107	C004-2	1328		**405**
D	2400	SV107	C004-3	1328		**405**
D	2400	SV107	C004-4	1328		**405**

Diagnosis Type Code

Code identifying the type of diagnosis.

D	2300	HI01	C022-1	1270		**266**
D	2300	HI02	C022-1	1270		**266**
D	2300	HI03	C022-1	1270		**267**
D	2300	HI04	C022-1	1270		**268**
D	2300	HI05	C022-1	1270		**268**
D	2300	HI06	C022-1	1270		**269**
D	2300	HI07	C022-1	1270		**269**
D	2300	HI08	C022-1	1270		**270**

Disability From Date

The beginning date the patient, in the provider's opinion, was or will be unable to perform the duties normally associated with his/her work.

D	2300	DTP03	-	1251		**202**

Disability To Date

The ending date the patient, in the provider's opinion, will be able to perform the duties normally associated with his/her work.

D	2300	DTP03	-	1251	.....	**204**

Discipline Type Code

Code indicating discipline(s) ordered by the physician.

D	2305	CR701	-	921	.....	**276**

Durable Medical Equipment Duration

Length of time durable medical equipment (DME) is needed.

D	2400	CR303	-	380	.....	**422**

Duration of Visits Units

The unit (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit every three days occurs over a duration of days.

D	2305	HSD05	-	615	.....	**280**
D	2400	HSD05	-	615	.....	**493**

Duration of Visits, Number of Units

The number of units (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit every three days occurs over a duration of 21 days.

D	2305	HSD06	-	616	.....	**280**
D	2400	HSD06	-	616	.....	**493**

EPSDT Indicator

An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line.

D	2400	SV111	-	1073	.....	**406**

Emergency Indicator

An indicator of whether or not emergency care was rendered in response to the sudden and unexpected onset of a medical condition, a severe injury, or an acute exacerbation of a chronic condition which was threatening to life, limb or sight, and which req

D	2400	SV109	-	1073	.....	**406**

End Stage Renal Disease Payment Amount

Amount of payment under End Stage Renal Disease benefit.

D	2320	MOA08	-	782	.....	**349**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual

H	1000A	NM101	-	98	.....	**68**
H	1000B	NM101	-	98	.....	**75**
D	2000A	CUR01	-	98	.....	**82**
D	2010AA	NM101	-	98	.....	**85**
D	2010AB	NM101	-	98	.....	**100**
D	2010BA	NM101	-	98	.....	**118**
D	2010BB	NM101	-	98	.....	**131**
D	2010BC	NM101	-	98	.....	**140**
D	2010BD	NM101	-	98	.....	**147**
D	2010CA	NM101	-	98	.....	**157**
D	2310A	NM101	-	98	.....	**283**
D	2310B	NM101	-	98	.....	**291**
D	2310C	NM101	-	98	.....	**299**
D	2310D	NM101	-	98	.....	**304**
D	2310E	NM101	-	98	.....	**313**
D	2330A	NM101	-	98	.....	**351**
D	2330B	NM101	-	98	.....	**360**
D	2330C	NM101	-	98	.....	**375**
D	2330D	NM101	-	98	.....	**379**
D	2330E	NM101	-	98	.....	**383**
D	2330F	NM101	-	98	.....	**387**
D	2330G	NM101	-	98	.....	**391**
D	2330H	NM101	-	98	.....	**395**
D	2420A	NM101	-	98	.....	**502**
D	2420B	NM101	-	98	.....	**510**
D	2420C	NM101	-	98	.....	**515**
D	2420D	NM101	-	98	.....	**524**
D	2420E	NM101	-	98	.....	**530**
D	2420F	NM101	-	98	.....	**542**
D	2420G	NM101	-	98	.....	**550**

Entity Type Qualifier

Code qualifying the type of entity

H	1000A	NM102	-	1065	.....	**68**
H	1000B	NM102	-	1065	.....	**75**
D	2010AA	NM102	-	1065	.....	**85**
D	2010AB	NM102	-	1065	.....	**100**
D	2010BA	NM102	-	1065	.....	**118**
D	2010BB	NM102	-	1065	.....	**131**
D	2010BC	NM102	-	1065	.....	**140**
D	2010BD	NM102	-	1065	.....	**147**
D	2010CA	NM102	-	1065	.....	**158**
D	2310A	NM102	-	1065	.....	**283**
D	2310B	NM102	-	1065	.....	**291**
D	2310C	NM102	-	1065	.....	**299**
D	2310D	NM102	-	1065	.....	**304**
D	2310E	NM102	-	1065	.....	**313**
D	2330A	NM102	-	1065	.....	**351**
D	2330B	NM102	-	1065	.....	**360**
D	2330C	NM102	-	1065	.....	**375**
D	2330D	NM102	-	1065	.....	**379**
D	2330E	NM102	-	1065	.....	**383**
D	2330F	NM102	-	1065	.....	**387**
D	2330G	NM102	-	1065	.....	**391**
D	2330H	NM102	-	1065	.....	**395**
D	2420A	NM102	-	1065	.....	**502**
D	2420B	NM102	-	1065	.....	**510**
D	2420C	NM102	-	1065	.....	**515**
D	2420D	NM102	-	1065	.....	**524**
D	2420E	NM102	-	1065	.....	**530**
D	2420F	NM102	-	1065	.....	**542**
D	2420G	NM102	-	1065	.....	**550**

Estimated Birth Date

Date delivery is expected.

D	2300	DTP03	-	1251	.....	**199**

Exception Code

Exception code generated by the Third Party Organization.

D	2300	HCP15		-	1527	**275**
D	2400	HCP15		-	1527	**500**

Facility Type Code

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.

D	2300	CLM05	C023-1		1331	**173**

Family Planning Indicator

An indicator of whether or not Family Planning Services are involved with this detail line.

D	2400	SV112		-	1073	**406**

Fixed Format Information

Data in fixed format agreed upon by sender and receiver

D	2300	K301		-	449	**245**
D	2400	K301		-	449	**487**

Form Identifier

Letter or number identifying a specific form.

D	2440	LQ02		-	1271	**568**

Frequency Count

The count of the frequency units of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit occurs at three day intervals.

D	2305	HSD04		-	1167.....	**280**
D	2400	HSD04		-	1167.....	**493**

Frequency Period

The units specifying the frequency of home health visits (e.g., days, months, etc.) Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the the one visit occurs at a frequency of days.

D	2305	HSD03		-	355	**279**
D	2400	HSD03		-	355	**492**

HCPCS Payable Amount

Amount due under Medicare HCPCS system.

D	2320	MOA02		-	782	**348**

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

D	2000A	HL04		-	736	**78**
D	2000B	HL04		-	736	**109**
D	2000C	HL04		-	736	**153**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

D	2000A	HL01		-	628	**78**
D	2000B	HL01		-	628	**109**
D	2000C	HL01		-	628	**153**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

D	2000A	HL03		-	735	**78**
D	2000B	HL03		-	735	**109**
D	2000C	HL03		-	735	**153**

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

D	2000B	HL02		-	734	**109**
D	2000C	HL02		-	734	**153**

Hierarchical Structure Code

Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

H		BHT01		-	1005	**63**

Homebound Indicator

A code indicating whether a patient is homebound.

D	2300	CRC03		-	1321	**264**

Hospice Employed Provider Indicator

An indicator of whether or not the treatment in the Hospice was rendered by a Hospice employed provider.

D	2400	CRC02		-	1073	**431**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67)

H	1000A	NM108		-	66	**68**
H	1000B	NM108		-	66	**75**
D	2010AA	NM108		-	66	**86**
D	2010AB	NM108		-	66	**101**
D	2010BA	NM108		-	66	**119**
D	2010BB	NM108		-	66	**131**
D	2010BD	NM108		-	66	**147**
D	2010CA	NM108		-	66	**159**
D	2300	PWK05		-	66	**216**
D	2310A	NM108		-	66	**284**
D	2310B	NM108		-	66	**292**
D	2310C	NM108		-	66	**299**
D	2310D	NM108		-	66	**305**
D	2310E	NM108		-	66	**314**
D	2330A	NM108		-	66	**352**
D	2330B	NM108		-	66	**360**
D	2330C	NM108		-	66	**375**
D	2420A	NM108		-	66	**503**
D	2420B	NM108		-	66	**510**

D | 2420C | NM108 | - | 66 ..... **515**
D | 2420D | NM108 | - | 66 ..... **525**
D | 2420E | NM108 | - | 66 ..... **531**
D | 2420F | NM108 | - | 66 ..... **543**
D | 2420G | NM108 | - | 66 ..... **550**

Immunization Batch Number

The manufacturer's lot number for vaccine used in immunization.

D | 2400 | REF02 | - | 127 ..... **478**

Individual Relationship Code

Code indicating the relationship between two individuals or entities

D | 2000B | SBR02 | - | 1069 ..... **111**
D | 2000C | PAT01 | - | 1069 ..... **154**
D | 2320 | SBR02 | - | 1069 ..... **319**

Initial Treatment Date

Date that the patient initially sought treatment for this condition.

D | 2300 | DTP03 | - | 1251 ..... **183**
D | 2400 | DTP03 | - | 1251 ..... **459**

Insurance Type Code

Code identifying the type of insurance.

D | 2000B | SBR05 | - | 1336 ..... **111**
D | 2320 | SBR05 | - | 1336 ..... **321**

Insured Group Name

Name of the group or plan through which the insurance is provided to the insured.

D | 2000B | SBR04 | - | 93 ..... **111**

Insured Group or Policy Number

The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

D | 2000B | SBR03 | - | 127 ..... **111**
D | 2320 | SBR03 | - | 127 ..... **320**

Insured Individual Death Date

Date of death for subscriber or dependent.

D | 2000B | PAT06 | - | 1251 ..... **115**

Investigational Device Exemption Identifier

Number or reference identifying exemption assigned to an ivestigational device referenced in the claim.

D | 2300 | REF02 | - | 127 ..... **236**

Laboratory or Facility Address Line

Address line of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D | 2310D | N301 | - | 166 ..... **307**
D | 2310D | N302 | - | 166 ..... **307**
D | 2420C | N301 | - | 166 ..... **518**
D | 2420C | N302 | - | 166 ..... **518**

Laboratory or Facility City Name

City of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D | 2310D | N401 | - | 19 ..... **308**
D | 2420C | N401 | - | 19 ..... **519**

Laboratory or Facility Name

Name of laboratory or other facility performing Laboratory testing on the claim where the health care service was performed/rendered.

D | 2310D | NM103 | - | 1035 ..... **304**
D | 2420C | NM103 | - | 1035 ..... **515**

Laboratory or Facility Name Additional Text

Additional name information identifying the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D | 2310D | N201 | - | 93 ..... **306**
D | 2420C | N201 | - | 93 ..... **517**

Laboratory or Facility Postal Zone or ZIP Code

Postal ZIP or zonal code of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D | 2310D | N403 | - | 116..... **309**
D | 2420C | N403 | - | 116..... **520**

Laboratory or Facility Primary Identifier

Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.

D | 2310D | NM109 | - | 67 ..... **305**
D | 2420C | NM109 | - | 67 ..... **516**

Laboratory or Facility Secondary Identifier

Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D | 2310D | REF02 | - | 127 ..... **311**

Laboratory or Facility State or Province Code

State or province of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D | 2310D | N402 | - | 156 ..... **309**
D | 2420C | N402 | - | 156 ..... **520**

Last Certification Date

The date of the last certification.

D | 2400 | DTP03 | - | 1251 ..... **443**

Last Menstrual Period Date

The date of the last menstrual period (LMP).

D | 2300 | DTP03 | - | 1251 ..... **196**

Last Seen Date

Date the patient was last seen by the referring or ordering physician for a claim billed by a provider whose services require physician certification.

D | 2300 | DTP03 | - | 1251 ..... **187**
D | 2400 | DTP03 | - | 1251 ..... **446**

Last Worked Date

Date patient last worked at the patient's current occupation

D | 2300 | DTP03 | - | 1251 ..... **205**

Last X-Ray Date

Date patient received last X-Ray.

D | 2300 | DTP03 | - | 1251 ..... **198**
D | 2400 | DTP03 | - | 1251 ..... **455**

Line Item Charge Amount

Charges related to this service.

D | 2400 | SV102 | - | 782 ..... **402**

Line Item Control Number

Identifier assigned by the submitter/provider to this line item.

D | 2400 | REF02 | - | 127 ..... **473**

Line Note Text

Narrative text providing additional information related to the service line.

D | 2400 | NTE02 | - | 352 ..... **488**

Mammography Certification Number

HCFA assigned Certification Number of the certified mammography screening center

D | 2300 | REF02 | - | 127 ..... **226**
D | 2400 | REF02 | - | 127 ..... **474**

Measurement Qualifier

Code identifying a specific product or process characteristic to which a measurement applies

D | 2400 | MEA02 | - | 738 ..... **465**

Measurement Reference Identification Code

Code identifying the broad category to which a measurement applies

D | 2400 | MEA01 | - | 737 ..... **465**

Medical Record Number

A unique number assigned to patient by the provider to assist in retrieval of medical records.

D | 2300 | REF02 | - | 127 ..... **241**

Medicare Assignment Code

An indication, used by Medicare or other government programs, that the provider accepted assignment.

D | 2300 | CLM07 | - | 1359 ..... **174**

Medicare Section 4081 Indicator

Code indicating Medicare Section 4081 applies.

D | 2300 | REF02 | - | 127 ..... **225**

Monthly Treatment Count

Number of treatments rendered in the month of service.

D | 2300 | CR207 | - | 380 ..... **255**
D | 2400 | CR207 | - | 380 ..... **419**

Non-Payable Professional Component Billed Amount

Amount of non-payable charges included in the bill related to professional services.

D | 2320 | MOA09 | - | 782 ..... **349**

Note Reference Code

Code identifying the functional area or purpose for which the note applies.

D | 2300 | NTE01 | - | 363 ..... **247**
D | 2400 | NTE01 | - | 363 ..... **488**

Number of Visits

The number of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating the number of visits, i.e., one.

D | 2305 | HSD02 | - | 380 ..... **279**
D | 2400 | HSD02 | - | 380 ..... **492**

Onset Date

Date of onset of indicated patient condition.

D | 2400 | DTP03 | - | 1251 ..... **453**

Onset of Current Illness or Injury Date

Date of onset of indicated patient condition.

D | 2300 | DTP03 | - | 1251 ..... **189**

Order Date

Date the service(s) was ordered.

D | 2300 | DTP03 | - | 1251 ..... **181**
D | 2400 | DTP03 | - | 1251 ..... **444**

Ordering Provider Address Line

Address line of the provider ordering services for the patient.

D | 2420E | N301 | - | 166 ..... **533**
D | 2420E | N302 | - | 166 ..... **533**

Ordering Provider City Name

City of provider ordering services for the patient

D | 2420E | N401 | - | 19 ..... **534**

Ordering Provider Contact Name

Contact person to whom inquiries should be directed at the provider ordering services for the patient.

D | 2420E | PER02 | - | 93 ..... **539**

Ordering Provider First Name

The first name of the provider who ordered or prescribed this service.

D | 2420E | NM104 | - | 1036 ..... **530**

Ordering Provider Identifier

The identifier assigned by the Payer to the provider who ordered or prescribed this service.

D | 2420E | NM109 | - | 67 ..... **531**

Ordering Provider Last Name

The last name of the provider who ordered or prescribed this service.

D | 2420E | NM103 | - | 1035 ..... **530**

Ordering Provider Middle Name

Middle name of the provider ordering services for the patient.

D | 2420E | NM105 | - | 1037 ..... **530**

Ordering Provider Name Additional Text

Additional name infromation for the provider ordering services for the patient.

D | 2420E | N201 | - | 93 ..... **532**

Ordering Provider Name Suffix

Suffix to the name of the provider ordering services for the patient.

D | 2420E | NM107 | - | 1039 ..... **530**

Ordering Provider Postal Zone or ZIP Code

Postal ZIP code of the provider ordering services for the patient.

D | 2420E | N403 | - | 116..... **535**

Ordering Provider Secondary Identifier

Additional identifier for the provider ordering services for the patient.

D | 2420E | REF02 | - | 127 ..... **537**

Ordering Provider State Code

The State Postal Code of the provider who ordered / prescribed this service.

D | 2420E | N402 | - | 156 ..... **535**

Originator Application Transaction Identifier

An identification number that identifies a transaction within the originator's applications system.

H | | BHT03 | - | 127 ..... **64**

Other Insured Additional Identifier

Number providing additional identification of the other insured.

D | 2330A | REF02 | - | 127 ..... **358**

Other Insured Additional Name

Additional name information for the other insured.

D | 2330A | N201 | - | 93 ..... **353**

Other Insured Address Line

Address line of the additional insured individual's mailing address.

D | 2330A | N301 | - | 166 ..... **354**
D | 2330A | N302 | - | 166 ..... **354**

Other Insured Birth Date

The birth date of the additional insured individual.

D | 2320 | DMG02 | - | 1251 ..... **343**

Other Insured City Name

The city name of the additional insured individual.

D | 2330A | N401 | - | 19 ..... **355**

Other Insured First Name

The first name of the additional insured individual.

D | 2330A | NM104 | - | 1036 ..... **351**

Other Insured Gender Code

A code to specify the sex of the additional insured individual.

D | 2320 | DMG03 | - | 1068 ..... **343**

Other Insured Group Name

Name of the group or plan through which the insurance is provided to the other insured.

D | 2320 | SBR04 | - | 93 ..... **320**

Other Insured Identifier

An identification number, assigned by the third party payer, to identify the additional insured individual.

D | 2330A | NM109 | - | 67 ..... **352**

Other Insured Last Name

The last name of the additional insured individual.

D | 2330A | NM103 | - | 1035 ..... **351**

Other Insured Middle Name

The middle name of the additional insured individual.

D | 2330A | NM105 | - | 1037 ..... **351**

Other Insured Name Suffix

The suffix to the name of the additional insured individual.

D | 2330A | NM107 | - | 1039 ..... **352**

Other Insured Postal Zone or ZIP Code

The Postal ZIP code of the additional insured individual's mailing address.

D | 2330A | N403 | - | 116..... **356**

Other Insured State Code

The state code of the additional insured individual's mailing address.

D | 2330A | N402 | - | 156 ..... **356**

Other Payer Additional Name Text

Additional name information for the other payer organization.

D | 2330B | N201 | - | 93 ..... **362**

Other Payer Claim Adjustment Indicator

Indicates the other payer has made a previous claim adjustment to this claim.

D | 2330B | REF02 | - | 127 ..... **373**

Other Payer Contact Name

Name of other payer contact.

D | 2330B | PER02 | - | 93 ..... **364**

Other Payer Covered Amount

Amount determined by other payer to be covered for the claim for coordination of benefits.

D | 2320 | AMT02 | - | 782 ..... **336**

Other Payer Discount Amount

Amount determined by other payer to be subject to discount provisions.

D | 2320 | AMT02 | - | 782 ..... **337**

Other Payer Identification Number

The non-destination (COB) payer's identification number.

D | 2420G | NM109 | - | 67 ..... **551**

Other Payer Last or Organization Name

The name of the other payer organization.

D | 2330B | NM103 | - | 1035 ..... **360**

Other Payer Patient Paid Amount

Amount reported by other payer as paid by the patient

D | 2320 | AMT02 | - | 782 ..... **339**

Other Payer Patient Primary Identifier

The non-destination (COB) payer's patient's primary identification number.

D | 2330C | NM109 | - | 67 ..... **375**

Other Payer Patient Responsibility Amount

Amount determined by other payer to be the amount owed by the patient.

D | 2320 | AMT02 | - | 782 ..... **335**

Other Payer Patient Secondary Identifier

The non-destination (COB) payer's patient's secondary identification number(s).

D | 2330C | REF02 | - | 127 ..... **377**

Other Payer Per Day Limit Amount

Amount determined by other payer to be the maximum payable per day under the contract.

D | 2320 | AMT02 | - | 782 ..... **338**

Other Payer Pre-Tax Claim Total Amount

Total claim amount before applying taxes as reported by other payer.

D | 2320 | AMT02 | - | 782 ..... **341**

Other Payer Primary Identifier

An identification number for the other payer.

D | 2330B | NM109 | - | 67 ..... **361**
D | 2430 | SVD01 | - | 67 ..... **555**

Other Payer Prior Authorization or Referral Number

The non-destination (COB) payer's prior authorization or referral number.

D | 2330B | REF02 | - | 127 ..... **371**
D | 2420G | REF02 | - | 127 ..... **552**

Other Payer Purchased Service Provider Identifier

The non-destination (COB) payer's purchased service provider identifier.

D | 2330F | REF02 | - | 127 ..... **389**

Other Payer Referring Provider Identifier

The non-destination (COB) payer's referring provider identifier.

D | 2330D | REF02 | - | 127 ..... **381**

Other Payer Rendering Provider Secondary Identifier

The non-destination (COB) payer's rendering provider identifier.

D | 2330E | REF02 | - | 127 ..... **385**

Other Payer Secondary Identifier

Additional identifier for the other payer organization

D | 2330B | REF02 | - | 127 ..... **369**

Other Payer Service Facility Location Identifier

The non-destination (COB) payer's service facility location identifier.

D | 2330G | REF02 | - | 127 ..... **393**

Other Payer Supervising Provider Identifier

The non-destination (COB) payer's supervising provider identifier.

D | 2330H | REF02 | - | 127 ..... **397**

Other Payer Tax Amount

Amount of taxes related to the claim as determined By other payer.

D | 2320 | AMT02 | - | 782 ..... **340**

Oxygen Flow Rate

The oxygen flow rate in liters per minute.

D | 2400 | REF02 | - | 127 ..... **481**

Oxygen Saturation Quantity

The oxygen saturation (oximetry) test results.

D | 2400 | CR511 | - | 380 ..... **425**

Oxygen Saturation Test Date

Date patient received oxygen saturation test.

D | 2400 | DTP03 | - | 1251 ..... **450**

Oxygen Test Condition Code

Code indicating the conditions under which a patient was tested.

D | 2400 | CR512 | - | 1349 ..... **425**

Oxygen Test Findings Code

Code indicating the findings of oxygen tests performed on a patient.

D | 2400 | CR513 | - | 1350 ..... **425**
D | 2400 | CR514 | - | 1350 ..... **425**
D | 2400 | CR515 | - | 1350 ..... **426**

Paid Service Unit Count

Units of service paid by the payer for coordination of benefits.

D | 2430 | SVD05 | - | 380 ..... **557**

Participation Agreement

Code indicating a participating claim submitted by a non-participating provider.

D | 2300 | CLM16 | - | 1360 ..... **178**

Patient Account Number

Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim.

D | 2300 | CLM01 | - | 1028 ..... **171**

Patient Additional Name

Additional name information for the patient.

D | 2010CA | N201 | - | 93 ..... **160**

Patient Address Line

Address line of the street mailing address of the patient.

D	2010CA	N301		-	166	**161**
D	2010CA	N302		-	166	**161**

Patient Amount Paid

The amount the provider has received from the patient (or insured) toward payment of this claim.

D	2300	AMT02		-	782	**220**

Patient Birth Date

Date of birth of the patient.

D	2010CA	DMG02		-	1251	**165**

Patient City Name

The city name of the patient.

D	2010CA	N401		-	19	**162**

Patient Condition Code

Code indicating the condition of the patient.

D	2300	CR208		-	1342	**255**
D	2400	CR208		-	1342	**419**

Patient Condition Description

Free-form description of the patient's condition.

D	2300	CR210		-	352	**256**
D	2300	CR211		-	352	**256**
D	2400	CR210		-	352	**420**
D	2400	CR211		-	352	**420**

Patient Death Date

Date of the patient's death.

D	2000C	PAT06		-	1251	**156**

Patient First Name

The first name of the individual to whom the services were provided.

D	2010CA	NM104		-	1036	**158**

Patient Gender Code

A code indicating the sex of the patient.

D	2010CA	DMG03		-	1068	**165**

Patient Last Name

The last name of the individual to whom the services were provided.

D	2010CA	NM103		-	1035	**158**
D	2330C	NM103		-	1035	**375**

Patient Middle Name

The middle name of the individual to whom the services were provided.

D	2010CA	NM105		-	1037	**158**

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

D	2010CA	NM107		-	1039	**158**

Patient Postal Zone or ZIP Code

The ZIP Code of the patient.

D	2010CA	N403		-	116	**163**

Patient Primary Identifier

Identifier assigned by the payer to identify the patient

D	2010CA	NM109		-	67	**159**

Patient Secondary Identifier

Additional identifier assigned to the patient by the payer.

D	2010CA	REF02		-	127	**167**

Patient Signature Source Code

Code indication how the patient/subscriber authorization signatures were obtained and how they are being retained by the provider.

D	2300	CLM10		-	1351	**176**
D	2320	OI04		-	1351	**345**

Patient State Code

The State Postal Code of the patient.

D	2010CA	N402		-	156	**162**

Patient Weight

Weight of the patient at time of treatment or transport.

D	2000B	PAT08		-	81	**115**
D	2000C	PAT08		-	81	**156**
D	2300	CR102		-	81	**249**
D	2400	CR102		-	81	**413**

Pay-to Provider Additional Name

Additional name information for the provider to receive payment.

D	2010AB	N201		-	93	**102**

Pay-to Provider Address Line

Address line of the provider to receive payment

D	2010AB	N301		-	166	**103**
D	2010AB	N302		-	166	**103**

Pay-to Provider City Name

City name of the provider to receive payment.

D	2010AB	N401		-	19	**104**

Pay-to Provider First Name

First name of the provider to receive payment.

D	2010AB	NM104		-	1036	**100**

Pay-to Provider Identifier

Identification number for the provider or organization that will receive payment.

D | 2010AB | NM109 | - | 67 ..... **101**
D | 2010AB | REF02 | - | 127 ..... **107**

Pay-to Provider Last or Organizational Name

Last or organizational name of the provider to receive payment.

D | 2010AB | NM103 | - | 1035 ..... **100**

Pay-to Provider Middle Name

The middle name of the pay-to provider.

D | 2010AB | NM105 | - | 1037 ..... **100**

Pay-to Provider Name Suffix

The suffix, including generation, of the provider that will receive payment.

D | 2010AB | NM107 | - | 1039 ..... **101**

Pay-to Provider Postal Zone or ZIP Code

Postal ZIP code of the provider to receive payment

D | 2010AB | N403 | - | 116..... **105**

Pay-to Provider State Code

State of the provider to receive payment.

D | 2010AB | N402 | - | 156 ..... **104**

Payer Additional Identifier

Additional identifier for the payer.

D | 2010BB | REF02 | - | 127 ..... **138**

Payer Additional Name

Additional name information for the payer.

D | 2010BB | N201 | - | 93 ..... **133**

Payer Address Line

Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N301 | - | 166 ..... **134**
D | 2010BB | N302 | - | 166 ..... **134**

Payer City Name

The City Name of the Payer's claim mailing address for this particular payer ID and claim office.

D | 2010BB | N401 | - | 19 ..... **135**

Payer Identifier

Number identifying the payer organization.

D | 2010BB | NM109 | - | 67 ..... **131**

Payer Name

Name identifying the payer organization.

D | 2010BB | NM103 | - | 1035 ..... **131**
D | 2420G | NM103 | - | 1035 ..... **550**

Payer Paid Amount

The amount paid by the payer on this claim.

D | 2320 | AMT02 | - | 782 ..... **332**

Payer Postal Zone or ZIP Code

The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N403 | - | 116..... **136**

Payer Responsibility Sequence Number Code

Code identifying the insurance carrier's level of responsibility for a payment of a claim

D | 2000B | SBR01 | - | 1138.....**110**
D | 2320 | SBR01 | - | 1138..... **319**

Payer State Code

State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.

D | 2010BB | N402 | - | 156 ..... **136**

Place of Service Code

The code that identifies where the service was performed.

D | 2400 | SV105 | - | 1331 ..... **404**

Policy Compliance Code

The code that specifies policy compliance.

D | 2300 | HCP14 | - | 1526 ..... **274**
D | 2400 | HCP14 | - | 1526 ..... **499**

Postage Claimed Amount

Cost of postage used to provide service or to process associated paper work.

D | 2400 | AMT02 | - | 782 ..... **486**

Pregnancy Indicator

A yes/no code indicating whether a patient is pregnant.

D | 2000B | PAT09 | - | 1073 .....**116**
D | 2000C | PAT09 | - | 1073 ..... **156**

Prescription Date

The date the prescription was issued by the referring physician.

D | 2300 | DTP03 | - | 1251 ..... **200**

Prescription Number

The unique identification number assigned by the pharmacy or supplier to the prescription.

D	2400	SV401	-	127	.....	**409**

Pricing Methodology

Pricing methodology at which the claim or line item has been priced or repriced.

D	2300	HCP01	-	1473	.....	**272**
D	2400	HCP01	-	1473	.....	**496**

Prior Authorization or Referral Number

A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization, or that a referral for services has been approved.

D	2300	REF02	-	127	.....	**228**
D	2400	REF02	-	127	.....	**470**

Procedure Code

Code identifying the procedure, product or service.

D	2400	SV101	C003-2	234	.....	**401**
D	2400	HCP10	-	234	.....	**498**
D	2430	SVD03	C003-2	234	.....	**556**

Procedure Code Description

Description clarifying the Product/Service Procedure Code and related data elements.

D	2430	SVD03	C003-7	352	.....	**557**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

D	2400	SV101	C003-3	1339	.....	**401**
D	2400	SV101	C003-4	1339	.....	**402**
D	2400	SV101	C003-5	1339	.....	**402**
D	2400	SV101	C003-6	1339	.....	**402**
D	2430	SVD03	C003-3	1339	.....	**556**
D	2430	SVD03	C003-4	1339	.....	**556**
D	2430	SVD03	C003-5	1339	.....	**556**
D	2430	SVD03	C003-6	1339	.....	**556**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

D	2400	SV101	C003-1	235	.....	**401**
D	2400	HCP09	-	235	.....	**498**
D	2430	SVD03	C003-1	235	.....	**555**

Property Casualty Claim Number

Identification number for property casualty claim associated with the services identified on the bill.

D	2010BA	REF02	-	127	.....	**129**
D	2010CA	REF02	-	127	.....	**169**

Provider Code

Code identifying the type of provider.

