National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim: Dental

837

ASC X12N 837 (004010X097)

May 2000

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1 Purpose and Business Overview

1.1 Document Purpose

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

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

1.1.1 Trading Partner Agreements

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

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

Second is the specific processing, or adjudication, of the transactions in each trading partner's individual system. Since this will vary from site to site (e.g., payer to payer), additional documentation which gives information regarding the processing, or adjudication, will prove helpful to each site's trading partners (e.g., providers), and will simplify implementation.

It is important that these trading partner agreements NOT:

- Modify the definition, condition, or use of a data element or segment in the standard Implementation Guide
- Add any additional data elements or segments to this Implementation Guide
- Utilize any code or data values which are not valid in this Implementation Guide
- Change the meaning or intent of this Implementation Guide

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

1.1.2 HIPAA Role in Implementation Guides

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

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

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

1.2 Version and Release

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

1.3 Business Use and Definition

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

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

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

Disclaimers within the Transactions

The developers of this Implementation Guideline strongly discourage the transmission of a disclaimer as a part of the transaction. Any disclaimer necessary should be outlined in the agreement between trading partners. Under no circumstances should there be more than one disclaimer returned per individual response.

1.3.1 Terminology

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

Dependent
In the hierarchical loop coding, the dependent code indicates the use of the patient hierarchical loop.

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

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

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

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

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

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

1.3.2 Batch and Real Time Definitions

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

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

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

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

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

1.4 Information Flows

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

1.4.1 National Standard Format (NSF)

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

1.4.2 Coordination of Benefits

One primary goal of this specific version and release of the 837 is to further develop the capability of handling coordination of benefits (COB) in a totally EDI environment. Electronic data interchange COB is predicated upon using two transactions — the 837 and the 835 (Health Care Claim Payment/Advice). See Sections 1.4.2.1, 1.4.2.2, and 1.4.2.3 for details about the two methods of using the 837 in conjunction with the 835 to achieve electronic COB. See Section 4, EDI Transmission Examples for Different Business Uses, for several detailed examples.

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

1.4.2.1 Coordination of Benefits Data Models - Detail

The 837 transaction handles two models of coordinating benefits. Both models are discussed in Section 1.4.2.1, Coordination of Benefits Data Models. See section 4, EDI Transmission Examples for Diffferent Business Uses, for examples of these models. The implementation guide contains notes on each COB-related data element specifying when it is used. See the final HIPAA rules for more information on COB.

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

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

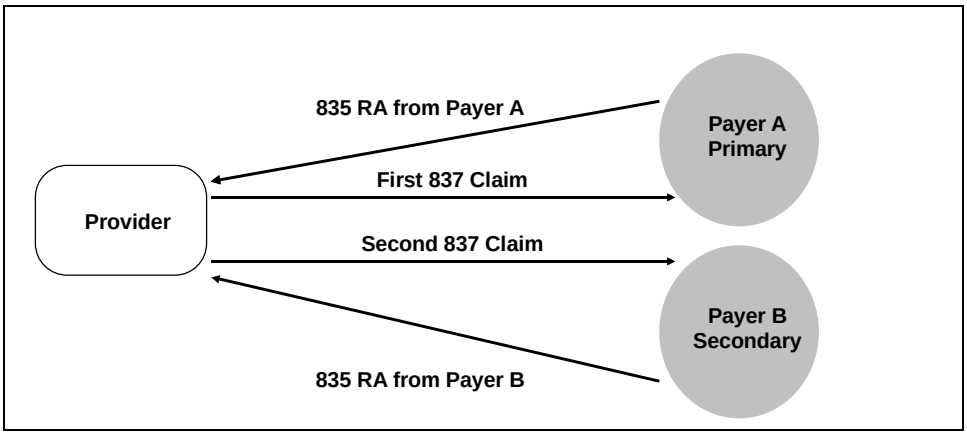


Figure 1. Provider-to-Payer-to-Provider COB Model

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

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

Model 2 — Provider-to-Payer-to-Payer

Step 1. In model 2, the provider originates the transaction and sends claim information to Payer A, the primary payer. See Figure 2, Provider-to-Payer-to-Payer COB Model. The Subscriber loop (Loop-ID 2000B) contains information about the person who holds the policy with Payer A. All other subscriber/payer information is included in Loop-ID 2320. In this model, the primary payer adjudicates the claim and sends an 835 back to the provider.

