



**CENPATICO**<sup>®</sup>  
behavioral health  
*A CenCorp Health Solution*

# 837P Inbound Companion Guide

Professional Claim Submission

Version 2.2

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### Overview

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) legislation mandates that many of the major health care electronic data exchanges, such as electronic claims and eligibility, be standardized into the same national format for all payers, providers and clearinghouses.

HIPAA specifies the electronic standards that must be followed when certain health care information is exchanged. These standards are published in National Electronic Data Interchange Transaction Set Implementation Guides. They are commonly called Implementation Guides (IG) and are referred to as IG throughout this document. The following table illustrates the adopted standards and the related CENPATICO BEHAVIORAL HEALTH (CBH) business categories.

**Table 1.1 – Standards and Business Categories**

Business Category	Transaction Name – Implementation Guide (IG)	Description
Enrollment Roster	ASC X12N 834 (004010X095A1)	Enrollment/Disenrollment in a Health Plan
Capitation Payment Reporting	ASC X12N 820 (004010X061A1)	Health Plan Premium Payments
Claims Processing	ASC X12N 837 (004010X098A1)	Healthcare Claim or Encounter: Professional
Claims Processing	ASC X12N 837 (004010X097A1)	Healthcare Claim or Encounter: Dental
Claims Processing	ASC X12N 837 (004010X096A1)	Healthcare Claim or Encounter: Institutional
Explanation of Payment/Remittance Advice	ASC X12N 835 (004010X091A1)	Claim payment and Remittance Advice
Eligibility Verification	ASC X12N 270/271 (004010X092A1)	Health Plan Eligibility
Claim Status	ASC X12N 276/277 (004010X093A1)	Health Claim Status
Prior Authorization	ASC X12N 278 (004010X094A1)	Referral Certification and Authorization

The IG's are available for download through the Washington Publishing Company Web site at <http://hipaa.wpc-edi.com>. Developers should have copies of the respective IG's prior to beginning the development process.

CBH has developed technical companion guides to assist application developers during the implementation process. The information contained in the CBH Companion Guide is only intended to supplement the adopted IG's and provide guidance and clarification as it applies to CBH. The CBH Companion Guide is never intended to modify, contradict, or interpret the rules established in HIPAA or IG's.

## EDI Registration and Trading Partner Agreements

### EDI Registration

There is no EDI Enrollment form to be filled out, however, prior to submitting claims electronically to CBH, providers are encouraged to contact the Provider Relations Department and verify the appropriate provider number(s) are on file. In order for EDI claims to be accepted into the Claim Processing system, the provider number must be on file.

### Trading Partner Agreement

Anyone wanting to exchange Health Information electronically directly with CBH must obtain plan approval then complete and submit a Trading Partner Agreement.

## Data Flow

CBH has secure options available for exchanging data electronically. All transactions will be submitted in a batch mode. *Section 02: Method of Transmission* provides information on data transmissions.

For each batch transaction received, CBH will return a 997 – Functional Acknowledgement. This file acknowledges the receipt of the file and reports any data compliance issues. CBH also expects to receive a 997 – Functional Acknowledgement transaction when the trading partner receives any outbound batch transaction. For additional information about the use of the 997 transactions, refer to *Section 04: Acknowledgements and Reports*, of this companion guide.

CBH has created an Audit Report for any health care claim transaction (837I and 837P) received. This is not a HIPAA-mandated report; however it summarizes the number of claims received and any claims that were rejected due to invalid information. Additional information is available in *Section 04 – Acknowledgements and Reports*.

A batch request or inquiry transaction, 270, 276, 278 results in the creation of the response transaction, 271, 277 or 278 respectively. CBH will post the responses in a reasonable amount of time for the requestor to retrieve. *Section 02: Method of Transmission* provides communication specifications for data exchange.

Finally, some transactions can be submitted interactively. CBH only creates a 997 – *Acknowledgement* for an interactive request transaction if it fails the compliance check. Otherwise, the appropriate response transaction serves as the acknowledgement of the receipt of the transaction.

## Processing Assumptions

Some transactions are created and generated by, or on behalf of, a provider. Others are created by CBH either in response to a request received from a provider or as a means to

provide pertinent information to providers or contracted vendors. The following list identifies each transaction by CBH’s definition as inbound and/or outbound:

**Table 1.2 – CBH Transaction Definition**

Inbound	Outbound
NCPDP (Provider)	NCPDP (State Agency)
270	271
276	277
278 (request)	278 (response)
820 (State Agency)	820 (Provider)
834 (State Agency)	834 (Provider)
835 (State Agency)	835 (Provider)
837I (Provider)	837I (State Agency)
837P (Provider)	837P (State Agency)
837D (Provider)	837D (State Agency)

## Basic Technical Information

The following list includes basic technical information for each transaction:

- ▶ Lower case characters on inbound transactions are converted to uppercase on outbound transactions

- ▶ The following delimiters are used for all outbound transactions:

*	(Asterisk)	=	Data element separator
:	(Colon)	=	Sub element separator
~	(Tilde)	=	Segment separator

- ▶ All monetary amounts and quantity fields have explicit decimals. 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, with the decimal point at the right end, the decimal point should be omitted. See the *IG* for additional clarification. CBH is referred to as *CBH* in applicable Submitter and Receiver segments.

- ▶ The *TA1 – Interchange Acknowledgement*, is not used.

- ▶ The *997 – Functional Acknowledgement*, is generated in response to all inbound batch transactions.

- ▶ The *997 – Functional Acknowledgement*, is expected in response to all outbound batch transactions created by CBH.

- ▶ Required data elements considered non-critical to CBH processing that must be returned on outbound transactions, such as member’s birth date, are returned as they appear on the CBH files.

- ▶ If one item within a functional group is non-compliant, the entire transaction, ST-SE, is rejected.
- ▶ Data elements required by the *IG*, but not used by CBH can be gap-filled with any valid value to avoid compliance errors.
- ▶ The submitter number will be assigned by CBH and will need to be evident in the following ASC X12N 837 locations: ISA06 and Loop 1000A, NM109
- ▶ The ASC X12N 837 location in which the Payer ID must be present is in Loop 2010BB (Payer Name), NM109

## Provider Selection Criteria Information

The following criteria will be used to select the appropriate provider for claim processing.

- **NM109 = Provider NPI**
- **REF01 = Tax ID**
- **PRV03 = Provider Taxonomy**
- **N403 = Provider 9-digit Zip Code (required in loop 2010AA only)**

Loop 2010AA – Billing Provider is a required loop. The provider TaxID, NPI and Taxonomy Code are required in this loop. The billing provider can also be the pay-to provider as well as the rendering provider.

Provider Selection Criteria if used from loop 2010AA:

- NM108 = qualifier XX , NM109 = Provider NPI number
- REF01 = qualifier EI, REF02 = Employer/Tax Identification number
- PRV01= qualifier BI or PT, PRV02 = Provider Taxonomy Code

If the Pay-To provider on the claim is different then the Billing provider, the provider TaxID, NPI and Taxonomy Code are required in Loop 2010AB.

Provider Selection Criteria if used from loop 2010AB:

- NM108 = qualifier XX , NM109 = Provider NPI number
- REF01 = qualifier EI, REF02 = Employer/Tax Identification number
- PRV01= qualifier BI or PT, PRV02 = Provider Taxonomy Code

If a single provider that rendered all of the services on the claim and the rendering provider is not the same as the billing provider in Loop 2010AA or the pay-to provider in Loop 2010AB, the provider TaxID, NPI and Taxonomy Code must be in Loop 2310B.

Provider Selection Criteria if used from loop 2310B:

- NM108 = qualifier XX , NM109 = Provider NPI number
- REF01 = qualifier EI, REF02 = Employer/Tax Identification number
- PRV01= qualifier PE, PRV02 = Provider Taxonomy Code

If there are different providers that rendered the services evident at the service lines of the claim, the provider TaxID, NPI and Taxonomy Code must be in Loop 2420A.

Provider Selection Criteria if used from loop 2420A:

- NM108 = qualifier XX , NM109 = Provider NPI number
- REF01 = qualifier EI, REF02 = Employer/Tax Identification number
- PRV01= qualifier PE, PRV02 = Provider Taxonomy Code

## Atypical Provider Selection Criteria Information

Atypical providers – are not always assigned a NPI number, however, if an Atypical provider has been assigned a NPI number, then they need to follow the same requirements as Medical providers.

Atypical Providers who provide non-medical services are not required to have an NPI number, (e.g., carpenters, transportation, etc.).

Atypical providers need to only send the Provider TaxID in the NM1 segment and their Medicaid number or Health Plan Identifier in REF segment.

Atypical Provider Selection Criteria used in all loops:

- NM108 = qualifier 24, NM109 = Provider TaxID number
- N403 = Provider 9-digit Zip Code (required in loop 2010AA only)
- REF01 = qualifier 1D, REF02 = Medicaid number or Health Plan Identifier

### Communications

The methods of sending and receiving electronic transactions with CBH are:

- ✓ Cenpatico Bulletin Board System (BBS)
  - Requires terminal emulation software
    - Hypterminal (standard on windows O/S), ProComm Plus, Tiny Term
- ✓ Cenpatico secure ftp site (sftp)
  - Requires transfer client that can support SSL/TLS:
    - CoreFTP, CuteFtp, WSFTP Pro

If you would prefer to utilize the BBS, please contact your EDI Business Analysts at 800-225-2573 extension 25525. Direct submitters are required to receive approval from the health plan along with completion of the Trading Partner Agreement.

## SECTION 03: INTERCHANGE CONTROL STRUCTURE

### Overview

Appendix A, Section A.1.1 of each X12N HIPAA IG provides detail about the rules for ensuring integrity and maintaining the efficiency of data exchange. Data files are transmitted in an *electronic envelope*. The communication envelope consists of an interchange envelope and functional groups. The interchange control structure is used for inbound and outbound files. An inbound interchange control structure is the envelope that wraps all transaction data (ST-SE) sent to CBH for processing. Examples include 837, 270 and 276 transactions. An outbound interchange control structure wraps transactions that are created by CBH and returned to the requesting provider or contracted vendor. Examples of outbound transactions include 835, 271 and 277 transactions. The following tables define the use of this control structure as it relates to communication with CBH.

### Inbound Transactions

Segment Name	Interchange Control Header		
Segment ID	ISA		
Loop ID	N/A		
Usage	Required		
Segment Notes	<p>All positions within each data element in the ISA segment must be filled. Delimiters are specified in the interchange header segment.</p> <p>The character immediately following the segment ID, <i>ISA</i>, defines the data elements separator. The last character in the segment defines the component element separator, and the segment terminator is the byte that immediately follows the component element separator. Examples of the separators are as follows:</p>		
	Character	Name	Delimiter
	*	Asterisk	Data Element Separator
	:	Colon	Sub-element Separator
	~	Tilde	Segment Terminator

While it is not required that submitters use these specific delimiters, it is recommended. If other delimiters will be used, CBH needs to be notified prior to the first file being sent.

Element ID	Usage	Guide Description/Valid Values	Comments
ISA01	R	Authorization Information Qualifier <b>00 – No Authorization Information Present</b>	
ISA02	R	Authorization Information	Always blank
ISA03	R	Security Information Qualifier <b>00 – No Security Information Present</b>	
ISA04	R	Security Information	Always blank
ISA05	R	Interchange ID Qualifier	

Element ID	Usage	Guide Description/Valid Values	Comments
		<b>ZZ – Mutually Defined</b>	
ISA06	R	Interchange Sender ID	For batch transactions, this is the sender ID assigned by the Trading Partner. This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
ISA07	R	Interchange ID Qualifier <b>ZZ – Mutually defined</b>	
ISA08	R	Interchange Receiver ID	This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
ISA09	R	Interchange Date	The date format is YYMMDD.
ISA10	R	Interchange Time	The time format is HHMM.
ISA11	R	Interchange Control Standards Identifier <b>U – U.S. EDI Community of ASC X12, TDCC, and UCS</b>	
ISA12	R	Interchange Control Version Number <b>00401 – Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997</b>	
ISA13	R	Interchange Control Number	The interchange control number is created by the submitter and must be identical to the associated Interchange Trailer (IEA02). This is a numeric field and must be zero filled. This number should be unique and CBH recommends that it be incremented by one with each ISA segment.
ISA14	R	Acknowledgment Requested <b>0 – No acknowledgment requested</b> <b>1 – Interchange Acknowledgment Requested</b>	CBH always creates an acknowledgment file for each file received.
ISA15	R	Usage Indicator <b>P – Production Data</b> <b>T – Test Data</b>	During testing the usage indicator entered must be <b>T</b> . After testing approval, <b>P</b> must be entered for production transactions.
ISA16	R	Component Element Separator	The component element separator is a delimiter and not a data element. This field provides the

Element ID	Usage	Guide Description/Valid Values	Comments
			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.