D	2000A	PRV01	-	1221	.....	**79**
D	2310A	PRV01	-	1221	.....	**285**
D	2310B	PRV01	-	1221	.....	**293**
D	2420A	PRV01	-	1221	.....	**504**
D	2420F	PRV01	-	1221	.....	**544**

Provider Taxonomy Code

Code designating the provider type, classification, and specialization.

D	2000A	PRV03	-	127	.....	**80**
D	2310A	PRV03	-	127	.....	**286**
D	2310B	PRV03	-	127	.....	**294**
D	2420A	PRV03	-	127	.....	**505**
D	2420F	PRV03	-	127	.....	**545**

Provider or Supplier Signature Indicator

An indicater that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.

D	2300	CLM06	-	1073	.....	**174**

Purchased Service Charge Amount

The charge for the purchased service.

D	2400	PS102	-	782	.....	**490**

Purchased Service Provider Identifier

The provider number of the entity from which service was purchased.

D	2310C	NM109	-	67	.....	**300**
D	2400	PS101	-	127	.....	**489**
D	2420B	NM109	-	67	.....	**511**

Purchased Service Provider Name

The name of the provider of the purchased service.

D	2330F	NM103	-	1035	.....	**387**

Purchased Service Provider Secondary Identifier

Additional identifier for the provider of purchased services.

D	2310C	REF02	-	127	.....	**302**
D	2420B	REF02	-	127	.....	**513**

Quantity Qualifier

Code specifying the type of quantity

D	2400	QTY01	-	673	.....	**462**

Question Number/Letter

Identifies the question or letter number.

D	2440	FRM01	-	350		**570**

Question Response

A yes/no question response.

D	2440	FRM02	-	1073		**570**
D	2440	FRM03	-	127		**571**
D	2440	FRM04	-	373		**571**
D	2440	FRM05	-	332		**571**

Receiver Additional Name

Additional name information for the receiver.

H	1000B	N201	-	93		**76**

Receiver Name

Name of organization receiving the transaction.

H	1000B	NM103	-	1035		**75**

Receiver Primary Identifier

Primary identification number for the receiver of the transaction.

H	1000B	NM109	-	67		**75**

Reference Identification Qualifier

Code qualifying the reference identification

H		REF01	-	128		**66**
D	2000A	PRV02	-	128		**80**
D	2010AA	REF01	-	128		**92**
D	2010AA	REF01	-	128		**94**
D	2010AB	REF01	-	128		**106**
D	2010BA	REF01	-	128		**126**
D	2010BA	REF01	-	128		**128**
D	2010BB	REF01	-	128		**137**
D	2010BD	REF01	-	128		**150**
D	2010CA	REF01	-	128		**166**
D	2010CA	REF01	-	128		**168**
D	2300	REF01	-	128		**222**
D	2300	REF01	-	128		**224**
D	2300	REF01	-	128		**226**
D	2300	REF01	-	128		**228**
D	2300	REF01	-	128		**230**
D	2300	REF01	-	128		**232**
D	2300	REF01	-	128		**233**
D	2300	REF01	-	128		**235**
D	2300	REF01	-	128		**236**
D	2300	REF01	-	128		**239**
D	2300	REF01	-	128		**240**
D	2300	REF01	-	128		**241**
D	2300	REF01	-	128		**242**
D	2310A	PRV02	-	128		**286**
D	2310A	REF01	-	128		**288**
D	2310B	PRV02	-	128		**294**
D	2310B	REF01	-	128		**296**
D	2310C	REF01	-	128		**301**
D	2310D	REF01	-	128		**310**
D	2310E	REF01	-	128		**316**
D	2330A	REF01	-	128		**357**
D	2330B	REF01	-	128		**368**
D	2330B	REF01	-	128		**370**
D	2330B	REF01	-	128		**373**
D	2330C	REF01	-	128		**376**
D	2330D	REF01	-	128		**380**
D	2330E	REF01	-	128		**384**
D	2330F	REF01	-	128		**388**
D	2330G	REF01	-	128		**392**
D	2330H	REF01	-	128		**396**
D	2400	REF01	-	128		**468**
D	2400	REF01	-	128		**469**
D	2400	REF01	-	128		**470**
D	2400	REF01	-	128		**472**
D	2400	REF01	-	128		**474**
D	2400	REF01	-	128		**475**
D	2400	REF01	-	128		**477**
D	2400	REF01	-	128		**478**
D	2400	REF01	-	128		**479**
D	2400	REF01	-	128		**480**
D	2400	REF01	-	128		**483**
D	2420A	PRV02	-	128		**504**
D	2420A	REF01	-	128		**507**
D	2420B	REF01	-	128		**512**
D	2420C	REF01	-	128		**521**
D	2420D	REF01	-	128		**527**
D	2420E	REF01	-	128		**536**
D	2420F	PRV02	-	128		**545**
D	2420F	REF01	-	128		**547**
D	2420G	REF01	-	128		**552**

Referral Date

Date of referral.

D	2300	DTP03	-	1251		**185**
D	2400	DTP03	-	1251		**439**

Referring CLIA Number

Referring Clinical Laboratory Improvement Amendment (CLIA) facility identification.

D	2400	REF02	-	127		**477**

Referring Provider First Name

The first name of provider who referred the patient to the provider of service on this claim.

D	2310A	NM104	-	1036		**283**
D	2420F	NM104	-	1036		**542**

Referring Provider Identifier

The identification number for the referring physician.

D	2310A	NM109	-	67		**284**
D	2420F	NM109	-	67		**543**

Referring Provider Last Name

The Last Name of Provider who referred the patient to the provider of service on this claim.

D	2310A	NM103	-	1035		**283**
D	2330D	NM103	-	1035		**379**
D	2420F	NM103	-	1035		**542**

Referring Provider Middle Name

Middle name of the provider who is referring patient for care.

D	2310A	NM105	-	1037		**284**
D	2420F	NM105	-	1037		**543**

Referring Provider Name Additional Text

Additional name information identifying the referring provider.

D	2310A	N201		-	93	**287**
D	2420F	N201		-	93	**546**

Referring Provider Name Suffix

Suffix to the name of the provider referring the patient for care.

D	2310A	NM107		-	1039	**284**
D	2420F	NM107		-	1039	**543**

Referring Provider Secondary Identifier

Additional identification number for the provider referring the patient for service.

D	2310A	REF02		-	127	**289**
D	2420F	REF02		-	127	**548**

Reimbursement Rate

Rate used when payment is based upon a percentage of applicable charges.

D	2320	MOA01		-	954	**347**

Reject Reason Code

Code assigned by issuer to identify reason for rejection

D	2300	HCP13		-	901	**274**
D	2400	HCP13		-	901	**499**

Related Causes Code

Code identifying an accompanying cause of an illness, injury, or an accident.

D	2300	CLM11	C024-1		1362	**176**
D	2300	CLM11	C024-2		1362	**177**
D	2300	CLM11	C024-3		1362	**177**

Related Hospitalization Admission Date

The date the patient was admitted for inpatient care related to current service.

D	2300	DTP03		-	1251	**209**

Related Hospitalization Discharge Date

The date the patient was discharged from the inpatient care referenced in the applicable hospitalization or hospice date.

D	2300	DTP03		-	1251	**211**

Release of Information Code

Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.

D	2300	CLM09		-	1363	**175**
D	2320	OI06		-	1363	**345**

Remark Code

Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list.

D	2320	MOA03		-	127	**348**
D	2320	MOA04		-	127	**348**
D	2320	MOA05		-	127	**348**
D	2320	MOA06		-	127	**348**
D	2320	MOA07		-	127	**349**

Rendering Provider First Name

The first name of the provider who performed the service.

D	2310B	NM104		-	1036	**291**
D	2420A	NM104		-	1036	**502**

Rendering Provider Identifier

The identifier assigned by the Payor to the provider who performed the service.

D	2310B	NM109		-	67	**292**
D	2420A	NM109		-	67	**503**

Rendering Provider Last or Organization Name

The last name or organization of the provider who performed the service

D	2310B	NM103		-	1035	**291**
D	2330E	NM103		-	1035	**383**
D	2420A	NM103		-	1035	**502**

Rendering Provider Middle Name

Middle name of the provider who has provided the services to the patient.

D	2310B	NM105		-	1037	**292**
D	2420A	NM105		-	1037	**503**

Rendering Provider Name Additional Text

Additional name information identifying the rendering provider.

D	2310B	N201		-	93	**295**
D	2420A	N201		-	93	**506**

Rendering Provider Name Suffix

Name suffix of the provider who has provided the services to the patient.

D	2310B	NM107		-	1039	**292**
D	2420A	NM107		-	1039	**503**

Rendering Provider Secondary Identifier

Additional identifier for the provider providing care to the patient.

D	2310B	REF02		-	127	**297**
D	2420A	REF02		-	127	**508**

Repriced Allowed Amount

The maximum amount determined by the repricer as being allowable under the provisions of the contract prior to the determination of the actual payment.

D | 2300 | HCP02 | - | 782 ..... **272**
D | 2400 | HCP02 | - | 782 ..... **496**

Repriced Approved Ambulatory Patient Group Amount

Amount of payment by the repricer for the referenced Ambulatory Patient Group.

D | 2300 | HCP07 | - | 782 ..... **273**
D | 2400 | HCP07 | - | 782 ..... **497**

Repriced Approved Ambulatory Patient Group Code

Identifier for Ambulatory Patient Group assigned to the claim by the repricer.

D | 2300 | HCP06 | - | 127 ..... **273**
D | 2400 | HCP06 | - | 127 ..... **497**

Repriced Approved Service Unit Count

Number of service units approved by pricing or repricing entity.

D | 2400 | HCP12 | - | 380 ..... **499**

Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify the claim.

D | 2300 | REF02 | - | 127 ..... **233**

Repriced Line Item Reference Number

Identification number of a line item repriced by a third party or prior payer.

D | 2400 | REF02 | - | 127 ..... **468**

Repriced Saving Amount

The amount of savings related to Third Party Organization claims.

D | 2300 | HCP03 | - | 782 ..... **273**
D | 2400 | HCP03 | - | 782 ..... **497**

Repricing Organization Identifier

Reference or identification number of the repricing organization.

D | 2300 | HCP04 | - | 127 ..... **273**
D | 2400 | HCP04 | - | 127 ..... **497**

Repricing Per Diem or Flat Rate Amount

Amount used to determine the flat rate or per diem price by the repricing organization.

D | 2300 | HCP05 | - | 118..... **273**
D | 2400 | HCP05 | - | 118..... **497**

Responsible Party Additional Name

Additional name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | N201 | - | 93 ..... **142**

Responsible Party Address Line

Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | N301 | - | 166 ..... **143**
D | 2010BC | N302 | - | 166 ..... **143**

Responsible Party City Name

City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | N401 | - | 19 ..... **144**

Responsible Party First Name

First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | NM104 | - | 1036 ..... **140**

Responsible Party Last or Organization Name

Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | NM103 | - | 1035 ..... **140**

Responsible Party Middle Name

Middle name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | NM105 | - | 1037 ..... **141**

Responsible Party Postal Zone or ZIP Code

Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | N403 | - | 116..... **145**

Responsible Party State Code

State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations.

D | 2010BC | N402 | - | 156 ..... **144**

Responsible Party Suffix Name

Suffix for name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BC | NM107 | - | 1039 ..... **141**

Round Trip Purpose Description

Free-form description of the purpose of the ambulance transport round trip.

D | 2300 | CR109 | - | 352 ..... **250**
D | 2400 | CR109 | - | 352 ..... **414**

Sales Tax Amount

Amount of sales tax attributable to the referenced Service.

D | 2400 | AMT02 | - | 782 ..... **484**

Service Authorization Exception Code

Code identifying the service authorization exception.

D | 2300 | REF02 | - | 127 ..... **223**

Service Date

Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.

D | 2400 | DTP03 | - | 1251 ..... **436**

Service Facility Location Secondary Identifier

Secondary identifier for service facility location.

D | 2420C | REF02 | - | 127 ..... **522**

Service Facility Name

Name of the service facility.

D | 2330G | NM103 | - | 1035 ..... **391**

Service Line Paid Amount

Amount paid by the indicated payer for a service line

D | 2430 | SVD02 | - | 782 ..... **555**

Service Unit Count

The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS codes, revenue code or procedure code.

D | 2400 | SV104 | - | 380 ..... **403**

Ship, Delivery or Calendar Pattern Code

The time delivery pattern for the services.

D | 2305 | HSD07 | - | 678 ..... **280**
D | 2400 | HSD07 | - | 678 ..... **493**

Shipped Date

Date product shipped.

D | 2400 | DTP03 | - | 1251 ..... **451**

Similar Illness or Symptom Date

Date of onset of a similar illness or symptom.

D | 2300 | DTP03 | - | 1251 ..... **193**
D | 2400 | DTP03 | - | 1251 ..... **461**

Special Program Indicator

A code indicating the Special Program under which the services rendered to the patient were performed.

D | 2300 | CLM12 | - | 1366 ..... **178**

Stretcher Purpose Description

Free-form description of the purpose of the use of a stretcher during ambulance service.

D | 2300 | CR110 | - | 352 ..... **250**
D | 2400 | CR110 | - | 352 ..... **414**

Subluxation Level Code

Code identifying the specific level of subluxation.

D | 2300 | CR203 | - | 1367 ..... **252**
D | 2300 | CR204 | - | 1367 ..... **253**
D | 2400 | CR203 | - | 1367 ..... **416**
D | 2400 | CR204 | - | 1367 ..... **417**

Submitter Contact Name

Name of the person at the submitter organization to whom inquiries about the transaction should be directed.

H | 1000A | PER02 | - | 93 ..... **72**

Submitter First Name

The first name of the person submitting the transaction or receiving the transaction, as identified by the preceding identification code.

H | 1000A | NM104 | - | 1036 ..... **68**

Submitter Identifier

Code or number identifying the entity submitting the claim.

H | 1000A | NM109 | - | 67 ..... **69**

Submitter Last or Organization Name

The last name or the organizational name of the entity submitting the transaction

H | 1000A | NM103 | - | 1035 ..... **68**

Submitter Middle Name

The middle name of the person submitting the transaction

H | 1000A | NM105 | - | 1037 ..... **68**

Subscriber Address Line

Address line of the current mailing address of the insured individual or subscriber to the coverage.

D | 2010BA | N301 | - | 166 ..... **121**
D | 2010BA | N302 | - | 166 ..... **121**

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG02 | - | 1251 ..... **125**

Subscriber City Name

The City Name of the insured individual or subscriber to the coverage

D | 2010BA | N401 | - | 19 ..... **122**

Subscriber First Name

The first name of the insured individual or subscriber to the coverage

D | 2010BA | NM104 | - | 1036 .....**118**

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG03 | - | 1068 ..... **125**

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage

D | 2010BA | NM103 | - | 1035 .....**118**

Subscriber Middle Name

The middle name of the subscriber to the indicated coverage or policy.

D | 2010BA | NM105 | - | 1037 .....**118**

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

D | 2010BA | NM107 | - | 1039 .....**118**

Subscriber Postal Zone or ZIP Code

The ZIP Code of the insured individual or subscriber to the coverage

D | 2010BA | N403 | - | 116..... **123**

Subscriber Primary Identifier

Primary identification number of the subscriber to the coverage.

D | 2010BA | NM109 | - | 67 .....**119**

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage

D | 2010BA | N402 | - | 156 ..... **123**

Subscriber Supplemental Description

Text information clarifying subscriber additional information

D | 2010BA | N201 | - | 93 ..... **120**

Subscriber Supplemental Identifier

Identifies another or additional distinguishing code number associated with the subscriber.

D | 2010BA | REF02 | - | 127 ..... **127**

Supervising Provider First Name

The First Name of the Provider who supervised the rendering of a service on this claim.

D | 2310E | NM104 | - | 1036 ..... **313**
D | 2420D | NM104 | - | 1036 ..... **524**

Supervising Provider Identifier

The Identification Number for the Supervising Provider.

D | 2310E | NM109 | - | 67 ..... **314**
D | 2420D | NM109 | - | 67 ..... **525**

Supervising Provider Last Name

The Last Name of the Provider who supervised the rendering of a service on this claim.

D | 2310E | NM103 | - | 1035 ..... **313**
D | 2330H | NM103 | - | 1035 ..... **395**
D | 2420D | NM103 | - | 1035 ..... **524**

Supervising Provider Middle Name

Middle name of the provider supervising care rendered to the patient.

D | 2310E | NM105 | - | 1037 ..... **313**
D | 2420D | NM105 | - | 1037 ..... **524**

Supervising Provider Name Additional Text

Additional name information of the provider supervising care rendered to the patient.

D	2310E	N201	-	93		**315**
D	2420D	N201	-	93		**526**

Supervising Provider Name Suffix

Suffix to the name of the provider supervising care rendered to the patient.

D	2310E	NM107	-	1039		**313**
D	2420D	NM107	-	1039		**524**

Supervising Provider Secondary Identifier

Additional identifier for the provider supervising care rendered to the patient.

D	2310E	REF02	-	127		**317**
D	2420D	REF02	-	127		**528**

Terms Discount Percentage

Discount percentage available to the payer for payment within a specific time period.

D	2300	CN105	-	338		**218**
D	2400	CN105	-	338		**467**

Test Performed Date

The date the patient was tested for arterial blood. gas and/or oxygen saturation on room air.

D	2400	DTP03	-	1251		**448**

Test Results

If tests are performed under other conditions such as oxygen, give test results and information necessary for interpreting the tests and why performed under these conditions.

D	2400	MEA03	-	739		**465**

Total Claim Charge Amount

The sum of all charges included within this claim.

D	2300	CLM02	-	782		**172**

Total Purchased Service Amount

Amount of charges associated with the claim attributable to purchased services

D	2300	AMT02	-	782		**221**

Total Visits Rendered Count

Total visits on this billl rendered prior to re-certification date.

D	2305	CR702	-	1470		**277**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

D		SE01	-	96		**572**

Transaction Set Control Number

The unique identification number within a transaction set.

H		ST02	-	329		**62**
D		SE02	-	329		**572**

Transaction Set Creation Date

Identifies the date the submitter created the transaction

H		BHT04	-	373		**64**

Transaction Set Creation Time

Time file is created for transmission.

H		BHT05	-	337		**65**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H		ST01	-	143		**62**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

H		BHT02	-	353		**64**

Transmission Type Code

Code identifying the type of transaction or transmission included in the transaction set.

H		REF02	-	127		**66**

Transport Distance

Distance traveled during the ambulance transport.

D	2300	CR106	-	380		**250**
D	2400	CR106	-	380		**414**

Treatment Count

Total number of treatments in the series.

D	2300	CR202	-	380		**252**
D	2400	CR202	-	380		**416**

Treatment Period Count

The number of time periods during which treatment will be provided to patient.

D	2300	CR206	-	380		**255**
D	2400	CR206	-	380		**419**
D	2400	CR502	-	380		**424**

Treatment Series Number

Number this treatment is in the series of services.

D	2300	CR201	-	609		**252**

D | 2400 | CR201 | - | 609 ..... **416**

Unit or Basis for Measurement Code

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.

D | 2000B | PAT07 | - | 355 ..... **115**
D | 2000C | PAT07 | - | 355 ..... **156**
D | 2300 | CR101 | - | 355 ..... **249**
D | 2300 | CR105 | - | 355 ..... **250**
D | 2300 | CR205 | - | 355 ..... **254**
D | 2400 | SV103 | - | 355 ..... **403**
D | 2400 | CR101 | - | 355 ..... **413**
D | 2400 | CR105 | - | 355 ..... **414**
D | 2400 | CR205 | - | 355 ..... **418**
D | 2400 | CR302 | - | 355 ..... **422**
D | 2400 | HCP11 | - | 355 ..... **498**

Universal Product Number

Industry standard code identifying supplies and materials.

D | 2400 | REF02 | - | 127 ..... **483**

Visits

The unit for home health visitations. Example: One visit every three days for 21 days. This element qualifies that the data is communicating visits.

D | 2305 | HSD01 | - | 673 ..... **279**
D | 2400 | HSD01 | - | 673 ..... **492**

Work Return Date

Date patient was or is able to return to the patient's normal occupation or to a similar or substitute occupation.

D | 2300 | DTP03 | - | 1251 ..... **207**

X-ray Availability Indicator

Indicates if X-Rays are on file for chiropractor spinal manipulation.

D | 2300 | CR212 | - | 1073 ..... **256**
D | 2400 | CR212 | - | 1073 ..... **420**

F NSF Mapping

Truncation: Because payer processing is often predicated on flat file data content and field lengths, payers will accept the maximum ANSI ASC X12 field lengths established by the implementation guide, but may only process the maximum flat file field lengths, thus resulting in some truncation.

Mappings: The 837 is a variable length record designed for wire transmissions and is not suitable for use in an application program. Therefore mappings to and from the national standard format flat file have been provided to assist users in the translation of the 837 for applications system processing. The requirement to engage in this standard flat file translation step may vary by payer.

F.1 X12N-NSF Map

This is a list of all the NSF 3.01 fields referred to in the body of the 837 professional

implementation guide listed by: **Loop ID | Reference Designator | Composite ID-Composite Sequence | Data Element Number / Code Value**

AA0-02.0
1000A | NM109 . . . . . **69**
AA0-05.0
BHT03 . . . . . **64**
AA0-06.0
1000A | NM103 . . . . . **68**
AA0-13.0
1000A | PER02 . . . . . **72**
AA0-14.0
1000A | PER04 . . . . . **72**
AA0-15.0
BHT04 . . . . . **64**
AA0-16.0
BHT05 . . . . . **65**
AA0-17.0
1000B | NM109 . . . . . **75**
AA0-23.0
BHT02 . . . . . **64**
BA0-02.0
2010AA | NM109 . . . . . **86**
BA0-02.0
2010AB | NM109 . . . . . **101**
BA0-02.0
2010AB | REF02 . . . . . **107**
BA0-02.0
2010AA | REF02 . . . . . **92**
BA0-06.0
2010AA | NM109 . . . . . **86**
BA0-06.0
2010AA | REF02 . . . . . **92**
BA0-06.0
2010AB | NM109 . . . . . **101**
BA0-06.0
2010AB | REF02 . . . . . **107**
BA0-08.0
2010AA | REF02 . . . . . **92**
BA0-09.0
2010AA | NM109 . . . . . **86**
BA0-09.0
2010AB | NM109 . . . . . **101**
BA0-09.0
2010AB | REF02 . . . . . **107**
BA0-10.0
2010AA | NM109 . . . . . **86**
BA0-10.0
2010AA | REF02 . . . . . **92**
BA0-10.0
2010AB | NM109 . . . . . **101**
BA0-10.0
2010AB | REF02 . . . . . **107**
BA0-12.0
2010AA | NM109 . . . . . **86**
BA0-12.0
2010AA | REF02 . . . . . **92**
BA0-12.0
2010AB | NM109 . . . . . **101**
BA0-12.0
2010AB | REF02 . . . . . **107**
BA0-13.0
2010AA | NM109 . . . . . **86**
BA0-13.0
2010AA | REF02 . . . . . **92**
BA0-13.0
2010AB | NM109 . . . . . **101**