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

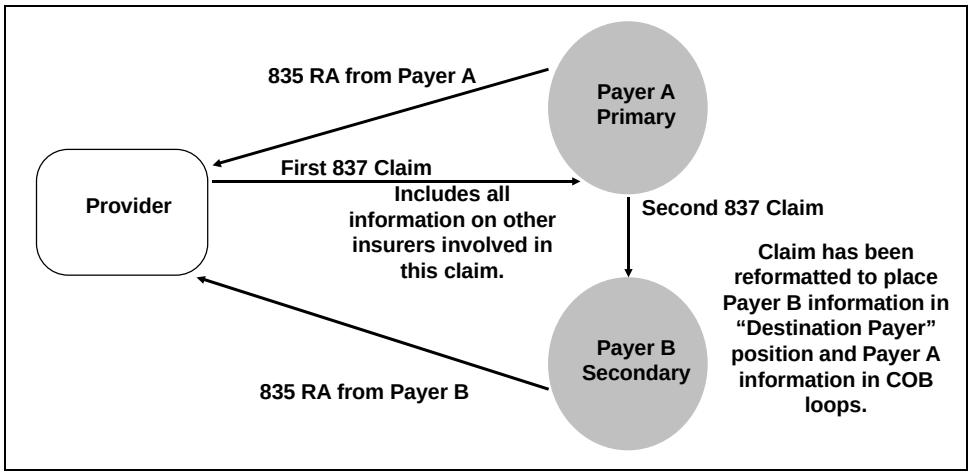


Figure 2. Provider-to-Payer-to-Payer COB Model

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

1.4.2.1.1 Coordination of Benefits — Claim Level

Loop ID-2320 occurs once for each payer responsible for the claim, except for the payer receiving the 837 transaction set (destination payer). The destination payer's information is located in Loop ID-2000B. In addition, any destination-payer specific claim information (e.g., referral number) is located in the 2300 loop. All provider identifiers in the 2310 and 2420 loops are specific to the destination payer.

Loop ID-2320 contains the following:

- claim level adjustments
- insured demographics
- various amounts
- payer type
- assignment of benefits indicator
- patient signature indicator

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

Sending the Claim to the First Destination Payer:

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

Sending the Claim to the Second Destination Payer:

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

Sending the Claim to the Third Destination Payer:

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

1.4.2.1.2 Coordination of Benefits — Service Line Level

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

Loop ID-2430 contains the following:

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

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

1.4.2.2 Coordination of Benefits — Correction Detail

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

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

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

Submitted charges:	$100.00
Adjustments	
Disallowed amount	$20.00
Co-insurance $16.00	
Deductible $24.00	
Payment amount	$40.00

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

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

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

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

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

CAS*CO*45*20~

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

Original Secondary 837:
The 837 that is sent to the secondary payer as follows.

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

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

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

CAS*CO*45*20~

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

AMT*D*40~

D = Payer Amount Paid code
40 = Amount

AMT*F2*40~

F2 = Patient Responsibility code
40 = Amount

1.4.2.2.1 Reversal and Correction Method of COB

Corrected Remittance Advice and Claim:

The primary payer finds an error in the original claim adjudication that requires a correction. In this case, the disallowed amount should have been $40.00 instead of the original $20.00. The co-insurance amount should have been $12.00 instead of $16.00, and the deductible amount remained the same.

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

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

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

Reversal 835:

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

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

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

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

Corrected 835:

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

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

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

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

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

CAS*CO*45*40~

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

Corrected secondary 837:

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

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

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

CAS*CO*45*40~

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

AMT*D*24~

D = Payer Amount Paid code
24 = Amount

AMT*F2*36~

F2 = Patient Responsibility code
36 = Amount

1.4.3 Service Line Procedure Code Bundling and Unbundling

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

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

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

Bundling:

When bundling, the health care claim should report all of the originally submitted procedures. The first bundled procedure should include the new bundled procedure code in the SVD (Service Line Adjudication) segment (SVD03). The other procedure or procedures that are bundled into the same line should be reported as originally submitted with the following:

- an SVD segment with zero payment (SVD02),
- a pointer to the new bundled procedure code (SVD06, data element 554 (Assigned Number) is the bundled service line number that refers to the LX assigned number of the service line into which this service line was bundled),
- a CAS segment with a claim adjustment reason code of 97 (payment is included in the allowance for the basic service), and
- an adjustment amount equal to the submitted charge.