Segment Name	Functional Group Header
Segment ID	GS
Loop ID	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
GS01	R	Functional Identifier Code <b>HC – Health Care Claim (837)</b>	Use the appropriate identifier to designate the type of transaction data to follow the GS segment.
GS02	R	Application Sender's Code	Same as ISA06
GS03	R	Application Receiver's Code	Same as ISA08
GS04	R	Date	The date format is CCYYMMDD.
GS05	R	Time	The time format is HHMMSS
GS06	R	Group Control Number	Assigned number originated and maintained by the sender. This must match the number in the corresponding GE02 data element on the GE group trailer segment.
GS07	R	Responsible Agency Code <b>X – Accredited Standards Committee X12</b>	
GS08	R	Version/Release/Industry Identifier Code <b>004010X098A1 – 837P</b> <b>004010X096A1 – 837 I</b>	Use the appropriate identifier to designate the identifier code for the type of transaction data to follow the GS segment. Refer to specific transaction <i>IG</i> for proper value.

Segment Name	Functional Group Trailer
Segment ID	GE
Loop ID	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
GE01	R	Number of Transaction Sets Included	Use the number of transaction sets included in this functional group.
GE01	R	Group Control Number	Group control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

Segment Name	Interchange Control Trailer
Segment ID	IEA
Loop ID	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
IEA01	R	Number of Included Functional Groups	Use the number of functional groups included in this interchange envelope.
IEA02	R	Interchange Control Number	Interchange control number IEA02 in this trailer must be identical to the same data element in the associated interchange control header, ISA13, including padded zeros.

## Outbound Transactions

Segment Name	Interchange Control Header		
Segment ID	ISA		
Loop ID	N/A		
Usage	Required		
Segment Notes	All positions within each data element in the ISA segment must be filled. Delimiters are specified in the interchange header segment.		
	The character immediately following the segment ID, <i>ISA</i> , defines the data elements separator. The last character in the segment defines the component element separator, and the segment terminator is the byte that immediately follows the component element separator. Examples of the separators are as follows:		
	Character	Name	Delimiter
	*	Asterisk	Data Element Separator
:	Colon	Sub-element Separator	
~	Tilde	Segment Terminator	
While it is not required that submitters use these specific delimiters, it is recommended. If other delimiters will be used, CBH needs to be notified prior to the first file being sent.			

Element ID	Usage	Guide Description/Valid Values	Comments
ISA01	R	Authorization Information Qualifier <b>00 – No Authorization Information Present</b>	
ISA02	R	Authorization Information	Always blank. Insert 10 blank spaces.
ISA03	R	Security Information Qualifier <b>00 – No Security Information Present</b>	
ISA04	R	Security Information	Always blank. Insert 10 blank spaces.
ISA05	R	Interchange ID Qualifier <b>ZZ – Mutually Defined</b>	
ISA06	R	Interchange Sender ID	For batch transactions, this is the sender ID assigned by CBH. This field has a required length of 15 bytes; therefore, the field must be blank filled to the right.
ISA07	R	Interchange ID Qualifier <b>ZZ – Mutually Defined</b>	
ISA08	R	Interchange Receiver ID	For batch transactions, this is the sender ID assigned by the Trading Partner. This field has a required

Element ID	Usage	Guide Description/Valid Values	Comments
			length of 15 bytes; therefore, the field must be blank filled to the right.
ISA09	R	Interchange Date	The date format is YYMMDD.
ISA10	R	Interchange Time	The time format is HHMM.
ISA11	R	Interchange Control Standards Identifier <b>U – U.S. EDI Community of ASC X12, TDCC, and UCS</b>	
ISA12	R	Interchange Control Version Number <b>00401 – Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997</b>	
ISA13	R	Interchange Control Number	This number is unique and increments by 1 with each ISA segment. It also matches the interchange control number of the IEA02 of the interchange control trailer.
ISA14	R	Acknowledgment Requested <b>1 – Interchange Acknowledgment Requested</b>	CBH always requires an acknowledgment file for each file submitted to a trading partner.
ISA15	R	Usage Indicator <b>P – Production Data</b> <b>T – Test Data</b>	During testing the usage indicator is a <b>T</b> . After the trading partner has approved, the usage indicator will be a <b>P</b> .
ISA16	R	Component Element Separator	The component element separator is a delimiter and not a data element. This is always a colon ( : ).

Segment Name	Functional Group Header
Segment ID	GS
Loop ID	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
GS01	R	Functional Identifier Code <b>HC – Health Care Claim (837)</b>	Use the appropriate identifier to designate the type of transaction data to follow the GS segment.
GS02	R	Application Sender's Code	Same as ISA06

Element ID	Usage	Guide Description/Valid Values	Comments
GS03	R	Application Receiver's Code	Same as ISA08
GS04	R	Date	The date format is CCYYMMDD.
GS05	R	Time	The time format is HHMMSS
GS06	R	Group Control Number	This data element contains a uniquely assigned number and matches the number in the corresponding GS02 data element on the GE group trailer segment
GS07	R	Responsible Agency Code <b>X – Accredited Standards Committee X12</b>	
GS08	R	Version/Release/Industry Identifier Code <b>004010X098A1 – 837P</b> <b>004010X096A1 – 837 I</b>	This data element contains the appropriate identifier to designate the identifier code for the type of transaction data to follow the GS segment.

Segment Name	Functional Group Trailer
Segment ID	GE
Loop ID	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
GE01	R	Number of Transaction Sets Included	This data element contains the number of transaction sets included in this functional group.
GE01	R	Group Control Number	Group control number GE02 in this trailer is identical to the same data element in the associated functional group header, GS06.

Segment Name	Interchange Control Trailer
Segment ID	IEA
Loop ID	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
IEA01	R	Number of Included Functional Groups	This data element contains the number of functional groups

Element ID	Usage	Guide Description/Valid Values	Comments
			included in this interchange envelope.
IEA02	R	Interchange Control Number	Interchange control number IEA02 in this trailer is identical to the same data element in the associated interchange control header, ISA13, including padded zeros.

## SECTION 04: PROFESSIONAL CLAIM SUBMISSIONS

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### Introduction

The ASC X12N 837 (004010X098) transaction is the HIPAA-mandated transaction for submitting CBH medical claims to Covered Entities and Business Associates.

This is intended only as a companion guide and is not intended to contradict or replace any information in the Implementation Guide or Health Plan Provider Manual's.

It is highly recommended that implementers have the following resources available during the development process:

- ▶ This document (837 Implementation Companion Document)
- ▶ ASC X12N 837 (004010X098A1) Implementation Guide

### Segment Usage

The following matrix lists all segments available to the submitted on the 4010 version of the 837 Implementation Guide. Additionally, it includes a Usage column that identifies those segments, which are required, situational, or not used by CBH. A required segment and element will be reported on all transactions. A situational segment may not be reported on every transaction record; however, a situational segment may be reported under certain circumstances. For example, any data in a segment that is identified in the Usage column with an X will be ignored by CBH. Any segment identified in the Usage column as Required is explained in detail in the Data and Element Description Section of the Companion Document.

#### Reminders

1. The maximum number of records within a single 837 Transaction is 1,000. Therefore, multiple 837 transactions may exist within one file.
2. Some element values may be defined as NULL. This means that there will not be a value in this element (i.e. INS\*Y\*18\*001\*\*A\*B\*\*FT)

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
ST	N/A	Transaction Set Header	R
BHT	N/A	Beginning of Hierarchical Transaction	R
REF	N/A	Transmission Type Identification	R
NM1	1000A	Submitter Name	R
N2	1000A	Additional Submitter Name Information	X – deleted per addenda
PER	1000A	Submitter EDI Contact Information	R
NM1	1000B	Receiver Name	R
N2	1000B	Receiver Additional Name Information	X – deleted per addenda
HL	2000A	Billing/Pay-To Hierarchical Level	R
PRV	2000A	Billing/Pay-To Specialty Information	S
CUR	2000A	Foreign Currency Information	X
NM1	2010AA	Billing Provider Name	R
N2	2010AA	Additional Billing Provider Name Information	X – deleted per addenda
N3	2010AA	Billing Provider Address	R
N4	2010AA	Billing Provider City/State/ZIP Code	R
REF	2010AA	Billing Provider Secondary Information	R
REF	2010AA	Credit/Debit Card Billing Information	X
PER	2010AA	Billing Provider Contact Information	R
NM1	2010AB	Pay-To Provider Name	S
N2	2010AB	Additional Pay-to-Provider Name Information	X – deleted per addenda
N3	2010AB	Pay-To Provider Address	S
N4	2010AB	Pay-To Provider City/State/ZIP Code	S
REF	2010AB	Pay-To Provider Secondary Information	S
HL	2000B	Subscriber Hierarchical Level	R
SBR	2000B	Subscriber Information	R
PAT	2000B	Patient Information	S
NM1	2010BA	Subscriber Name	R

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
N2	2010BA	Additional Subscriber Name Information	X – deleted per addenda
N3	2010BA	Subscriber Address	R
N4	2010BA	Subscriber City/State/ZIP Code	R
DMG	2010BA	Subscriber Demographic Information	R
REF	2010BA	Subscriber Secondary Information	X
REF	2010BA	Property and Casualty Claim Number	X
NM1	2010BB	Payer Name	R
N2	2010BB	Additional Payer Name Information	X – deleted per addenda
N3	2010BB	Payer Address	R
N4	2010BB	Payer City/State/ZIP Code	R
REF	2010BB	Payer Secondary Information	R
NM1	2010B C	Responsible Party Name	S
N2	2010B C	Additional Responsible Party Name Information	X – deleted per addenda
N3	2010B C	Responsible Party Address	S
N4	2010B C	Responsible Party City/State/ZIP Code	S
NM1	2010B D	Credit/Debit Card Holder Name	X
N2	2010B D	Additional Credit/Debit Card Holder Name Information	X – deleted per addenda
REF	2010B D	Credit/Debit Card Information	X
HL	2000C	Patient Hierarchical Level	S
PAT	2000C	Patient Information	S
NM1	2010C A	Patient Name	S
N2	2010C A	Additional Patient Name Information	X – deleted per addenda
N3	2010C A	Patient Address	S

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
N4	2010C A	Patient City/State/ZIP Code	S
DMG	2010C A	Patient Demographic Information	S
REF	2010C A	Patient Secondary Information Number	X
REF	2010C A	Property and Casualty Claim Number	X
CLM	2300	Claim Information	R
DTP	2300	Date – Order Date	X – deleted per addenda
DTP	2300	Date – Initial Treatment	S
DTP	2300	Date – Referral Date	X – deleted per addenda
DTP	2300	Date – Date Last Seen	S
DTP	2300	Date – Onset of Current Illness/Symptom	S
DTP	2300	Date – Acute Manifestation	S
DTP	2300	Date – Similar Illness/Symptom Onset	S
DTP	2300	Date – Accident	S
DTP	2300	Date – Last Menstrual Period	S
DTP	2300	Date – Last X-Ray	S
DTP	2300	Date – Estimated Date of Birth	X – deleted per addenda
DTP	2300	Date – Hearing and Vision Prescription Date	X
DTP	2300	Date – Disability Begin	S
DTP	2300	Date – Disability End	S
DTP	2300	Date – Date Last Worked	X
DTP	2300	Date – Authorized Return to Work	S
DTP	2300	Date – Admission	S
DTP	2300	Date – Date Discharge	S
DTP	2300	Date – Assumed and Relinquished Care Dates	S
PWK	2300	Claim Supplemental Information	X