BA0-13.0
2010AB | REF02 . . . . . **107**

BA0-14.0
2010AA | NM109 . . . . . **86**

BA0-14.0
2010AA | REF02 . . . . . **92**

BA0-14.0
2010AB | NM109 . . . . . **101**

BA0-14.0
2010AB | REF02 . . . . . **107**

BA0-15.0
2010AA | NM109 . . . . . **86**

BA0-15.0
2010AA | REF02 . . . . . **92**

BA0-15.0
2010AB | NM109 . . . . . **101**

BA0-15.0
2010AB | REF02 . . . . . **107**

BA0-16.0
2010AA | NM109 . . . . . **86**

BA0-16.0
2010AA | REF02 . . . . . **92**

BA0-16.0
2010AB | NM109 . . . . . **101**

BA0-16.0
2010AB | REF02 . . . . . **107**

BA0-17.0
2010AA | NM109 . . . . . **86**

BA0-17.0
2010AA | REF02 . . . . . **92**

BA0-17.0
2010AB | NM109 . . . . . **101**

BA0-17.0
2010AB | REF02 . . . . . **107**

BA0-18.0 or BA0-19.0
2010AA | NM103 . . . . . **85**

BA0-18.0 or BA0-19.0
2010AB | NM103 . . . . . **100**

BA0-20.0
2010AA | NM104 . . . . . **85**

BA0-20.0
2010AB | NM104 . . . . . **100**

BA0-21.0
2010AA | NM105 . . . . . **85**

BA0-21.0
2010AB | NM105 . . . . . **100**

BA0-22.0
2000A | PRV03 . . . . . **80**

BA0-24.0
2010AA | NM109 . . . . . **86**

BA0-24.0
2010AA | REF02 . . . . . **92**

BA0-24.0
2010AB | NM109 . . . . . **101**

BA0-24.0
2010AB | REF02 . . . . . **107**

BA1-02.0
2010AA | NM109 . . . . . **86**

BA1-02.0
2010AB | NM109 . . . . . **101**

BA1-02.0
2010AB | REF02 . . . . . **107**

BA1-02.0
2010AA | REF02 . . . . . **92**

BA1-07.0
2010AA | N301 . . . . . **88**

BA1-07.0
2010AB | N301 . . . . . **103**

BA1-08.0
2010AA | N302 . . . . . **88**

BA1-08.0
2010AB | N302 . . . . . **103**

BA1-09.0
2010AA | N401 . . . . . **89**

BA1-09.0
2010AB | N401 . . . . . **104**

BA1-10.0
2010AA | N402 . . . . . **90**

BA1-10.0
2010AB | N402 . . . . . **104**

BA1-11.0
2010AA | N403 . . . . . **90**

BA1-11.0
2010AB | N403 . . . . . **105**

BA1-12.0
2010AA | PER04 . . . . . **97**

BA1-13.0
2010AB | N301 . . . . . **103**

BA1-13.0
2010AA | N301 . . . . . **88**

BA1-14.0
2010AB | N302 . . . . . **103**

BA1-14.0
2010AA | N302 . . . . . **88**

BA1-15.0
2010AB | N401 . . . . . **104**

BA1-15.0
2010AA | N401 . . . . . **89**

BA1-16.0
2010AB | N402 . . . . . **104**

BA1-16.0
2010AA | N402 . . . . . **90**

BA1-17.0
2010AB | N403 . . . . . **105**

BA1-17.0
2010AA | N403 . . . . . **90**

BA1-18.0
2010AA | PER04 . . . . . **97**

CA0-03.0
2300 | CLM01 . . . . . **171**

CA0-04.0
2010BA | NM103 . . . . . **118**

CA0-04.0
2010CA | NM103 . . . . . **158**

CA0-05.0
2010BA | NM104 . . . . . **118**

CA0-05.0
2010CA | NM104 . . . . . **158**

CA0-06.0
2010BA | NM105 . . . . . **118**

CA0-06.0
2010CA | NM105 . . . . . **158**

CA0-07.0
2010BA | NM107 . . . . . **118**

CA0-07.0
2010CA | NM107 . . . . . **158**

CA0-08.0
2010BA | DMG02 . . . . . **125**

CA0-08.0
2010CA | DMG02 . . . . . **165**

CA0-09.0
2010BA | DMG03 . . . . . **125**

CA0-09.0
2010CA | DMG03 . . . . . **165**

CA0-11.0
2010BA | N301 . . . . . **121**

CA0-11.0
2010CA | N301 . . . . . **161**

CA0-12.0
2010BA | N302 . . . . . **121**

CA0-12.0
2010CA | N302 . . . . . **161**

CA0-13.0
2010BA | N401 . . . . . **122**

CA0-13.0
2010CA | N401 . . . . . **162**

CA0-14.0
2010BA | N402 . . . . . **123**

CA0-14.0
2010CA | N402 . . . . . **162**

CA0-15.0
2010BA | N403 . . . . . **123**

CA0-15.0
2010CA | N403 . . . . . **163**

CA0-21.0
2000B | PAT06 . . . . . **115**

CA0-21.0
2000C | PAT06 . . . . . **156**

CA0-23.0 (B)
2000B | SBR09 | 1032/WC **113**

CA0-23.0 (C)
2000B | SBR09 | 1032/MB **113**

CA0-23.0 (D)
2000B | SBR09 | 1032/MC **113**

CA0-23.0 (E)
2000B | SBR09 | 1032/OF **113**

CA0-23.0 (F)
2000B | SBR09 | 1032/CI **113**

CA0-23.0 (G)
2000B | SBR09 | 1032/BL **112**

CA0-23.0 (H)
2000B | SBR09 | 1032/CH **113**

CA0-23.0 (I)
2000B | SBR09 | 1032/HM **113**

CA0-23.0 (K)
2000B | SBR09 | 1032/10 . . . . . **112**

CA0-23.0 (K)
2320 | SBR09 | 1032/10 . . . . . **321**

CA0-23.0 (P)
2000B | SBR09 | 1032/BL **112**

CA0-23.0 (Z)
2000B | SBR09 | 1032/ZZ **113**

CA0-25.0
2010BC | NM101 . . . . . **140**

CA0-28.0
2010AA | NM109 . . . . . **86**

CA0-28.0
2010AB | NM109 . . . . . **101**

CA0-28.0
2010AB | REF02 . . . . . **107**

CA0-28.0
2010AA | REF02 . . . . . **92**

CA1-03.0
2300 | CLM01 . . . . . **171**

CA1-05.0
2010BA | NM109 . . . . . **119**

CA1-06.0
2010BA | NM109 . . . . . **119**

CB0-03.0
2300 | CLM01 . . . . . **171**

CB0-04.0
2010BC | NM103 . . . . . **140**

CB0-05.0
2010BC | NM104 . . . . . **140**

CB0-06.0
2010BC | NM105 . . . . . **141**

CB0-07.0
2010BC | N301 . . . . . **143**

CB0-08.0
2010BC | N302 . . . . . **143**

CB0-09.0
2010BC | N401 . . . . . **144**

CB0-10.0
2010BC | N402 . . . . . **144**

CB0-11.0
2010BC | N403 . . . . . **145**

DA0-02.0
2000B | SBR01 . . . . . **110**

DA0-02.0
2320 | SBR01 . . . . . **319**

DA0-03.0
2300 | CLM01 . . . . . **171**

DA0-05.0
2320 | SBR09 . . . . . **321**

DA0-05.0 (B)
2000B | SBR09 | 1032/WC **113**

DA0-05.0 (C)
2000B | SBR09 | 1032/MB **113**

DA0-05.0 (D)
2000B | SBR09 | 1032/MC **113**

DA0-05.0 (E)
2000B | SBR09 | 1032/OF **113**

DA0-05.0 (F)
2000B | SBR09 | 1032/CI **113**

DA0-05.0 (G)
2000B | SBR09 | 1032/BL **112**

DA0-05.0 (H)
2000B | SBR09 | 1032/CH **113**

DA0-05.0 (I)
2000B | SBR09 | 1032/HM **113**

DA0-05.0 (K)
2000B | SBR09 | 1032/10 . . . . . **112**

DA0-05.0 (K)
2320 | SBR09 | 1032/10 . . . . . **321**

DA0-05.0 (P)
2000B | SBR09 | 1032/BL **112**

DA0-05.0 (T)
2000B | SBR09 | 1032/TV **113**

DA0-05.0 (V)
2000B | SBR09 | 1032/VA **113**

DA0-05.0 (Z)
2000B | SBR09 | 1032/ZZ **113**

DA0-06.0
2000B | SBR05 . . . . . **111**

DA0-06.0
2320 | SBR05 . . . . . **321**

DA0-07.0
2330B | NM109 . . . . . **361**

DA0-07.0
2010BB | NM109 . . . . . **131**

DA0-08.0
2010BB | REF02 . . . . . **138**

DA0-09.0
2010BB | NM103 . . . . . **131**

DA0-09.0
2330B | NM103 . . . . . **360**

DA0-10.0
2320 | SBR03 . . . . . **320**

DA0-10.0
2000B | SBR03 . . . . . **111**

DA0-11.0
2320 | SBR04 . . . . . **320**

DA0-11.0
2000B | SBR04 . . . . . **111**

DA0-14.0
2300 | REF02 . . . . . **228**

DA0-15.0
2300 | CLM08 . . . . . **175**

DA0-15.0
2320 | OI03 . . . . . **345**

DA0-16.0
2300 | CLM10 . . . . . **176**

DA0-16.0
2320 | OI04 . . . . . **345**

DA0-17.0
2000B | SBR02 . . . . . **111**

DA0-17.0
2000C | PAT01 . . . . . **154**

DA0-17.0
2320 | SBR02 . . . . . **319**

DA0-18.0
2010BA | NM109 . . . . . **119**

DA0-18.0
2010CA | NM109 . . . . . **159**

DA0-18.0
2330A | NM109 . . . . . **352**

DA0-19.0
2010BA | NM103 . . . . . **118**

DA0-19.0
2330A | NM103 . . . . . **351**

DA0-20.0
2010BA | NM104 . . . . . **118**

DA0-20.0
2330A | NM104 . . . . . **351**

DA0-21.0
2010BA | NM105 . . . . . **118**

DA0-21.0
2330A | NM105 . . . . . **351**

DA0-22.0
2010BA | NM107 . . . . . **118**

DA0-22.0
2330A | NM107 . . . . . **352**

DA0-23.0
2010BA | DMG03 . . . . . **125**

DA0-23.0
2320 | DMG03 . . . . . **343**

DA0-24.0
2320 | DMG02 . . . . . **343**

DA0-24.0
2010BA | DMG02 . . . . . **125**

DA0-30.0
2300 | REF02 . . . . . **225**

DA1-02.0
2000B | SBR01 . . . . . **110**

DA1-02.0
2320 | SBR01 . . . . . **319**

DA1-03.0
2300 | CLM01 . . . . . **171**

DA1-04.0
2010BB | N301 . . . . . **134**

DA1-05.0
2010BB | N302 . . . . . **134**

DA1-06.0
2010BB | N401 . . . . . **135**

DA1-07.0
2010BB | N402 . . . . . **136**

DA1-08.0
2010BB | N403 . . . . . **136**

DA1-09.0
2320 | CAS03 . . . . . **327**

DA1-10.0
2320 | CAS03 . . . . . **327**

DA1-11.0
2320 | CAS03 . . . . . **327**

DA1-12.0
2320 | CAS03 . . . . . **327**

DA1-13.0
2320 | CAS03 . . . . . **327**

DA1-16.0
2320 | CAS02 . . . . . **326**

DA1-17.0
2320 | CAS05 . . . . . **327**

DA1-18.0
2320 | CAS08 . . . . . **328**

DA1-27.0
2330B | DTP03 . . . . . **367**

DA1-30.0
2320 | CAS02 . . . . . **326**

DA1-30.0
2320 | CAS05 . . . . . **327**

DA1-30.0
2320 | CAS08 . . . . . **328**

DA1-30.0
2320 | CAS11 . . . . . **329**

DA1-30.0
2320 | CAS14 . . . . . **329**

DA1-30.0
2320 | CAS17 . . . . . **330**

DA1-30.0
2320 | CAS03 . . . . . **327**

DA1-30.0
2320 | CAS06 . . . . . **327**

DA1-30.0
2320 | CAS09 . . . . . **328**

DA1-30.0
2320 | CAS12 . . . . . **329**

DA1-30.0
2320 | CAS15 . . . . . **330**

DA1-30.0
2320 | CAS18 . . . . . **330**

DA1-33.0
2320 | CAS03 . . . . . **327**

DA1-33.0
2320 | CAS06 . . . . . **327**

DA1-33.0
2320 | CAS09 . . . . . **328**

DA1-33.0
2320 | CAS12 . . . . . **329**

DA1-33.0
2320 | CAS15 . . . . . **330**

DA1-33.0
2320 | CAS18 . . . . . **330**

DA1-37.0
2320 | AMT02 . . . . . **333**

DA2-02.0
2000B | SBR01 . . . . . **110**

DA2-02.0
2320 | SBR01 . . . . . **319**

DA2-03.0
2300 | CLM01 . . . . . **171**

DA2-04.0
2010BA | N301 . . . . . **121**

DA2-04.0
2330A | N301 . . . . . **354**

DA2-05.0
2010BA | N302 . . . . . **121**

DA2-05.0
2330A | N302 . . . . . **354**

DA2-06.0
2010BA | N401 . . . . . **122**

DA2-06.0
2330A | N401 . . . . . **355**

DA2-07.0
2010BA | N402 . . . . . **123**

DA2-07.0
2330A | N402 . . . . . **356**

DA2-08.0
2010BA | N403 . . . . . **123**

DA2-08.0
2330A | N403 . . . . . **356**

DA3-04.0
2320 | CAS02 . . . . . **326**

DA3-04.0
2320 | CAS05 . . . . . **327**

DA3-04.0
2320 | CAS08 . . . . . **328**

DA3-04.0
2320 | CAS11 . . . . . **329**

DA3-04.0
2320 | CAS14 . . . . . **329**

DA3-04.0
2320 | CAS17 . . . . . **330**

DA3-05.0
2320 | CAS03 . . . . . **327**
DA3-05.0
2320 | CAS06 . . . . . **327**
DA3-05.0
2320 | CAS09 . . . . . **328**
DA3-05.0
2320 | CAS12 . . . . . **329**
DA3-05.0
2320 | CAS15 . . . . . **330**
DA3-05.0
2320 | CAS18 . . . . . **330**
DA3-06.0
2320 | CAS02 . . . . . **326**
DA3-06.0
2320 | CAS05 . . . . . **327**
DA3-06.0
2320 | CAS08 . . . . . **328**
DA3-06.0
2320 | CAS11 . . . . . **329**
DA3-06.0
2320 | CAS14 . . . . . **329**
DA3-06.0
2320 | CAS17 . . . . . **330**
DA3-07.0
2320 | CAS03 . . . . . **327**
DA3-07.0
2320 | CAS06 . . . . . **327**
DA3-07.0
2320 | CAS09 . . . . . **328**
DA3-07.0
2320 | CAS12 . . . . . **329**
DA3-07.0
2320 | CAS15 . . . . . **330**
DA3-07.0
2320 | CAS18 . . . . . **330**
DA3-08.0
2320 | CAS02 . . . . . **326**
DA3-08.0
2320 | CAS05 . . . . . **327**
DA3-08.0
2320 | CAS08 . . . . . **328**
DA3-08.0
2320 | CAS11 . . . . . **329**
DA3-08.0
2320 | CAS14 . . . . . **329**
DA3-08.0
2320 | CAS17 . . . . . **330**
DA3-09.0
2320 | CAS03 . . . . . **327**
DA3-09.0
2320 | CAS06 . . . . . **327**
DA3-09.0
2320 | CAS09 . . . . . **328**
DA3-09.0
2320 | CAS12. . . . . **329**
DA3-09.0
2320 | CAS15. . . . . **330**
DA3-09.0
2320 | CAS18. . . . . **330**
DA3-10.0
2320 | CAS02. . . . . **326**
DA3-10.0
2320 | CAS05. . . . . **327**
DA3-10.0
2320 | CAS08. . . . . **328**
DA3-10.0
2320 | CAS11. . . . . **329**
DA3-10.0
2320 | CAS14. . . . . **329**
DA3-10.0
2320 | CAS17. . . . . **330**
DA3-11.0
2320 | CAS03. . . . . **327**
DA3-11.0
2320 | CAS06. . . . . **327**
DA3-11.0
2320 | CAS09. . . . . **328**
DA3-11.0
2320 | CAS12. . . . . **329**
DA3-11.0
2320 | CAS15. . . . . **330**
DA3-11.0
2320 | CAS18. . . . . **330**
DA3-12.0
2320 | CAS02. . . . . **326**
DA3-12.0
2320 | CAS05. . . . . **327**
DA3-12.0
2320 | CAS08. . . . . **328**
DA3-12.0
2320 | CAS11. . . . . **329**
DA3-12.0
2320 | CAS14. . . . . **329**
DA3-12.0
2320 | CAS17. . . . . **330**
DA3-13.0
2320 | CAS03. . . . . **327**
DA3-13.0
2320 | CAS06. . . . . **327**
DA3-13.0
2320 | CAS09. . . . . **328**
DA3-13.0
2320 | CAS12. . . . . **329**
DA3-13.0
2320 | CAS15. . . . . **330**
DA3-13.0
2320 | CAS18. . . . . **330**

DA3-14.0
2320 | CAS02 . . . . . **326**

DA3-14.0
2320 | CAS05 . . . . . **327**

DA3-14.0
2320 | CAS08 . . . . . **328**

DA3-14.0
2320 | CAS11 . . . . . **329**

DA3-14.0
2320 | CAS14 . . . . . **329**

DA3-14.0
2320 | CAS17 . . . . . **330**

DA3-15.0
2320 | CAS03 . . . . . **327**

DA3-15.0
2320 | CAS06 . . . . . **327**

DA3-15.0
2320 | CAS09 . . . . . **328**

DA3-15.0
2320 | CAS12 . . . . . **329**

DA3-15.0
2320 | CAS15 . . . . . **330**

DA3-15.0
2320 | CAS18 . . . . . **330**

DA3-16.0
2320 | CAS02 . . . . . **326**

DA3-16.0
2320 | CAS05 . . . . . **327**

DA3-16.0
2320 | CAS08 . . . . . **328**

DA3-16.0
2320 | CAS11 . . . . . **329**

DA3-16.0
2320 | CAS14 . . . . . **329**

DA3-16.0
2320 | CAS17 . . . . . **330**

DA3-17.0
2320 | CAS03 . . . . . **327**

DA3-17.0
2320 | CAS06 . . . . . **327**

DA3-17.0
2320 | CAS09 . . . . . **328**

DA3-17.0
2320 | CAS12 . . . . . **329**

DA3-17.0
2320 | CAS15 . . . . . **330**

DA3-17.0
2320 | CAS18 . . . . . **330**

DA3-18.0
2320 | MOA03 . . . . . **348**

DA3-18.0
2320 | MOA04 . . . . . **348**

DA3-18.0
2320 | MOA05 . . . . . **348**

DA3-18.0
2320 | MOA06 . . . . . **348**

DA3-18.0
2320 | MOA07 . . . . . **349**

DA3-19.0
2320 | MOA03 . . . . . **348**

DA3-19.0
2320 | MOA04 . . . . . **348**

DA3-19.0
2320 | MOA05 . . . . . **348**

DA3-19.0
2320 | MOA06 . . . . . **348**

DA3-19.0
2320 | MOA07 . . . . . **349**

DA3-20.0
2320 | MOA03 . . . . . **348**

DA3-20.0
2320 | MOA04 . . . . . **348**

DA3-20.0
2320 | MOA05 . . . . . **348**

DA3-20.0
2320 | MOA06 . . . . . **348**

DA3-20.0
2320 | MOA07 . . . . . **349**

DA3-21.0
2320 | MOA03 . . . . . **348**

DA3-21.0
2320 | MOA04 . . . . . **348**

DA3-21.0
2320 | MOA05 . . . . . **348**

DA3-21.0
2320 | MOA06 . . . . . **348**

DA3-21.0
2320 | MOA07 . . . . . **349**

DA3-22.0
2320 | MOA03 . . . . . **348**

DA3-22.0
2320 | MOA04 . . . . . **348**

DA3-22.0
2320 | MOA05 . . . . . **348**

DA3-22.0
2320 | MOA06 . . . . . **348**

DA3-22.0
2320 | MOA07 . . . . . **349**

DA3-24.0
2330B | REF02 . . . . . **373**

DA3-25.0
2320 | CAS03. . . . . **327**

DA3-25.0
2320 | CAS06. . . . . **327**

DA3-25.0
2320 | CAS09. . . . . **328**

DA3-25.0
2320 | CAS12. . . . . **329**

DA3-25.0
2320 | CAS15 . . . . . **330**

DA3-25.0
2320 | CAS18 . . . . . **330**

DA3-26.0
2320 | CAS03 . . . . . **327**

DA3-26.0
2320 | CAS06 . . . . . **327**

DA3-26.0
2320 | CAS09 . . . . . **328**

DA3-26.0
2320 | CAS12 . . . . . **329**

DA3-26.0
2320 | CAS15 . . . . . **330**

DA3-26.0
2320 | CAS18 . . . . . **330**

DA3-29.0
2330B | REF02 . . . . . **369**

EA0-03.0
2300 | CLM01 . . . . . **171**

EA0-04.0 - Employment
2300 | CLM11 | C024-01 . . . . . **176**

EA0-04.0 - Employment
2300 | CLM11 | C024-02 . . . . . **177**

EA0-04.0 - Employment
2300 | CLM11 | C024-03 . . . . . **177**

EA0-05.0 - Auto Accident or Other Accident
2300 | CLM11 | C024-01 . . . . . **176**

EA0-05.0 - Auto Accident or Other Accident
2300 | CLM11 | C024-02 . . . . . **177**

EA0-05.0 - Auto Accident or Other Accident
2300 | CLM11 | C024-03 . . . . . **177**

EA0-07.0
2300 | DTP03 . . . . . **189**

EA0-07.0
2300 | DTP03 . . . . . **196**

EA0-07.0
2400 | DTP03 . . . . . **453**

EA0-07.0 - Accident Date
2300 | DTP03 . . . . . **195**

EA0-09.0 - Responsibility Indicator
2300 | CLM11 | C024-01 . . . . . **176**

EA0-09.0 - Responsibility Indicator
2300 | CLM11 | C024-02 . . . . . **177**

EA0-09.0 - Responsibility Indicator
2300 | CLM11 | C024-03 . . . . . **177**

EA0-10.0
2300 | CLM11 | C024-04 . . . . . **177**

EA0-11.0 Accident Hour (no minutes)
2300 | DTP03 . . . . . **195**

EA0-13.0
2300 | CLM09 . . . . . **175**

EA0-16.0
2300 | DTP03 . . . . . **193**

EA0-16.0
2400 | DTP03 . . . . . **453**

EA0-18.0
2300 | DTP03 . . . . . **202**

EA0-19.0
2300 | DTP03 . . . . . **204**

EA0-20.0
2310A | NM109 . . . . . **284**

EA0-20.0
2310A | REF02 . . . . . **289**

EA0-24.0
2310A | NM103 . . . . . **283**

EA0-25.0
2310A | NM104 . . . . . **283**

EA0-26.0
2310A | NM105 . . . . . **284**

EA0-28.0
2300 | DTP03 . . . . . **209**

EA0-29.0
2300 | DTP03 . . . . . **211**

EA0-31.0
2300 | AMT02 . . . . . **221**

EA0-32.0
2300 | HI01 | C022-02 . . . . . **266**

EA0-33.0
2300 | HI02 | C022-02 . . . . . **266**

EA0-34.0
2300 | HI03 | C022-02 . . . . . **267**

EA0-35.0
2300 | HI04 | C022-02 . . . . . **268**

EA0-36.0
2300 | CLM07 . . . . . **174**

EA0-37.0
2300 | CLM06 . . . . . **174**

EA0-39.0
2310D | NM103 . . . . . **304**

EA0-40.0
2300 | PWK02 . . . . . **216**

EA0-40.0
2400 | PWK02 . . . . . **411**

EA0-41.0
2300 | PWK01 . . . . . **215**

EA0-43.0
2300 | CLM12 . . . . . **178**

EA0-43.0
2300 | REF02 . . . . . **243**

EA0-47.0
2300 | REF02 . . . . . **230**

EA0-48.0
2300 | DTP03 . . . . . **187**

EA0-48.0
2400 | DTP03 . . . . . **446**

EA0-50.0
2300 | CRC03 | 1321/IH **264**

EA0-53.0
2310D | NM109 . . . . . **305**

EA0-53.0
2310D | REF02 . . . . . **311**

EA0-54.0
2300 | REF02 . . . . . **236**

EA1-03.0
2300 | CLM01 . . . . . **171**

EA1-04.0
2310D | NM109 . . . . . **305**

EA1-04.0
2310D | REF02 . . . . . **311**

EA1-06.0
2310D | N301 . . . . . **307**

EA1-07.0
2310D | N302 . . . . . **307**

EA1-08.0
2310D | N401 . . . . . **308**

EA1-09.0
2310D | N402 . . . . . **309**

EA1-10.0
2310D | N403 . . . . . **309**

EA1-12.0
2300 | DTP03 . . . . . **207**

EA1-16.0
2310E | NM109 . . . . . **314**

EA1-16.0
2310E | REF02 . . . . . **317**

EA1-18.0
2310E | NM103 . . . . . **313**

EA1-19.0
2310E | NM104 . . . . . **313**

EA1-20.0
2310E | NM105 . . . . . **313**

EA1-25.0 - Provider Assumed Care Date
2300 | DTP03 . . . . . **213**

EA2-03.0
2300 | CLM01 . . . . . **171**

FA0-02.0
2400 | LX01 . . . . . **399**

FA0-03.0
2300 | CLM01 . . . . . **171**

FA0-04.0
2400 | REF02 . . . . . **473**

FA0-05.0
2400 | DTP03 . . . . . **436**

FA0-06.0
2400 | DTP03 . . . . . **436**

FA0-07.0
2300 | CLM05 | C023 . . . . . **172**

FA0-07.0
2400 | SV105 . . . . . **404**

FA0-09.0
2400 | SV101 | C003-02 . . . . . **401**

FA0-10.0
2400 | SV101 | C003-03 . . . . . **401**

FA0-11.0
2400 | SV101 | C003-04 . . . . . **402**

FA0-12.0
2400 | SV101 | C003-05 . . . . . **402**

FA0-13.0
2400 | SV102 . . . . . **402**

FA0-14.0
2400 | SV107 | C004-01 . . . . . **405**

FA0-15.0
2400 | SV107 | C004-02 . . . . . **405**

FA0-16.0
2400 | SV107 | C004-03 . . . . . **405**

FA0-17.0
2400 | SV107 | C004-04 . . . . . **405**

FA0-18.0
2400 | SV104 . . . . . **403**

FA0-19.0
2400 | SV104 . . . . . **403**

FA0-20.0
2400 | SV109 . . . . . **406**

FA0-23.0
2310B | NM109 . . . . . **292**

FA0-23.0
2420A | NM109 . . . . . **503**

FA0-24.0
2420F | NM109 . . . . . **543**

FA0-27.0
2430 | CAS03 . . . . . **560**

FA0-28.0
2430 | CAS03 . . . . . **560**

FA0-31.0
2300 | REF02 . . . . . **226**

FA0-31.0
2400 | REF02 . . . . . **474**

FA0-34.0
2300 | REF02 . . . . . **232**

FA0-34.0
2400 | REF02 . . . . . **476**

FA0-35.0
2430 | CAS03 . . . . . **560**

FA0-36.0
2400 | SV101 | C003-06 . . . . . **402**

FA0-37.0
2310B | PRV03 . . . . . **294**

FA0-37.0
2420A | PRV03 . . . . . **505**

FA0-40.0
2400 | CRC02 . . . . . **431**

FA0-41.0
2400 | DTP03 . . . . . **448**

FA0-42.0 - Hemoglobin
2400 | MEA03 . . . . . **465**

FA0-43.0 - Hematocrit
2400 | MEA03 . . . . . **465**

FA0-44.0
2000B | PAT08 . . . . . **115**

FA0-44.0
2000C | PAT08 . . . . . **156**

FA0-45.0 - Epoetin Starting Dosage
2400 | MEA03 . . . . . **465**

FA0-46.0
2400 | DTP03 . . . . . **448**

FA0-47.0 - Creatin
2400 | MEA03 . . . . . **465**

FA0-48.0
2430 | CAS03 . . . . . **560**

FA0-50.0
2300 | CR106 . . . . . **250**

FA0-50.0
2400 | SV103 . . . . . **403**

FA0-50.0
2400 | CR106 . . . . . **414**

FA0-51.0
2400 | AMT02 . . . . . **485**

FA0-52.0
2430 | SVD02 . . . . . **555**

FA0-53.0
2430 | CAS03 . . . . . **560**

FA0-53.0
2430 | CAS06 . . . . . **561**

FA0-53.0
2430 | CAS09 . . . . . **562**

FA0-53.0
2430 | CAS12 . . . . . **563**

FA0-53.0
2430 | CAS15 . . . . . **564**

FA0-53.0
2430 | CAS18 . . . . . **565**

FA0-54.0
2430 | CAS03 . . . . . **560**

FA0-54.0
2430 | CAS06 . . . . . **561**

FA0-54.0
2430 | CAS09 . . . . . **562**

FA0-54.0
2430 | CAS12 . . . . . **563**

FA0-54.0
2430 | CAS15 . . . . . **564**

FA0-54.0
2430 | CAS18 . . . . . **565**

FA0-57.0
2310B | NM108 . . . . . **292**

FA0-57.0
2310B | REF01 . . . . . **296**

FA0-57.0
2420A | NM108 . . . . . **503**

FA0-58.0
2310B | NM109 . . . . . **292**

FA0-58.0
2310B | REF02 . . . . . **297**

FA0-58.0
2420A | NM109 . . . . . **503**

FA0-59.0
2300 | CLM07 . . . . . **174**

FA0-62.0
2400 | REF02 . . . . . **483**

FB0-02.0
2400 | LX01 . . . . . **399**

FB0-03.0
2300 | CLM01 . . . . . **171**

FB0-04.0
2400 | REF02 . . . . . **473**

FB0-05.0
2400 | PS102 . . . . . **490**

FB0-06.0
2430 | CAS03 . . . . . **560**

FB0-07.0
2430 | CAS03 . . . . . **560**

FB0-08.0
2430 | CAS03 . . . . . **560**

FB0-09.0
2420E | NM109 . . . . . **531**

FB0-10.0
2420E | N402 . . . . . **535**

FB0-11.0
2310C | REF02 . . . . . **302**

FB0-11.0
2400 | PS101 . . . . . **489**

FB0-11.0
2420B | REF02 . . . . . **513**

FB0-11.0
2310C | NM109 . . . . . **300**

FB0-11.0
2420B | NM109 . . . . . **511**

FB0-15.0
2400 | SV101 | C003-02 . . . . . **401**

FB0-16.0
2400 | SV104 . . . . . **403**

FB0-21.0
2400 | SV115 . . . . . **407**

FB0-22.0
2400 | SV111 . . . . . **406**

FB0-23.0
2400 | SV112 . . . . . **406**

FB1-02.0
2400 | LX01 . . . . . **399**

FB1-03.0
2300 | CLM01 . . . . . **171**

FB1-04.0
2400 | REF02 . . . . . **473**

FB1-06.0
2420E | NM103 . . . . . **530**

FB1-07.0
2420E | NM104 . . . . . **530**

FB1-08.0
2420E | NM105 . . . . . **530**

FB1-09.0
2420E | NM109 . . . . . **531**

FB1-10.0
2420F | NM103 . . . . . **542**

FB1-11.0
2420F | NM104 . . . . . **542**

FB1-12.0
2420F | NM105 . . . . . **543**

FB1-13.0
2420F | NM109 . . . . . **543**

FB1-14.0
2310B | NM103 . . . . . **291**

FB1-14.0
2420A | NM103 . . . . . **502**

FB1-15.0
2310B | NM104 . . . . . **291**

FB1-15.0
2420A | NM104 . . . . . **502**

FB1-16.0
2310B | NM105 . . . . . **292**

FB1-16.0
2420A | NM105 . . . . . **503**

FB1-18.0
2420D | NM103 . . . . . **524**

FB1-19.0
2420D | NM104 . . . . . **524**

FB1-20.0
2420D | NM105 . . . . . **524**

FB1-21.0
2420D | NM109 . . . . . **525**

FB1-21.0
2420D | REF02 . . . . . **528**

FB2-02.0
2400 | LX01 . . . . . **399**

FB2-03.0
2300 | CLM01 . . . . . **171**

FB2-04.0
2400 | REF02 . . . . . **473**

FB2-06.0
2420E | N301 . . . . . **533**

FB2-07.0
2420E | N302 . . . . . **533**

FB2-08.0
2420E | N401 . . . . . **534**

FB2-09.0
2420E | N402 . . . . . **535**

FB2-10.0
2420E | N403 . . . . . **535**

FB3-05.0
2430 | CAS02 . . . . . **560**

FB3-05.0
2430 | CAS05 . . . . . **561**

FB3-05.0
2430 | CAS08 . . . . . **562**

FB3-05.0
2430 | CAS11 . . . . . **563**

FB3-05.0
2430 | CAS14 . . . . . **564**

FB3-05.0
2430 | CAS17 . . . . . **565**

FB3-06.0
2430 | CAS03 . . . . . **560**

FB3-06.0
2430 | CAS06 . . . . . **561**

FB3-06.0
2430 | CAS09 . . . . . **562**

FB3-06.0
2430 | CAS12 . . . . . **563**

FB3-06.0
2430 | CAS15 . . . . . **564**

FB3-06.0
2430 | CAS18 . . . . . **565**

FB3-07.0
2430 | CAS02 . . . . . **560**

FB3-07.0
2430 | CAS05 . . . . . **561**

FB3-07.0
2430 | CAS08 . . . . . **562**

FB3-07.0
2430 | CAS11 . . . . . **563**

FB3-07.0
2430 | CAS14 . . . . . **564**

FB3-07.0
2430 | CAS17 . . . . . **565**

FB3-08.0
2430 | CAS03 . . . . . **560**

FB3-08.0
2430 | CAS06 . . . . . **561**

FB3-08.0
2430 | CAS09 . . . . . **562**

FB3-08.0
2430 | CAS12 . . . . . **563**

FB3-08.0
2430 | CAS15 . . . . . **564**

FB3-08.0
2430 | CAS18 . . . . . **565**

FB3-09.0
2430 | CAS02 . . . . . **560**

FB3-09.0
2430 | CAS05 . . . . . **561**
FB3-09.0
2430 | CAS08 . . . . . **562**
FB3-09.0
2430 | CAS11 . . . . . **563**
FB3-09.0
2430 | CAS14 . . . . . **564**
FB3-09.0
2430 | CAS17 . . . . . **565**
FB3-10.0
2430 | CAS03 . . . . . **560**
FB3-10.0
2430 | CAS06 . . . . . **561**
FB3-10.0
2430 | CAS09 . . . . . **562**
FB3-10.0
2430 | CAS12 . . . . . **563**
FB3-10.0
2430 | CAS15 . . . . . **564**
FB3-10.0
2430 | CAS18 . . . . . **565**
FB3-11.0
2430 | CAS02 . . . . . **560**
FB3-11.0
2430 | CAS05 . . . . . **561**
FB3-11.0
2430 | CAS08 . . . . . **562**
FB3-11.0
2430 | CAS11 . . . . . **563**
FB3-11.0
2430 | CAS14 . . . . . **564**
FB3-11.0
2430 | CAS17 . . . . . **565**
FB3-12.0
2430 | CAS03 . . . . . **560**
FB3-12.0
2430 | CAS06 . . . . . **561**
FB3-12.0
2430 | CAS09 . . . . . **562**
FB3-12.0
2430 | CAS12 . . . . . **563**
FB3-12.0
2430 | CAS15 . . . . . **564**
FB3-12.0
2430 | CAS18 . . . . . **565**
FB3-13.0
2430 | CAS02 . . . . . **560**
FB3-13.0
2430 | CAS05 . . . . . **561**
FB3-13.0
2430 | CAS08 . . . . . **562**
FB3-13.0
2430 | CAS11 . . . . . **563**
FB3-13.0
2430 | CAS14 . . . . . **564**
FB3-13.0
2430 | CAS17 . . . . . **565**
FB3-14.0
2430 | CAS03 . . . . . **560**
FB3-14.0
2430 | CAS06 . . . . . **561**
FB3-14.0
2430 | CAS09 . . . . . **562**
FB3-14.0
2430 | CAS12 . . . . . **563**
FB3-14.0
2430 | CAS15 . . . . . **564**
FB3-14.0
2430 | CAS18 . . . . . **565**
FB3-15.0
2430 | CAS02 . . . . . **560**
FB3-15.0
2430 | CAS05 . . . . . **561**
FB3-15.0
2430 | CAS08 . . . . . **562**
FB3-15.0
2430 | CAS11 . . . . . **563**
FB3-15.0
2430 | CAS14 . . . . . **564**
FB3-15.0
2430 | CAS17 . . . . . **565**
FB3-16.0
2430 | CAS03 . . . . . **560**
FB3-16.0
2430 | CAS06 . . . . . **561**
FB3-16.0
2430 | CAS09 . . . . . **562**
FB3-16.0
2430 | CAS12 . . . . . **563**
FB3-16.0
2430 | CAS15 . . . . . **564**
FB3-16.0
2430 | CAS18 . . . . . **565**
FB3-17.0
2430 | CAS02 . . . . . **560**
FB3-17.0
2430 | CAS05 . . . . . **561**
FB3-17.0
2430 | CAS08 . . . . . **562**
FB3-17.0
2430 | CAS11 . . . . . **563**
FB3-17.0
2430 | CAS14 . . . . . **564**
FB3-17.0
2430 | CAS17 . . . . . **565**
FB3-18.0
2430 | CAS03 . . . . . **560**