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

Bundling Example

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

The following example includes only segments specific to bundling.

Claim Level (Loop ID-2320)

CAS*PR*1*50~

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

Service Line Level (Loop ID-2430)

LX*1~

1 = Service line 1

SV3*AD:A*100~

AD = ADA qualifier
A = ADA code
100 = Submitted charge

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

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

CAS*PR*2*20~

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

LX*2~

2 = Service line 2

SV3*AD:B*100~

AD = AD qualifier
B = ADA code
100 = Submitted charge

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

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

CAS*CO*97*100~

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

Bundling with COB Example

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

Original 837

LX*1~ (Loop 2400)

1 = Service line 1

SV2*HC:A*100*UN*1N~**

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

REF*6R*2J01K~

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

LX*2~ (Loop 2400)

2 = Service line 2

SV2*HC:B*100*UN*1N~**

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

REF*6R*2J02K~

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

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

Claim Level (Loop ID-2320)

CAS*PR*1*50~

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

Service Line Level (Loop ID-2400)

SV2*HC:A*100*UN*1N~**

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

REF*6R*2J01K~

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

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

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

CAS*PR*2*20~

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

LX*2~ (Loop 2400)

2 = Service line 2

SV2*HC:B*100*UN*1N~**

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

REF*6R*2J02K~

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

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

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

CAS*CO*97*100~

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

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

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

2330A Loop
NM1*identifies other subscriber for payer A

2330B Loop
NM1* identifies payer A

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

2330A Loop
NM1*identifies other subscriber for payer B

2330B Loop
NM1* identifies payer B

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

2330A Loop
NM1*identifies other subscriber for payer C

2330B Loop
NM1* identifies payer C

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

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

2400 Loop

LX*1~

SV2* original data from provider

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

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

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

2400 Loop

LX*2~

SV2* original data from provider for line 2

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

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

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

Etc.

Unbundling

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

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

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

CAS*OA*93*0~

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

Service Line Level (Loop ID-2400):

LX*1~

1 = Service line 1

SV3*AD:A*200~

AD = AD qualifier
A = ADA code
200 = Submitted charge

Service Line Adjudication Information:(Loop ID-2430)

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

Payer ID = ID of the payer who adjudicated this service line
70 = Payer amount paid
AD = ADA qualifier
C = ADA code for unbundled procedure
1 = Paid units of service

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

Payer ID = ID of the payer who adjudicated this service line
60 = Payer amount paid
AD = ADA qualifier
B = ADA code for unbundled procedure
1 = Paid units of service

CAS*CO*45*140~

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

SVD*PAYER ID*60*AD:C~

Payer ID = ID of payer who adjudicated this service line
60 = Payer amount paid
AD = ADA qualifier
C = Unbundled ADA code

CAS*CO*45*140~

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

1.4.4 Crosswalking COB Data Elements

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

exactly which data must be moved around within the 837 to facilitate an automation of COB. Either payers or providers can elect to use this strategy.

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

Business Model:

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

Example:

A claim is filed which involves three payers A, B, and C. In any 837 one payer is always the destination payer (the payer receiving the claim) and two 'other' payers carried in the 2320/2330 loops. In this example, the claim is first sent to payer A and payer B and C are carried in the 2320/2330 loops. In Table 1 the information specific to the destination payer is carried in the elements indicated in the second column (Destination Payer Location). Information specific to the non-destination payers is carried in the elements listed in the third column (Other Payer Location).