**Table 3.1 – Segment Usage – 837 Professional**

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
CN1	2300	Contract Information	X
AMT	2300	Credit/Debit Card Maximum Amount	X
AMT	2300	Patient Paid Amount	S
AMT	2300	Total Purchased Service Amount	S
REF	2300	Service Authorization Exception Code	X
REF	2300	Mandatory Medicare (Section 4081) Crossover Indicator	X
REF	2300	Mammography Certification Number	X
REF	2300	Prior Authorization or Referral Number	S
REF	2300	Original Reference Number (ICN/DCN)	X
REF	2300	Clinical Laboratory Improvement Amendment (CLIA)	X
REF	2300	Repriced Claim Number	X
REF	2300	Adjusted Repriced Claim Number	X
REF	2300	Investigational Device Exemption Number	X
REF	2300	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S
REF	2300	Ambulatory Patient Group (APG)	X
REF	2300	Medical Record Number	X
REF	2300	Demonstration Project Identifier	X
K3	2300	File Information	X
NTE	2300	Claim Note	S
CR1	2300	Ambulance Transport Information	S
CR2	2300	Spine Manipulation Service Information	S
CRC	2300	Ambulance Certification	S
CRC	2300	Patient Condition Information: Vision	S
CRC	2300	Homebound Indicator	X
CRC	2300	EPSDT Referral – <i>New segment per Addenda</i>	S
HI	2300	Health Care Diagnosis Code	R

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
HCP	2300	Claim Pricing/Repricing Information	X
CR7	2305	Home Health Care Plan Delivery	X
HSD	2305	Health Care Services Delivery	X
NM1	2310A	Referring Provider Name	S
PRV	2310A	Referring Provider Specialty Information	S
N2	2310A	Additional Referring Provider Name Information	X – deleted per addenda
REF	2310A	Referring Provider Secondary Information	S
NM1	2310B	Rendering Provider Name	S
PRV	2310B	Rendering Provider Specialty Information	S
N2	2310B	Additional Rendering Provider Name Information	X – deleted per addenda
REF	2310B	Rendering Provider Secondary Information	S
NM1	2310C	Purchased Service Provider Name	X
REF	2310C	Purchased Service Provider Secondary Information	X
NM1	2310D	Service Facility Location	S
N2	2310D	Additional Service Facility Location Name Information	X – deleted per addenda
N3	2310D	Service Facility Location Address	S
N4	2310D	Service Facility Location City/State/ZIP Code	S
REF	2310D	Service Facility Location Secondary Information	X
NM1	2310E	Supervising Provider Name	S
N2	2310E	Additional Supervising Provider Name Information	X – deleted per addenda
REF	2310E	Supervising Provider Secondary Information	S
SBR	2320	Other Subscriber Information	S
CAS	2320	Claim Level Adjustment	X

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
AMT	2320	Coordination of Benefits (COB) Payer Paid Amount	X
AMT	2320	Coordination of Benefits (COB) Approved Amount	X
AMT	2320	Coordination of Benefits (COB) Allowed Amount	X
AMT	2320	Coordination of Benefits (COB) Patient Responsibility Amount	X
AMT	2320	Coordination of Benefits (COB) Covered Amount	X
AMT	2320	Coordination of Benefits (COB) Discount Amount	X
AMT	2320	Coordination of Benefits (COB) Per Day Limit Amount	X
AMT	2320	Coordination of Benefits (COB) Patient Paid Amount	X
AMT	2320	Coordination of Benefits (COB) Tax Amount	X
AMT	2320	Coordination of Benefits (COB) Total Claim Before Taxes Amount	X
DMG	2320	Subscriber Demographic Information	S
OI	2320	Other Insurance Coverage Information	S
MOA	2320	Medicare Outpatient Adjudication Information	X
NM1	2330A	Other Subscriber Name	S
N2	2330A	Additional Other Subscriber Name Information	X – deleted per addenda
N3	2330A	Other Subscriber Address	S
N4	2330A	Other Subscriber City/State/ZIP Code	S
REF	2330A	Other Subscriber Secondary Information	X
NM1	2330B	Other Payer Name	S
N2	2330B	Additional Other Payer Name Information	X – deleted per addenda
PER	2330B	Other Payer Contact Information	X
DTP	2330B	Claim Adjudication Date	X

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
REF	2330B	Other Payer Secondary Identifier	X
REF	2330B	Other Payer Prior Authorization or Referral Number	X
REF	2330B	Other Payer Claim Adjustment Indicator	X
NM1	2330C	Other Payer Patient Information	X
REF	2330C	Other Payer Patient Identification	X
NM1	2330D	Other Payer Referring Provider	X
REF	2330D	Other Payer Referring Provider Identification	X
NM1	2330E	Other Payer Rendering Provider	X
REF	2330E	Other Payer Rendering Provider Secondary Identification	X
NM1	2330F	Other Payer Purchased Service Provider	X
REF	2330F	Other Payer Purchased Service Provider Identification	X
NM1	2330G	Other Payer Service Facility Location	X
REF	2330G	Other Payer Service Facility Location Identification	X
NM1	2330H	Other Payer Supervising Provider	X
REF	2330H	Other Payer Supervising Provider Identification	X
LX	2400	Service Line Number	R
SV1	2400	Professional Service	R
SV4	2400	Prescription Number	X – deleted per addenda
SV5	2400	Durable Medical Equipment Service	X
PWK	2400	DMERC CMN Indicator	X
CR1	2400	Ambulance Transport Information	S
CR2	2400	Spinal Manipulation Service Information	S
CR3	2400	Durable Medical Equipment Certification	X
CR5	2400	Home Oxygen Therapy Information	X

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
CRC	2400	Ambulance Certification	S
CRC	2400	Hospice Employee Indicator	S
CRC	2400	DMERC Condition Indicator	X
DTP	2400	Date – Service Date	R
DTP	2400	Date – Certification Revision Date	X
DTP	2400	Date – Referral Date	X – deleted per addenda
DTP	2400	Date – Begin Therapy Date	X
DTP	2400	Date – Last Certification Date	X
DTP	2400	Date – Order Date	X – deleted per addenda
DTP	2400	Date – Date Last Seen	X
DTP	2400	Date – Test	X
DTP	2400	Date – Oxygen Saturation/Arterial Blood Gas Test	X
DTP	2400	Date – Shipped	X
DTP	2400	Date – Onset of Current Symptom/Illness	S
DTP	2400	Date – Last X-ray	X
DTP	2400	Date – Acute Manifestation	X
DTP	2400	Date – Initial Treatment	X
DTP	2400	Date – Similar Illness/Symptom Onset	X
QTY	2400	Anesthesia Modifying Units	X – deleted per addenda
MEA	2400	Test Result	S
CN1	2400	Contract Information	X
REF	2400	Repriced Line Item Reference Number	X
REF	2400	Adjusted Repriced Line Item Reference Number	X
REF	2400	Prior Authorization or Referral Number	X
REF	2400	Line Item Control Number	S
REF	2400	Mammography Certification Number	X
REF	2400	Clinical Laboratory Improvement	X

**Table 3.1 – Segment Usage – 837 Professional**

Segment ID	Loop ID	Segment Name	IHCP Usage R – Required S – Situational X – Not Used
		Amendment (CLIA) Information	
REF	2400	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification	X
REF	2400	Immunization Batch Number	X
REF	2400	Ambulatory Patient Group (APG)	X
REF	2400	Oxygen Flow Rate	X
REF	2400	Universal Product Number (UPN)	X
AMT	2400	Sales Tax Amount	X
AMT	2400	Approved Amount	X
AMT	2400	Postage Claimed Amount	X
K3	2400	File Information	X
NTE	2400	Line Note	S
PS1	2400	Purchased Service Information	X
HSD	2400	Health Care Services Delivery	X
HCP	2400	Line Pricing/Repricing Information	X
LIN	2410	Drug Identification – <i>New segment per Addenda</i>	X
CTP	2410	Drug Pricing – <i>New segment per addenda</i>	X
REF	2410	Prescription Number – <i>New segment per Addenda</i>	X
NM1	2420A	Rendering Provider Name	S
PRV	2420A	Rendering Provider Specialty Information	S
N2	2420A	Additional Rendering Provider Name Information	X – deleted per addenda
REF	2420A	Rendering Provider Secondary Information	S
NM1	2420B	Purchased Service Provider Name	X
REF	2420B	Purchased Service Provider Secondary Information	X
NM1	2420C	Service Facility Location	S
N2	2420C	Additional Service Facility Location Name Information	X – deleted per addenda

**Table 3.1 – Segment Usage – 837 Professional**

<b>Segment ID</b>	<b>Loop ID</b>	<b>Segment Name</b>	<b>IHCP Usage R – Required S – Situational X – Not Used</b>
N3	2420C	Service Facility Location Address	S
N4	2420C	Service Facility Location City/State/ZIP Code	S
REF	2420C	Service Facility Location Secondary Information	X
NM1	2420D	Supervising Provider Name	S
N2	2420D	Additional Supervising Provider Name Information	X – deleted per addenda
REF	2420D	Supervising Provider Secondary Information	S
NM1	2420E	Ordering Provider Name	S
N2	2420E	Additional Ordering Provider Name Information	X – deleted per addenda
N3	2420E	Ordering Provider Address	S
N4	2420E	Ordering Provider City/State/ZIP Code	S
REF	2420E	Ordering Provider Secondary Identification	X
PER	2420E	Ordering Provider Contact Information	X
NM1	2420F	Referring Provider Name	S
PRV	2420F	Referring Provider Specialty Information	S
N2	2420F	Additional Referring Provider Name Information	X – deleted per addenda
REF	2420F	Referring Provider Secondary Information	X
NM1	2420G	Other Payer Prior Authorization or Referral Number	X
REF	2420G	Other Payer Prior Authorization or Referral Number	X
SVD	2430	Line Adjudication Information	X
CAS	2430	Line Adjustment	X
DTP	2430	Line Adjudication Date	X
LQ	2440	Form Identification Code	X
FRM	2440	Supporting Documentation	X
SE	N/A	Transaction Set Trailer	R

## Segment and Data Element Description

This section contains a tabular representation of any segment that is required or situational for the CBH HIPAA implementation of the 837. Each segment table contains rows and columns describing different elements of the segment.

Segment Name	The industry assigned segment name as identified in the Implementation Guide (IG)
Segment ID	The industry assigned segment ID as identified in the IG
Loop ID	The loop within which the segment should appear
Usage	Identifies the segment as required or situational
Segment Notes	A brief description of the purpose or use of the segment
Element ID	
Usage	Identifies the data element as R-required, S-situational, or X-not used
Guide Description/Valid Values	Industry name associated with the data element. If no industry name exists, this is the IG data element name. This column also lists in <b>BOLD</b> type values and/or code sets to be used.
Comments	Description of the contents of the data elements (including field lengths)

<b>Segment Name</b>		<b>Transaction Set Header</b>	
<b>Segment ID</b>		ST	
<b>Loop ID</b>		N/A	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
ST01	R	Transaction Set Identifier Code	<b>837: Health Care Claim</b>
ST02	R	Transaction set Control Number	

<b>Segment Name</b>		<b>Beginning of Hierarchical Transaction</b>	
<b>Segment ID</b>		BHT	
<b>Loop ID</b>		N/A	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
BHT01	R	Hierarchical Structure Code	<b>0019- Information Source, Subscriber, Dependent</b>
BHT02	R	Transaction Set Purpose Code	<b>00: Original 18 Reissue</b>

BHT03	R	Originator Application Transaction Identifier	Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.
BHT04	R	Transaction Set Creation Date	Date expressed CCYYMMDD. Use this date to identify the date on which the submitter created the file.
BHT05	R	Transaction Set Creation Time	Use this time to identify the time of day that the submitter created the file.
BHT06	R	Claim or Encounter Identifier	<p><b>CH: Chargeable</b> Use this code when the transmission contains only fee-for-service claims or claims with at least one chargeable line item.</p> <p><b>RP: Reporting</b> Use this code to send a batch of encounters.</p>

<b>Segment Name</b>		<b>Transmission type Identification</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		N/A	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	<b>87: Functional Category</b>
REF02	R	Transmission Type Code	<b>When piloting this transaction set, this value is 004010X098D. When this draft is used to send the transaction set in a production mode, this value is 004010X098.</b>
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used.