FB3-18.0
2430 | CAS06 . . . . . **561**

FB3-18.0
2430 | CAS09 . . . . . **562**

FB3-18.0
2430 | CAS12 . . . . . **563**

FB3-18.0
2430 | CAS15 . . . . . **564**

FB3-18.0
2430 | CAS18 . . . . . **565**

FD0-03.0
2300 | CLM01 . . . . . **171**

FD0-04.0
2400 | REF02 . . . . . **473**

FE0-03.0
2300 | CLM01 . . . . . **171**

FE0-04.0
2400 | REF02 . . . . . **473**

FE0-06.0 (TPO Reference Number)
2300 | REF02 . . . . . **233**

GA0-02.0
2400 | LX01 . . . . . **399**

GA0-03.0
2300 | CLM01 . . . . . **171**

GA0-05.0
2300 | CR102 . . . . . **249**

GA0-05.0
2400 | CR102 . . . . . **413**

GA0-06.0
2300 | CRC03 | 1321/01 . . . . . **258**

GA0-06.0
2400 | CRC03 | 1321/01 . . . . . **428**

GA0-07.0
2300 | CR103 . . . . . **249**

GA0-07.0
2400 | CR103 . . . . . **413**

GA0-08.0
2300 | CRC03 | 1321/02 . . . . . **258**

GA0-08.0
2400 | CRC03 | 1321/02 . . . . . **428**

GA0-09.0
2300 | CRC03 | 1321/03 . . . . . **258**

GA0-09.0
2400 | CRC03 | 1321/03 . . . . . **428**

GA0-10.0
2300 | CRC03 | 1321/04 . . . . . **258**

GA0-10.0
2400 | CRC03 | 1321/04 . . . . . **428**

GA0-11.0
2300 | CRC03 | 1321/05 . . . . . **258**

GA0-11.0
2400 | CRC03 | 1321/05 . . . . . **428**

GA0-12.0
2300 | CRC03 | 1321/06 . . . . . **258**

GA0-12.0
2400 | CRC03 | 1321/06 . . . . . **428**

GA0-13.0
2300 | CRC03 | 1321/07 . . . . . **258**

GA0-13.0
2400 | CRC03 | 1321/07 . . . . . **428**

GA0-14.0
2300 | CRC03 | 1321/08 . . . . . **258**

GA0-14.0
2400 | CRC03 | 1321/08 . . . . . **428**

GA0-15.0
2300 | CR104 . . . . . **249**

GA0-15.0
2400 | CR104 . . . . . **413**

GA0-16.0
2300 | CRC03 | 1321/09 . . . . . **259**

GA0-16.0
2400 | CRC03 | 1321/09 . . . . . **429**

GA0-17.0
2300 | CR106 . . . . . **250**

GA0-17.0
2400 | CR106 . . . . . **414**

GA0-20.0
2300 | CR109 . . . . . **250**

GA0-20.0
2400 | CR109 . . . . . **414**

GA0-21.0
2300 | CR110 . . . . . **250**

GA0-21.0
2400 | CR110 . . . . . **414**

GA0-22.0 (for Ambulance Claims only)
2300 | DTP03 . . . . . **211**

GA0-23.0 (for ambulance claims only)
2300 | DTP03 . . . . . **209**

GA0-24.0
2300 | CRC03 | 1321/60 . . . . . **259**

GA0-24.0
2400 | CRC03 | 1321/60 . . . . . **429**

GC0-02.0
2400 | LX01 . . . . . **399**

GC0-03.0
2300 | CLM01 . . . . . **171**

GC0-05.0
2400 | DTP03 . . . . . **459**

GC0-05.0
2300 | DTP03 . . . . . **183**

GC0-06.0
2300 | DTP03 . . . . . **198**

GC0-06.0
2400 | DTP03 . . . . . **455**

GC0-07.0
2300 | CR201 . . . . . **252**

GC0-07.0
2300 | CR202 . . . . . **252**

GC0-07.0
2400 | CR201 . . . . . **416**

GC0-07.0
2400 | CR202 . . . . . **416**

GC0-08.0
2300 | CR203 . . . . . **252**

GC0-08.0
2300 | CR204 . . . . . **253**

GC0-08.0
2400 | CR203 . . . . . **416**

GC0-08.0
2400 | CR204 . . . . . **417**

GC0-09.0
2300 | CR206 . . . . . **255**

GC0-09.0
2400 | CR206 . . . . . **419**

GC0-10.0
2300 | CR207 . . . . . **255**

GC0-10.0
2400 | CR207 . . . . . **419**

GC0-11.0
2300 | CR208 . . . . . **255**

GC0-11.0
2400 | CR208 . . . . . **419**

GC0-12.0
2300 | DTP03 . . . . . **191**

GC0-12.0
2400 | DTP03 . . . . . **457**

GC0-13.0
2300 | CR209 . . . . . **255**

GC0-13.0
2400 | CR209 . . . . . **419**

GC0-14.0
2300 | CR210 . . . . . **256**

GC0-14.0
2300 | CR211 . . . . . **256**

GC0-14.0
2400 | CR210 . . . . . **420**

GC0-14.0
2400 | CR211 . . . . . **420**

GC0-15.0
2300 | CR212 . . . . . **256**

GC0-15.0
2400 | CR212 . . . . . **420**

GU0-02.0
2400 | LX01 . . . . . **399**

GU0-03.0
2300 | CLM01 . . . . . **171**

GU0-04.0
2400 | CR301 . . . . . **421**

GU0-05.0
2400 | SV105 . . . . . **404**

GU0-06.0
2400 | CRC03 | 1321/ZV **434**

GU0-07.0
2400 | SV101 | C003-02. . . . . **401**

GU0-08.0
2400 | SV101 | C003-03. . . . . **401**

GU0-12.0
2300 | HI01 | C022-02 . . . . . **266**

GU0-13.0
2300 | HI02 | C022-02 . . . . . **266**

GU0-14.0
2300 | HI03 | C022-02 . . . . . **267**

GU0-15.0
2300 | HI04 | C022-02 . . . . . **268**

GU0-16.0 - Patient Height
2400 | MEA03 . . . . . **465**

GU0-17.0
2000B | PAT08 . . . . . **115**

GU0-17.0
2000C | PAT08 . . . . . **156**

GU0-19.0
2400 | DTP03. . . . . **441**

GU0-20.0
2400 | DTP03. . . . . **438**

GU0-21.0
2400 | CR303. . . . . **422**

GU0-22.0
2400 | DTP03. . . . . **443**

GU0-23.0
2420E | PER04 . . . . . **539**

GU0-24.0
2400 | CRC03 | 1321/38 . . . . . **433**

GU0-25.0
2440 | LQ02 . . . . . **568**

GU0-26.0
2440 | FRM02 . . . . . **570**

GU0-27.0
2440 | FRM02 . . . . . **570**

GU0-28.0
2440 | FRM02 . . . . . **570**

GU0-28.0
2440 | FRM03 . . . . . **571**

GU0-29.0
2440 | FRM02 . . . . . **570**

GU0-30.0
2440 | FRM02 . . . . . **570**

GU0-31.0
2440 | FRM02 . . . . . **570**

GU0-31.0
2440 | FRM03 . . . . . **571**

GU0-32.0
2440 | FRM02 . . . . . **570**

GU0-33.0
2440 | FRM02 . . . . . **570**

GU0-33.0
2440 | FRM03 . . . . . **571**

GU0-34.0
2440 | FRM02 . . . . . **570**

GU0-35.0
2440 | FRM02 . . . . . **570**

GU0-36.0
2440 | FRM02 . . . . . **570**

GU0-37.0
2440 | FRM02 . . . . . **570**

GU0-38.0
2440 | FRM02 . . . . . **570**

GU0-39.0
2440 | FRM02 . . . . . **570**

GU0-40.0
2440 | FRM02 . . . . . **570**

GU0-43.0
2440 | FRM02 . . . . . **570**

GU0-44.0
2440 | FRM02 . . . . . **570**

GU0-45.0
2440 | FRM03 . . . . . **571**

GU0-46.0
2440 | FRM03 . . . . . **571**

GU0-47.0
2440 | FRM03 . . . . . **571**

GU0-48.0
2440 | FRM03 . . . . . **571**

GU0-49.0
2440 | FRM03 . . . . . **571**

GU0-50.0
2440 | FRM03 . . . . . **571**

GU0-51.0
2440 | FRM03 . . . . . **571**

GU0-53.0
2440 | FRM04 . . . . . **571**

GU0-54.0
2440 | FRM04 . . . . . **571**

GU0-55.0
2440 | FRM04 . . . . . **571**

GU0-56.0
2440 | FRM04 . . . . . **571**

GU0-57.0
2440 | FRM03 . . . . . **571**

GU0-58.0
2440 | FRM03 . . . . . **571**

GU0-59.0
2440 | FRM03 . . . . . **571**

GU0-60.0
2440 | FRM03 . . . . . **571**

GU0-61.0
2440 | FRM03 . . . . . **571**

GU0-62.0
2440 | FRM03 . . . . . **571**

GU0-63.0
2440 | FRM03 . . . . . **571**

GU0-64.0
2440 | FRM03 . . . . . **571**

GU0-65.0
2440 | FRM03 . . . . . **571**

GU0-66.0
2440 | FRM03 . . . . . **571**

GU0-67.0
2440 | FRM03 . . . . . **571**

GU0-68.0
2440 | FRM03 . . . . . **571**

GU0-69.0
2440 | FRM05 . . . . . **571**

GU0-70.0
2440 | FRM05 . . . . . **571**

GU0-71.0
2440 | FRM05 . . . . . **571**

GX0-02.0
2400 | LX01 . . . . . **399**

GX0-03.0
2300 | CLM01 . . . . . **171**

GX0-04.0
2400 | CR501 . . . . . **424**

GX0-05.0
2400 | CRC03 | 1321/37 . . . . . **433**

GX0-05.0
2400 | CRC03 | 1321/AL **433**

GX0-06.0
2400 | CR502 . . . . . **424**

GX0-10.0
2400 | DTP03 . . . . . **441**

GX0-11.0
2400 | DTP03 . . . . . **438**

GX0-11.0
2400 | DTP03 . . . . . **443**

GX0-14.0
2400 | REF02 . . . . . **481**

GX0-17.0 - Arterial Blood Gas on 4 liters/minute
2400 | MEA03 . . . . . **465**

GX0-18.0 - Oxygen Saturation on 4 liters/minute
2400 | MEA03 . . . . . **465**

GX0-19.0
2400 | DTP03 . . . . . **450**

GX0-20.0
2400 | CRC03 | 1321/P1 . . . . . **434**

GX0-22.0
2400 | CR510 . . . . . **424**

GX0-23.0
2400 | CR511 . . . . . **425**

GX0-24.0
2400 | DTP03 . . . . . **450**

GX0-25.0
2420C | NM103 . . . . . **515**

GX0-26.0
2400 | CR512 . . . . . **425**

GX0-27.0
2400 | CR513 . . . . . **425**

GX0-27.0
2400 | CR514 . . . . . **425**

GX0-27.0
2400 | CR515 . . . . . **426**

GX0-29.0
2420E | NM109 . . . . . **531**

GX0-30.0
2420E | PER04 . . . . . **539**

GX0-31.0
2300 | HI01 | C022-02 . . . . . **266**

GX0-32.0
2300 | HI02 | C022-02 . . . . . **266**

GX0-33.0
2300 | HI03 | C022-02 . . . . . **267**

GX0-34.0
2300 | HI04 | C022-02 . . . . . **268**

GX0-35.0
2400 | CRC03 | 1321/38 . . . . . **433**

GX2-02.0
2400 | LX01 . . . . . **399**

GX2-03.0
2300 | CLM01 . . . . . **171**

GX2-04.0
2420C | N301 . . . . . **518**

GX2-05.0
2420C | N302 . . . . . **518**

GX2-06.0
2420C | N401 . . . . . **519**

GX2-07.0
2420C | N402 . . . . . **520**

GX2-08.0
2420C | N403 . . . . . **520**

HA0-02.0
2400 | LX01 . . . . . **399**

HA0-03.0
2300 | CLM01 . . . . . **171**

HA0-04.0
2400 | REF02 . . . . . **473**

HA0-05.0
2300 | NTE02 . . . . . **247**

HA0-05.0
2400 | K301 . . . . . **487**

HA0-05.0
2400 | NTE02 . . . . . **488**

HA0-05.0
2300 | K301 . . . . . **245**

HA0-05.0 - Provider Relinquished Care Date
2300 | DTP03 . . . . . **213**

XA0-03.0
2300 | CLM01 . . . . . **171**

XA0-12.0
2300 | CLM02 . . . . . **172**

XA0-19.0
2300 | AMT02 . . . . . **220**

YA0-02.0
2010AA | NM109 . . . . . **86**

YA0-02.0
2010AB | NM109 . . . . . **101**

YA0-02.0
2010AB | REF02 . . . . . **107**

YA0-02.0
2010AA | REF02 . . . . . **92**

YA0-06.0
2010AA | NM109 . . . . . **86**

YA0-06.0
2010AA | REF02 . . . . . **92**

YA0-06.0
2010AB | NM109 . . . . . **101**

YA0-06.0
2010AB | REF02 . . . . . **107**

ZA0-02.0
1000A | NM109 . . . . . **69**

ZA0-04.0
1000B | NM109 . . . . . **75**

F.2 Complete NSF to ASC X12 837 Map

This NSF matrix shows all data elements in NSF 3.01 and their corresponding ASC X12 element by table-position-data element and associated code value where pertinent. “Translator” means this value is created via the translator not the transaction set.

Moving from a flat file format to a nested loop structure has many ramifications. Qualifiers are often used in the nested loop structure to determine the meaning of a subsequent element. When this happens, it is possible that more than one NSF value may be mapped to a single X12 element. An example of this is shown on page 560 in CAS03. The NSF values mapped to CAS03 will map dependent upon the values in CAS01 and CAS02. For example, FB0-07.0 (Deductible) maps if CAS01=PR and CAS02=1 (Deductible). FB0-08.0 (Co-insurance) maps if CAS01=PR and CAS02=2.

AA0-01.0 RECORD ID AA0	“AA0"
AA0-02.0 SUB ID	1-020-NM101 (41) 1-020-NM109
AA0-03.0 RESERVED (AA0-03.0)	Not Mapped
AA0-04.0 SUBMISSION TYPE	“CPU”
AA0-05.0 SUBMISSION NO	1-010-BHT03
AA0-06.0 SUB NAME	1-020-NM103
AA0-07.0 SUB ADDR1	Not Mapped
AA0-08.0 SUB ADDR2	Not Mapped
AA0-09.0 SUB CITY	Not Mapped
AA0-10.0 SUB STATE	Not Mapped
AA0-11.0 SUB ZIP	Not Mapped
AA0-12.0 SUB REGION	Not Mapped
AA0-13.0 SUB CONTACT	1-045-PER02
AA0-14.0 SUB PHONE	1-045-PER04
AA0-15.0 CREATION DATE	1-010-BHT04
AA0-16.0 SUBMISSION TIME	1-010-BHT05
AA0-17.0 RECEIVER ID	1-020-NM109 1-020-NM101 (40)
AA0-18.0 RECEIVER TYPE CODE	2-005-SBR09
AA0-19.0 VERSION CODE-NATIONAL	“003.01"
AA0-20.0 VERSION CODE-LOCAL	Not Mapped
AA0-21.0 TEST/PROD IND	0-010-ISA15
AA0-22.0 PASSWORD	0-010-ISA04
AA0-23.0 RETRANSMISSION STATUS	0-010-BHT02
AA0-24.0 ORIGINAL SUB ID	Not Mapped
AA0-25.0 VENDOR APP CAT	Not Mapped
AA0-26.0 VENDOR SOFTWARE VER	Not Mapped
AA0-27.0 VENDOR SOFTWARE UP-DTE	Not Mapped
AA0-28.0 **COB FILE INDICATOR (COB)**	Not Mapped
AA0-29.0 PROCESS FROM DATE (COB)	Not Mapped
AA0-30.0 PROCESS THRU DATE (COB)	Not Mapped
AA0-31.0 ACKNOWLEDGEMENT RE-QUESTED	Not Mapped
AA0-32.0 DATE OF RECEIPT	Translator
AA0-33.0 FILLER-NATIONAL	Not Mapped
BA0-01.0 RECORD ID BA0	“BA0"
BA0-02.0 EMC PROV ID	2-015-NM109 (85,87) 2-035-REF02
BA0-03.0 BATCH TYPE	“100"

BA0-04.0 BATCH NO	Translator
BA0-05.0 BATCH ID	Not Mapped
BA0-06.0 PROV TAX ID	2-015-NM109 (85,87) 2-035-REF02 (SY,EI)
BA0-07.0 RESERVED (BA0-07.0)	Not Mapped
BA0-08.0 PROV TAX ID TYPE	2-015-NM109 (85,87) 2-035-REF02
BA0-09.0 NATIONAL PROVIDER IDENTIFIER	2-035-REF02 2-015-NM109(85,87)
BA0-10.0 PROV UPIN NUMBER	2-015-NM109 (85,87) 2-035-REF02 (1G)
BA0-11.0 RESERVED (BA0-11.0)	Not Mapped
BA0-12.0 PROV MEDICAID NO	2-015-NM109 (85,87) 2-035-REF02 (1D)
BA0-13.0 PROV CHAMPUS NO	2-015-NM109 (85,87) 2-035-REF02 (1H)
BA0-14.0 PROV BLUE SHIELD NO	2-015-NM109 (85,87) 2-035-REF02 (1B)
BA0-15.0 PROV COMMERCIAL NO	2-015-NM109 (85,87) 2-035-REF02 (G2)
BA0-16.0 PROV NO 1	2-015-NM109 (85,87) 2-035-REF02
BA0-17.0 PROV NO 2	2-015-NM109 (85,87) 2-035-REF02
BA0-18.0 ORGANIZATION NAME	2-015-NM103 (85,87)
BA0-19.0 PROV LAST NAME	2-015-NM103 (85,87)
BA0-20.0 PROV FIRST NAME	2-015-NM104 2-035-REF02 (0B)
BA0-21.0 PROV MI	2-015-NM105
BA0-22.0 PROV SPECIALTY	2-003-PRV03
BA0-23.0 SPECIALTY LICENSE NO	Not Mapped
BA0-24.0 STATE LICENSE NO	2-015-NM109 (85,87) 2-035-REF02(0B)
BA0-25.0 DENTIST LICENSE NO	Not Mapped
BA0-26.0 ANESTHESIA LICENSE NO	Not Mapped
BA0-27.0 PROV PARTICIPATION IND (COB)	Not Mapped
BA0-28.0 FILLER-NATIONAL	Not Mapped
BA1-01.0 RECORD ID BA1	“BA1"
BA1-02.0 EMC PROV ID	2-015-NM109 (85,87) 2-035-REF02
BA1-03.0 BATCH TYPE	“100"
BA1-04.0 BATCH NO	Translator
BA1-05.0 BATCH ID	Not Mapped
BA1-06.0 PROV TYPE ORG	Not Mapped
BA1-07.0 PROV SVC ADDR1	2-025-N301
BA1-08.0 PROV SVC ADDR2	2-025-N302
BA1-09.0 PROV SVC CITY	2-030-N401
BA1-10.0 PROV SVC STATE	2-030-N402
BA1-11.0 PROV SVC ZIP	2-030-N403
BA1-12.0 PROV SVC PHONE	2-040-PER04
BA1-13.0 PROV PAY TO ADDR1	2-025-N301
BA1-14.0 PROV PAY TO ADDR2	2-025-N302
BA1-15.0 PROV PAY TO CITY	2-030-N401
BA1-16.0 PROV PAY TO STATE	2-030-N402
BA1-17.0 PROV PAY TO ZIP	2-030-N403
BA1-18.0 PROV PAY TO PHONE	2-040-PER04
BA1-19.0 FILLER-NATIONAL	Not Mapped
CA0-01.0 RECORD ID CA0	“CA0"
CA0-02.0 RESERVED (CA0-02.0)	Not Mapped
CA0-03.0 PAT CONTROL NO	2-130-CLM01
CA0-04.0 PAT LAST NAME	2-015-NM103 (QC)
CA0-05.0 PAT FIRST NAME	2-015-NM104
CA0-06.0 PAT MI	2-015-NM105
CA0-07.0 PAT GENERATION	2-015-NM107

CA0-08.0 PAT DATE OF BIRTH	2-032-DMG02
CA0-09.0 PAT SEX	2-032-DMG03
CA0-10.0 PAT TYPE OF RESIDENCE	Not Mapped
CA0-11.0 PAT ADDR1	2-025-N301
CA0-12.0 PAT ADDR2	2-025-N302
CA0-13.0 PAT CITY	2-030-N401
CA0-14.0 PAT STATE	2-030-N402
CA0-15.0 PAT ZIP	2-030-N403
CA0-16.0 PAT PHONE	Not Mapped
CA0-17.0 PAT MARITAL STATUS	Not Mapped
CA0-18.0 PAT STUDENT STATUS	Not Mapped
CA0-19.0 PAT EMPLOYMENT STATUS	Not Mapped
CA0-20.0 PAT DEATH IND	Translator
CA0-21.0 PAT DATE OF DEATH	2-007-PAT06
CA0-22.0 OTHER INSURANCE IND	Not Mapped
CA0-23.0 CLAIM EDITING IND	2-005-SBR09
CA0-24.0 TYPE OF CLAIM IND	Not Mapped
CA0-25.0 LEGAL REP IND	2-015-NM101 (QD)
CA0-26.0 ORIGIN CODE	Not Mapped
CA0-27.0 PAYOR CLM CONTROL NO	Not Mapped
CA0-28.0 PROVIDER NUMBER	2-015-NM109 (85,87) 2-035-REF02
CA0-29.0 CLAIM ID NO	Not Mapped
CA0-30.0 FILLER-NATIONAL	Not Mapped
CA1-01.0 RECORD ID CA1	“CA1"
CA1-02.0 RESERVED (CA1-02.0)	Not Mapped
CA1-03.0 PAT CONTROL NO	2-130-CLM01
CA1-04.0 PURCHASE ORDER NUMBER	Not Mapped
CA1-05.0 TRIBE	2-015-NM109 2-015-NM108 (PB)
CA1-06.0 RESIDENCY CODE	2-015-NM109 2-015-NM108 (PB)
CA1-07.0 PATIENT HEALTH RECORD NUMBER	Not Mapped
CA1-08.0 AUTH FACILITY NUMBER	Not Mapped
CA1-09.0 MULTIPLE CLAIM INDICATOR	Not Mapped
CA1-10.0 FILLER-NATIONAL	Not Mapped
CB0-01.0 RECORD ID CB0	“CB0"
CB0-02.0 RESERVED (CB0-02.0)	Not Mapped
CB0-03.0 PAT CONTROL NO	2-130-CLM01
CB0-04.0 RESP PERSON LAST NAME	2-015-NM103 (QD)
CB0-05.0 RESP PERSON FIRST NAME	2-015-NM104
CB0-06.0 RESP PERSON MI	2-015-NM105
CB0-07.0 RESP PERSON ADDR1	2-025-N301
CB0-08.0 RESP PERSON ADDR2	2-025-N302
CB0-09.0 RESP PERSON CITY	2-030-N401
CB0-10.0 RESP PERSON STATE	2-030-N402
CB0-11.0 RESP PERSON ZIP	2-030-N403
CB0-12.0 RESP PERSON PHONE	Not Mapped
CB0-13.0 FILLER-NATIONAL	Not Mapped

NOTE: If the patient has other primary insurance and Medicare is secondary, the NSF requires a separate DA0 record for each payer. The first DA0 carries information about the primary payer, the second DA0 holds information about the secondary payer. (See Section H for sequencing and payer specific mapping of the NSF)

DA0-01.0 RECORD ID DA0	“DA0"
DA0-02.0 SEQUENCE NO	2-005-SBR01 2-290-SBR01
DA0-03.0 PAT CONTROL NO	2-130-CLM01

DA0-04.0 CLAIM FILING IND	Translator
DA0-05.0 SOURCE OF PAY	2-005-SBR09 2-290-SBR09
DA0-06.0 INSURANCE TYPE CODE	2-005-SBR05 2-290-SBR05
DA0-07.0 PAYOR ORGANIZATION ID	2-325-NM109 2-015-NM109 2-540-SVD01
DA0-08.0 PAYOR CLAIM OFFICE NO	2-035-REF02
DA0-09.0 PAYOR NAME	2-325-NM103 (PR)
DA0-10.0 GROUP NO	2-290-SBR03 2-005-SBR03
DA0-11.0 GROUP NAME	2-290-SBR04 2-005-SBR04
DA0-12.0 PPO/HMO IND	Not Mapped
DA0-13.0 PPO ID	Not Mapped
DA0-14.0 PRIOR AUTH NO	2-180-REF02 (G1)
DA0-15.0 ASSIGN OF BENEFITS	2-310-OI03 2-130-CLM08
DA0-16.0 PAT SIGNATURE SOURCE	2-310-OI04 2-130-CLM10
DA0-17.0 PAT REL TO INSURED	2-005-SBR02 2-290-SBR02 2-007-PAT01 (18)
DA0-18.0 INSURED ID NO	2-015-NM109 (C1) 2-325-NM109 (C1)
DA0-19.0 INSURED LAST NAME	2-015-NM103 2-325-NM103
DA0-20.0 INSURED FIRST NAME	2-015-NM104 2-325-NM104
DA0-21.0 INSURED MI	2-015-NM105 2-325-NM105
DA0-22.0 INSURED GENERATION	2-015-NM107 2-325-NM107
DA0-23.0 INSURED SEX	2-032-DMG03 2-305-DMG03
DA0-24.0 INSURED DATE OF BIRTH	2-032-DMG02 2-305-DMG02
DA0-25.0 INSURED EMPL STATUS	Not Mapped
DA0-26.0 SUPPLEMENTAL INS IND	Not Mapped
DA0-27.0 INSURANCE LOCATION ID	Not Mapped
DA0-28.0 MEDICAID ID NUMBER	Not Mapped
DA0-29.0 SUPPLMTL PATIENT ID (COB)	Not Mapped
DA0-30.0 ASSIGN FOR 4081 CLM (COB)	2-470-REF02 (F5)
DA0-31.0 COB ROUTING INDICATOR (COB)	Not Mapped
DA0-32.0 FILLER-NATIONAL	Not Mapped
DA1-01.0 RECORD ID DA1	“DA1"
DA1-02.0 SEQUENCE NO	2-005-SBR01 2-290-SBR01
DA1-03.0 PAT CONTROL NO	2-130-CLM01
DA1-04.0 PAYOR ADDR1	2-025-N301
DA1-05.0 PAYOR ADDR2	2-025-N302
DA1-06.0 PAYOR CITY	2-030-N401
DA1-07.0 PAYOR STATE	2-030-N402
DA1-08.0 PAYOR ZIP	2-030-N403
DA1-09.0 DISALLOWED COST CONT	2-295-CAS03
DA1-10.0 DISALLOWED OTHER	2-295-CAS03
DA1-11.0 ALLOWED AMOUNT	2-295-CAS03
DA1-12.0 DEDUCTIBLE AMOUNT	2-295-CAS03
DA1-13.0 COINSURANCE AMOUNT	2-295-CAS03
DA1-14.0 PAYOR AMOUNT PAID	2-295-CAS03
DA1-15.0 ZERO PAY IND	Not Mapped
DA1-16.0 ADJUDICATION IND 1	2-295-CAS02
DA1-17.0 ADJUDICATION IND 2	2-295-CAS05
DA1-18.0 ADJUDICATION IND 3	2-295-CAS08
DA1-19.0 CHAMPUS SPNSR BRANCH	Not Mapped

DA1-20.0 CHAMPUS SPNSR GRADE	Not Mapped
DA1-21.0 CHAMPUS SPNSR STATUS	Not Mapped
DA1-22.0 INS CARD EFFECT DATE	Not Mapped
DA1-23.0 INS CARD TERM DATE	Not Mapped
DA1-24.0 BALANCE DUE	Not Mapped
DA1-25.0 EOMB DATE 1 (COB)	Not Mapped
DA1-26.0 EOMB DATE 2 (COB)	Not Mapped
DA1-27.0 EOMB DATE 3 (COB)	Not Mapped
DA1-28.0 EOMB DATE 4 (COB)	Not Mapped
DA1-29.0 CLAIM RECEIPT DATE (COB)	Not Mapped
DA1-30.0 BENE PAID AMT (COB)	2-295-CAS03 2-295-CAS06 2-295-CAS09 2-295-CAS12 2-295-CAS15 2-295-CAS18
DA1-31.0 BENE CHECK/EFT TRACE NO (COB)	Not Mapped
DA1-32.0 BENE CHECK/EFT DATE (COB)	Not Mapped
DA1-33.0 PROV PAID AMT (COB)	2-295-CAS03 2-295-CAS06 2-295-CAS09 2-295-CAS12 2-295-CAS15 2-295-CAS18
DA1-34.0 PROV CHECK/EFT TRACE NO (COB)	Not Mapped
DA1-35.0 PROV CHECK DATE (COB)	Not Mapped
DA1-36.0 INTEREST PAID (COB)	Not Mapped
DA1-37.0 APPROVED AMOUNT (COB)	2-300-AMT02 (AAE)
DA1-38.0 CONTRACTUAL AGREEMENT IND	Not Mapped
DA1-39.0 FILLER-NATIONAL	Not Mapped
DA2-01.0 RECORD ID DA2	“DA2"
DA2-02.0 SEQUENCE NO	2-005-SBR01 2-290-SBR01
DA2-03.0 PAT CONTROL NO	2-130-CLM01
DA2-04.0 INSURED ADDR1	2-025-N301 (IL) 2-332-N301 (IL)
DA2-05.0 INSURED ADDR2	2-025-N302 2-332-N302
DA2-06.0 INSURED CITY	2-030-N401 2-340-N401
DA2-07.0 INSURED STATE	2-030-N402 2-340-N402
DA2-08.0 INSURED ZIP	2-030-N403 2-340-N403
DA2-09.0 INSURED PHONE	Not Mapped
DA2-10.0 INSURED RETIRE DATE	Not Mapped
DA2-11.0 INSURED SPOUSE RETIRE	Not Mapped
DA2-12.0 INSURED EMPLR NAME	Not Mapped
DA2-13.0 INSURED EMPLR ADDR1	Not Mapped
DA2-14.0 INSURED EMPLR ADDR2	Not Mapped
DA2-15.0 INSURED EMPLR CITY	Not Mapped
DA2-16.0 INSURED EMPLR STATE	Not Mapped
DA2-17.0 INSURED EMPLR ZIP	Not Mapped
DA2-18.0 EMPLOYEE ID NO	Not Mapped
DA2-19.0 FILLER-NATIONAL	Not Mapped
DA3-01.0 RECORD ID DA3	“DA3”
DA3-02.0 SEQUENCE NO	2-005-SBR01 2-290-SBR01
DA3-03.0 PAT CONTROL NO	2-130-CLM01
DA3-04.0 CLAIM REASON 1	2-295-CAS02 2-295-CAS05 2-295-CAS08 2-295-CAS11 2-295-CAS14 2-295-CAS17