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

Data Element Name	Destination Payer Location Loop - Segment Element	Other Payer Location Loop - Segment Element
Subscriber Last/Org Name	2010BA | NM103	2330A | NM103
Subscriber Last/Org Name	2010BA | NM103	2330A | NM103
Subscriber First Name	2010BA | NM104	2330A | NM104
Subscriber Middle Name	2010BA | NM105	2330A | NM105
Subscriber Suffix Name	2010BA | NM107	2330A | NM107
Subscriber Identification Number	2010BA | NM108/09	2330A | NM108/09
Subscriber Street Address (1)	2010BA | N301	2330A | N301

Data Element Name	Destination Payer Location Loop - Segment Element	Other Payer Location Loop - Segment Element
Subscriber Street Address (2)	2010BA | N302	2330A | N302
Subscriber City	2010BA | N401	2330A | N401
Subscriber State	2010BA | N402	2330A | N402
Subscriber ZIP Code	2010BA | N403	2330A | N403
Payer Name	2010BB | NM103	2330B | NM103
Payer ID	2010BB | NM108/09	2330B | NM108/09
Patient Identification Number	2010CA | NM108/09	2330A | REF02
Relationship of subscriber to patient	2000B | SBR02	2320 | SBR02
Assignment of Benefits Indicator	2300 - CLM	2320 | OI03
Patient's Signature Source Code	2300 - CLM	Not Used
Release of Information	2300 - CLM	2320 | OI06
Referral Numer - claim level	2300 | REF02	2330B | REF02 of Prior Auth/Other Payer Referral REF.
Provider identification number(s) - claim level	2310A | REF02 2310B | REF02	2330D | REF02 2330E | REF02
Payer specific amounts	NO ELEMENTS[1]	All AMTs in the 2320 loop are specific to the payer identified in the 2330B loop of that iteration of the 2320 loop.
Referral Number - line level	2400 | REF02	N/A
Provider identification number(s) - line level	2420A | REF01/02	Not Crosswalked

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

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

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

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

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

tion payer location" elements. Payer A's information remains in the "other payer location" elements.

1.5 Property and Casualty

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

2 Data Overview

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

2.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set — the implementation view and the standard view. The implementation view of the transaction set is presented in Section 2.1, Overall Data Architecture. See figure 3, 837 Transaction Set Listing, for the implementation view. Figure 4 displays only the segments described in this implementation guide and their designated health care names. The standard view, which is presented in Section 3, Transaction Set, displays all segments available within the transaction set and their assigned ASC X12 names.

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
005	ST	Transaction Set Header	R	1	
010	BHT	Beginning of Hierarchical Transaction	R	1	
015	REF	Transmission Type and Submission/Resubmission Number	S	1	
		...			

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

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

Figure 3. 837 Transaction Set Listing

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

2.2 Loop Labeling and Use

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

The order of equivalent loops is less important. Equivalent subloops do not need to be sent in the same order in which they appear in this implementation guide. In this transaction, subloops are those with a number that does not end in 00 (e.g., Loop ID-2010, Loop ID-2420, etc.). For example, loop 2310 has five possible uses identified: referring provider, rendering provider, service facility location. These loops are labeled 2310A, 2310B, 2310C. Each of these 2310 loops is an equivalent loop. Because they do not specify an HL, it is not necessary to use them in any particular order. In a similar fashion, it is acceptable to send subloops 2010BB, 2010BA, and 2010BC in that order as long as they all belong to the same subloop. However, it is **not** acceptable to send subloop 2330 before loop 2310 because these are not equivalent subloops.

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

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

2.2.1 Required and Situational Loops

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

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

In the 837 Dental Implementation Guide, loops that are required on all claims/encounters are: the Header, 1000A - Submitter Name, 1000B - Receiver Name, 2000A - Billing/Pay-to Provider Hierarchical Level, 2010AA - Billing Provider Name, 2000B - Subscriber Hierarchical Level, 2010BA - Subscriber Name, 2010BB - Payer Name, 2300 - Claim Level Information and 2400 - Service Line Level Information.

The use of all other loops is dependent upon the nature of the claim/encounter.

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

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

2.3 Data Use by Business Use

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

2.3.1 Table 1 — Transaction Control Information

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

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
005	ST	Transaction Set Header	R	1	
010	BHT	Beginning of Hierarchical Transaction	R	1	
015	REF	Transaction Type and Submission/Resubmission Number	R	1	
		. . .			