<b>Segment Name</b>		<b>Submitter Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		1000A	
<b>Usage</b>		Required	

Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
NM101	R	Entity Identifier Code	<b>41: Submitter</b>
NM102	R	Entity Type Qualifier	<b>1: Person 2: Non-Person Entity</b>
NM103	R	Submitter Last or Organizational Name	
NM104	S	Submitter First Name	<b>Required if NM102 = 1(person)</b>
NM105	S	Submitter Middle Name	<b>Required if NM102 = 1 and the middle name/initial of the person is known.</b>
NM106	N/A	Name Prefix	Not Used
NM107	N/A	Name Suffix	Not Used
NM108	R	Identification Code Qualifier	<b>46: Electronic Transmitter Identification Number (ETIN) Established by a Trading Partner agreement.</b>
NM109	R	Submitter Identifier	
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

Segment Name		Submitter EDI Contact Information	
Segment ID		PER	
Loop ID		1000A	
Usage		Required	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
PER01	R	Contact Function Code	<b>IC: Information Contact</b>
PER02	R	Submitter Contact Name	
PER03	R	Communication Number Qualifier	<b>ED: Electronic Data Interchange Access Number EM: Electronic Mail FX: Facsimile TE: Telephone</b>
PER04	R	Communication Number	
PER05	S	Communication Number Qualifier	<b>Used when additional contact numbers are to be communicated. ED: Electronic Data Interchange Access Number</b>

			<b>EM: Electronic Mail</b> <b>EX: Telephone Extension-</b> the use of this number indicates it is the extension of the number in PER04. <b>FX: Facsimile</b> <b>TE: Phone</b>
PER06	S	Communication Number	
PER07	S	Communication Number Qualifier	<b>Used when additional contact numbers are to be communicated.</b> <b>ED: Electronic Data Interchange Access Number</b> <b>EM: Electronic Mail</b> <b>EX: Telephone Extension-</b> the use of this number indicates it is the extension of the number in PER06. <b>FX: Facsimile</b> <b>TE: Phone</b>
PER08	S	Communication Number	
PER09	N/A	Contact Inquiry Reference	Not Used

<b>Segment Name</b>		<b>Receiver Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		1000B	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>40: Receiver</b>
NM102	R	Entity Type Qualifier	<b>2: Non-Person Entity</b>
NM103	R	Submitter Last or Organizational Name	
NM104	N/A	Name First	Not Used
NM105	N/A	Name Middle	Not Used
NM106	N/A	Name Prefix	Not Used
NM107	N/A	Name Suffix	Not Used
NM108	R	Identification Code Qualifier	<b>46: Electronic Transmitter Identification Number (ETIN) Established by a Trading Partner agreement.</b>
NM109	R	Receiver Identifier	
NM110	N/A	Entity Relationship Code	Not Used

NM111	N/A	Entity Identifier Code	Not Used
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Segment Name		Billing/Pay to Hierarchical Level	
Segment ID		HL	
Loop ID		2000A	
Usage		Required	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
HL01	R	Hierarchical ID Number	<b>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.</b>
HL02	N/A	Hierarchical Parent ID Number	Not Used
HL03	R	Hierarchical Level Code	20: Information Source
HL04	R	Hierarchical Child Code	<b>1: Additional Subordinate HL Data Segment in this hierarchical structure.</b>

Segment Name		Billing/Pay to Provider Specialty Information	
Segment ID		PRV	
Loop ID		2000A Repeat : 1	
Usage		Situational	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
PRV01	R	Provider Code	<b>BI = Billing PT = Pay to</b>
PRV02	R	Reference Identification Qualifier	<b>ZZ</b>
PRV03	R	Reference Identification	Provider Taxonomy Code

Segment Name		Provider Billing Name	
Segment ID		NM1	
Loop ID		2010 Repeat: 10	
Usage		Required	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
NM101	R	Entity Identifier Code	<b>85: Billing Provider</b> <b>Use this code to indicate billing provider, billing submitter, and encounter reporting entity.</b>
NM102	R	Entity Type Qualifier	<b>1: Person</b> <b>2: Non-person Entity</b>
NM103	R	Billing Provider Last or Organizational Name	
NM104	S	Name First	
NM105	S	Name Middle	Not Used
NM106	N/A	Name Prefix	Not Used
NM107	S	Name Suffix	Not Used
NM108	R	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop.</b> <b>24: Employer Identification Number</b> <b>34: Social Security number</b> <b>XX: HCFA National Provider Identifier</b> (NPI is required for typical providers.)
NM109	R	Billing Provider Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SSN If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

Segment Name		Billing Provider Address	
Segment ID		N3	
Loop ID		2010	
Usage		Required	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
N301	R	Billing Provider	

		Address Line	
N302	S	Billing Provider Address Line	<b>Required if a second address line exists</b>

<b>Segment Name</b>		<b>Billing Provider City/State/Zip Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2010AA	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	R	Billing Provider City Name	
N402	R	Billing Provider State or Province Code	
N403	R	Billing Provider Postal Zone or ZIP code	
N404	S	Country Code	<b>This data element is required when the address is outside of the U.S.</b>
N405	N/A	Location Qualifier	Not Used
N406	N/A	Location Identifier	Not Used

<b>Segment Name</b>		<b>Billing Provider Secondary Information</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2010AA	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identifier Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Billing Provider Additional Identifier	Provider Number
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Billing Provider Contact Information</b>	
<b>Segment ID</b>		PER	
<b>Loop ID</b>		2010AA	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element</b>	<b>Usage</b>	<b>Guide</b>	<b>Comments</b>

ID		Description/Valid Values	
PER01	R	Contact Function Code	<b>IC: Information Contact</b>
PER02	R	Billing Provider Contact Name	
PER03	R	Communication Number Qualifier	<b>EM: Electronic Mail FX: Facsimile TE: Telephone</b>
PER04	R	Communication Number	
PER05	S	Communication Number Qualifier	<b>EM: Electronic Mail FX: Facsimile TE: Telephone</b>
PER06	S	Communication Number	<b>Used at the discretion of the billing provider.</b>
PER07	S	Communication Number Qualifier	<b>EM: Electronic Mail EX Telephone Extension FX: Facsimile TE: Telephone</b>
PER08	S	Communication Number	
PER09	N/A	Contact Inquiry Reference	Not Used

Segment Name		Pay –to Provider Name	
Segment ID		NM1	
Loop ID		2010AB	
Usage		Situational	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
NM101	R	Entity Identifier Code	<b>87: Pay to Provider</b>
NM102	R	Entity Type Qualifier	<b>1: Person 2: Non-Person Entity</b>
NM103	R	Pay to Provider Last or Organizational Name	
NM104	S	Pay to Provider First Name	
NM105	S	Pay to Provider Middle Name	<b>Required if NM102=1 and the middle name/initial of the person is known.</b>
NM106	N/A	Name Prefix	Not Used
NM107	S	Pay to Provider Name Suffix	<b>Required if known</b>

NM108	R	Identification Code Qualifier	If "XX" is used, then either the Employer's Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop. 24: Employer Identification Number 34: Social Security number XX: HCFA National Provider Identifier (NPI is required for typical providers.)
NM109	R	Pay to Provider Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SSN If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Pay –to Provider Address</b>	
<b>Segment ID</b>		N3	
<b>Loop ID</b>		2010AB	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N301	R	Pay to Provider Address Line	
N302	S	Pay to Provider Address Line 2	<b>Required if a second address exists.</b>

<b>Segment Name</b>		<b>Pay –to Provider City/State/Zip Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2010	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	R	Pay to Provider City Name	
N402	R	Pay to Provider State Code	
N403	R	Pay to Provider Zip Code	

N404	S	Pay to Provider Country Code	<b>Required if the address is outside of the U.S.</b>
N405	N/A	Location Qualifier	<b>Not Used</b>
N406	N/A	Location Identifier	<b>Not Used</b>

<b>Segment Name</b>		<b>Pay –to Provider Secondary Information</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2010AB	
<b>Usage</b>		Situational	
<b>Segment Notes</b>		Required if Pay-to provider information supplied	
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Pay to Provider Identifier	Provider Number
REF03	N/A	Description	<b>Not Used</b>
REF04	N/A	Reference Identifier	<b>Not Used</b>

<b>Segment Name</b>		<b>Subscriber Hierarchical Level</b>	
<b>Segment ID</b>		HL	
<b>Loop ID</b>		2000B	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
HL01	R	Hierarchical ID Number	
HL02	R	Hierarchical Parent ID Number	
HL03	R	Hierarchical Level Code	
HL04	R	Hierarchical Child Code	

<b>Segment Name</b>		<b>Subscriber Information</b>	
<b>Segment ID</b>		SBR	
<b>Loop ID</b>		2000B	
<b>Usage</b>		Required	

<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
SBR01	R	Payer Responsibility Sequence Number Code	<b>Code:</b> <b>P: Primary</b> <b>S: Secondary</b> <b>T: Tertiary</b> <b>Use to indicate 'payor of last resort'</b>
SBR02	S	Individual Relationship Code	<b>18: Self</b>
SBR03	S	Insured Group or Policy Number	
SBR04	S	Insured Group Name	<b>Required if the subscriber's payer identification includes a Group or a Plan Name.</b>
SBR05	S	Insurance Type Code	
SBR06	N/A	Coordination of Benefits Code	Not Used
SBR07	N/A	Yes/No Condition or Response Code	Not Used
SBR08	N/A	Employment Status Code	
SBR09	S	Claim Filing Indicator Code	

<b>Segment Name</b>		<b>Patient Information</b>	
<b>Segment ID</b>		PAT	
<b>Loop ID</b>		2000	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
PAT01	N/A	Individual Relationship Code	<b>Not Used</b>
PAT02	N/A	Patient Location Code	<b>Not Used</b>
PAT03	N/A	Employment Status Code	<b>Not Used</b>
PAT04	N/A	Student Status Code	<b>Not Used</b>
PAT05	S	Date Time Period Format Qualifier	<b>Required if Patient is known to be deceased.</b>
PAT06	S	Insured Individual Death Date	<b>Required if Patient is known to be deceased.</b>
PAT07	S	Unit or Basis for Measurement Code	<b>GR: Gram</b> <b>This data element is used when the</b>

			patient's age is less then 29 days old.
PAT08	s	Patient Weight	
PAT09	s	Pregnancy Indicator	Y: Yes

<b>Segment Name</b>		<b>Subscriber Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2010BA	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>IL: Insured or Subscriber</b>
NM102	R	Entity Type Qualifier	<b>1: Person 2: Non-Person Entity</b>
NM103	R	Subscriber Last Name	
NM104	S	Subscriber First Name	
NM105	S	Subscriber Middle Name	<b>This data element is required when NM102 equals one (1) and the middle initial of the person is known.</b>
NM106	N/A	Name Prefix	Not Used
NM107	S	Subscriber Name Suffix	
NM108	S	Identification Code Qualifier	<b>MI: Member Identification Number ZZ: Mutually defined</b>
NM109	S	Subscriber Primary Identifier	<b>This data element is required when NM102 equals one (1) person.</b>
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Subscriber Address</b>	
<b>Segment ID</b>		N3	
<b>Loop ID</b>		2010	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N301	R	Subscriber Address	

		Line	
N302	<b>S</b>	Subscriber Address Line	<b>Required if a second address line exists</b>

<b>Segment Name</b>		<b>Subscriber City/State/ Zip Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2010BA	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	R	Subscriber City Name	
N402	R	Subscriber State Code	
N403	R	Subscriber Postal Zone or ZIP code	
N404	S	Country Code	<b>This data element is required when the address is outside the US.</b>
N405	N/A	Location Qualifier	Not Used
N406	N/A	Location Identifier	Not Used

<b>Segment Name</b>		<b>Subscriber Demographic Information</b>	
<b>Segment ID</b>		DMG	
<b>Loop ID</b>		2010BA	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DMG01	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in Format CCYYMMDD</b>
DMG02	R	Subscriber Birth Date	
DMG03	R	Subscriber Gender Code	<b>F: Female M: Male U: Unknown</b>
DMG04	N/A	Marital Status Code	Not Used
DMG05	N/A	Race or Ethnicity Code	Not Used
DMG06	N/A	Citizenship Status Code	Not Used
DMG07	N/A	Country Code	Not Used
DMG08	N/A	Basis of Verification	Not Used
DMG09	N/A	Quantity	Not Used

<b>Segment Name</b>		<b>Payer Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2010BB	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>PR: Payer</b>
NM102	R	Entity Type Qualifier	<b>2: Non-person entity</b>
NM103	R	Payer Name	
NM104	N/A	Name First	Not Used
NM105	N/A	Name Middle	Not Used
NM106	N/A	Name Prefix	Not Used
NM107	N/A	Name Suffix	Not Used
NM108	R	Identification Code Qualifier	<b>PI: Payer Identification XV: Health Care Financing Administration National Plan ID</b>
NM109	R	Payer Identifier	
NM110	N/A	Entity Relationship code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Payer Address</b>	
<b>Segment ID</b>		N3	
<b>Loop ID</b>		2010BB	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N301	R	Payer Address Line	
N302	S	Payer Address Line	<b>Required if a second address line exists.</b>