DA3-05.0	
DOLLAR AMOUNT 1	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-06.0	
CLAIM REASON CODE 2	2-295-CAS02
	2-295-CAS05
	2-295-CAS08
	2-295-CAS11
	2-295-CAS14
	2-295-CAS17
DA3-07.0	
DOLLAR AMOUNT 2	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-08.0	
CLAIM REASON CODE 3	2-295-CAS02
	2-295-CAS05
	2-295-CAS08
	2-295-CAS11
	2-295-CAS14
	2-295-CAS17
DA3-09.0	
DOLLAR AMOUNT 3	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-10.0	
CLAIM REASON CODE 4	2-295-CAS02
	2-295-CAS05
	2-295-CAS08
	2-295-CAS11
	2-295-CAS14
	2-295-CAS17
DA3-11.0	
DOLLAR AMOUNT 4	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-12.0	
CLAIM REASON CODE 5	2-295-CAS02
	2-295-CAS05
	2-295-CAS08
	2-295-CAS11
	2-295-CAS14
	2-295-CAS17
DA3-13.0	
DOLLAR AMOUNT 5	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-14.0	
CLAIM REASON CODE 6	2-295-CAS02
	2-295-CAS05
	2-295-CAS08
	2-295-CAS11
	2-295-CAS14
	2-295-CAS17
DA3-15.0	
DOLLAR AMOUNT 6	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-16.0	
CLAIM REASON CODE 7	2-295-CAS02
	2-295-CAS05
	2-295-CAS08
	2-295-CAS11
	2-295-CAS14
	2-295-CAS17
DA3-17.0	
DOLLAR AMOUNT 7	2-295-CAS03
	2-295-CAS06
	2-295-CAS09
	2-295-CAS12
	2-295-CAS15
	2-295-CAS18
DA3-18.0	
CLAIM MESSAGE CODE 1	2-320-MOA03
	2-320-MOA04
	2-320-MOA05
	2-320-MOA06
	2-320-MOA07
DA3-19.0	
CLAIM MESSAGE CODE 2	2-320-MOA03
	2-320-MOA04
	2-320-MOA05
	2-320-MOA06
	2-320-MOA07
DA3-20.0	
CLAIM MESSAGE CODE 3	2-320-MOA03
	2-320-MOA04
	2-320-MOA05
	2-320-MOA06
	2-320-MOA07
DA3-21.0	
CLAIM MESSAGE CODE 4	2-320-MOA03
	2-320-MOA04
	2-320-MOA05
	2-320-MOA06
	2-320-MOA07
DA3-22.0	
CLAIM MESSAGE CODE 5	2-320-MOA03
	2-320-MOA04
	2-320-MOA05
	2-320-MOA06
	2-320-MOA07
DA3-23.0	
CLAIM DETAIL LINE COUNT	Translator
DA3-24.0	
CLAIM ADJUST IND	2-355-REF02 (T4)

DA3-25.0 PROV ADJUST AMT	2-295-CAS03 2-295-CAS06 2-295-CAS09 2-295-CAS12 2-295-CAS15 2-295-CAS18
DA3-26.0 BENE ADJUST AMT	2-295-CAS03 2-295-CAS06 2-295-CAS09 2-295-CAS12 2-295-CAS15 2-295-CAS18
DA3-27.0 ORIG APPROVE AMT	Not Mapped
DA3-28.0 ORIG PAID AMT	Not Mapped
DA3-29.0 ORIG PAYOR CLM CON-TROL NO	2-355-REF02(F8)
DA3-30.0 FILLER-NATIONAL	Not Mapped
EA0-01.0 RECORD ID EA0	“EA0"
EA0-02.0 RESERVED (EA0-02.0)	Not Mapped
EA0-03.0 PAT CONTROL NO	2-130-CLM01
EA0-04.0 EMPL RELATED IND	2-130-CLM11-1
EA0-05.0 ACCIDENT IND	2-130-CLM11-1
EA0-06.0 SYMPTOM IND	2-135-DTP01 (431) OR 2-135-DTP01 (439) OR 2-135-DTP01 (484)
EA0-07.0 ACCIDENT/SYMPTOM DATE	2-135-DTP03 (439)
EA0-08.0 EXT CAUSE OF ACCIDENT	Not Mapped
EA0-09.0 RESPONSIBILITY IND	2-130-CLM11-1 (AP)
EA0-10.0 ACCIDENT STATE	2-130-CLM11-4
EA0-11.0 ACCIDENT HOUR	2-135-DTP03 (439) 2-135-DTP02 (TR)
EA0-12.0 ABUSE IND	Not Mapped
EA0-13.0 RELEASE OF INFO IND	2-130-CLM09
EA0-14.0 RELEASE OF INFO DATE	Not Mapped
EA0-15.0 SAME/SIMILAR SYMP IND	Translator
EA0-16.0 SAME/SIMILAR SYMP DATE	2-135-DTP03 (438)
EA0-17.0 DISABILITY TYPE	Not Mapped
EA0-18.0 DISABILITY-FROM DATE	2-135-DTP03 (360)
EA0-19.0 DISABILITY-TO DATE	2-135-DTP03 (361)
EA0-20.0 REFER PROV NPI	2-250-NM109 (UP) 2-271-REF02
EA0-21.0 REFER PROV UPIN (COB)	Not Mapped
EA0-22.0 REFER PROV TAX TYPE (COB)	Not Mapped
EA0-23.0 REFER PROV TAX ID (COB)	Not Mapped
EA0-24.0 REFER PROV LAST NAME	2-250-NM103 (DN)
EA0-25.0 REFER PROV FIRST NAME	2-250-NM104
EA0-26.0 REFER PROV MI	2-250-NM105
EA0-27.0 REFER PROV STATE	Not Mapped
EA0-28.0 ADMISSION DATE-1	2-135-DTP03 (435)
EA0-29.0 DISCHARGE DATE-1	2-135-DTP03 (096)
EA0-30.0 LAB IND	Translator
EA0-31.0 LAB CHARGES	2-175-AMT02 (NE)
EA0-32.0 DIAGNOSIS CODE-1	2-231-HI01-2 (BK)
EA0-33.0 DIAGNOSIS CODE-2	2-231-HI02-2 (BF)
EA0-34.0 DIAGNOSIS CODE-3	2-231-HI03-2 (BF)
EA0-35.0 DIAGNOSIS CODE-4	2-231-HI04-2 (BF)
EA0-36.0 PROV ASSIGN IND	2-130-CLM07
EA0-37.0 PROV SIGNATURE IND	2-130-CLM06
EA0-38.0 PROV SIGNATURE DATE	Not Mapped
EA0-39.0 FACILITY/LAB NAME	2-250-NM103 (FA,TL,77,LI)
EA0-40.0 DOCUMENTATION IND	2-155-PWK02 2-420-PWK02
EA0-41.0 TYPE OF DOCUMENTATION	2-155-PWK01
EA0-42.0 FUNCTNL STATUS CODE	Not Mapped

EA0-43.0 SPECIAL PROGRAM IND	2-130-CLM12 2-180-REF02
EA0-44.0 CHAMPUS NONAVAIL IND	Not Mapped
EA0-45.0 SUPV PROV IND	Not Mapped
EA0-46.0 RESUBMISSION CODE	Not Mapped
EA0-47.0 RESUB REFERENCE NO	2-180-REF02 (F8)
EA0-48.0 DATE LAST SEEN	2-135-DTP03 (304) 2-455-DTP03 (304)
EA0-49.0 DATE DOCUMENT SENT	Not Mapped
EA0-50.0 HOMEBOUND INDICATOR	2-220-CRC01 (75) 2-220-CRC03 (IH)
EA0-51.0 BLOOD UNITS PAID (COB)	Not Mapped
EA0-52.0 BLOOD UNITS REMAINING (COB)	Not Mapped
EA0-53.O CARE PLAN OVERSIGHT (CPO) ID	2-250-NM109 2-250-NM101 (FA) 2-250-NM108 (MP) 2-271-REF02
EA0-54.0 INVESTIGAT DEVICE EXEMPTION ID	2-180-REF01 (LX) 2-180-REF02
EA0-55.0 FILLER-NATIONAL	Not Mapped
EA1-01.0 RECORD ID EA1	“EA1"
EA1-02.0 RESERVED (EA1-02.0)	Not Mapped
EA1-03.0 PAT CONTROL NO	2-130-CLM01
EA1-04.0 FACILITY/LAB NPI	2-250-NM103 (FA,TL,77,LI) 2-271-REF02
EA1-05.0 RESERVED (EA1-05.0)	Not Mapped
EA1-06.0 FACILITY/LAB ADDR1	2-265-N301
EA1-07.0 FACILITY/LAB ADDR2	2-265-N302
EA1-08.0 FACILITY/LAB CITY	2-270-N401
EA1-09.0 FACILITY/LAB STATE	2-270-N402
EA1-10.0 FACILITY/LAB ZIP CODE	2-270-N403
EA1-11.0 MEDICAL RECORD NO	Not Mapped
EA1-12.0 RETURN TO WORK DATE	2-135-DTP03 (296)
EA1-13.0 CONSULT/SURGERY DATE	Not Mapped
EA1-14.0 ADMISSION DATE-2	Not Mapped
EA1-15.0 DISCHARGE DATE-2	Not Mapped
EA1-16.0 SUPV PROV NPI	2-250-NM109 (MP) 2-271-REF02
EA1-17.0 RESERVED (EA1-17.0)	Not Mapped
EA1-18.0 SUPV PROV LAST	2-250-NM103 (DQ)
EA1-19.0 SUPV PROV FIRST	2-250-NM104
EA1-20.0 SUPV PROV MI	2-250-NM105
EA1-21.0 SUPV PROV STATE	Not Mapped
EA1-22.0 EMT/PARAMEDIC LAST NAME	Not Mapped
EA1-23.0 EMT/PARAMEDIC FIRST NAME	Not Mapped
EA1-24.0 EMT/PARAMEDIC MI	Not Mapped
EA1-25.0 DATE CARE ASSUMED	2-135-DTP03 (090)
EA1-26.0 DIAGNOSIS CODE -5	Not Mapped
EA1-27.0 DIAGNOSIS CODE -6	Not Mapped
EA1-28.0 DIAGNOSIS CODE -7	Not Mapped
EA1-29.0 DIAGNOSIS CODE -8	Not Mapped
EA1-30.0 FILLER-NATIONAL	Not Mapped
EA2-01.0 RECORD ID EA2	“EA2"
EA2-02.0 RESERVED (EA2-02.0)	Not Mapped
EA2-03.0 PAT CONTROL NO	Not Mapped
EA2-04.0 FILLER-EPSDT	Not Mapped
EA2-94.0 FILLER-NATIONAL	Not Mapped
EA2-95.0 FILLER-LOCAL	Not Mapped
FA0-01.0 RECORD ID FA0	“FA0"
FA0-02.0 SEQUENCE NO	2-365-LX01

FA0-03.0 PAT CONTROL NO	2-130-CLM01
FA0-04.0 LINE ITEM CONTROL NO	2-470-REF02 (6R)
FA0-05.0 SVC FROM DATE	2-455-DTP03 (472)
FA0-06.0 SVC TO DATE	2-455-DTP03 (472)
FA0-07.0 PLACE OF SVC	2-130-CLM05-1 2-370-SV105
FA0-08.0 TYPE OF SVC CODE	2-370-SV106
FA0-09.0 HCPCS PROCEDURE CODE	2-370-SV101-2 (HC)
FA0-10.0 HCPCS MODIFIER 1	2-370-SV101-3
FA0-11.0 HCPCS MODIFIER 2	2-370-SV101-4
FA0-12.0 HCPCS MODIFIER 3	2-370-SV101-5
FA0-13.0 LINE CHARGES	2-370-SV102
FA0-14.0 DIAG CODE POINTER1	2-370-SV107-1
FA0-15.0 DIAG CODE POINTER2	2-370-SV107-2
FA0-16.0 DIAG CODE POINTER3	2-370-SV107-3
FA0-17.0 DIAG CODE POINTER4	2-370-SV107-4
FA0-18.0 UNITS OF SVC	2-370-SV104 (UN)
FA0-19.0 ANESTHESIA/OXYGEN MINUTES	2—370-SV104 (MJ)
FA0-20.0 EMERGENCY IND	2-370-SV109
FA0-21.0 COB IND	Not Mapped
FA0-22.0 HPSA IND	Not Mapped
FA0-23.0 RENDERING PROV NPI	2-250-NM109 (MP) OR 2-500-NM109 (MP)
FA0-24.0 REFERRING PROV NPI	2-250-NM109 (UP) 2-500-NM109 (UP)
FA0-25.0 REFERRING PROV STATE	Not Mapped
FA0-26.0 PUR SVC IND	Translator
FA0-27.0 DISALLOW COST CONTAIN	2-545-CAS03
FA0-28.0 DISALLOWED OTHER	2-545-CAS03
FA0-29.0 REVIEW BY CODE IND	Not Mapped
FA0-30.0 MULTI PROCEDURE IND	Not Mapped
FA0-31.0 MAMMOGRAPHY CERT NO	2-470-REF02 (EW)
FA0-32.0 CLASS FINDINGS	Not Mapped
FA0-33.0 PODIATRY SVC COND	Not Mapped
FA0-34.0 CLIA ID NO	2-470-REF02 (X4) 2-180-REF02(X4)
FA0-35.0 PRIMARY PAID AMOUNT	2-545-CAS03
FA0-36.0 HCPCS MODIFIER 4	2-370-SV101-6
FA0-37.0 PROVIDER SPECIALTY	2-255-PRV03
FA0-38.0 PODIATRY THERAPY IND	Not Mapped
FA0-39.0 PODIATRY THERAPY TYPE	Not Mapped
FA0-40.0 HOSPICE EMPLOYED PROV IND	2-450-CRC02 (70)
FA0-41.0 HGB/HCT DATE	2-455-DTP03 (738)
FA0-42.0 HGB RESULT	2-462-MEA03 (TR,R1)
FA0-43.0 HCT RESULT	2-462-MEA03 (TR,R2)
FA0-44.0 PATIENT WEIGHT	2-090-PAT08 (01)
FA0-45.0 EPO DOSAGE	2-462-MEA03 (OG,R3)
FA0-46.0 SERUM CREATINE DATE	2-455-DTP03 (739)
FA0-47.0 CREATINE RESULT	2-462-MEA03 (TR,R4)
FA0-48.0 OBLIGATED ACCEPT AMT	2-545-CAS03
FA0-49.0 DRUG DISCOUNT AMOUNT	Not Mapped
FA0-50.0 TYPE OF UNITS INDICATOR (COB)	2-370-SV103 2-195-CR106 2-425-CR106
FA0-51.0 APPROVED AMOUNT (COB)	2-475-AMT02 (AAE)
FA0-52.0 PAID AMOUNT (COB)	2-540-SVD02

FA0-53.0 BENE LIABILITY AMOUNT (COB)	2-545-CAS03 2-545-CAS06 2-545-CAS09 2-545-CAS12 2-545-CAS15 2-545-CAS18
FA0-54.0 BALANCE BILL LIMITING CHG (COB)	2-545-CAS03 2-545-CAS06 2-545-CAS09 2-545-CAS12 2-545-CAS15 2-545-CAS18
FA0-55.0 LIMITING CHARGE PER-CENT (COB)	Not Mapped
FA0-56.0 PERF PROV PHONE (COB)	Not Mapped
FA0-57.0 PERF PROV TAX TYPE (COB)	2-500-NM108 (24,34) 2-525-REF01 (SY,EI)
FA0-58.0 PERF PROV TAX ID (COB)	2-500-NM108 (24,34) 2-525-REF02 (SY,EI)
FA0-59.0 PERF PROV ASSIGN IND (COB)	2-130-CLM07
FA0-60.0 PRE-TRANSPLANT IND	Not Mapped
FA0-61.0 ICD-10-PCS	Not Mapped
FA0-62.0 UNIVERSAL PRODUCT CODE NUMBER	2-470-REF02 (OZ) 2-470-REF02 (VP)
FA0-63.0 DIAG CODE POINTER 5	Not Mapped
FA0-64.0 DIAG CODE POINTER 6	Not Mapped
FA0-65.0 DIAG CODE POINTER 7	Not Mapped
FA0-66.0 DIAG CODE POINTER 8	Not Mapped
FB0-01.0 RECORD ID FB0	“FB0"
FB0-02.0 SEQUENCE NO	2-365-LX01
FB0-03.0 PAT CONTROL NO	2-130-CLM01
FB0-04.0 LINE ITEM CONTROL NO	2-470-REF02 (6R)
FB0-05.0 PUR SVC CHARGE	2-490-PS102
FB0-06.0 ALLOWED AMOUNT	2-545-CAS03
FB0-07.0 DEDUCTIBLE AMOUNT	2-545-CAS03
FB0-08.0 COINSURANCE AMOUNT	2-545-CAS03
FB0-09.0 ORDERING PROV ID	2-500-NM109 (UP)
FB0-10.0 ORDERING PROV STATE	Not Mapped
FB0-11.0 PUR SVC PROV ID	2-490-PS101 (QB) 2-500-NM109 (QB) 2-271-REF02 2-250-NM109
FB0-12.0 PUR SVC STATE	Not Mapped
FB0-13.0 PEN GRAMS OF PROTEIN	Not Mapped
FB0-14.0 PEN CALORIES	Not Mapped
FB0-15.0 NATIONAL DRUG CODE	2-370-SV101-2
FB0-16.0 NATIONAL DRUG UNITS	2-370-SV104
FB0-17.0 PRESCRIPTION NO	Not Mapped
FB0-18.0 PRESCRIPTION DATE	Not Mapped
FB0-19.0 PRESCRIPT NO OF MOS	Not Mapped
FB0-20.0 SPEC PRICING IND	Not Mapped
FB0-21.0 COPAY STATUS IND	2-370-SV115
FB0-22.0 EPSDT IND	2-370-SV111
FB0-23.0 FAMILY PLANNING IND	2-370-SV112
FB0-24.0 DME CHARGE IND	Not Mapped
FB0-25.0 HPSA FACILITY ID	Not Mapped
FB0-26.0 HPSA FACILITY ZIP	Not Mapped
FB0-27.0 PUR SVC NAME	Not Mapped
FB0-28.0 PUR SVC ADDR1	Not Mapped
FB0-29.0 PUR SVC ADDR2	Not Mapped
FB0-30.0 PUR SVC CITY	Not Mapped
FB0-31.0 PUR SVC ZIP	Not Mapped
FB0-32.0 PUR SVC PHONE	Not Mapped
FB0-33.0 DRUG DAYS SUPPLY	Not Mapped

FB0-34.0 PAYMENT TYPE IND (COB)	Not Mapped
FB0-35.0 FILLER-NATIONAL	Not Mapped
FB1-01.0 RECORD ID FB1	“FB1"
FB1-02.0 SEQUENCE NO	2-365-LX01
FB1-03.0 PAT CONTROL NO	2-130-CLM01
FB1-04.0 LINE ITEM CONTROL NO	2-470-REF02 (6R)
FB1-05.0 PLACE OF SVC NAME	Not Mapped
FB1-06.0 ORDERING PROV LAST	2-500-NM103 (DK)
FB1-07.0 ORDERING PROV FIRST	2-500-NM104
FB1-08.0 ORDERING PROV MI	2-500-NM105
FB1-09.0 ORDERING PROV UPIN	2-500-NM109 (UP)
FB1-10.0 REFERRING PROV LAST	2-500-NM103 (DN)
FB1-11.0 REFERRING PROV FIRST	2-500-NM104
FB1-12.0 REFERRING PROV MI	2-500-NM105
FB1-13.0 REFERRING PROV UPIN	2-500-NM109 (UP)
FB1-14.0 RENDERING PROV LAST	2-250-NM103 (82) 2-500-NM103 (82)
FB1-15.0 RENDERING PROV FIRST	2-250-NM104 2-500-NM104
FB1-16.0 RENDERING PROV MI	2-250-NM105 2-500-NM105
FB1-17.0 RENDERING PROV UPIN	Not Mapped
FB1-18.0 SUPV PROV LAST	2-500-NM103 (DQ)
FB1-19.0 SUPV PROV FIRST	2-500-NM104
FB1-20.0 SUPV PROV MI	2-500-NM105
FB1-21.0 SUPV PROV ID	2-500-NM109 (MP)
FB1-22.0 SUPV PROV UPIN	Not Mapped
FB1-23.0 FILLER-NATIONAL	Not Mapped
FB2-01.0 RECORD ID FB2	“FB2"
FB2-02.0 SEQUENCE NO	2-365-LX01
FB2-03.0 PAT CONTROL NO	2-130-CLM01
FB2-04.0 LINE ITEM CONTROL NO	2-470-REF02 (6R)
FB2-05.0 PROV TYPE IND A	Not Mapped
FB2-06.0 PROV A TYPE ADDR 1	2-514-N301 (DK,DQ)
FB2-07.0 PROV A TYPE ADDR 2	2-514-N302
FB2-08.0 PROV A TYPE CITY	2-520-N401
FB2-09.0 PROV A TYPE STATE	2-520-N402
FB2-10.0 PROV A ZIP	2-520-N403
FB2-11.0 PROV TYPE IND B	Not Mapped
FB2-12.0 PROV B TYPE ADDR 1	Not Mapped
FB2-13.0 PROV B TYPE ADDR 2	Not Mapped
FB2-14.0 PROV B TYPE CITY	Not Mapped
FB2-15.0 PROV B TYPE STATE	Not Mapped
FB2-16.0 PROV B ZIP	Not Mapped
FB2-17.0 PROV TYPE IND C	Not Mapped
FB2-18.0 PROV C TYPE ADDR 1	Not Mapped
FB2-19.0 PROV C TYPE ADDR 2	Not Mapped
FB2-20.0 PROV C TYPE CITY	Not Mapped
FB2-21.0 PROV C TYPE STATE	Not Mapped
FB2-22.0 PROV C ZIP	Not Mapped
FB2-23.0 FILLER-NATIONAL	Not Mapped
FB3-01.0 RECORD ID FB3	“FB3"
FB3-02.0 SEQUENCE NO	2-365-LX01
FB3-03.0 PAT CONTROL NO	2-130-CLM01
FB3-04.0 LINE ITEM CONTROL NO	2-470-REF02(6R)
FB3-05.0 REASON CODE 1	2-545-CAS02 2-545-CAS05 2-545-CAS08 2-545-CAS11 2-545-CAS14 2-545-CAS17

FB3-06.0	
DOLLAR AMOUNT 1	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18
FB3-07.0	
REASON CODE 2	2-545-CAS02
	2-545-CAS05
	2-545-CAS08
	2-545-CAS11
	2-545-CAS14
	2-545-CAS17
FB3-08.0	
DOLLAR AMOUNT 2	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18
FB3-09.0	
REASON CODE 3	2-545-CAS02
	2-545-CAS05
	2-545-CAS08
	2-545-CAS11
	2-545-CAS14
	2-545-CAS17
FB3-10.0	
DOLLAR AMOUNT 3	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18
FB3-11.0	
REASON CODE 4	2-545-CAS02
	2-545-CAS05
	2-545-CAS08
	2-545-CAS11
	2-545-CAS14
	2-545-CAS17
FB3-12.0	
DOLLAR AMOUNT 4	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18
FB3-13.0	
REASON CODE 5	2-545-CAS02
	2-545-CAS05
	2-545-CAS08
	2-545-CAS11
	2-545-CAS14
	2-545-CAS17
FB3-14.0	
DOLLAR AMOUNT 5	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18

FB3-15.0	
REASON CODE 6	2-545-CAS02
	2-545-CAS05
	2-545-CAS08
	2-545-CAS11
	2-545-CAS14
	2-545-CAS17
FB3-16.0	
DOLLAR AMOUNT 6	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18
FB3-17.0	
REASON CODE 7	2-545-CAS02
	2-545-CAS05
	2-545-CAS08
	2-545-CAS11
	2-545-CAS14
	2-545-CAS17
FB3-18.0	
DOLLAR AMOUNT 7	2-545-CAS03
	2-545-CAS06
	2-545-CAS09
	2-545-CAS12
	2-545-CAS15
	2-545-CAS18
FB3-19.0	
FILLER-NATIONAL	Not Mapped
FD0-01.0	
RECORD ID FD0	“FD0"
FD0-02.0	
SEQUENCE NO	Not Mapped
FD0-03.0	
PAT CONTROL NO	Not Mapped
FD0-04.0	
FILLER-DENTAL	Not Mapped
FD0-64.0	
FILLER-NATIONAL	Not Mapped
FE0-01.0	
RECORD ID FE0	“FE0"
FE0-02.0	
SEQUENCE NO	Not Mapped
FE0-03.0	
PAT CONTROL NO	Not Mapped
FE0-04.0	
FILLER-TPO	Not Mapped
FE0-06.0	
TPO REFERENCE NUMBER	2-180-REF02 (9A)
FE0-16.0	
FILLER-NATIONAL	Not Mapped
GA0-01.0	
RECORD ID GA0	“GA0"
GA0-02.0	
SEQUENCE NO	2-365-LX01
GA0-03.0	
PAT CONTROL NO	2-130-CLM01
GA0-04.0	
RESERVED (GA0-04.0)	Not Mapped

GA0-05.0 PATIENTS WEIGHT	2-195-CR102 (LB) 2-425-CR102 (LB)
GA0-06.0 HOSPITAL ADMIT	2-220-CRC03 (01) 2-450-CRC03 (01)
GA0-07.0 TYPE OF TRANSPORT	2-195-CR103 2-425-CR103
GA0-08.0 BED CONFINED-BEFORE	2-220-CRC03 (02) 2-450-CRC03 (02)
GA0-09.0 BED CONFINED-AFTER	2-220-CRC03 (03) 2-450-CRC03 (03)
GA0-10.0 MOVED BY STRETCHER	2-220-CRC03 (04) 2-450-CRC03 (04)
GA0-11.0 UNCONSCIOUS/SHOCK	2-220-CRC03 (05) 2-450-CRC03 (05)
GA0-12.0 EMERGENCY SITUATION	2-220-CRC03 (06) 2-450-CRC03 (06)
GA0-13.0 PHYSICAL RESTRAINTS	2-220-CRC03 (07) 2-450-CRC03 (07)
GA0-14.0 VISIBLE HEMORRHAGING	2-220-CRC03 (08) 2-450-CRC03 (08)
GA0-15.0 TRANSPORTED TO/FOR	2-195-CR104 2-425-CR104
GA0-16.0 MEDICALLY NECESSARY	2-220-CRC03 (09) 2-450-CRC03 (09)
GA0-17.0 MILES	2-195-CR106 (DH) 2-425-CR106 (DH)
GA0-18.0 ORIGIN INFO	Not Mapped
GA0-19.0 DESTINATION INFO	Not Mapped
GA0-20.0 PURPOSE OF ROUND TRIP	2-195-CR109 2-425-CR109
GA0-21.0 PURPOSE OF STRETCHER	2-195-CR110 2-425-CR110
GA0-22.0 PATIENT DISCHARGED	2-135-DTP03 (096)
GA0-23.0 PATIENT ADMITTED	2-135-DTP03 (435)
GA0-24.0 SERVICES AVAILABLE	2-220-CRC03 (60) 2-450-CRC03 (60)
GA0-25.0 FILLER-NATIONAL	Not Mapped
GC0-01.0 RECORD ID GC0	“GC0"
GC0-02.0 SEQUENCE NO	2-365-LX01
GC0-03.0 PAT CONTROL NO	2-130-CLM01
GC0-04.0 RESERVED (GC0-04.0)	Not Mapped
GC0-05.0 INITIAL TREATMENT DATE	2-135-DTP03 (454) 2-455-DTP03 (454)
GC0-06.0 DATE OF LAST X-RAY	2-135-DTP03 (455) 2-455-DTP03 (455)
GC0-07.0 NO IN SERIES	2-200-CR201 2-430-CR201 2-200-CR202 2-430-CR202
GC0-08.0 LEVEL OF SUBLUXATION	2-200-CR203 2-430-CR203
GC0-08.0 LEVEL OF SUBLUXATION	2-200-CR204 2-430-CR204
GC0-09.0 TREATMENT MONTHS/YEARS	2-200-CR206 (MO) 2-430-CR206 (MO)
GC0-10.0 NO TREATMENTS - MONTH	2-200-CR207 2-430-CR207
GC0-11.0 NATURE OF CONDITION	2-200-CR208 2-430-CR208
GC0-12.0 DATE OF MANIFESTATION	2-135-DTP03 (453) 2-455-DTP03 (453)
GC0-13.0 COMPLICATION IND	2-200-CR209 2-430-CR209
GC0-14.0 SYMPTOMS DESCRIPTION	2-200-CR210 2-430-CR210
GC0-14.0 SYMPTOMS DESCRIPTION	2-200-CR211 2-430-CR211
GC0-15.0 X-RAY IND	2-200-CR212 2-430-CR212
GC0-16.0 FILLER-NATIONAL	Not Mapped
GD0-01.0 RECORD ID GD0	Not Mapped
GD0-02.0 SEQUENCE NO	Not Mapped
GD0-03.0 PAT CONTROL NO	Not Mapped
GD0-04.0 CERTIFICATION TYPE	Not Mapped
GD0-05.0 MEDICAL NECESSITY	Not Mapped

GD0-06.0 PROGNOSIS	Not Mapped
GD0-07.0 HCPCS PROCEDURE CODE	Not Mapped
GD0-08.0 AMBULATORY	Not Mapped
GD0-09.0 AMBULATION/THERAPY	Not Mapped
GD0-10.0 CONFINED BED/CHAIR	Not Mapped
GD0-11.0 ROOM CONFINED	Not Mapped
GD0-12.0 AMBULATION/MOBILITY	Not Mapped
GD0-13.0 BODY POSITIONING	Not Mapped
GD0-14.0 RESPIRATORY/OTHER	Not Mapped
GD0-15.0 BREATHING IMPAIRED	Not Mapped
GD0-16.0 FREQ/IMMED CHANGES	Not Mapped
GD0-17.0 OPERATE CONTROLS	Not Mapped
GD0-18.0 SIDERAILS PART/BED	Not Mapped
GD0-19.0 OWNS EQUIPMENT	Not Mapped
GD0-20.0 MATTRESS/SIDERAILS	Not Mapped
GD0-21.0 EQUIPMENT/ASSISTANCE	Not Mapped
GD0-22.0 ORTHOPEDIC IMPAIR	Not Mapped
GD0-23.0 PLANNED REGIMEN	Not Mapped
GD0-24.0 DECUBITUS ULCERS	Not Mapped
GD0-25.0 EQUIPMENT USE	Not Mapped
GD0-26.0 INSULIN DEPENDENT	Not Mapped
GD0-27.0 DIABETIC CONTROL	Not Mapped
GD0-28.0 APNEA EPISODES	Not Mapped
GD0-29.0 SURGERY ALTERNATIVE	Not Mapped
GD0-30.0 TOTAL KNEE REPLACE	Not Mapped
GD0-31.0 DATE SURGERY	Not Mapped
GD0-32.0 DATE CPM	Not Mapped
GD0-33.0 LYMPHEDEMA	Not Mapped
GD0-34.0 ORDERING PROV LAST	Not Mapped
GD0-35.0 ORDERING PROV FIRST	Not Mapped
GD0-36.0 ORDERING PROV MI	Not Mapped
GD0-37.0 ORDERING PROV ID	Not Mapped
GD0-38.0 ORDERING PROV PHONE	Not Mapped
GD0-39.0 DATE CERTIFICATION	Not Mapped
GD0-40.0 CERTIFICATION ON FILE	Not Mapped
GD0-41.0 DIAGNOSIS CODE-1	Not Mapped
GD0-42.0 DIAGNOSIS CODE-2	Not Mapped
GD0-43.0 DIAGNOSIS CODE-3	Not Mapped
GD0-44.0 DIAGNOSIS CODE-4	Not Mapped
GD0-45.0 NURSING HOME IND	Not Mapped
GD0-46.0 NH FROM DATE	Not Mapped
GD0-47.0 NH TO DATE	Not Mapped
GD0-48.0 RESPIRATORY TRACT	Not Mapped
GD0-49.0 SUPV OF EQUIPMENT USE	Not Mapped
GD0-50.0 PROPEL/LIFT CHAIR	Not Mapped
GD0-51.0 LEG ELEVATION	Not Mapped
GD0-52.0 PATIENT WEIGHT	Not Mapped
GD0-53.0 RECLINING WHEELCHAIR	Not Mapped
GD0-54.0 MANUAL OPERATION	Not Mapped
GD0-55.0 SIDE TRANSFER CHAIR	Not Mapped
GD0-56.0 FILLER-NATIONAL	Not Mapped
GD1-01.0 RECORD ID GD1	Not Mapped
GD1-02.0 SEQUENCE NO	Not Mapped
GD1-03.0 PAT CONTROL NO	Not Mapped
GD1-04.0 NARRATIVE	Not Mapped
GD1-05.0 FILLER-NATIONAL	Not Mapped

GE0-01.0 RECORD ID GE0	Not Mapped
GE0-02.0 SEQUENCE NO	Not Mapped
GE0-03.0 PAT CONTROL NO	Not Mapped
GE0-04.0 CERTIFICATION TYPE	Not Mapped
GE0-05.0 ONSET DT OF THERAPY	Not Mapped
GE0-06.0 THERAPY DURATION	Not Mapped
GE0-07.0 LAST CERT DATE	Not Mapped
GE0-08.0 NO OF MONTHS CERT	Not Mapped
GE0-09.0 DT LAST SEEN BY PHY	Not Mapped
GE0-10.0 NON VISIT IND	Not Mapped
GE0-11.0 PAT AGE	Not Mapped
GE0-12.0 PAT HEIGHT	Not Mapped
GE0-13.0 PAT WEIGHT	Not Mapped
GE0-14.0 LEVEL OF CONS IND	Not Mapped
GE0-15.0 AMBULATORY IND	Not Mapped
GE0-16.0 OTHER FORMS OF NUTR IND	Not Mapped
GE0-17.0 METHOD ADMIN IND	Not Mapped
GE0-18.0 ADMIN TECH IND	Not Mapped
GE0-19.0 TOTAL CAL PER DAY	Not Mapped
GE0-20.0 PRODUCT NAME 1	Not Mapped
GE0-21.0 CAL PER PRODUCT 1	Not Mapped
GE0-22.0 HCPCS PROCEDURE CODE	Not Mapped
GE0-23.0 HCPCS MODIFIER 1	Not Mapped
GE0-24.0 HCPCS MODIFIER 2	Not Mapped
GE0-25.0 ENTERAL FREQ FED 1	Not Mapped
GE0-26.0 NARRATIVE FIELD	Not Mapped
GE0-27.0 PRODUCT NAME 2	Not Mapped
GE0-28.0 CAL PER PRODUCT 2	Not Mapped
GE0-29.0 ENTERAL FREQ FED 2	Not Mapped
GE0-30.0 FILLER-NATIONAL	Not Mapped
GP0-01.0 RECORD ID GP0	Not Mapped
GP0-02.0 SEQUENCE NO	Not Mapped
GP0-03.0 PAT CONTROL NO	Not Mapped
GP0-04.0 CERTIFICATION TYPE	Not Mapped
GP0-05.0 ONSET DT OF THERAPY	Not Mapped
GP0-06.0 THERAPY DURATION	Not Mapped
GP0-07.0 LAST CERT DATE	Not Mapped
GP0-08.0 NO OF MONTHS CERT	Not Mapped
GP0-09.0 DT LAST SEEN BY PHY	Not Mapped
GP0-10.0 NON VISIT IND	Not Mapped
GP0-11.0 PAT AGE	Not Mapped
GP0-12.0 PAT HEIGHT	Not Mapped
GP0-13.0 PAT WEIGHT	Not Mapped
GP0-14.0 LEVEL OF CONS IND	Not Mapped
GP0-15.0 AMBULATORY IND	Not Mapped
GP0-16.0 OTHER FORMS OF NUTR IND	Not Mapped
GP0-17.0 TYPE OF MIX IND	Not Mapped
GP0-18.0 PARENTERAL FREQ FED	Not Mapped
GP0-19.0 HCPCS PROCEDURE CODE	Not Mapped
GP0-20.0 HCPCS MODIFIER 1	Not Mapped
GP0-21.0 HCPCS MODIFIER 2	Not Mapped
GP0-22.0 AMINO ACID NAME	Not Mapped
GP0-23.0 AMINO ACID VOLUME	Not Mapped
GP0-24.0 AMINO ACID CONC	Not Mapped
GP0-25.0 AMINO ACID WEIGHT	Not Mapped
GP0-26.0 DEXTROSE VOLUME	Not Mapped

GP0-27.0 DEXTROSE CONC	Not Mapped
GP0-28.0 LIPIDS VOLUME	Not Mapped
GP0-29.0 LIPIDS CONC	Not Mapped
GP0-30.0 LIPIDS FREQ	Not Mapped
GP0-31.0 NARRATIVE FIELD	Not Mapped
GP0-32.0 ADMIN TECH IND	Not Mapped
GP0-33.0 FILLER-NATIONAL	Not Mapped
GU0-01.0 RECORD ID GU0	“GU0"
GU0-02.0 SEQUENCE NO	2-365-LX01
GU0-03.0 PAT CONTROL NO	2-130-CLM01
GU0-04.0 **CERTIFICATION TYPE**	2-435-CR301
GU0-05.0- **PLACE OF SERVICE**	2-370-SV105
GU0-06.0 **REPLACEMENT ITEM**	2-445-CRC01 (09), 2-445-CRC02 (Y or N) 2-445-CRC03 (ZV)
GU0-07.0 **HCPCS PROCEDURE CODE**	2-370-SV101-2
GU0-08.0 **HCPCS MODIFIER**	2-370-SV101-3
GU0-09.0 **WARRANTY REPLY**	Not Mapped
GU0-10.0 WARRANTY LENGTH	Not Mapped
GU0-11.0 WARRANTY TYPE	Not Mapped
GU0-12.0 DIAGNOSIS CODE-1	2-231-HI01-2 2-231-HI01-1 (BK)
GU0-13.0 DIAGNOSIS CODE-2	2-231-HI02-2 2-231-HI02-1 (BF)
GU0-14.0 DIAGNOSIS CODE-3	2-231-HI03-2 2-231-HI03-1 (BF)
GU0-15.0 DIAGNOSIS CODE-4	2-231-HI04-2 2-231-HI04-1 (BF)
GU0-16.0 PATIENT HEIGHT	2-462-MEA03 2-462-MEA01 (OG) 2-462-MEA02 (HT)
GU0-17.0 PATIENT WEIGHT	2-007- PAT08
GU0-18.0 DT LAST MEDICAL EXAM	Not Mapped
GU0-19.0 INITIAL DATE	2-455-DTP03 2-455-DTP01 (463)
GU0-20.0 REV RECERT DATE	2-455- DTP03 2-455-DTP01 (607)
GU0-21.0 LENGTH OF NEED	2-435-CR303 2-435-CR302 (MO)
GU0-22.0 DATE CERT SIGNED	2-455-DTP03 2-455-DTP01 (461)
GU0-23.0 ORDERING PROV PHONE	2-530-PER04 2-530-PER01 (IC) 2-530-NM101 (DK)
GU0-24.0 CERT ON FILE	2-455- CRC01 (09) 2-455-CRC02 (Y) 2-455-CRC03 (38)
GU0-25.0 CERT FORM NUMBER	2-551-LQ02
GU0-26.0 REPLY ALN L01 N01	2-552-FRM02
GU0-27.0 REPLY ALN L01 N02	2-552-FRM02
GU0-28.0 REPLY ALN L01 N03	2-552-FRM02 OR 2-552-FRM03
GU0-29.0 REPLY ALN L01 N04	2-552-FRM02
GU0-30.0 REPLY ALN L01 N05	2-552-FRM02
GU0-31.0 REPLY ALN L01 N06	2-552-FRM02 OR 2-552-FRM03
GU0-32.0 REPLY ALN L01 N07	2-552-FRM02
GU0-33.0 REPLY ALN L01 N08	2-552-FRM02 OR 2-552-FRM03
GU0-34.0 REPLY ALN L01 N09	2-552-FRM02
GU0-35.0 REPLY ALN L01 N10	2-552-FRM02
GU0-36.0 REPLY ALN L01 N11	2-552-FRM02
GU0-37.0 REPLY ALN L01 N12	2-552-FRM02
GU0-38.0 REPLY ALN L01 N13	2-552-FRM02
GU0-39.0 REPLY ALN L01 N14	2-552-FRM02
GU0-40.0 REPLY ALN L01 N15	2-552-FRM02
GU0-41.0 REPLY ALN L01 N16	Not Mapped

GU0-42.0 REPLY ALN L01 N17	Not Mapped
GU0-43.0 REPLY ALN L01 N18	2-552-FRM02
GU0-44.0 REPLY ALN L01 N19	2-552-FRM02
GU0-45.0 REPLY ALN L01 N20	2-552-FRM03
GU0-46.0 REPLY ALN L01 N21	2-552-FRM03
GU0-47.0 REPLY ALN L01 N22	2-552-FRM03
GU0-48.0 REPLY ALN L01 N23	2-552-FRM03
GU0-49.0 REPLY ALN L01 N24	2-552-FRM03
GU0-50.0 REPLY ALN L05 N01	2-552-FRM03
GU0-51.0 REPLY ALN L05 N02	2-552-FRM03
GU0-52.0 REPLY ALN L05 N03	Not Mapped
GU0-53.0 REPLY ALN L08 N01	2-552-FRM04
GU0-54.0 REPLY ALN L08 N02	2-552-FRM04
GU0-55.0 REPLY ALN L08 N03	2-552-FRM04
GU0-56.0 REPLY ALN L08 N04	2-552-FRM04
GU0-57.0 REPLY ALN L20 N01	2-552-FRM03
GU0-58.0 REPLY ALN L60 N01	2-552-FRM03
GU0-59.0 REPLY NUM L01 N01	2-552-FRM03
GU0-60.0 REPLY NUM L01 N02	2-552-FRM03
GU0-61.0 REPLY NUM L01 N03	2-552-FRM03
GU0-62.0 REPLY NUM L04 N01	2-552-FRM03
GU0-63.0 REPLY NUM L04 N02	2-552-FRM03
GU0-64.0 REPLY NUM L04 N03	2-552-FRM03
GU0-65.0 REPLY NUM L04 N04	2-552-FRM03
GU0-66.0 REPLY NUM L04 N05	2-552-FRM03
GU0-67.0 REPLY NUM L04 N06	2-552-FRM03
GU0-68.0 REPLY NUM L04 N07	2-552-FRM03
GU0-69.0 REPLY PCT L04 N01	2-552-FRM05
GU0-70.0 REPLY PCT L04 N02	2-552-FRM05
GU0-71.0 REPLY PCT L04 N03	2-552-FRM05
GU0-72.0 FILLER - NATIONAL	Not Mapped
GX0-01.0 RECORD ID GX0	Not Mapped
GX0-02.0 SEQUENCE NO	2-365-LX01
GX0-03.0 PAT CONTROL NO	2-130-CLM01
GX0-04.0 TYPE OF CERTIFICATION	2-215-CR501 2-445-CR501
GX0-05.0 TYPE OF OXYGEN SYSTEM “Value Y”	2-215-CRC02 (N) 2-215-CRC03 (37) 2-215-CRC03 (AL) 2-445-CRC02 (N) 2-445-CRC03 (37) 2-445-CRC03 (AL)
GX0-05.0 TYPE OF OXYGEN SYSTEM “Value N”	2-215-CRC02 (N) 2-215-CRC03 (37) 2-215-CRC02 (Y) 2-215-CRC03 (AL) 2-445-CRC02 (N) 2-445-CRC03 (37) 2-445-CRC02 (Y) 2-445-CRC03 (AL)
GX0-05.0 TYPE OF OXYGEN SYSTEM “Value D”	2-215-CRC02 (Y) 2-215-CRC03 (37) 2-445-CRC02 (Y) 2-445-CRC03 (37)
GX0-06.0 LENGTH OF NEED	2-215-CR502 2-445-CR502
GX0-07.0 TYPE OF EQUIPMENT 1	Not Mapped
GX0-08.0 TYPE OF EQUIPMENT 2	Not Mapped
GX0-09.0 REASON FOR EQUIPMENT	Not Mapped
GX0-10.0 OXYGEN PRESCRIBED FROM DATE	2-455-DTP03 (463)
GX0-11.0 OXYGEN PRESCRIBED TO DATE	2-455-DTP03 (607)
GX0-12.0 DATE OXYGEN PRESCRIBED	2-455-DTP03 (461)
GX0-13.0 DATE PATIENT EVALUATED	Not Mapped

GX0-14.0 OXYGEN FLOW RATE	2-470-REF02 2-470-REF01 (TP)
GX0-15.0 FREQUENCY OF USE	Not Mapped
GX0-16.0 DURATION	Not Mapped
GX0-17.0 ARTERIAL BLOOD GAS ON 4 LPM	2-462-MEA03 2-462-MEA01 (TR) 2-462-MEA02 (C0N)
GX0-18.0 OXYGEN SATURATION ON 4 LPM	2-264-MEA03 2-462-MEA01 (TR) 2-462-MEA02 (ZO)
GX0-19.0 DATE TEST PRESCRIBED ON 4LPM	2-135-DTP03 (119) 2-455-DTP03 (119)
GX0-20.0 INPATIENT/OUTPATIENT INDICATOR	2-215-CRC03 (P1) 2-455-CRC03 (P1)
GX0-21.0 NATIONAL FILLER	NOT MAPPED
GX0-22.0 ARTERIAL BLOOD GAS	2-445-CR510
GX0-23.0 OXYGEN SATURATION	2-445-CR511
GX0-24.0 DATE TEST PERFORMED	2-455-DTP03 (481) 2-455-DTP03 (480)
GX0-25.0 ENTITY PERFORMING O2/ABG TEST	2-500-NM103 2-500-NM101 (TL)
GX0-26.0 TEST CONDITIONS	2-445-CR512
GX0-27.0 CLINICAL FINDINGS “Value Y,byte260"	2-445-CR513 (1)
GX0-27.0 CLINICAL FINDINGS “Value Y,byte261"	2-445-CR514 (1)
GX0-27.0 CLINICAL FINDINGS “Value Y,byte262"	2-445-CR515 (1)
GX0-28.0 PORTABLE OXYGEN FLOW RATE	Not Mapped
GX0-29.0 ORDERING PHYSICIAN ID	2-500-NM109 (DK)
GX0-30.0 ORDERING PROVIDER PHONE	2-530-PER04)
GX0-31.0 DIAGNOSIS CODE-1	2-231-HI01-2 (BK)
GX0-32.0 DIAGNOSIS CODE-2	2-231-HI02-2 (BF)
GX0-33.0 DIAGNOSIS CODE-3	2-231-HI03-2 (BF)
GX0-34.0 DIAGNOSIS CODE-4	2-231-HI04-02 (BF)
GX0-35.0 CERTIFICATION ON FILE	2-450-CRC02 (Y) 2-450-CRC03 (38)
GX0-36.0 DELIVERY SYSTEM TYPE	Not Mapped
GX0-37.0 FILLER-NATIONAL	Not Mapped
GX1-01.0 RECORD ID GX1	Not Mapped
GX1-02.0 SEQUENCE NO	Not Mapped
GX1-03.0 PAT CONTROL NO	Not Mapped
GX1-04.0 TEST RESULTS	Not Mapped
GX1-05.0 MEDICAL FINDINGS	Not Mapped
GX1-06.0 EXERCISE ROUTIN	Not Mapped
GX1-07.0 FILLER-NATIONAL	Not Mapped
GX1-08.0 FILLER-LOCAL	Not Mapped
GX2-01.0 RECORD ID GX2	Not Mapped
GX2-02.0 SEQUENCE NO	2-365-LX01
GX2-03.0 PAT CONTROL NO	2-130-CLM11
GX2-04.0 TEST FACILITY ADDR 1	2-514-N301 NM101=TL
GX2-05.0 TEST FACILITY ADDR 2	2-514-N302
GX2-06.0 TEST FACILITY CITY	2-520-N401
GX2-07.0 TEST FACILITY STATE	2-520-N402
GX2-08.0 TEST FACILITY ZIP	2-520-N403
GX2-09.0 PAT FACILITY NAME	Not Mapped
GX2-10.0 PAT FACILITY ADDR 1	Not Mapped
GX2-11.0 PAT FACILITY ADDR 2	Not Mapped
GX2-12.0 PAT FACILITY CITY	Not Mapped
GX2-13.0 PAT FACILITY STATE	Not Mapped
GX2-14.0 PAT FACILITY ZIP	Not Mapped
GX2-15.0 FILLER-NATIONAL	Not Mapped

HA0-01.0 RECORD ID HA0	"HA0"
HA0-02.0 SEQUENCE NO	2-365-LX01
HA0-03.0 PAT CONTROL NO	2-130-CLM01
HA0-04.0 LINE ITEM CONTROL NO	2-470-REF02 (6R)
HA0-05.0 EXTRA NARRATIVE DAA	2-190-NTE02 2-485-NTE02 2-185-K301 2-480-K301 2-135-DTP03 (091)
XA0-01.0 RECORD ID XA0	"XA0"
XA0-02.0 RESERVED (XA0-02.0)	Not Mapped
XA0-03.0 PAT CONTROL NO	2-130-CLM01
XA0-04.0 RECORD CXX COUNT	Translator
XA0-05.0 RECORD DXX COUNT	Translator
XA0-06.0 RECORD EXX COUNT	Translator
XA0-07.0 RECORD FXX COUNT	Translator
XA0-08.0 RECORD GXX COUNT	Translator
XA0-09.0 RECORD HXX COUNT	Translator
XA0-10.0 CLAIM RECORD COUNT	Translator
XA0-11.0 RESERVED (XA0-11.0)	Not Mapped
XA0-12.0 TOTAL CLAIM CHARGES	2-130-CLM02
XA0-13.0 TOTAL DISAL COST CONT CHGS	Translator
XA0-14.0 TOTAL DISAL OTHER CHARGES	Translator
XA0-15.0 TOTAL ALLOWED AMOUNT	Translator
XA0-16.0 TOTAL DEDUCTIBLE AMOUNT	Translator
XA0-17.0 TOTAL COINSURANCE AMOUNT	Translator
XA0-18.0 TOTAL PAYOR AMOUNT PAID	Translator
XA0-19.0 PAT AMOUNT PAID	2-175-AMT02 (F5)
XA0-20.0 TOTAL PURCHASE SVC CHARGES	Translator
XA0-21.0 PROV DISCOUNT INFORMATION	Not Mapped
XA0-22.0 REMARKS	Not Mapped
XA0-23.0 FILLER-NATIONAL	Not Mapped
YA0-01.0 RECORD ID YA0	"YA0"
YA0-02.0 EMC PROV ID	2-015-NM109 (85,87) 2-035-REF02
YA0-03.0 BATCH TYPE	"100"
YA0-04.0 BATCH NO	Translator
YA0-05.0 BATCH ID	Not Mapped
YA0-06.0 PROV TAX ID	2-015-NM109 (85,87) 2-035-REF02 (SY,EI)
YA0-07.0 RESERVED (YA0-07.0)	Not Mapped
YA0-08.0 BATCH SVC LINE COUNT	Translator
YA0-09.0 BATCH RECORD COUNT	Translator
YA0-10.0 BATCH CLAIM COUNT	Translator
YA0-11.0 BATCH TOTAL CHARGES	Translator
YA0-12.0 FILLER-NATIONAL	Not Mapped
ZA0-01.0 RECORD ID ZA0	"ZA0"
ZA0-02.0 SUB ID	1-020-NM101 (41) 1-020-NM109
ZA0-03.0 RESERVED (ZA0-03.0)	Not Mapped
ZA0-04.0 RECEIVER ID	1-020-NM101 (40) 1-020-NM109
ZA0-05.0 FILE SVC LINE COUNT	Translator
ZA0-06.0 FILE RECORD COUNT	Translator
ZA0-07.0 FILE CLAIM COUNT	Translator
ZA0-08.0 BATCH COUNT	Translator
ZA0-09.0 FILE TOTAL CHARGES	Translator

ZA0-10.0 FILE TOTAL PAID AMT (COB)	Not Mapped	ZA0-11.0 FILE TOTAL APPROV AMT (COB)	Not Mapped
		ZA0-12.0 FILLER-NATIONAL	Not Mapped

G Credit/Debit Card Use

G.1 Credit/Debit Card Scenario 837 Transaction Set

A business scenario using credit/debit cards as an alternate payment vehicle for the patient portion of post-adjudicated claims is defined in this appendix. This scenario does not apply to all health care business environments using the 837. Implementers of this option must ensure that no current federal or state privacy regulations are violated. The use of this payment option is currently prohibited in conjunction with federal health plans such as Medicaid, Champus, VA, etc. This capability, which can be used to improve the provider's accounts receivable situation, is applicable only when trading partners agree to the opportunities and constraints defined in the following business scenario. The scenario has been included as an appendix to this 837 implementation guide after several years of work, as well as presentations and review with the appropriate ANSI X12N committees, including the 837 work group, the 835 work group, and work group 11 (business modeling).

The Business Need: Patient to Provider Payment Options

Providers today can offer patients a variety of service payment options when the patient's portion of the cost is known either before or at the time of service. Examples of payment options include cash, check, and billing (i.e., being billed). Another option, which is the topic of this appendix, is to use a patient's credit or debit card when the amount of the co-payment or service charge is known. Providers typically have a credit card terminal that is connected through a dial-up phone line to their credit card processing network.

The business need of increasing cash flow and providing payment options to a patient reflects a new use of a patient's credit/debit card as an option for payment of the patient/subscriber portion of a claim when that amount is not known at the time of service. This new payment option is being requested to:

- improve patient payment flexibility
- potentially reduce provider billing costs
- provide faster access to monies due from patients, and improve accounts receivable management

Before using this flexible payment option, the provider, value-added network, and/or an intermediary have to form a partnership where credit/debit card transactions are accepted as part of the reimbursement process. These agreements must comply with all current federal and state privacy regulations.

The patient/subscriber also must choose to use his or her credit/debit card for a future yet-to-be-determined amount. The patient/subscriber would provide his or her consent up to a maximum amount allowing the provider/ value-added network to bill the credit card after the claim has been adjudicated. This patient consent form also authorizes the transmission of credit/debit card information over a health care EDI network. The consent form must identify how the transaction will be used, and who will receive the information . It authorizes the service providers to use the account number in this transaction as described. The concept of pre-

authorized payment is currently in use in other industries, and customer acceptance of this type of payment vehicle has increased.

To implement this payment alternative, the patient's/subscriber's credit or debit card information would be carried in the 837, along with selected provider information. This information involves approximately 200 characters of data for each instance of credit or debit card use.

The provider's claims submission system would be enhanced to incorporate the required credit/debit card information into the 837 transaction. The 837 would then be transmitted to the Automated Clearing House/ processor/payer for claim adjudication. After the claim is adjudicated and coordination of benefits issues are resolved, the payer pays his or her portion of the claim and returns its explanation in an 835.

At this point, the value-added network could determine the amount to be applied to the patient's credit or debit card, and initiate a credit or debit card transaction to complete the claim payment. The amount charged to the patient's credit or debit card would then be reported to the provider in a separate transaction.

- Figure G1, Scenario: Patient Uses a Credit/Debit Card, depicts an example of how credit/debit card information could be transmitted using the standard 837 methodology.

Business Process Flow for Credit/Debit Card Payment Alternative for Post-adjudicated Claims

A. The provider/Automated Clearing House agrees to accept credit or debit cards.

B. The subscriber signs a consent form to pre-authorize charges up to a maximum amount and authorizes the use of their account number in this network.

C. The patient incurs the charges.

D. The provider submits an 837, including some claims containing credit or debit card information.

E. The Automated Clearing House notes the credit or debit card option and information, and passes the claim to the payer.

F. The payer adjudicates the claim and determines the coordination of benefits (COB). If no COB is involved, the payer returns the adjudicated claim to the Automated Clearing House or provider with the 835.

G. The Automated Clearing House creates the credit or debit card transaction(s), as appropriate, to close out the claim payment.

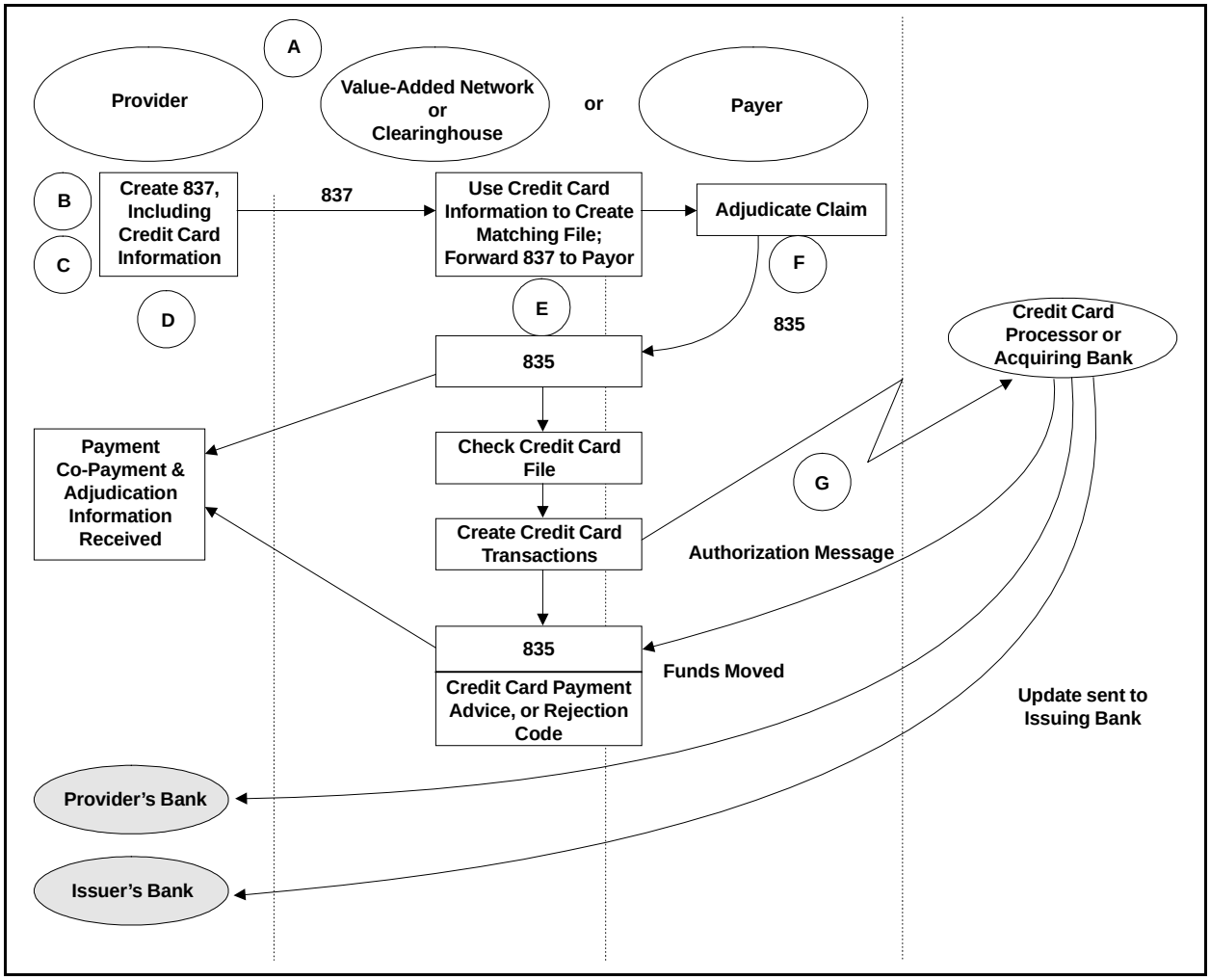


Figure G1. Scenario: Patient Uses a Credit/Debit Card (Patient payment amount unknown)

Credit/Debit Card Information

This is a map of only the additional information necessary to carry credit/debit card information. Loop ID-2010BD carries only information about the person whose credit/debit card is being used in the transaction. This person may or may not be the subscriber.