<b>Segment Name</b>		<b>Payer City/State/Zip Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2010BB	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	R	Payer City Name	

N402	R	Payer State Code	
N403	R	Payer Postal Zone or Post Code	
N404	S	Payer Country Code	<b>This data element is required if the address is outside of the U.S.</b>
N405	N/A	Location Qualifier	Not Used
N406	N/A	Location Identifier	Not Used

<b>Segment Name</b>		<b>Payer Secondary Identification</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2010BB	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	<b>2U: Payer Identification Number FY: Claim Office Number NF: National Association of Insurance Commissioners Code TJ: Federal Taxpayer's Identification Number</b>
REF02	R	Payer Additional Identifier	
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Responsible Party Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2010BC	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>QD: Responsible Party</b>
NM102	R	Entity Type Qualifier	<b>1: Person 2: Non-Person Entity</b>
NM103	R	Responsible Party Last or Organizational Name	
NM104	S	Responsible Party Name First	
NM105	S	Responsible Party Name Middle Name	
NM106	N/A	Name Prefix	Not Used

NM107	S	Responsible Party Name Suffix	
NM108	N/A	Identification Code Qualifier	Not Used
NM109	N/A	Identification Code	Not Used
NM110	N/A	Entity Relationship code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Responsible Party Address</b>	
<b>Segment ID</b>		N3	
<b>Loop ID</b>		2010BC	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N301	R	Patient Address Information	
N302	S	Patient Address Information	<b>Required if a second address line exists.</b>

<b>Segment Name</b>		<b>Responsibility Party City/State/Zip Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2010BC	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	R	Responsible Party City Name	
N402	R	Responsible Party State Name	
N403	R	Responsible Party Postal Zone or Zip Code	
N404	S	Responsible Party Country Code	<b>Required if the address is out of the U.S.</b>
N405	N/A	Location Qualifier	<b>Not Used</b>
N406	N/A	Location Identifier	<b>Not Used</b>

<b>Segment Name</b>		<b>Claim Information</b>	
<b>Segment ID</b>		CLM	
<b>Loop ID</b>		2300	
<b>Usage</b>		Required	

Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
CLM01	R	Patient Account Number	
CLM02	R	Total Claim Charge Amount	
CLM03	N/A	Claim Filing Indicator Code	Not Used
CLM04	N/A	Non- Institutional Claim type code	Not Used
CLM05	R	Health Care Service Location Information	
CLM05-1	R	Facility Type Code	
CLM05-02	R	Facility Code Qualifier	
CLM05-03	R	Claim Frequency Code	
CLM06	R	Provider or Supplier Signature Indicator	<b>N: No Y: Yes</b>
CLM07	S	Medicare Assignment Code	
CLM08	R	Benefits Assignment Certification Indicator	<b>N: No Y: Yes</b>
CLM09	R	Release of Information Code	
CLM10	S	Patient Signature Source Code	Not Used
CLM11	S	Related Causes Information	
CLM11-1	R	Related Causes Code	
CLM11-2	S	Related Causes Code	
CLM11-3	S	Related Causes Code	
CLM11-4	S	Auto Accident State or Province Code	
CLM11-5	S	Country Code	<b>Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.</b>
CLM12	S	Special Program Indicator	
CLM13	N/A	Yes/No Condition Response Code	Not Used
CLM14	N/A	Level of Service Code	Not Used

CLM15	N/A	Yes/No Condition Response Code	Not Used
CLM16	S	Participation Agreement	
CLM17	N/A	Claim Status Code	Not Used
CLM18	N/A	Explanation of Benefits Indicator	Not Used
CLM19	N/A	Claim Submission Reason Code	Not Used
CLM20	S	Delay Reason Code	

<b>Segment Name</b>		<b>Date – Initial Treatment</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>454: Initial Treatment</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in Format CCYYMMDD</b>
DTP03	R	Initial Treatment Date	

<b>Segment Name</b>		<b>Date- Date Last Seen</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>304: Latest Visit or Consultation</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Last Seen Date	

<b>Segment Name</b>		<b>Date – Onset of the current Illness/Symptom</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			

Element ID	Usage	Guide Description/Valid Values	Comments
DTP01	R	Date Time Qualifier	<b>453: Onset of the current Illness/Symptom</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Onset of Current Illness/Injury Date	

Segment Name		Date – Acute Manifestation	
Segment ID		DTP	
Loop ID		2300	
Usage		Situational	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
DTP01	R	Date Time Qualifier	<b>453: Acute Manifestation of Chronic Condition</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Acute Manifestation Date	

Segment Name		Date – Similar Illness/Symptom Onset	
Segment ID		DTP	
Loop ID		2300	
Usage		Situational	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
DTP01	R	Date Time Qualifier	<b>438: Onset of similar illness/symptoms</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Similar Illness or Symptom Date	

<b>Segment Name</b>		<b>Date- Accident</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>439: Accident</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Accident Date	

<b>Segment Name</b>		<b>Date- Last Menstruation Period</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>484: Last Menstruation Period</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Last Menstruation Period Date	

<b>Segment Name</b>		<b>Date Last X-ray</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>455: Last X-ray</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Last X- ray Date	

<b>Segment Name</b>		<b>Date - Disability Begin</b>	
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<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>360: Disability Begin</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Disability From Date	

<b>Segment Name</b>		<b>Date- Disability End</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>361: Disability End</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Disability To Date	

<b>Segment Name</b>		<b>Date- Authorized Return to Work</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>296: Return to Work</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Work Return Date	

<b>Segment Name</b>	<b>Date Admission</b>
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<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>435: Admission</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Related Hospitalization Admission date	

<b>Segment Name</b>		<b>Date – Discharge</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>096: Discharge</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Related Hospitalization Discharge date	

<b>Segment Name</b>		<b>Date – Assumed and Relinquished Care Dates</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>090: Report Start 091: Report End</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date Expressed in format CCYYMMDD</b>
DTP03	R	Assumed and Relinquished Care Dates	

<b>Segment Name</b>		<b>Patient Paid Amount</b>	
<b>Segment ID</b>		AMT	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
AMT01	R	Amount Qualifier Code	<b>F5: Amount Paid</b>
AMT02	R	Patient Paid Amount	
AMT03	N/A	Credit/Debit Flag Code	Not Used

<b>Segment Name</b>		<b>Total Purchased Service Amount</b>	
<b>Segment ID</b>		AMT	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
AMT01	R	Amount Qualifier Code	<b>NE: Net Billed</b>
AMT02	R	Total Purchased Service Amount	
AMT03	N/A	Credit/Debit Flag Code	Not Used

<b>Segment Name</b>		<b>Prior Authorization or Referral Number</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	<b>9F: Referral Number G1: Prior Authorization Number</b>
REF02	R	Prior Authorization or	

		Referral Number	
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Claim Identification Number for Clearinghouses and Other Transmission Intermediaries</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	<b>D9: Claim Number</b>
REF02	R	Clearinghouse Trace Number	
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Ambulance Transport Information</b>	
<b>Segment ID</b>		CR1	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
CR101	S	Unit or Basis for Measurement Code	<b>LB: pound</b>
CR102	S	Patient Weight	
CR103	R	Ambulance Transport Code	<b>I: Initial Trip R: Return Trip T: Transfer trip X: Round trip</b>
CR104	R	Ambulance Reason Code	
CR105	R	Unit or Basis for Measurement Code	<b>DH: Miles</b>
CR106	R	Transport Distance	

CR107	N/A	Address Information	
CR108	N/A	Address Information	
CR109	S	Round Trip Purpose Description	
CR110	S	Stretcher Purpose Description	

Segment Name		Spinal Manipulation Service Information	
Segment ID		CR2	
Loop ID		2300	
Usage		Situational	
Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
CR201	R	Treatment Series Number	
CR202	R	Treatment Count	
CR203	S	Subluxation Level Code	
CR204	S	Subluxation Level Code	
CR205	R	Unit or Basis for Measurement Code	
CR206	R	Treatment Period Count	
CR207	R	Monthly Treatment Count	
CR208	R	Patient Condition Code	
CR209	R	Complication Indicator	<b>N: No Y: Yes</b>
CR210	S	Patient Condition Description	<b>Used at the discretion of the submitter.</b>
CR211	S	Patient Condition Description	<b>Used at the discretion of the submitter.</b>
CR212	R	X- Ray Availability Indicator	<b>N: No Y: Yes</b>

Segment Name		Ambulance Certification	
Segment ID		CRC	
Loop ID		2300	
Usage		Situational	

Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
CRC01	R	Code Category	<b>07: Ambulance Certification</b>
CRC02	R	Certification Condition Indicator	<b>N: NO Y: Yes</b>
CRC03	R	Condition Code	
CRC04	S	Condition Code	<b>Required if needed. Use code in CRC03.</b>
CRC05	S	Condition Code	<b>Required if needed. Use code in CRC03</b>
CRC06	S	Condition Code	<b>Required if needed. Use code in CRC03</b>
CRC07	S	Condition Code	<b>Required if needed. Use code in CRC03</b>

<b>Segment Name</b>		<b>ESPDT --- New Added to Addenda</b>	
<b>Segment ID</b>		CRC	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
Element ID	Usage	Guide Description/Valid Values	Comments
CRC01	R	Code Category	<b>ZZ</b>
CRC02	R	Certification Condition Indicator	<b>“Y” or “N” If No, then choose “NU” in CRC03</b>
CRC03	R	Condition Indicator	Valid values are: AV NU S2 ST
CRC04	S	Condition Code	Use code in CRC03 if needed
CRC05	S	Condition Code	Use code in CRC03 if needed
CRC06		Not Used	
CRC07		Not Used	

<b>Segment Name</b>		<b>Vision</b>	
<b>Segment ID</b>		CRC	
<b>Loop ID</b>		2300	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
Element ID	Usage	Guide Description/Valid Values	Comments
CRC01	R	Code Category	<b>E1: Spectacle Lenses</b>

			<b>E2: Contact Lenses</b> <b>E3: Spectacle Frames</b>
CRC02	R	Certification Condition Indicator	“Y” or “N” “N” Value indicates condition codes in CRC03 through CRC07 do not apply
CRC03	R	Condition Indicator	Valid values: <b>L1: General Standard of 20 Degrees or .5 Diopter Sphere or Cylinder Change Met</b> <b>L2: Replacement Due to Loss or Theft</b> <b>L3: Replacement Due to Breakage or Damage</b> <b>L4: Replacement Due to Patient Preference</b> <b>L5: Replacement Due to Medical Reason</b>
CRC04	S	Condition Code	Use code in CRC03 if needed
CRC05	S	Condition Code	Use code in CRC03 if needed
CRC06	S	Not Used	Use code in CRC03 if needed
CRC07	S	Not Used	Use code in CRC03 if needed

<b>Segment Name</b>		<b>Health Care Diagnosis Code</b>	
<b>Segment ID</b>		HI	
<b>Loop ID</b>		2300	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
HI01	R	Health Care Code Information	
HI01-01	R	Diagnosis Type Code	<b>BK: principle diagnosis</b>
HI01-02	R	Diagnosis Code	
HI01-03	N/A	Date Time Period Format Qualifier	Not Used
HI01-04	N/A	Date Time Period	Not Used
HI01-05	N/A	Monetary Amount	Not Used
HI01-06	N/A	Quantity	Not Used
HI01-07	N/A	Version Identifier	Not Used
HI02	S	Health Care Code Information	
HI02-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI02-02	R	Diagnosis Code	
HI02-03	N/A	Date Time Period	Not Used

		Format Qualifier	
HI02-04	N/A	Date Time Period	Not Used
HI02-05	N/A	Monetary Amount	Not Used
HI02-06	N/A	Quantity	Not Used
HI02-07	N/A	Version Identifier	Not Used
HI03	S	Health Care Code Information	
HI03-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI03-02	R	Diagnosis Code	
HI03-03	R	Date Time Period Format Qualifier	
HI03-04	N/A	Date Time Period	Not Used
HI03-05	N/A	Monetary Amount	Not Used
HI03-06	N/A	Quantity	Not Used
HI03-07	N/A	Version Identifier	Not Used
HI04	S	Health Care Code Information	
HI04-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI04-02	R	Diagnosis Code	
HI04-03	R	Date Time Period Format Qualifier	
HI04-04	N/A	Date Time Period	Not Used
HI04-05	N/A	Monetary Amount	Not Used
HI04-06	N/A	Quantity	Not Used
HI04-07	N/A	Version Identifier	Not Used
HI05	S	Health Care Code Information	
HI05-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI05-02	R	Diagnosis Code	
HI05-03	R	Date Time Period Format Qualifier	
HI05-04	N/A	Date Time Period	Not Used
HI05-05	N/A	Monetary Amount	Not Used
HI05-06	N/A	Quantity	Not Used
HI05-07	N/A	Version Identifier	Not Used
HI06	S	Health Care Code Information	
HI06-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI06-02	R	Diagnosis Code	
HI06-03	R	Date Time Period Format Qualifier	
HI06-04	N/A	Date Time Period	Not Used
HI06-05	N/A	Monetary Amount	Not Used
HI06-06	N/A	Quantity	Not Used
HI06-07	N/A	Version Identifier	Not Used

HI07	S	Health Care Code Information	
HI07-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI07-02	R	Diagnosis Code	
HI07-03	R	Date Time Period Format Qualifier	
HI07-04	N/A	Date Time Period	Not Used
HI07-05	N/A	Monetary Amount	Not Used
HI07-06	N/A	Quantity	Not Used
HI07-07	N/A	Version Identifier	Not Used
HI08	S	Health Care Code Information	
HI08-01	R	Diagnosis Type Code	<b>BF: Diagnosis ICD-9 Codes</b>
HI08-02	R	Diagnosis Code	
HI08-03	R	Date Time Period Format Qualifier	
HI08-04	N/A	Date Time Period	Not Used
HI08-05	N/A	Monetary Amount	Not Used
HI08-06	N/A	Quantity	Not Used
HI08-07	N/A	Version Identifier	Not Used
HI09	N/A	Health Care Code Information	Not Used
HI10	N/A	Health Care Code Information	Not Used
HI11	N/A	Health Care Code Information	Not Used
HI12	N/A	Health Care Code Information	Not Used

<b>Segment Name</b>		<b>Referring Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2310A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>DN: Referring Provider P3: Primary Care Provider</b>
NM102	R	Entity Type Qualifier	<b>1: Person 2: Non-Person Entity</b>
NM103	R	Referring Provider	<b>Required of NM102=1 (person).</b>

		Last Name	
NM104	S	Referring Provider First Name	
NM105	S	Referring Provider Middle Name	<b>Required of NM102=1 (person) and if the middle name of the person is known.</b>
NM106	N/A	Name Prefix	Not Used
NM107	S	Name Suffix	
NM108	S	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop. 24: Employer Identification Number 34: Social Security number XX: HCFA National Provider Identifier (NPI is required for typical providers.)</b>
NM109	S	Referring Provider Primary Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Referring Provider Specialty Information</b>	
<b>Segment ID</b>		PRV	
<b>Loop ID</b>		2310A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
PRV01	R	Provider Code	RF
PRV02	R	Reference Identification Qualifier	ZZ
PRV03	R	Reference Identification	Provider Taxonomy Code

<b>Segment Name</b>		<b>Referring Provider Secondary Identification</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2310A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid</b>	<b>Comments</b>

		<b>Values</b>	
REF01	R	Reference Identification Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Referring Provider Secondary Identifier	Provider Number
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Rendering Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2310B	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>82: Rendering Provider</b>
NM102	R	Entity Type Qualifier	<b>1: Person</b> <b>2: Non-Person Entity</b>
NM103	R	Rendering Provider last or Organization Name	
NM104	S	Rendering Provider First Name	
NM105	S	Rendering Provider Middle Name	
NM106	N/A	Name Prefix	Not Used
NM107	S	Rendering Provider Name Suffix	
NM108	R	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop.</b> <b>24: Employer Identification Number</b> <b>34: Social Security number</b> <b>XX: HCFA National Provider Identifier</b> (NPI is required for typical providers.)
NM109	R		If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI
NM110	N/A		Not Used
NM111	N/A		Not Used

<b>Segment Name</b>		<b>Rendering Provider Specialty Information</b>	
<b>Segment ID</b>		PRV	
<b>Loop ID</b>		2310B	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
PRV01	R	Provider Code	<b>PE: Performing</b>
PRV02	R	Reference Identification Qualifier	<b>ZZ</b>
PRV03	R	Reference Identification	Provider Taxonomy Code
PRV04	N/A	State or Province Code	Not Used
PRV05	N/A	Provider Specialty Information	Not Used
PRV06	N/A	Provider Organization Code	Not Used

<b>Segment Name</b>		<b>Rendering Provider Secondary Information</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2310B	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Rendering Provider Secondary Information	Provider Number
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Supervising Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2310E	
<b>Usage</b>		Situational	

Segment Notes			
Element ID	Usage	Guide Description/Valid Values	Comments
NM101	R	Entity Identifier Code	<b>DQ: Supervising Provider</b>
NM102	R	Entity Type Qualifier	<b>1: Person</b>
NM103	R	Supervising Provider last or Organization Name	
NM104	R	Supervising Provider First Name	
NM105	S	Supervising Provider Middle Name	<b>Required if NM102=1 (person) and the middle name of the provider is known.</b>
NM106	N/A	Name Prefix	Not Used
NM107	S	Supervising Provider Name Suffix	
NM108	S	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop. 24: Employer Identification Number 34: Social Security number XX: HCFA National Provider Identifier (NPI is required for typical providers.)</b>
NM109	S	Supervising Provider Primary Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

Segment Name		Supervising Provider Secondary Identification	
Segment ID	REF	Loop ID	2310E
Usage	Situational	Segment Notes	
Element ID	Usage	Guide Description/Valid Values	Comments
REF01	R	Reference Identification Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Reference Identification	Provider Number

REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Other Subscriber Information</b>	
<b>Segment ID</b>		SBR	
<b>Loop ID</b>		2320	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
SBR01	R	Payer Responsibility Sequence Number Code	
SBR02	R	Individual Relationship Code	
SBR03	S	Insured Group or Policy Number	
SBR04	S	Other Insured Group Name	
SBR05	R	Insurance Type Code	
SBR06	N/A	Coordination of Benefits	
SBR07	N/A	Yes/No Condition Response Code	
SBR08	N/A	Employment Status Code	
SBR09	S	Claim Filing Indicator Code	

<b>Segment Name</b>		<b>Subscriber Demographic Information</b>	
<b>Segment ID</b>		AMT	
<b>Loop ID</b>		2320	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
AMT01	R	Date Time Period Format Qualifier	<b>D8: Date expressed in format CCYYMMDD</b>
AMT02	R	Other Insured Birth date	

AMT03	R	Other Insured Gender Code	
AMT04	N/A	Marital Status Code	Not Used
AMT05	N/A	Race or Ethnicity Code	Not Used
AMT06	N/A	Citizenship Status Code	Not Used
AMT07	N/A	Country Code	Not Used
AMT08	N/A	Basis of Verification Code	Not Used
AMT09	N/A	Quantity	Not Used

<b>Segment Name</b>		<b>Other Insurance Coverage Information</b>	
<b>Segment ID</b>		OI	
<b>Loop ID</b>		2320	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
OI01	N/A	Claim Filing Indicator Code	Not Used
OI02	N/A	Claim Submission Reason Code	Not Used
OI03	R	Benefits Assignment Certification Indicator	
OI04	S	Patient Signature Source Code	
OI05	N/A	Provider Agreement Code	Not Used
OI06	R	Release of Information Code	

<b>Segment Name</b>		<b>Other Subscriber Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2330A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>IL: Insured or Subscriber</b>

NM102	R	Entity Type Qualifier	1: Person 2: Non-Person Entity
NM103	R	Other Insured Last Name	
NM104	S	Other Insured First Name	
NM105	S	Other Insured Middle Name	
NM106	N/A	Name Prefix	
NM107	S	Other Insured Name Suffix	
NM108	R	Identification Code Qualifier	MI: Member Identification Number ZZ: Mutually Defined
NM109	R	Supervising Provider Primary Identifier	
NM110	N/A	Entity Relationship Code	
NM111	N/A	Entity Identifier Code	

<b>Segment Name</b>		<b>Other Subscriber Address</b>	
<b>Segment ID</b>		N3	
<b>Loop ID</b>		2330A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N301	R	Other Insured Address Line	
N302	S	Other Insured Address Line 2	Required if a second address line exists.

<b>Segment Name</b>		<b>Other Subscriber City/State/ZIP Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2330A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	S	Other Insured City Name	
N402	S	Other Insured State	

		Code	
N403	S	Other Insured Postal Zone or ZIP Code	
N404	S	Country Code	Required if the address is outside of the U.S.
N405	N/A	Location Qualifier	Not Used
N406	N/A	Location Identifier	Not Used

<b>Segment Name</b>		<b>Other Payer Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2330B	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>PR: payer</b>
NM102	R	Entity Type Qualifier	<b>2: Non- person Entity</b>
NM103	R	Other Payer Last or Organization Name	
NM104	N/A	First Name	Not Used
NM105	N/A	Middle Name	Not Used
NM106	N/A	Name Prefix	Not Used
NM107	N/A	Name Suffix	Not Used
NM108	R	Identification Code Qualifier	
NM109	R	Other Payer Primary Identifier	
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Service Line Number</b>	
<b>Segment ID</b>		LX	
<b>Loop ID</b>		2400	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
This segment contains the line item number that is incremented by one for each service line/detail. MHS processes a maximum of 99 LX segments (2400 loops) for each CLM segment.			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
LX01	R	Assigned Number	

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<b>Segment Name</b>	<b>Professional Service</b>
<b>Segment ID</b>	SVI
<b>Loop ID</b>	2400
<b>Usage</b>	Required
<b>Segment Notes</b>	This segment reports procedure code, modifiers, charge amounts, and units. MSH only recognizes the first 99 service lines on a claim. The Total Claim Charge Amount from CLM02 must reflect the total of the first 99 details. Failure to comply results in denial of the claim for an out of balance condition.

<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
SV1	R	Composite Medical Procedure Identifier	
SV101-01	R	Product/Service ID Qualifier	
SV101-02	R	Product/Service ID	
SV101-03	S	Procedure Modifier	
SV101-04	S	Procedure Modifier	
SV101-05	S	Procedure Modifier	
SV101-06	S	Procedure Modifier	
SV101-07	N/A	Description	Not Used
SV102	R	Line Item Charge Amount	
SV103	R	Unit or Basis for Measurement Code	
SV104	R	Service Unit Count	
SV105	S	Place of Service Code	
SV106	N/A	Service Type Code	Not Used
SV107	R	Composite Diagnosis Code Pointer	
SV107-01	R	Diagnosis Code Pointer	
SV107-02	S	Diagnosis Code Pointer	
SV107-03	S	Diagnosis Code Pointer	
SV107-04	S	Diagnosis Code Pointer	
SV108	N/A	Monetary Amount	Not Used

SV109	R	Emergency Indicator	
SV110	N/A	Multiple Procedure Code	Not Used
SV111	S	EPSDT Indicator	<b>Y: Yes</b>
SV112	S	Family Planner Indicator	<b>Y: Yes</b>
SV113	N/A	Review Code	Not Used
SV114	N/A	National or Local Assigned Review Value	Not Used
SV115	S	Co-Pay Status Code	<b>0: Copay Exempt</b>
SV116	N/A	Health Care Professional Shortage Area	Not Used
SV117	N/A	Reference Identification	Not Used
SV118	N/A	Postal Code	Not Used
SV119	N/A	Monetary Amount	Not Used
SV120	N/A	Level of Care Code	Not Used
SV121	N/A	Provider Agreement Code	Not Used

<b>Segment Name</b>		<b>Ambulance Transport Information</b>	
<b>Segment ID</b>		CR1	
<b>Loop ID</b>		2400	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
CR101	S	Unit or Basis for Measurement Code	<b>LB: Pound</b>
CR102	S	Patient Weight	
CR103	R	Ambulance Transport Code	
CR104	R	Ambulance Transport Reason Code	
CR105	R	Unit or Basis for Measurement Code	<b>DH: Miles</b>
CR106	R	Transport Distance	
CR107	N/A	Address Information	Not Used
CR108	N/A	Address Information	Not Used
CR109	S	Round Trip Purpose Description	
CR110	S	Stretcher Purpose Description	<b>Required if needed to justify the usage of a stretcher.</b>