Table	Loop	Position	Seg't ID	Data Element	Qualifier	Description
2	2010AA	035	REF01/02	128	8U	Bank Assigned Security ID
					LU	Location Number
					ST	Store Number
					TT	Terminal Code
					06	Systems Number
					IJ	SIC
					RB	Rate Code
					EM	Electronic Payment Reference Number

2	2010BD	055	NM101	98	AO	Account of Credit Card Holder
2	2010BD	055	NM108/09	66	MI	Charge Card Number
2	2010BD	085	REF01/02	128	BB	Authorization Number; card read or data manually entered
2	2300	175	AMT01/02	522	MA	Maximum Amount

H Medicare Primary, Secondary and Supplemental Payers

How To Map Other Insurance Coverage To The NSF

The 837 transaction set is used to submit a claim to a Payer for payment. If the Payer on the 837 is Medicare, Medicare can be either the primary or secondary payer. When Medicare is the secondary payer, primary payer information MUST be supplied in loop 2320.

In some situations, after Medicare adjudicates a claim, Medicare will forward the claim to one or two supplementary payer(s) for additional payment. The 837 transaction set is used to identify the supplemental payer(s).

H.1 How to Indicate Whether Medicare is Primary or Secondary

When Medicare is the primary payer, send a “P” in segment SBR (Position 005). Loop 2320 is not required if the patient does not have other supplemental insurance.

When Medicare is the secondary payer, send “S” in segment SBR (Position 005). Report the primary payer in the first occurrence of loop 2320 and repeat for other insurance.

H.2 How to Indicate Other Payers Supplementary to Medicare

The 837 transaction set will accommodate a total of three payers including Medicare. These can be (1) Medicare as primary payer and a maximum of two supplemental payers (supply supplemental information in the first and second occurrence of the 2320 loop), or (2) another primary payer, Medicare as secondary payer, and a maximum of one supplemental payer (supply the primary payer in the first occurrence of the 2320 loop and the supplemental payer information in the second occurrence of the 2320 loop).

Medicare as Primary Payer

If Medicare is primary and the patient has NO other insurance coverage:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-005	SBR01	P	DA0-02.0	01	
2-005	SBR05		NO MAP		Not Used IF Medicare Primary
			DA0-04.0	P	TRANSLATOR GENERATED
2-005	SBR09	MB	DA0-05.0	C	
			DA0-06.0	MP	TRANSLATOR GENERATED

If Medicare is primary and the patient has other insurance coverage, such supplementary coverage will be mapped to loop 2320 as described later in this Section. The Medicare primary coverage is mapped as described above.

Medicare as Secondary Payer

If the patient has other primary insurance and Medicare is secondary, the NSF requires a separate DA0 record for each payer. The first DA0 carries information about the primary payer, the second DA0 holds information about the secondary payer (Medicare B).

Produce the second DA0 using the following map:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-005	SBR01	S	DA0-02.0	02	
2-005	SBR05	12,13, 14, 15, 16, 41, 42, 43	DA0-06.0	12,13, 14, 15, 16, 41, 42, 43	
2-005	SBR09	MB	DA0-05.0	C	

Produce the first DA0/DA1 using the following map to loop 2320:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-290	SBR01	P	DA0-02.0	01	
2-290	SBR02		DA0-17.0		See Implementation Detail
2-290	SBR03		DA0-10.0		Prim Payor Grp Nmbr
2-290	SBR04		DA0-11.0		Prim Payor Grp Name
2-290	SBR05	GP, OT	DA0-06.0	GP, OT	ANSI=NSF
2-290	SBR08		DA0-25.0		See Implementation Detail
2-295	CAS02	B6	NO MAP		
2-295	CAS03		DA1-11.0		Prim Payr Allwd Amt
2-295	CAS02	D	NO MAP		
2-295	CAS03		DA1-14.0		Prim Payr Paid Amt
2-295	CAS02	C9	NO MAP		
2-295	CAS03		DA1-09.0		Prim Payr Disallwd Cost Cont
2-295	CAS02	A6	NO MAP		
2-295	CAS03		DA1-10.0		Prim Payr Disallowed
2-295	CAS02	D2	NO MAP,		
2-295	CAS03		DA1-12.0		Prim Payr Deductible
2-295	CAS02	B9	NO MAP		
2-300	CAS03		DA1-13.0		Prim Payr Coinsurance
2-290	SBR09		DA0-05.0		See Implementation Detail
2-310	OI03		DA0-15.0		ANSI=NSF
2-310	OI04		DA0-16.0		ANSI=NSF
2-325	NM101	PR	NO MAP		
2-325	NM102	2	NO MAP		
2-325	NM103		DA0-09.0		Primary Payer Name
2-325	NM108	PI	NO MAP		
2-325	NM109		DA0-07.0		Prim Ident. Number
2-332	N301		DA1-04.0		Prim Payr Address 1
2-332	N302		DA1-05.0		Prim Payr Address 2
2-340	N401		DA1-06.0		Prim Payr City

2-340	N402		DA1-07.0	Prim Payr State
2-340	N403		DA1-08.0	Prim Payr Zip

Only report the primary policy holder (Insured) name, ID number, address and demographics if patient is not the insured on primary payers policy:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-305	DMG01	D8	NO MAP		
2-305	DMG02		DA0-24.0		Insured date of birth
2-305	DMG03		DA0-23.0		Insured sex
2-325	NM101	IL	NO MAP		
2-325	NM102	1	NO MAP	,	
2-325	NM103		DA0-19.0		Insured Last Name
2-325	NM104		DA0-20.0		Insured first Name
2-325	NM105		DA0-21.0		Insured Middle Initial
2-325	NM108	CI	NO MAP		
2-325	NM109		DA0-18.0		Insured Ident. Number
2-332	N301		DA2-04.0		Insured Address 1
2-332	N302		DA2-05.0		Insured Address 2
2-340	N401		DA2-06.0		Insured City
2-340	N402		DA2-07.0		Insured State
2-340	N403		DA2-08.0		Insured Zip

Report the Employer's name if the insured's policy is an employer group plan.

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-325	NM101	36	NO MAP		
2-325	NM102	2	NO MAP		
2-325	NM103		DA2-12.0		Employer Name

Supplementary Coverage

If the patient has other insurance coverage supplementary to Medicare, if Medicare is Primary, the supplementary coverage will be secondary, and if Medicare is Secondary (another primary payor exists), the supplementary coverage will be tertiary. Map both cases as follows:

Produce the second or third DA0 using the following map:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-005	SBR01	S, T	DA0-02.0	02, 03	Secondary/Tertiary
2-005	SBR05		NO MAP		Not Used
			DA0-04.0	P	Translator Generated
2-005	SBR09	MB	DA0-05.0	C	
			DA0-06.0	MP	Translator Generated

Produce the second or third DA0/DA1 using the following map to LOOP 2320:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-290	SBR01	S, T	DA0-02.0	02, 03	Secondary/Tertiary
2-290	SBR02		DA0-17.0		See Implementation Detail
2-290	SBR03		DA0-10.0		Supp. Payer Group Number
2-290	SBR04		DA0-11.0		Supp. Payer Group Name
2-290	SBR05		DA0-06.0		See Implementation Detail
			DA0-04.0	I	Translator Generated

Report the supplementary payer name, ID, and address as required by Carrier:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-290	SBR09		DA0-05.0		See Implementation Detail
2-325	NM101	PR	NO MAP		
2-325	NM102	2	NO MAP		
2-325	NM103		DA0-09.0		Supp. Payer Name
2-325	NM108	PI	NO MAP		
2-325	NM109		DA0-07.0		Supp. Payer ID Number
2-332	N301		DA1-04.0		Supp. Payer Address 1
2-332	N302		DA1-05.0		Supp. Payer Address 2
2-340	N401		DA1-06.0		Supp. Payer City
2-340	N402		DA1-07.0		Supp. Payer State
2-340	N403		DA1-08.0		Supp. Payer Zip

Only report the supplementary policy holder (Insured) name, ID number, address and demographics if patient is not the insured on primary supplementary policy:

ANSI 837			NSF 3.01		
Tbl/Pos	**Seg/El**	**Value**	**Field #**	**Value**	**Comments**
2-305	DMG01	D8	NO MAP		
2-305	DMG02		DA0-24.0		Insured date of birth
2-305	DMG03		DA0-23.0		Insured sex
2-325	NM101	IL	NO MAP		
2-325	NM102	1	NO MAP		
2-325	NM103		DA0-19.0		Insured Last Name
2-325	NM104		DA0-20.0		Insured first Name
2-325	NM105		DA0-21.0		Insured Middle Initial
2-325	NM108	CI	NO MAP		
2-325	NM109		DA0-18.0		Insured ID Number
2-332	N301		DA2-04.0		Insured Address 1
2-332	N302		DA2-05.0		Insured Address 2
2-340	N401		DA2-06.0		Insured City
2-340	N402		DA2-07.0		Insured State
2-340	N403		DA2-08.0		Insured ZIP

I National Uniform Claim Committee Recommendations

I.1 National Uniform Claim Committee (NUCC)

The National Uniform Claim Committee was created to develop a data set for use by the non-institutional health care community to transmit claim and encounter information to and from all third-party payers. It is chaired by the American Medical Association (AMA), with the Health Care Financing Administration (HCFA) as a critical partner. The Committee includes representation from key provider and payer organizations, as well as standards setting organizations, state and federal regulators, and the National Uniform Billing Committee (NUBC). The NUCC was formally named in the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) as one of the organizations to be consulted by ANSI-accredited standards development organizations as they develop, adopt, or modify national standards for health care transactions. As such, the NUCC is intended to have an authoritative voice regarding national standard content and data definitions for non-institutional health care claims in the United States. The NUCC's recommendations in this area are explicitly designed to complement and expedite the work of X12 in complying with the provisions of P.L. 104-191.

The NUCC is comprised of key parties who are affected by health care EDI - those at either end of a health care transaction such as payors and providers. In addition, the NUCC includes representatives of standards development organizations, regulatory agencies, and the National Uniform Billing Committee. Criteria for membership are: a national scope and representation of a unique constituency affected by health care EDI from one of the above categories, with an emphasis on maintaining or enhancing the provider/payor balance in the original NUCC composition. Each Committee member is intended to represent the perspective of the sponsoring organization and the applicable constituency.

Representatives are responsible for communicating information between the Committee and the group(s) they represent.

The following organizations serve on the NUCC as voting members:

- American Medical Association
- Health Care Financing Administration
- Alliance for Managed Care
- American Association of Health Plans
- ANSI ASC X12N
- Blue Cross Blue Shield Association
- Health Insurance Association of America
- Medical Group Management Association
- National Association for Medical Equipment Services
- National Association of Insurance Commissioners
- National Association of State Medicaid Directors
- National Uniform Billing Committee

The National Uniform Claim Committee (NUCC) completed the development and voted to approve its standardized data set March 5, 1997. This data set is intended to apply to the claims and equivalent encounters and coordination of benefits transactions specified in the HIPAA. The NUCC data set was constructed based upon the combined universe of fields included in the HCFA 1500 paper claim form, the Medicare NSF and the ASC X12 837. Recommendations regarding data requirements were then made.

The definitions for the recommendations of the data requirements include the following:

R - Required:
provider must supply data element on every claim, payer must accept data element.

RIA - Required If Applicable:
conditional on a specific situation such as an accident.

NRUC - Not Required:
unless specified Under Contract (Includes federal or state government requirements that may not be formalized in a payer-provider contract but are not generally applicable to all payers).

NR - Not Required:
for submission/receipt of a claim or encounter.

J X12N 837 Professional Implementation Guide Alias Index

This is an alphabetical list of all segment and element names in the 837 professional implementation guide. It has been included in this Implementation Guide to assist users in locating specific data elements.

NAME	PAGE
Accident/Employment/Related Causes 2300 | CLM11 | C024	**170**
Additional Billing Provider Name Information 2010AA | N2	**87**
Additional Credit/Debit Card Holder Name Information 2010BD | N2	**149**
Additional Ordering Provider Name Information 2420E | N2	**532**
Additional Other Payer Name Information 2330B | N2	**362**
Additional Other Subscriber Name Information 2330A | N2	**353**
Additional Patient Name Information 2010CA | N2	**160**
Additional Pay-to Provider Name Information 2010AB | N2	**102**
Additional Payer Name Information 2010BB | N2	**133**
Additional Referring Provider Name Information 2310A | N2	**287**
Additional Referring Provider Name Information 2420F | N2	**546**
Additional Rendering Provider Name Information 2310B | N2	**295**
Additional Rendering Provider Name Information 2420A | N2	**506**
Additional Responsible Party Name Information 2010BC | N2	**142**

NAME	PAGE
Additional Service Facility Location Name Information 2310D | N2	**306**
Additional Service Facility Location Name Information 2420C | N2	**517**
Additional Submitter Name 1000A | N201	**70**
Additional Submitter Name Information 1000A | N2	**70**
Additional Subscriber Name Information 2010BA | N2	**120**
Additional Supervising Provider Name Information 2310E | N2	**315**
Additional Supervising Provider Name Information 2420D | N2	**526**
Adjusted Amount - Claim Level 2320 | CAS03	**323**
Adjusted Amount - Claim Level 2320 | CAS06	**323**
Adjusted Amount - Claim Level 2320 | CAS09	**323**
Adjusted Amount - Claim Level 2320 | CAS12	**323**
Adjusted Amount - Claim Level 2320 | CAS15	**323**
Adjusted Amount - Claim Level 2320 | CAS18	**323**
Adjusted Amount - Line Level 2430 | CAS03	**558**
Adjusted Amount - Line Level 2430 | CAS06	**558**
Adjusted Amount - Line Level 2430 | CAS09	**558**

NAME	PAGE
Adjusted Amount - Line Level 2430 | CAS12	**558**
Adjusted Amount - Line Level 2430 | CAS15	**558**
Adjusted Amount - Line Level 2430 | CAS18	**558**
Adjusted Repriced Claim Number 2300 | REF	**235**
Adjusted Repriced Line Item Reference Number 2400 | REF	**469**
Adjusted Units - Claim Level 2320 | CAS04	**323**
Adjusted Units - Claim Level 2320 | CAS07	**323**
Adjusted Units - Claim Level 2320 | CAS10	**323**
Adjusted Units - Claim Level 2320 | CAS13	**323**
Adjusted Units - Claim Level 2320 | CAS16	**323**
Adjusted Units - Claim Level 2320 | CAS19	**323**
Adjusted Units - Line Level 2430 | CAS04	**558**
Adjusted Units - Line Level 2430 | CAS07	**558**
Adjusted Units - Line Level 2430 | CAS10	**558**
Adjusted Units - Line Level 2430 | CAS13	**558**
Adjusted Units - Line Level 2430 | CAS16	**558**
Adjusted Units - Line Level 2430 | CAS19	**558**
Adjustment Group Code 2430 | CAS01	**558**
Adjustment Reason Code - Claim Level 2320 | CAS02	**323**
Adjustment Reason Code - Claim Level 2320 | CAS05	**323**
Adjustment Reason Code - Claim Level 2320 | CAS08	**323**
Adjustment Reason Code - Claim Level 2320 | CAS11	**323**
Adjustment Reason Code - Claim Level 2320 | CAS14	**323**

NAME	PAGE
Adjustment Reason Code - Claim Level 2320 | CAS17	**323**
Adjustment Reason Code - Line Level 2430 | CAS02	**558**
Adjustment Reason Code - Line Level 2430 | CAS05	**558**
Adjustment Reason Code - Line Level 2430 | CAS08	**558**
Adjustment Reason Code - Line Level 2430 | CAS11	**558**
Adjustment Reason Code - Line Level 2430 | CAS14	**558**
Adjustment Reason Code - Line Level 2430 | CAS17	**558**
Allowed amount, Pricing 2300 | HCP02	**271**
Ambulance Certification 2300 | CRC	**257**
Ambulance Certification 2400 | CRC	**427**
Ambulance transport code 2400 | CR103	**412**
Ambulance Transport Code 2300 | CR103	**248**
Ambulance Transport Information 2300 | CR1	**248**
Ambulance Transport Information 2400 | CR1	**412**
Ambulance Transport Reason Code 2300 | CR104	**248**
Ambulance Transport Reason Code 2400 | CR104	**412**
Ambulatory Patient Group (APG) 2300 | REF	**240**
Ambulatory Patient Group (APG) 2400 | REF	**479**
Anesthesia Modifying Units 2400 | QTY	**462**
Anesthesia Modifying Units 2400 | QTY02	**462**
Approved Amount 2400 | AMT	**485**
Approved APG amount, Pricing 2300 | HCP07	**271**
Approved APG amount, Pricing 2400 | HCP07	**495**

NAME PAGE

Approved APG code, Pricing
2300 | HCP06 ..... **271**

Approved APG code, Pricing
2400 | HCP06 ..... **495**

Arterial Blood Gas
2400 | CR510 ..... **423**

Assignment of Benefits Indicator
2300 | CLM08 ..... **170**

Assignment of Benefits Indicator
2320 | OI03 ..... **344**

Attachment Control Number
2300 | PWK06 ..... **214**

Attachment Report Type Code
2300 | PWK01 ..... **214**

Attachment Transmission Code
2300 | PWK02 ..... **214**

Attachment Transmission Code
2400 | PWK02 ..... **410**

Beginning of Hierarchical Transaction
BHT **63**

Billing Provider Additional Name
2010AA | N201 ..... **87**

Billing Provider Address
2010AA | N3 ..... **88**

Billing Provider Address 1
2010AA | N301 ..... **88**

Billing Provider Address 2
2010AA | N302 ..... **88**

Billing Provider City/State/ZIP Code
2010AA | N4 ..... **89**

Billing Provider Contact Information
2010AA | PER **96**

Billing Provider Country Code
2010AA | N404 ..... **89**

Billing Provider Name
2010AA | NM103 ..... **84**

Billing Provider Name
2010AA | NM104 ..... **84**

Billing Provider Name
2010AA | NM105 ..... **84**

Billing Provider Name
2010AA | NM107 ..... **84**

Billing Provider Name
2010AA | NM1 ..... **84**

Billing Provider Primary Identification Number
2010AA | NM109 ..... **84**

NAME PAGE

Billing Provider Secondary Identification
2010AA | REF **91**

Billing Provider Secondary Identification Number
2010AA | REF02 ..... **91**

Billing Provider's City
2010AA | N401 ..... **89**

Billing Provider's State
2010AA | N402 ..... **89**

Billing Provider's Zip Code
2010AA | N403 ..... **89**

Billing/Pay-to Provider Hierarchical Level
2000A | HL **77**

Billing/Pay-to Provider Specialty Information
2000A | PRV **79**

Bundled/Unbundled Line Number
2430 | SVD06 ..... **554**

Certification Condition Code Applies Indicator
2300 | CRC02 ..... **257**

Certification Condition Code Applies Indicator
2300 | CRC02 ..... **260**

Certification Condition Code Applies Indicator
2400 | CRC02 ..... **432**

Certification Condition Code, Ambulance Certification
2400 | CRC02 ..... **427**

Certification Period, Home Oxygen Therapy
2400 | CR502 ..... **423**

Certification Type Code. Oxygen Therapy
2400 | CR501 ..... **423**

Claim Adjudication Date
2330B | DTP **366**

Claim Adjustment Group Code
2320 | CAS01 ..... **323**

Claim filing indicator code
2320 | SBR09 ..... **318**

Claim Filing Indicator Code
2000B | SBR09 ..... **110**

Claim Identification Number for Clearing Houses and Other Transmission Intermediaries
2300 | REF **238**

NAME PAGE

Claim Information
2300 | CLM **170**

Claim Level Adjustments
2320 | CAS **323**

Claim Note
2300 | NTE **246**

Claim or Encounter Indicator
BHT06 ..... **63**

Claim Original Reference Number (ICN/DCN)
2300 | REF02 ..... **229**

Claim Pricing/Repricing Information
2300 | HCP **271**

Claim Submission Reason Code
2300 | CLM05 | C023-03 ..... **170**

Claim Supplemental Information
2300 | PWK **214**

Clinical Laboratory Improvement Amendment (CLIA) Identification
2400 | REF **475**

Clinical Laboratory Improvement Amendment (CLIA) Number
2300 | REF **231**

Co-Pay Waiver
2400 | SV115 ..... **400**

Complication Indicator. Spinal Manipulation
2300 | CR209 ..... **251**

Complication Indicator. Spinal Manipulation
2400 | CR209 ..... **415**

Condition Indicator
2300 | CRC04 ..... **257**

Condition Indicator
2300 | CRC05 ..... **257**

Condition Indicator
2300 | CRC06 ..... **257**

Condition Indicator
2300 | CRC07 ..... **257**

Condition Indicator
2400 | CRC03 ..... **427**

Condition Indicator
2400 | CRC04 ..... **427**

Condition Indicator
2400 | CRC05 ..... **427**

Condition Indicator
2400 | CRC06 ..... **427**

NAME PAGE

Condition Indicator
2400 | CRC07 ..... **427**

Condition Indicator
2400 | CRC03 ..... **432**

Condition Indicator
2400 | CRC04 ..... **432**

Condition Indicator
2400 | CRC05 ..... **432**

Condition Indicator
2400 | CRC06 ..... **432**

Condition Indicator
2400 | CRC07 ..... **432**

Condition Indicator
2300 | CRC03 ..... **257**

Condition Indicator
2300 | CRC03 ..... **260**

Contract Allowance or Charge Percent
2400 | CN103 ..... **466**

Contract Amount
2300 | CN102 ..... **217**

Contract Amount
2400 | CN102 ..... **466**

Contract Code
2300 | CN104 ..... **217**

Contract Code
2400 | CN104 ..... **466**

Contract Information
2300 | CN1 ..... **217**

Contract Information
2400 | CN1 ..... **466**

Contract Percent
2300 | CN103 ..... **217**

Contract Type Code
2300 | CN101 ..... **217**

Contract type code
2400 | CN101 ..... **466**

Contract Version
2400 | CN106 ..... **466**

Contract Version Identifier
2300 | CN106 ..... **217**

Coordination of Benefits (COB) Allowed Amount
2320 | AMT **334**

Coordination of Benefits (COB) Approved Amount
2320 | AMT **333**

NAME	PAGE
Coordination of Benefits (COB) Covered Amount 2320 | AMT	**336**
Coordination of Benefits (COB) Discount Amount 2320 | AMT	**337**
Coordination of Benefits (COB) Patient Paid Amount 2320 | AMT	**339**
Coordination of Benefits (COB) Patient Responsibility Amount 2320 | AMT	**335**
Coordination of Benefits (COB) Payer Paid Amount 2320 | AMT	**332**
Coordination of Benefits (COB) Per Day Limit Amount 2320 | AMT	**338**
Coordination of Benefits (COB) Tax Amount 2320 | AMT	**340**
Coordination of Benefits (COB) Total Claim Before Taxes Amount 2320 | AMT	**341**
Credit or Debit Card Authorization Number 2010BD | REF02	**150**
Credit-Debit Card Holder Additional Name Information 2010BD | N201	**149**
Credit/Debit Card Billing Information 2010AA | REF	**94**
Credit/Debit Card Holder Name 2010BD | NM103	**146**
Credit/Debit Card Holder Name 2010BD | NM104	**146**
Credit/Debit Card Holder Name 2010BD | NM105	**146**
Credit/Debit Card Holder Name 2010BD | NM107	**146**
Credit/Debit Card Holder Name 2010BD | NM1	**146**
Credit/Debit Card Information 2010BD | REF	**150**
Credit/Debit Card Maximum Amount 2300 | AMT	**219**
Credit/Debit Card Number 2010BD | NM109	**146**
Date - Accident 2300 | DTP	**194**
Date - Acute Manifestation 2300 | DTP	**190**
Date - Acute Manifestation 2400 | DTP	**456**
Date - Admission 2300 | DTP	**208**
Date - Assumed and Relinquished Care Dates 2300 | DTP	**212**
Date - Authorized Return to Work 2300 | DTP	**206**
Date - Begin Therapy Date 2400 | DTP	**440**
Date - Certification Revision Date 2400 | DTP	**437**
Date - Date Last Seen 2300 | DTP	**186**
Date - Date Last Seen 2400 | DTP	**445**
Date - Disability Begin 2300 | DTP	**201**
Date - Disability End 2300 | DTP	**203**
Date - Discharge 2300 | DTP	**210**
Date - Estimated Date of Birth 2300 | DTP	**199**
Date - Hearing and Vision Prescription Date 2300 | DTP	**200**
Date - Initial Treatment 2300 | DTP	**182**
Date - Initial Treatment 2400 | DTP	**458**
Date - Last Certification Date 2400 | DTP	**442**
Date - Last Menstrual Period 2300 | DTP	**196**
Date - Last Worked 2300 | DTP	**205**
Date - Last X-ray 2300 | DTP	**197**
Date - Last X-ray 2400 | DTP	**454**
Date - Onset of Current Illness/Symptom 2300 | DTP	**188**

NAME	PAGE
Date - Onset of Current Symptom/Illness 2400 | DTP	**452**
Date - Order Date 2300 | DTP	**180**
Date - Order Date 2400 | DTP	**444**
Date - Oxygen Saturation/Arterial Blood Gas Test 2400 | DTP	**449**
Date - Referral Date 2300 | DTP	**184**
Date - Referral Date 2400 | DTP	**439**
Date - Service Date 2400 | DTP	**435**
Date - Shipped 2400 | DTP	**451**
Date - Similar Illness/Symptom Onset 2300 | DTP	**192**
Date - Similar Illness/Symptom Onset 2400 | DTP	**460**
Date - Test 2400 | DTP	**447**
Date of Birth 2010CA | DMG02	**164**
Date of Birth - Patient 2010BA | DMG02	**124**
Date of Birth - Subscriber 2320 | DMG02	**342**
Date of Death 2000B | PAT06	**114**
Date of Death 2000C | PAT06	**154**
Delay Reason Code 2300 | CLM20	**170**
Demonstration Project Identifier 2300 | REF	**242**
Diagnosis 2300 | HI02 | C022	**265**
Diagnosis 2300 | HI03 | C022	**265**
Diagnosis 2300 | HI04 | C022	**265**
Diagnosis 2300 | HI05 | C022	**265**

NAME	PAGE
Diagnosis 2300 | HI06 | C022	**265**
Diagnosis 2300 | HI07 | C022	**265**
Diagnosis 2300 | HI08 | C022	**265**
Diagnosis Code Pointer 2400 | SV107 | C004	**400**
Discipline type code 2305 | CR701	**276**
DME Duration 2400 | CR303	**421**
DMERC CMN Indicator 2400 | PWK	**410**
DMERC Condition Indicator 2400 | CRC	**432**
DMERC Report Type Code 2400 | PWK01	**410**
Durable Medical Equipment Certification 2400 | CR3	**421**
Emergency Indicator 2400 | SV109	**400**
EPSDT Indicator 2400 | SV111	**400**
ESRD Paid Amount 2320 | MOA08	**347**
Estimated Date of Birth 2300 | DTP03	**199**
Exception code 2300 | HCP15	**271**
Exception code 2400 | HCP15	**495**
Facility Type Code 2300 | CLM05 | C023-01	**170**
Family Planning Indicator 2400 | SV112	**400**
File Information 2300 | K3	**244**
File Information 2400 | K3	**487**
Foreign Currency Information 2000A | CUR	**81**
Form Identification Code 2440 | LQ	**567**
Form Identification Code 2440 | LQ01	**567**