<b>Segment Name</b>		<b>Spinal Manipulation Service Information</b>	
<b>Segment ID</b>		CR2	
<b>Loop ID</b>		2400	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
CR201	R	Treatment Series Number	
CR202	R	Treatment Count	
CR203	S	Subluxation Level Code	
CR204	S	Subluxation Level Code	
CR205	R	Unit or Basis of Measurement Code	
CR206	R	Treatment Period Count	
CR207	R	Monthly Treatment Count	
CR208	R	Patient Condition Code	
CR209	R	Complication Indicator	<b>N: No Y: Yes</b>
CR210	S	Patient Condition Description	
CR211	S	Patient Condition Description	
CR212	R	X-ray Availability Indicator	<b>N: No Y: Yes</b>

<b>Segment Name</b>		<b>Ambulance Certification</b>	
<b>Segment ID</b>		CRC	
<b>Loop ID</b>		2400	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
CRC01	R	Code Category	<b>07: Ambulance Certification</b>
CRC02	R	Certification Condition	<b>N: No</b>

		Indicator	<b>Y: Yes</b>
CRC03	R	Condition Code	
CRC04	S	Condition Code	<b>Required if additional codes are needed.</b>
CRC05	S	Condition Code	<b>Required if additional codes are needed.</b>
CRC06	S	Condition Code	<b>Required if additional codes are needed.</b>
CRC07	S	Condition Code	<b>Required if additional codes are needed.</b>

<b>Segment Name</b>		<b>Hospice Employee Indicator</b>	
<b>Segment ID</b>		CRC	
<b>Loop ID</b>		2400	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
CRC01	R	Code Category	<b>70: Hospice</b>
CRC02	R	Hospice Employee Provider Indicator	<b>N: No Y: Yes</b>
CRC03	R	Condition Indicator	<b>65: Open</b>
CRC04	N/A	Condition Indicator	Not Used
CRC05	N/A	Condition Indicator	Not Used
CRC06	N/A	Condition Indicator	Not Used
CRC07	N/A	Condition Indicator	Not Used

<b>Segment Name</b>		<b>Date- Service Date</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2400	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>472: Service</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date expressed in format CCYYMMDD Range of dates expressed in format</b>

			<b>CCYYMMDD-CCYYMMDD</b>
DTP03	R	Service Date	

<b>Segment Name</b>		<b>Date- Onset of Current Symptom/Illness</b>	
<b>Segment ID</b>		DTP	
<b>Loop ID</b>		2400	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
DTP01	R	Date Time Qualifier	<b>431: Onset of Current Symptoms/Illness</b>
DTP02	R	Date Time Period Format Qualifier	<b>D8: Date expressed in format CCYYMMDD</b>
DTP03	R	Onset Date	

<b>Segment Name</b>		<b>Line Item Control Number</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2400	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	<b>6R: Provider Control Number</b>
REF02	R	Line Item Control Number	
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Rendering Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2420A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>82: Rendering Provider</b>

NM102	R	Entity Type Qualifier	<b>1: Person</b> <b>2: Non-Person Entity</b>
NM103	R	Rendering Provider Last or Organizational Name	
NM104	S	Rendering Provider First Name	
NM105	S	Rendering Provider Middle Name	
NM106	N/A	Name Prefix	Not Used
NM107	S	Rendering Provider Name Suffix	
NM108	R	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop.</b> <b>24: Employer Identification Number</b> <b>34: Social Security number</b> <b>XX: HCFA National Provider Identifier</b> (NPI is required for typical providers.)
NM109	R	Rendering Provider Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Rendering Provider Secondary Information</b>	
<b>Segment ID</b>		PRV	
<b>Loop ID</b>		2420A	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
PRV01	R	Provider Code	<b>PE</b>
PRV02	R	Reference Identification Qualifier	<b>ZZ</b>
PRV03	R	Reference Identification	Provider Taxonomy Code

<b>Segment Name</b>		<b>Rendering provider Secondary Information</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2420A	

<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Rendering Provider Secondary Identifier	Provider Number
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Supervising Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2420D	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>DQ: Supervising Physician</b>
NM102	R	Entity Type Qualifier	<b>1: Person</b>
NM103	R	Supervising Provider Last Name	
NM104	R	Supervising Provider First Name	
NM105	S	Supervising Provider Middle Name	
NM106	N/A	Name Prefix	Not Used
NM107	S	Supervising Provider Name Suffix	
NM108	S	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop.</b> <b>24: Employer Identification Number</b> <b>34: Social Security number</b> <b>XX: HCFA National Provider Identifier (NPI is required for typical providers.)</b>
NM109	S	Supervising Provider Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI

NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Supervising Provider Secondary Information</b>	
<b>Segment ID</b>		REF	
<b>Loop ID</b>		2420D	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
REF01	R	Reference Identification Qualifier	1D = Provider Medicaid Number G2 = Provider Commercial Number EI = Employer Identification number
REF02	R	Supervising Provider Secondary Identifier	Provider Number
REF03	N/A	Description	Not Used
REF04	N/A	Reference Identifier	Not Used

<b>Segment Name</b>		<b>Ordering Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2420E	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>DK: Ordering Physician</b>
NM102	R	Entity Type Qualifier	<b>1: Person</b>
NM103	R	Ordering Provider Last Name	
NM104	R	Ordering Provider First Name	
NM105	S	Ordering Provider Middle Name	
NM106	N/A	Name Prefix	Not Used
NM107	S	Ordering Provider Name Suffix	
NM108	S	Identification Code Qualifier	<b>If "XX" is used, then either the Employer's Identification number or the Social Security Number of the</b>

			provider must be carried in the REF segment, in this loop. <b>24: Employer Identification Number</b> <b>34: Social Security number</b> <b>XX: HCFA National Provider Identifier</b> (NPI is required for typical providers.)
NM109	S	Ordering Provider Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Ordering Provider Address</b>	
<b>Segment ID</b>		N3	
<b>Loop ID</b>		2420E	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N301	R	Ordering Physician Address Line	
N302	S	Ordering Physician Address Line 2	<b>Required is a second line exists.</b>

<b>Segment Name</b>		<b>Ordering Provider City/State/ZIP Code</b>	
<b>Segment ID</b>		N4	
<b>Loop ID</b>		2420E	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
N401	R	Ordering Provider City Name	
N402	R	Ordering Provider State Code	
N403	R	Ordering Provider Postal Zone or Zip Code	

N404	S	Ordering Provider Country Code	<b>Required if the address is outside of the U.S.</b>
N405	N/A	Location Qualifier	Not Used
N406	N/A	Location Identifier	Not Used

<b>Segment Name</b>		<b>Referring Provider Name</b>	
<b>Segment ID</b>		NM1	
<b>Loop ID</b>		2420F	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
NM101	R	Entity Identifier Code	<b>DN: Referring Provider P3: Primary Care Provider</b>
NM102	R	Entity Type Qualifier	<b>1: Person</b>
NM103	R	Referring Provider Last Name	
NM104	R	Referring Provider First Name	
NM105	S	Pr Referring Provider Middle Name	
NM106	N/A	Name Prefix	Not Used
NM107	S	Referring Provider Name Suffix	
NM108	S	Identification Code Qualifier	<b>If “XX” is used, then either the Employer’s Identification number or the Social Security Number of the provider must be carried in the REF segment, in this loop. 24: Employer Identification Number 34: Social Security number XX: HCFA National Provider Identifier (NPI is required for typical providers.)</b>
NM109	S	Referring Provider Identifier	If NM108 = 24, then give provider TIN, IRS number. If NM108 = 34, then give provider SS N If NM108 = XX, then give provider NPI
NM110	N/A	Entity Relationship Code	Not Used
NM111	N/A	Entity Identifier Code	Not Used

<b>Segment Name</b>		<b>Referring Provider Specialty Information</b>	
<b>Segment ID</b>		PRV	
<b>Loop ID</b>		2420F	
<b>Usage</b>		Situational	
<b>Segment Notes</b>			
<b>Element</b>	<b>Usage</b>	<b>Guide</b>	<b>Comments</b>

<b>ID</b>		<b>Description/Valid Values</b>	
PRV01	R	Provider Code	<b>RF</b>
PRV02	R	Reference Identification Qualifier	<b>ZZ</b>
PRV03	R	Reference Identification	Provider Taxonomy Code

<b>Segment Name</b>		<b>Transaction Trailer</b>	
<b>Segment ID</b>		SE	
<b>Loop ID</b>		N/A	
<b>Usage</b>		Required	
<b>Segment Notes</b>			
<b>Element ID</b>	<b>Usage</b>	<b>Guide Description/Valid Values</b>	<b>Comments</b>
SE01	R	Transaction Segment Count	
SE02	R	Transaction Set Control Number	

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## SECTION 05: ACKNOWLEDGEMENTS AND REPORTS

### 997 Functional Acknowledgement

A functional acknowledgement is to report the acceptance or rejection of functional group, transaction set or segment. CBH will generate an outbound 997 to acknowledge all inbound transactions received.

If any part of the transaction from the ISA to IEA does not pass Compliance, the transaction will be rejected and will need to be fixed by the sender and resent.

Segment Name	Transaction Set Header
Segment ID	ST
Loop	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
ST01	R	Transaction Set Identifier Code	<b>997 – Functional Acknowledgement</b>
ST02	R	Transaction Set Control Number	This number is assigned locally matches the value in the corresponding SE segment.

Segment Name	Functional Group Response Header
Segment ID	AK1
Loop	N/A
Usage	Required
Segment Notes	This segment is used to respond to the functional group information in the interchange envelope.

Element ID	Usage	Guide Description/Valid Values	Comments
AK101	R	Functional Identifier Code	The identifier code used for 997s generated by CBH in response to inbound 837 transactions. <b>HC – Health Care Claim (837)</b>

Element ID	Usage	Guide Description/Valid Values	Comments
AK102	R	Transaction Set Control Number	This data element contains the value from the GS06 data element from the GS segment of the original file being acknowledged.

Segment Name	Transaction Set Response Header
Segment ID	AK2
Loop	AK2
Usage	Situational
Segment Notes	This segment is used to start the acknowledgment of a transaction set. If there are no errors at the transaction set level, this segment is not returned.

Element ID	Usage	Guide Description/Valid Values	Comments
AK201	R	Functional Identifier Code	The identifier code used for 997s generated by in response to inbound 837 transactions. <b>HC – Health Care Claim (837)</b>
AK202	R	Transaction Set Control Number	This data element contains the value from the ST02 data element from the ST segment of the original file being acknowledged.

Segment Name	Data Segment Note
Segment ID	AK3
Loop	AK2/AK3
Usage	Situational
Segment Notes	This segment is used to report segment/looping errors in the submitted transaction.

Element ID	Usage	Guide Description/Valid Values	Comments
AK301	R	Segment ID Code	This data element lists the two or three byte segment ID that contains the error, such as ST, SBR.
AK302	R	Segment Position in Transaction Set	This data element contains the sequential position of the Segment ID identified in AK301. This count begins

			with <b>1</b> for the ST segment and increments by <b>1</b> from that point.
AK303	S	Loop Identifier Code	This data element identifies the loop where the erroneous segment resides.
AK304	S	Segment Syntax Error Code	This data element describes the type of error encountered. <b>See code list in the IG</b>

Segment Name	Data Segment Note
Segment ID	AK4
Loop	AK2/AK3
Usage	Situational
Segment Notes	This segment is used to report data element/composite errors in the submitted transaction.

Element ID	Usage	Guide Description/Valid Values	Comments
AK401	R	Position in Segment	This is a composite data element.
AK401-1	R	Segment Position in Transaction Set	This data element contains the sequential position of the simple data element or composite data structure. This count begins with <b>1</b> for the initial element and increments by <b>1</b> from that point.
AK401-2	S	Component Data Element Position in Composite	This data element identifies within the composite structure where the error occurs.
AK403	S	Data Element Reference Number	This is the Data Element Dictionary reference number associated with the erroneous data element/composite.
AK404	R	Data Element Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK405	S	Copy of Bad Data Element	

Segment Name	Transaction Set Response Trailer
Segment ID	AK5
Loop	AK2/AK3
Usage	Required
Segment Notes	This segment is used to acknowledge the acceptance or rejection

of a transaction and any report errors.