NAME PAGE

Form Identifier
2440 | LQ02 ..... **567**

Gender - Patient
2010CA | DMG03 ..... **164**

Gender - Patient
2010BA | DMG03 ..... **124**

Gender - Subscriber
2320 | DMG03 ..... **342**

Group or Plan Name
2000B | SBR04 ..... **110**

Group or Plan Name
2320 | SBR04 ..... **318**

Group or Policy Number
2000B | SBR03 ..... **110**

Group or Policy Number
2320 | SBR03 ..... **318**

HCPCS Payable Amount
2320 | MOA02 ..... **347**

Health Care Diagnosis Code
2300 | HI **265**

Health Care Services Delivery
2305 | HSD **278**

Health Care Services Delivery
2400 | HSD **491**

Home Health Care Plan Information
2305 | CR7 ..... **276**

Home Oxygen Therapy Information
2400 | CR5 ..... **423**

Homebound Indicator
2300 | CRC **263**

Hospice Employee Indicator
2400 | CRC02 ..... **430**

Hospice Employee Indicator
2400 | CRC **430**

Immunization Batch Number
2400 | REF **478**

Individual relationship code
2320 | SBR02 ..... **318**

Insurance type code
2000B | SBR05 ..... **110**

Insurance type code
2320 | SBR05 ..... **318**

Investigational Device Exemption Number
2300 | REF **236**

NAME PAGE

Laboratory/Facility Additional Name Information
2310D | N201 ..... **306**

Laboratory/Facility Address 1
2310D | N301 ..... **307**

Laboratory/Facility Address 2
2310D | N302 ..... **307**

Laboratory/Facility City
2310D | N401 ..... **308**

Laboratory/Facility Country Code
2310D | N404 ..... **308**

Laboratory/Facility Name
2310D | NM103 ..... **303**

Laboratory/Facility Primary Identifier
2310D | NM109 ..... **303**

Laboratory/Facility Secondary Identification Number
2310D | REF02 ..... **310**

Laboratory/Facility State
2310D | N402 ..... **308**

Laboratory/Facility Zip Code
2310D | N403 ..... **308**

Line Adjudication Date
2430 | DTP **566**

Line Adjudication Information
2430 | SVD **554**

Line Adjustment
2430 | CAS **558**

Line Counter
2400 | LX01 ..... **398**

Line Item Control Number
2400 | REF **472**

Line Note
2400 | NTE **488**

Line Pricing/Repricing Information
2400 | HCP **495**

Mammography Certification Number
2300 | REF **226**

Mammography Certification Number
2400 | REF **474**

Mandatory Medicare (Section 4081) Crossover Indicator
2300 | REF **224**

Measurement identifier
2400 | MEA01 ..... **464**

Medical Record Number
2300 | REF **241**

NAME	PAGE
Medicare Assignment Code 2300 | CLM07	**170**
Medicare Outpatient Adjudication Information 2320 | MOA	**347**
Modulus, Amount 2305 | HSD04	**278**
Modulus, Unit 2305 | HSD03	**278**
Nature of Condition Code. Spinal Manipulation 2300 | CR208	**251**
Nature of Condition Code. Spinal Manipulation 2400 | CR208	**415**
Ordering Provider Additional Name Information 2420E | N201	**532**
Ordering Provider Address 2420E | N3	**533**
Ordering Provider Address 1 2420E | N301	**533**
Ordering Provider Address 2 2420E | N302	**533**
Ordering Provider City 2420E | N401	**534**
Ordering Provider City/State/ZIP Code 2420E | N4	**534**
Ordering Provider Contact Information 2420E | PER	**538**
Ordering Provider Country Code 2420E | N404	**534**
Ordering Provider First Name 2420E | NM104	**529**
Ordering Provider Generation 2420E | NM107	**529**
Ordering Provider Last Name 2420E | NM103	**529**
Ordering Provider Middle Name 2420E | NM105	**529**
Ordering Provider Name 2420E | NM1	**529**
Ordering Provider Primary Identifier 2420E | NM109	**529**
Ordering Provider Secondary Identification 2420E | REF	**536**
Ordering Provider Secondary Identifier 2420E | REF02	**536**
Ordering Provider State 2420E | N402	**534**
Ordering Provider Zip Code 2420E | N403	**534**
Original Reference Number (ICN/DCN) 2300 | REF	**229**
Other Insurance Coverage Information 2320 | OI	**344**
Other Payer Claim Adjustment Indicator 2330B | REF	**372**
Other Payer Contact Information 2330B | PER	**363**
Other Payer Identification 2420G | NM109	**549**
Other Payer identification code 2430 | SVD01	**554**
Other Payer Name 2330B | NM1	**359**
Other Payer Patient Identification 2330C | REF	**376**
Other Payer Patient Information 2330C | NM1	**374**
Other Payer Primary Identification Number 2330B | NM109	**359**
Other Payer Prior Authorization or Referral Number 2330B | REF	**370**
Other Payer Prior Authorization or Referral Number 2420G | NM1	**549**
Other Payer Prior Authorization or Referral Number 2420G | REF	**552**
Other Payer Prior Authorization or Referral Number 2420G | REF02	**552**
Other Payer Purchased Service Provider 2330F | NM1	**386**
Other Payer Purchased Service Provider Identification 2330F | REF	**388**
Other Payer Referring Provider 2330D | NM1	**378**

NAME	PAGE
Other Payer Referring Provider Identification 2330D | REF	**380**
Other Payer Referring Provider Identification 2330D | REF02	**380**
Other Payer Rendering Provider 2330E | NM1	**382**
Other Payer Rendering Provider Secondary Identification 2330E | REF	**384**
Other Payer Secondary Identifier 2330B | REF	**368**
Other Payer Service Facility Location 2330G | NM1	**390**
Other Payer Service Facility Location Identification 2330G | REF	**392**
Other Payer Service Facility Location Identification 2330G | REF02	**392**
Other Payer Supervising Provider 2330H | NM1	**394**
Other Payer Supervising Provider Identification 2330H | REF	**396**
Other Payer Supervising Provider Identification 2330H | REF02	**396**
Other Subscriber Address 2330A | N3	**354**
Other Subscriber City/State/ZIP Code 2330A | N4	**355**
Other Subscriber Information 2320 | SBR	**318**
Other Subscriber Name 2330A | NM1	**350**
Other Subscriber Primary Identifier 2330A | NM109	**350**
Other Subscriber Secondary Identification 2330A | REF	**357**
Other Subscriber Secondary Identification 2330A | REF02	**357**
Outpatient Reimbursement Rate 2320 | MOA01	**347**
Oxygen Flow Rate 2400 | REF	**480**
Oxygen Saturation 2400 | CR511	**423**
Oxygen test condition code 2400 | CR512	**423**
Oxygen test finding code 2400 | CR513	**423**
Oxygen test finding code 2400 | CR514	**423**
Oxygen test finding code 2400 | CR515	**423**
Paid Amount 2430 | SVD02	**554**
Paid units of service 2430 | SVD05	**554**
Participation Agreement 2300 | CLM16	**170**
Patient Account Number 2300 | CLM01	**170**
Patient Additional Name Information 2010CA | N201	**160**
Patient Address 2010CA | N3	**161**
Patient Address 1 2010CA | N301	**161**
Patient Address 2 2010CA | N302	**161**
Patient Amount Paid 2300 | AMT	**220**
Patient Birth Date 2010BA | DMG02	**124**
Patient City Name 2010CA | N401	**162**
Patient City/State/ZIP Code 2010CA | N4	**162**
Patient Condition Description, Chiropractic 2400 | CR210	**415**
Patient Condition Description, Chiropractic 2400 | CR211	**415**
Patient Condition Description. Spinal Manipulation 2300 | CR210	**251**
Patient Condition Description. Spinal Manipulation 2300 | CR211	**251**
Patient Condition Information: Vision 2300 | CRC	**260**

NAME PAGE

Patient Country Code
2010CA | N404 ..... **162**

Patient Demographic Information
2010CA | DMG **164**

Patient First Name
2010CA | NM104 ..... **157**

Patient Gender Code
2010BA | DMG03 ..... **124**

Patient Generation
2010CA | NM107 ..... **157**

Patient Hierarchical Level
2000C | HL **152**

Patient Information
2000B | PAT **114**

Patient Information
2000C | PAT **154**

Patient Last Name
2010CA | NM103 ..... **157**

Patient Last Name
2330C | NM103 ..... **374**

Patient Middle Initial
2010CA | NM105 ..... **157**

Patient Name
2010CA | NM1 ..... **157**

Patient Secondary Identification
2010CA | REF **166**

Patient Signature Source Code
2300 | CLM10 ..... **170**

Patient Signature Source Code
2320 | OI04 ..... **344**

Patient State Code
2010CA | N402 ..... **162**

Patient Weight
2300 | CR102 ..... **248**

Patient Weight
2000C | PAT08 ..... **154**

Patient Weight
2400 | CR102 ..... **412**

Patient Weight
2000B | PAT08 ..... **114**

Patient Zip Code
2010CA | N403 ..... **162**

Patient's Other Payer Primary Identification Number
2330C | NM109 ..... **374**

NAME PAGE

Patient's Other Payer Secondary Identifier
2330C | REF02 ..... **376**

Patient's Primary Identification Number
2010CA | NM109 ..... **157**

Patients Relationship to Insured
2000C | PAT01 ..... **154**

Pattern Code
2305 | HSD07 ..... **278**

Pay-to Provider Additional Identifier
2010AB | REF02 ..... **106**

Pay-to Provider Additional Name
2010AB | N201 ..... **102**

Pay-to Provider Address
2010AB | N3 ..... **103**

Pay-to Provider Address 1
2010AB | N301 ..... **103**

Pay-to Provider Address 2
2010AB | N302 ..... **103**

Pay-to Provider City Name
2010AB | N401 ..... **104**

Pay-to Provider City/State/ZIP Code
2010AB | N4 ..... **104**

Pay-to Provider Country Code
2010AB | N404 ..... **104**

Pay-to Provider First Name
2010AB | NM104 ..... **99**

Pay-to Provider Last or Organizational Name
2010AB | NM103 ..... **99**

Pay-to Provider Middle Name
2010AB | NM105 ..... **99**

Pay-to Provider Name
2010AB | NM1 ..... **99**

Pay-to Provider Name Suffix
2010AB | NM107 ..... **99**

Pay-to Provider Primary Identification Number
2010AB | NM109 ..... **99**

Pay-to Provider State Code
2010AB | N402 ..... **104**

Pay-to Provider Zip Code
2010AB | N403 ..... **104**

Pay-to-Provider Secondary Identification
2010AB | REF **106**

Payer Additional Name Information
2010BB | N201 ..... **133**

NAME	PAGE
Payer Additional Name Information 2330B | N201	**362**
Payer Address 2010BB | N3	**134**
Payer Address 1 2010BB | N301	**134**
Payer Address 2 2010BB | N302	**134**
Payer City Name 2010BB | N401	**135**
Payer City/State/ZIP Code 2010BB | N4	**135**
Payer Country Code 2010BB | N404	**135**
Payer Name 2010BB | NM103	**130**
Payer Name 2330B | NM103	**359**
Payer Name 2420G | NM103	**549**
Payer Name 2010BB | NM1	**130**
Payer Primary Identifier 2010BB | NM109	**130**
Payer responsibility sequence number code 2320 | SBR01	**318**
Payer Responsibility Sequence Number Code 2000B | SBR01	**110**
Payer Secondary Identification 2010BB | REF	**137**
Payer State Code 2010BB | N402	**135**
Payer Zip Code 2010BB | N403	**135**
Place of Service Code 2300 | CLM05 | C023	**170**
Place of Service Code 2400 | SV105	**400**
Policy compliance code 2300 | HCP14	**271**
Policy compliance code 2400 | HCP14	**495**
Postage Claimed Amount 2400 | AMT	**486**
Pregnancy Indicator 2000B | PAT09	**114**
Prescription Number 2400 | SV4	**408**
Pricing rate 2300 | HCP05	**271**
Pricing/Repricing Allowed Amount 2400 | HCP02	**495**
Pricing/Repricing Approved Procedure Code 2400 | HCP10	**495**
Pricing/Repricing Approved Units or Inpatient Days 2400 | HCP12	**495**
Pricing/Repricing Identification Number 2400 | HCP04	**495**
Pricing/repricing methodology 2300 | HCP01	**271**
Pricing/repricing methodology 2400 | HCP01	**495**
Pricing/Repricing Rate 2400 | HCP05	**495**
Pricing/Repricing Savings Amount 2400 | HCP03	**495**
Principal Diagnosis 2300 | HI01 | C022	**265**
Prior Authorization or Referral Number 2300 | REF	**227**
Prior Authorization or Referral Number 2400 | REF	**470**
Procedure identifier 2400 | SV101 | C003	**400**
Procedure identifier 2430 | SVD03 | C003	**554**
Procedure Modifier 1 2400 | SV101 | C003-03	**400**
Procedure Modifier 1 2430 | SVD03 | C003-03	**554**
Procedure Modifier 2 2400 | SV101 | C003-04	**400**
Procedure Modifier 2 2430 | SVD03 | C003-04	**554**
Procedure Modifier 3 2400 | SV101 | C003-05	**400**
Procedure Modifier 3 2430 | SVD03 | C003-05	**554**

NAME PAGE

Procedure Modifier 4
2400 | SV101 | C003-06 ..... **400**

Procedure Modifier 4
2430 | SVD03 | C003-06 ..... **554**

Professional Component
2320 | MOA09 ..... **347**

Professional Service
2400 | SV1 ..... **400**

Property and Casualty Claim Number
2010BA | REF **128**

Property and Casualty Claim Number
2010CA | REF **168**

Provider Signature on File
2300 | CLM06 ..... **170**

Provider Specialty Code
2000A | PRV03 ..... **79**

Provider Specialty Code
2310A | PRV03 ..... **285**

Provider Specialty Code
2000A | PRV03 ..... **79**

Provider Specialty Code
2310A | PRV03 ..... **285**

Provider Specialty Code
2310B | PRV03 ..... **293**

Provider Specialty Code
2420A | PRV03 ..... **504**

Provider Specialty Code
2420F | PRV03 ..... **544**

Purchased Service Charge Amount
2400 | PS102 ..... **489**

Purchased Service Information
2400 | PS1 ..... **489**

Purchased Service Provider Identifier
2400 | PS101 ..... **489**

Purchased Service Provider Name
2310C | NM1 ..... **298**

Purchased Service Provider Name
2330F | NM103 ..... **386**

Purchased Service Provider Name
2420B | NM1 ..... **509**

Purchased Service Provider Primary Identifier
2310C | NM109 ..... **298**

Purchased Service Provider Secondary Identification
2310C | REF **301**

NAME PAGE

Purchased Service Provider Secondary Identification
2420B | REF **512**

Purchased Service Provider Secondary Identifier
2310C | REF02 ..... **301**

Purchased Service Provider Secondary Identifier
2420B | REF02 ..... **512**

Purchased Service Provider's Primary Identification Number
2420B | NM109 ..... **509**

Question Number/Letter
2440 | FRM01 ..... **569**

Question Response
2440 | FRM02 ..... **569**

Question Response
2440 | FRM03 ..... **569**

Question Response
2440 | FRM04 ..... **569**

Question Response
2440 | FRM05 ..... **569**

Receiver Additional Name Information
1000B | N2 ..... **76**

Receiver Additional Name Information
1000B | N201 ..... **76**

Receiver Name
1000B | NM103 ..... **74**

Receiver Name
1000B | NM1 ..... **74**

Receiver Primary Identification Number
1000B | NM109 ..... **74**

Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification
2400 | REF **477**

Referring Provider Additional Name Information
2310A | N201 ..... **287**

Referring Provider Additional Name Information
2420F | N201 ..... **546**

Referring Provider First Name
2310A | NM104 ..... **282**

Referring Provider Generation
2310A | NM107 ..... **282**

Referring Provider Generation
2420F | NM107 ..... **541**

NAME — PAGE

Referring Provider Last Name
2310A | NM103 ... **282**

Referring Provider Last Name
2330D | NM103 ... **378**

Referring Provider Middle Name
2310A | NM105 ... **282**

Referring Provider Name
2310A | NM1 ... **282**

Referring Provider Name
2420F | NM1 ... **541**

Referring Provider Primary Identifier
2310A | NM109 ... **282**

Referring Provider Secondary Identification
2310A | REF ... **288**

Referring Provider Secondary Identification
2420F | REF ... **547**

Referring Provider Secondary IdentifiER
2310A | REF02 ... **288**

Referring Provider Specialty Information
2310A | PRV ... **285**

Referring Provider Specialty Information
2420F | PRV ... **544**

Referring Provider's Identification Number
2420F | NM109 ... **541**

Reject reason code
2300 | HCP13 ... **271**

Reject reason code
2400 | HCP13 ... **495**

Relationship Code
2000B | SBR02 ... **110**

Release of Information Code
2300 | CLM09 ... **170**

Release of Information Code
2320 | OI06 ... **344**

Remarks Code
2320 | MOA03 ... **347**

Remarks Code
2320 | MOA04 ... **347**

Remarks Code
2320 | MOA05 ... **347**

Remarks Code
2320 | MOA06 ... **347**

NAME — PAGE

Remarks Code
2320 | MOA07 ... **347**

Rendering Provider Additional Name Information
2310B | N201 ... **295**

Rendering Provider Additional Name Information
2420A | N201 ... **506**

Rendering Provider First Name
2310B | NM104 ... **290**

Rendering Provider First Name
2420A | NM104 ... **501**

Rendering Provider Generation
2310B | NM107 ... **290**

Rendering Provider Generation
2420A | NM107 ... **501**

Rendering Provider Last Name
2310B | NM103 ... **290**

Rendering Provider Last Name
2420A | NM103 ... **501**

Rendering Provider Middle Name
2310B | NM105 ... **290**

Rendering Provider Middle Name
2420A | NM105 ... **501**

Rendering Provider Name
2310B | NM1 ... **290**

Rendering Provider Name
2420A | NM1 ... **501**

Rendering Provider Primary Identifier
2310B | NM109 ... **290**

Rendering Provider Primary Identifier
2420A | NM109 ... **501**

Rendering Provider Secondary Identification
2310B | REF ... **296**

Rendering Provider Secondary Identification
2420A | REF ... **507**

Rendering Provider Secondary Identifier
2310B | REF02 ... **296**

Rendering Provider Secondary Identifier
2420A | REF02 ... **507**

Rendering Provider Specialty Information
2310B | PRV ... **293**

NAME PAGE

Rendering Provider Specialty Information
2420A | PRV **504**

Repriced Claim Number
2300 | REF **233**

Repriced Line Item Reference Number
2400 | REF **468**

Repricing Organization Identifier
2300 | HCP04 ..... **271**

Responsible Party Additional Name Information
2010BC | N201 ..... **142**

Responsible Party Address
2010BC | N3 ..... **143**

Responsible Party Address 1
2010BC | N301 ..... **143**

Responsible Party Address 2
2010BC | N302 ..... **143**

Responsible Party City Name
2010BC | N401 ..... **144**

Responsible Party City/State/ZIP Code
2010BC | N4 ..... **144**

Responsible Party Country Code
2010BC | N404 ..... **144**

Responsible Party First Name
2010BC | NM104 ..... **139**

Responsible Party Generation
2010BC | NM107 ..... **139**

Responsible Party Last or Organization Name
2010BC | NM103 ..... **139**

Responsible Party Middle Name
2010BC | NM105 ..... **139**

Responsible Party Name
2010BC | NM1 ..... **139**

Responsible Party State Code
2010BC | N402 ..... **144**

Responsible Party Zip Code
2010BC | N403 ..... **144**

Round Trip Purpose Description
2300 | CR109 ..... **248**

Sales Tax Amount
2400 | AMT **484**

Savings amount, Pricing
2300 | HCP03 ..... **271**

Segment Count
SE01 ..... **572**

NAME PAGE

Service Authorization Exception Code
2300 | REF **222**

Service Facility Location
2310D | NM1 ..... **303**

Service Facility Location
2420C | NM1 ..... **514**

Service Facility Location Additional Name
2420C | N201 ..... **517**

Service Facility Location Address
2310D | N3 ..... **307**

Service Facility Location Address
2420C | N3 ..... **518**

Service Facility Location Address 1
2420C | N301 ..... **518**

Service Facility Location Address 2
2420C | N302 ..... **518**

Service Facility Location City
2420C | N401 ..... **519**

Service Facility Location City/State/ZIP
2310D | N4 ..... **308**

Service Facility Location City/State/ZIP
2420C | N4 ..... **519**

Service Facility Location Country Code
2420C | N404 ..... **519**

Service Facility Location Identification Number
2420C | NM109 ..... **514**

Service Facility Location Name
2420C | NM103 ..... **514**

Service Facility Location Secondary Identification
2310D | REF **310**

Service Facility Location Secondary Identification
2420C | REF **521**

Service Facility Location Secondary Identification Number
2420C | REF02 ..... **521**

Service Facility Location State
2420C | N402 ..... **519**

Service Facility Location ZIP Code
2420C | N403 ..... **519**

Service Facility Name
2330G | NM103 ..... **390**

Service Line
2400 | LX **398**

NAME	PAGE
Special Program Code 2300 | CLM12	**170**
Spinal Manipulation Service Information 2300 | CR2	**251**
Spinal Manipulation Service Information 2400 | CR2	**415**
Stretcher Purpose Description 2300 | CR110	**248**
Stretcher Purpose Description 2400 | CR110	**412**
Subluxation Level Code 2300 | CR203	**251**
Subluxation Level Code 2300 | CR204	**251**
Subluxation Level Code 2400 | CR203	**415**
Subluxation Level Code 2400 | CR204	**415**
Submitted charge amount 2400 | SV102	**400**
Submitter EDI Contact Information 1000A | PER	**71**
Submitter Name 1000A | NM103	**67**
Submitter Name 1000A | NM104	**67**
Submitter Name 1000A | NM105	**67**
Submitter Name 1000A | NM1	**67**
Submitter Primary Identification Number 1000A | NM109	**67**
Subscriber Additional Name Information 2330A | N201	**353**
Subscriber Address 2010BA | N3	**121**
Subscriber Address 1 2010BA | N301	**121**
Subscriber Address 1 2330A | N301	**354**
Subscriber Address 2 2010BA | N302	**121**
Subscriber Address 2 2330A | N302	**354**
Subscriber City Name 2010BA | N401	**122**
Subscriber City Name 2330A | N401	**355**
Subscriber City/State/ZIP Code 2010BA | N4	**122**
Subscriber Country Code 2010BA | N404	**122**
Subscriber Country Code 2330A | N404	**355**
Subscriber Demographic Information 2010BA | DMG	**124**
Subscriber Demographic Information 2320 | DMG	**342**
Subscriber First Name 2010BA | NM104	**117**
Subscriber First Name 2330A | NM104	**350**
Subscriber Generation 2010BA | NM107	**117**
Subscriber Generation 2330A | NM107	**350**
Subscriber Hierarchical Level 2000B | HL	**108**
Subscriber Information 2000B | SBR	**110**
Subscriber Last Name 2010BA | NM103	**117**
Subscriber Last Name 2330A | NM103	**350**
Subscriber Middle Name 2010BA | NM105	**117**
Subscriber Middle Name 2330A | NM105	**350**
Subscriber Name 2010BA | NM1	**117**
Subscriber Primary Identifier 2010BA | NM109	**117**
Subscriber Secondary Identification 2010BA | REF	**126**
Subscriber State Code 2010BA | N402	**122**
Subscriber State Code 2330A | N402	**355**
Subscriber Zip Code 2010BA | N403	**122**

NAME PAGE

Subscriber Zip Code
2330A | N403 ..... **355**

Subscriber's Additional Name Information
2010BA | N201 ..... **120**

Supervising Provider Additional Name Information
2310E | N201 ..... **315**

Supervising Provider Additional Name Information
2420D | N201 ..... **526**

Supervising Provider First Name
2310E | NM104 ..... **312**

Supervising Provider First Name
2420D | NM104 ..... **523**

Supervising Provider Generation
2310E | NM107 ..... **312**

Supervising Provider Generation
2420D | NM107 ..... **523**

Supervising Provider Last Name
2310E | NM103 ..... **312**

Supervising Provider Last Name
2330H | NM103 ..... **394**

Supervising Provider Last Name
2420D | NM103 ..... **523**

Supervising Provider Middle Name
2310E | NM105 ..... **312**

Supervising Provider Middle Name
2420D | NM105 ..... **523**

Supervising Provider Name
2310E | NM1 ..... **312**

Supervising Provider Name
2420D | NM1 ..... **523**

Supervising Provider Primary Identifier
2310E | NM109 ..... **312**

Supervising Provider Secondary Identification
2310E | REF **316**

Supervising Provider Secondary Identification
2420D | REF **527**

Supervising Provider Secondary Identifier
2310E | REF02 ..... **316**

Supervising Provider Secondary Identifier
2420D | REF02 ..... **527**

NAME PAGE

Supervising Provider's Identification Number
2420D | NM109 ..... **523**

Supporting Documentation
2440 | FRM **569**

Terms Discount Percent
2300 | CN105 ..... **217**

Terms discount percent
2400 | CN105 ..... **466**

Test Result
2400 | MEA **464**

Test Results
2400 | MEA03 ..... **464**

Time Code
2305 | HSD08 ..... **278**

Total Purchased Service Amount
2300 | AMT **221**

Total Submitted Charges
2300 | CLM02 ..... **170**

Total visits projected, home health
2305 | CR703 ..... **276**

Total visits rendered, home health
2305 | CR702 ..... **276**

Transaction Set Control Number
ST02 ..... **62**

Transaction Set Control Number
SE02 ..... **572**

Transaction Set Header
ST **62**

Transaction Set Purpose Code
BHT02 ..... **63**

Transaction Set Trailer
SE **572**

Transmission Type Identification
REF **66**

Transport Distance
2300 | CR106 ..... **248**

Transport Distance
2400 | CR106 ..... **412**

Transport purpose description
2400 | CR109 ..... **412**

Treatment Number in Month. Spinal Manipulation
2300 | CR207 ..... **251**

Treatment Number in Month. Spinal Manipulation
2400 | CR207 ..... **415**

NAME	PAGE
Treatment Number. Spinal Manipulation 2300 | CR201	**251**
Treatment Number. Spinal Manipulation 2400 | CR201	**415**
Treatment Series Period. Spinal Manipulation 2300 | CR206	**251**
Treatment Series Period. Spinal Manipulation 2400 | CR206	**415**
Treatment Series Total. Spinal Manipulation 2300 | CR202	**251**
Treatment Series Total. Spinal Manipulation 2400 | CR202	**415**
Units or Minutes 2400 | SV104	**400**
Universal Product Number (UPN) 2400 | REF	**482**
X-ray Availability Indicator, Chiropractic 2400 | CR212	**415**
X-ray Availability Indicator. Spinal Manipulation 2300 | CR212	**251**

K Loop 2440 Example

This Appendix is included to clarify how Loop 2440 - Form Identification - is used. On the next page is an example of a Medicare DMERC form, DMERC 08.02. If a DMERC provider were submitting a claim to Medicare and needed to include the information from this form on the claim submission, that information is carried in the 2440 loop in the following manner.

The LQ segment is used to identify the form that is being attached to the claim. LQ01 is the Form Identification Code. This is the qualifier to identify a specific industry code list. There are two possible values for LQ01:

Code “AS Form Type Code” is used to indicate that a Home Health form is being included with the claim.

Code “UT Health Care Financing Administration (HCFA) Durable Medical Equipment Regional Carrier (DMERC) Certificate of Medical Necessity (CMN) Forms” is used to indicate that a DMERC form is being included with the claim. LQ02 is the Form Identifier. This element carries the DMERC or Home Health form number.

In the example given on the next page the LQ segment would be completed as follows:

LQ*UT*0802~

The next segment, the FRM, is used to answer the questions on the form identified in the LQ segment. The FRM elements are used to identify the question being answered (FRM01) One FRM is used for each question answered. The answer is placed in the appropriate FRM element: for Yes/No answers use FRM02, for answers that are in text (and those that don’t fit another FRM element) use FRM03, for dates use FMR04, and for percents use FMR05.

For the example given on the next page the following FMR segments would look like this:

FRM*1AJ0234~**

FRM*1B500~**

FRM*1C4~**

FRM*4*Y~

FRM*5A5~**

FRM*5B3~**

FMR*8METHODIST HOSPITAL~**

FRM*9*INDIANAPOLIS~

FRM*10INDIANA~**

FRM*11*19971101~**

FRM*12*Y~

FRM*1*N~

Note that the answers to question 5A and 5B are carried in FRM03. It is not necessary to order the FRM segments in any particular order.

The entire 2440 loop would look like this: (carriage returns are not allowed in actual transmissions)

```
LQ*UT*0802~
FRM*1A**J0234~
FRM*1B**500~
FRM*1C**4~
FRM*4*Y~
FRM*5A**5~
FRM*5B**3~
FMR*8**METHODIST HOSPITAL~
FRM*9*INDIANAPOLIS~
FRM*10**INDIANA~
FRM*11***19971101~
FRM*12*Y~
FRM*1*N~
```

The loop can be used 1 time so only 1 form can be attached to a line, but there can be more than one line per claim (up to 50 lines, maximum).

DMERC Information Form: IMMUNOSUPPRESSIVE DRUGS

ALL INFORMATION ON THIS FORM MAY BE COMPLETED BY THE SUPPLIER

Certification Type/Date: [INITIAL] **REVISED**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
Mary Q. Public **1002 Main Street** **Indianapolis, IN 46250** **(317) 555 –9999** HICN ___**444-22-4444A**__	**XYZ Supplies** **9999 Clark Street** **Indianapolis, IN 46224** **(317) 555-7777** NSC # __**9911223344**_____
PLACE OF SERVICE **12** NAME and ADDRESS of FACILITY if applicable (see reverse):	PT DOB ; **10-15-23** Sex (M/[F]

TRANSPLANT DIAGNOSIS CODES (ICD-9) (CIRCLE APPROPRIATE CODES): V42.1 (HEART); V42.7 (LIVER);

[V42 .0 (KIDNEY)] [V42.6 (LUNG)] V42.8 (BONE MARROW); V42.8 (OTHER-SPECIFY)

ANSWERS	ANSWER QUESTIONS 1 - 5 AND 8 - 12 FOR IMMUNOSUPPRESSIVE DRUGS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Questions 6 and 7, reserved for other or future use.
	What are the drug(s) prescribed and the dosage and frequency of administration of each? HCPCS MG TIMES PER DAY 1. **J0234** **500** **4** 2. _____ _____ _____ 3. _____ _____ _____
[Y] N	4. Has the patient had an organ transplant that was covered by Medicare?
Enter Correct Number(s) 3 5	5. Which organ(s) have been transplanted? (List most recent transplant) (May enter up to three different organs). 1 - Heart 2 - Liver 3 - Kidney 4 - Bone Marrow 5 - Lung
Methodist Hospital	8. Name of facility where transplant was performed.
Indianapolis	9. City where facility is located.
Indiana	10. State where facility is located.
19971101	11. On what date was the patient discharged from the hospital following this transplant surgery?
Y [N]	12. Was there a prior transplant failure of this same organ?

PHYSICIAN NAME, ADDRESS (Printed or Typed)	
Dr. John R. Smith **1212 Hospital Lane** **Indianapolis, In 46224** **UPIN: D12345** **TELEPHONE #: (317) 272 -9999**	_____ **1-1-99** **SUPPLIER'S SIGNATURE** **DATE** **(A Stamped Signature Is Not Acceptable)** __**Jane Jones, Owner /XYZ Supplies**_____ **PRINT NAME**