Element ID	Usage	Guide Description/Valid Values	Comments
AK501	R	Transaction Set Acknowledgment Code	<b>A – Accepted</b> <b>R - Rejected</b>
AK502	S	Transaction Set Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK503	S	Transaction Set Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK504	S	Transaction Set Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK505	S	Transaction Set Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK506	S	Transaction Set Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>

Segment Name	Functional Group Response Trailer
Segment ID	AK9
Loop	N/A
Usage	Required
Segment Notes	This segment is used to acknowledge the acceptance or rejection of a functional group and report the number of transaction sets originally included, received, and accepted.

Element ID	Usage	Guide Description/Valid Values	Comments
AK901	R	Functional Group Acknowledgment Code	<b>A – Accepted</b> <b>R – Rejected</b> <b>P – Partial (considered rejected)</b>
AK902	S	Number of Transaction Sets Included	This data element contains the value from the GE01 data element from the GE segment of the original file being acknowledged.
AK903	S	Number of Received	

Element ID	Usage	Guide Description/Valid Values	Comments
		Transaction Sets	
AK904	S	Number of Accepted Transaction Sets	
AK905	S	Functional Group Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK906	S	Functional Group Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK907	S	Functional Group Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK908	S	Functional Group Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>
AK909	S	Functional Group Syntax Error Code	This data element describes the type of error encountered. <b>See code list in IG</b>

Segment Name	Transaction Set Trailer
Segment ID	SE
Loop	N/A
Usage	Required
Segment Notes	

Element ID	Usage	Guide Description/Valid Values	Comments
ST01	R	Number of Included Segments	This is the total number of segments included in this acknowledgment. This value includes the ST and SE segments.
ST02	R	Transaction Set Control Number	This number is assigned locally and matches the value in the preceding ST segment.

## Claim Audit Report

CBH will continue to provide a Claim Audit report for each Inbound 837 Transaction received for both Institutional and Professional files. The format of the report has not changed and the error codes will remain the same. A sample of the report is available in Samples A & B. A listing of the error codes can be found in Sample C.

Any claim that has been rejected and is acknowledge on this report, must be corrected and resent either electronically via an 837 or on paper. Those claims that have been rejected are based on front-end edits and do not pertain to our claims adjudication process.

## SECTION 06: PROPRIETARY FILE LAYOUT

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### Summary

Due to the HIPAA standards, CBH modified its internal processes, procedures and file layouts in order to produce ANSI transaction sets. Due to these modifications, those business partners who receive electronic files from CBH will be required to modify their current applications in order to incorporate the new file layouts in the HIPAA mandated transaction set.

CBH business associates who are considering themselves as a “non-covered entity” under the HIPAA guidelines will not be required to receive information in the HIPAA ANSI transaction sets.

### Summary

There are three levels of transaction testing required before an application is considered approved by CBH. These testing levels include the following:

- ▶ Compliance Testing
- ▶ CBH Specification Validation Testing
- ▶ End-to-End Testing

Prior to testing, anyone wanting to exchange information electronically directly with CBH must obtain plan approval then complete and submit a signed Trading Partner Agreement.

CBH requires a minimum of a three week testing cycle to include sending three test files containing “live” information to its’ business partners in the same manner as production files would be sent. This will allow us to test the file transmission process and the data content. The three files will contain multiple scenarios depending on the type of transaction being sent. If your company requires additional testing, please contact an EDI Business Analyst at 800-225-2573 extension 25525.

Once CBH and your company have approved this transaction, we will work together on setting up a timeframe to implement it into production.

## A: Sample Audit Report

Process Date	6 characters	Date Claims Processed (CCMMDD)
Claim Number	12 characters	Health Plan Claim Number
Member#	12 characters	Health Plan Member Number
Amt Billed	10 characters	Billed Amount for Claim 9(07)v99
Status	6 characters	ACCEPT or INVALID
Prov Nbr	6 characters	Health Plan Provider Number
Tax ID	9 characters	Provider Tax ID Number
Reason	2 characters	Reason for error if INVALID status (see below)
Serv Date	8 characters	Date of Service
Patient ID	17 characters	Patient ID as sent by provider (from clm segment)

PROCES S DATE	CLAIM NUMBER	MHS MEMBER	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT ID
080329	H089IHE00001	11111111111	000005500	INVALID	232323232	752674893	06	20011110	3T12579039
080329	H089IHE00002	22222222222	000160904	ACCEPT	200000	752674894		20011026	3T12579407
080329	H089IHE00003	33333333333	000007700	INVALID	300009	752674895	01	20011110	3T12579042
080329	H089IHE00004	44444444444	000014900	ACCEPT	555666	752674896		20011117	3T12579048
080329	H089IHE00005	44444444444	000007700	ACCEPT	555666	752674896		20011117	3T12579049
080329	H089IHE00006	44444444444	000007000	ACCEPT	555666	752674896		20011129	3T12580690
080329	H089IHE00007	44444444444	000022700	ACCEPT	555666	752674896	17	20011129	3T12580691
080329	H089IHE00008	44444444444	000005500	ACCEPT	555666	752674896		20011117	3T12579056
080329	H089IHE00009	44444444444	000009300	ACCEPT	555666	752674896		20011117	3T12580680
080329	H089IHE00010	55555555555	000030700	ACCEPT	808999	752674897		20011206	3T12583224
080329	H089IHE00011	55555555555	000036500	ACCEPT	808999	752674897		20011212	3T12583191
080329	H089IHE00012	66666666666	000027500	ACCEPT	776776	752674898		20011206	3T12583265
080329	H089IHE00013	77777777777	000037300	ACCEPT	220220	752674899		20011206	3T12583212
080329	H089IHE00014	12121212121	000022800	INVALID	100000	652674893	02	20011212	3T12583199
080329	H089IHE00015	13131313131	000110200	INVALID	999999999	652674893	08	20011209	3T12579770

\*\*\*TOTAL CLAIMS  
ACCEPTED 00011

\*\*\*TOTAL CLAIMS  
REJECTED 00004



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**B: Sample Audit Report B**

Process Date 6 characters Date Claims Processed (CCMMDD)  
 Claim Number 12 characters Health Plan Claim Number  
 Member# 12 characters Health Plan Member Number  
 Amt Billed 10 characters Billed Amount for Claim 9(07)v99  
 Status 6 characters ACCEPT or INVALID  
 Prov Nbr 6 characters Health Plan Provider Number  
 Tax ID 9 characters Provider Tax ID Number  
 Reason 2 characters Reason for error if INVALID status (see below)  
 Serv Date 8 characters Date of Service  
 Patnt ID 20 characters Patient ID as sent by provider in clm segment (revised from 17characters)  
 Ref/D9 30 characters Claim number for intermediaries

ST\*864\*000000001

BMG\*00\*CLAIM AUDIT REPORT\*CK

MIT\*20060601\*PROFESSIONAL CLAIM AUDIT REPORT\*136

MSG\*PROCESS DATE CLAIM NUMBER MEMBER NBR AMT BILLED STATUS PROV NBR TAX ID REASON SERV DATE PATIENT ACCT# REF/D9 CLM NO FOR INTERMEDIARIES MSG\*060531

MSG*	PROCESS DATE	CLAIM NUMBER	MEMBER NBR	AMT BILLED	STATUS	PROV NBR	TAX ID	REASON	SERV DATE	PATIENT ACCT#	REF/D9	CLM NO FOR INTERMEDIARIES	MSG*
061510001T80	00000242501	000003900	ACCEPT	100023	741842169	20060530	086987004792	12345678901234567890					
MSG*060531	H089IHE00001	00012570801	000006850	ACCEPT	100023	741842169	20060530	117168004808	23456789012345678901				
MSG*060531	H089IHE00002	00010908601	000003900	ACCEPT	100023	741842169	20060530	151696004839	34567890123456789012				
MSG*060531	H089IHE00003	00004153901	000006550	ACCEPT	100023	741842169	20060530	151698004840	45678901234567890123				
MSG*060531	H089IHE00004	00015280501	000003900	ACCEPT	100023	741842169	20060530	153592004843	56789012345678901234				
MSG*060531	H089IHE00005	00000149901	000027575	ACCEPT	100023	741842169	20060530	154091004845	67890123456789012345				
MSG*060531	H089IHE00006	00040551901	000003900	ACCEPT	100023	741842169	20060530	155920004848	78901234567890123456				
MSG*060531	H089IHE00007	00040684801	000006200	ACCEPT	101472	741842169	20060530	057202004779	89012345678901234567				

SE\*13\*000000001

**Where:**

BMG\*00\*CLAIM AUDIT REPORT\*CK

aa bbbbbbbbbbbbbbbb cc

a = submission type (00 = Original)

b = description

c = submission code (CK = Claim Submission)

MIT\*20060601\*PROFESSIONAL CLAIM AUDIT REPORT\*115

Aaaaaaaa bbbbbbbbbbbbbbbbbbbbbbbbbbbbbbbb ccc

- a = document control number
- b = description (yet another one)
- c = columns in report layout

BMG and MIT are mandatory, MSG can contain up to 264 characters of free-form text



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## C: Audit Report Error Codes

- 01 Invalid Mbr DOB
- 02 Invalid Mbr
- 06 Provider# or Medicaid TPI missing or does not match payer records / NPI
- 07 Invalid Member DOB; Invalid Provider ID or TPI nbr
- 08 Invalid Mbr & Prv
- 09 Mbr not valid at DOS
- 10 Invalid Mbr DOB; Mbr not valid at DOS
- 12 Provider# inactive at DOS
- 13 Invalid Mbr DOB; Prv not valid at DOS
- 14 Invalid Mbr; Prv not valid at DOS
- 15 Member inactive at DOS; Invalid Provider or TPI nbr
- 16 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv
- 17 Invalid Diag
- 18 Invalid Mbr DOB; Invalid Diag
- 19 Invalid Mbr; Invalid Diag
- 21 Mbr not valid at DOS; Prv not valid at DOS
- 22 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS
- 23 Invalid Prv; Invalid Diag
- 24 Invalid Mbr DOB; Invalid Prv; Invalid Diag
- 25 Invalid Mbr; Invalid Prv; Invalid Diag
- 26 Mbr not valid at DOS; Invalid Diag
- 27 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag
- 29 Prv not valid at DOS; Invalid Diag
- 30 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag
- 31 Invalid Mbr; Prv not valid at DOS; Invalid Diag
- 32 Mbr not valid at DOS; Prv not valid; Invalid Diag
- 33 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag
- 34 Invalid Proc
- 35 Invalid Mbr DOB; Invalid Proc
- 36 Invalid Mbr; Invalid Proc
- 38 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
- 39 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag
- 40 Invalid Prv; Invalid Proc
- 41 Invalid Mbr DOB, Invalid Prv; Invalid Proc

- 42 Invalid Mbr; Invalid Prv; Invalid Proc
- 43 Mbr not valid at DOS; Invalid Proc
- 44 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Proc
- 46 Prv not valid at DOS; Invalid Proc
- 48 Invalid Mbr; Prv not valid at DOS; Invalid Proc
- 49 Mbr not valid at DOS; Invalid Prv; Invalid Proc
- 51 Invalid Diag; Invalid Proc
- 52 Invalid Mbr DOB; Invalid Diag; Invalid Proc
- 53 Invalid Mbr; Invalid Diag; Invalid Proc
- 57 Invalid Prv; Invalid Diag; Invalid Proc
- 58 Invalid Mbr DOB; Invalid Prv; Invalid Diag; Invalid Proc
- 59 Invalid Mbr; Invalid Prv; Invalid Diag; Invalid Proc
- 60 Mbr not valid at DOS; Invalid Diag; Invalid Proc
- 61 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Diag; Invalid Proc
- 63 Prv not valid at DOS; Invalid Diag; Invalid Proc
- 64 Invalid Mbr DOB; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 65 Invalid Mbr; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 66 Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
- 67 Invalid Mbr DOB; Mbr not valid at DOS; Invalid Prv; Invalid Diag; Invalid Proc
- 72 Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 73 Invalid Mbr DOB; Mbr not valid at DOS; Prv not valid at DOS; Invalid Diag; Invalid Proc
- 74 Rejected. Date of service prior to MM/DD/CCYY
- 75 Invalid Units of service
- 81 Invalid Units, Invalid Prv