Figure 4. Table 1 — Header Level

2.3.1.1 837 Table 1 — Header Level

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

ST*837*0001~

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

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

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

REF*87*004010X097~

87 = Functional category
004010X097 = Dental Implementation Guide

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

The Beginning of Hierarchical Transaction (BHT) segment indicates that the transaction uses a hierarchical data structure. The value of 0019 in the hierarchical structure code data element, BHT01, describes the order of the hierarchical levels and the business purpose of each level. See Section 2.3.1.2, Hierarchical Level Data Structure, for additional information about the BHT01 data element.

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

Because the 837 is multi-functional, it is important for the receiver to know which business purpose is served, so the REF in the Header is used. A data value of 87 in REF 01 indicates the **functional category,** or type, of 837 being sent. Appropriate values for REF02 are as follows: 097 for a Dental 837 transaction, 098 for Professional, and 096 for Institutional.

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

2.3.1.2 Hierarchical Level Data Structure

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

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

The term “billing provider” indicates the information source hierarchical level (HL). The term “patient” indicates the dependent HL.

2.3.2 Table 2 — Detail Information

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

2.3.2.1 HL Segment

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

NOTE
Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this, the claim information is said to “float.” Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information is placed at the subscriber hierarchical level when the patient is the subscriber, **or** it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber.

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

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

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

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

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

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

BILLING PROVIDER
  SUBSCRIBER #1 (Patient #1)
    Claim level information
    Line level information, as needed
SUBSCRIBER #2
  PATIENT #P2.1 (e.g., subscriber #2 spouse)
    Claim level information
    Line level information, as needed
  PATIENT #P2.2 (e.g., subscriber #2 first child)
    Claim level information
    Line level information, as needed
  PATIENT #P2.3 (e.g., subscriber #2 second child)
    Claim level information
    Line level information, as needed
SUBSCRIBER #3 (Patient #3)
  Claim level information
  Line level information, as needed
SUBSCRIBER #4 (Patient #4)
  Claim level information
  Line level information, as needed
  PATIENT #P4.1 (e.g., #4 subscriber's first child)
    Claim level information
    Line level information, as needed

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

HL*120*1~**

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

HL*2*1*22*0~

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

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

3 = HL sequence number
1 = parent HL

22 = subscriber
1 = there is at least one child HL to this HL

HL*4*3*23*0~

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

HL*5*3*23*0~

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

HL*6*3*23*0~

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

HL*7*1*22*0~

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

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

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

HL*9*7*23*0~

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

If another billing provider is listed in the same ST-SE functional group, it could be listed as follows: **HL*100*0*20*1~**. The HL sequence number of 100 indicates that there are 99 previous HL segments, but it is the billing provider level HL (HL02 = **(blank)) and is a different entity than the first billing provider listed.

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

- HLs are numbered sequentially. The sequential number is found in HL01, which is the first data element in the HL segment.
- The second element, HL02, indicates the sequential number of the parent hierarchical level to which this hierarchical level (HL01) is subordinate. The billing

provider/information source has no parent. If the data value in HL02 is equal to "**(blank)", it is kown that this is the highest heirarchical level for all the contained subordinate levels. The billing provider level is not subordinate to any hierarchical level.

- The data value in data element HL03 describes the hierarchical level entity. For example, when HL03 equals 20, the hierarchical level is the billing provider; when HL03 equals 23, the hierarchical level is the dependent (patient).
- Data element HL04 indicates whether or not subordinate hierarchical levels exist. A value of "1" indicates subsequent hierarchical levels. A value of "0" or absence of a data value indicates that no subordinate hierarchical levels follow.
- HLs must be transmitted in order.

2.4 Loop ID-1000

Use of Loop ID-1000 is difficult to accurately define or describe. Originally, Loop ID-1000 was conceived of as an audit trail loop.[1] The audit trail concept is difficult to implement for a variety of reasons, and the developers of this implementation guide do not recommend using Loop ID-1000 as an audit trail in this transaction. Instead, the developers recommend using Loop ID-1000 to record the transaction submitter and the receiver. However, the submitter and receiver concepts are difficult to define accurately. The transaction submitter and receiver are not necessarily the two entities who may be passing the transaction between them. Given the complexity of transmission pathways, it is critical to define the original submitter and final receiver somewhere in the transmission.

Several figures follow to help clarify the difficulty in defining the terms "submitter" and "receiver." In Figure 5, Loop ID-1000 — Example 1, the submitter is not the

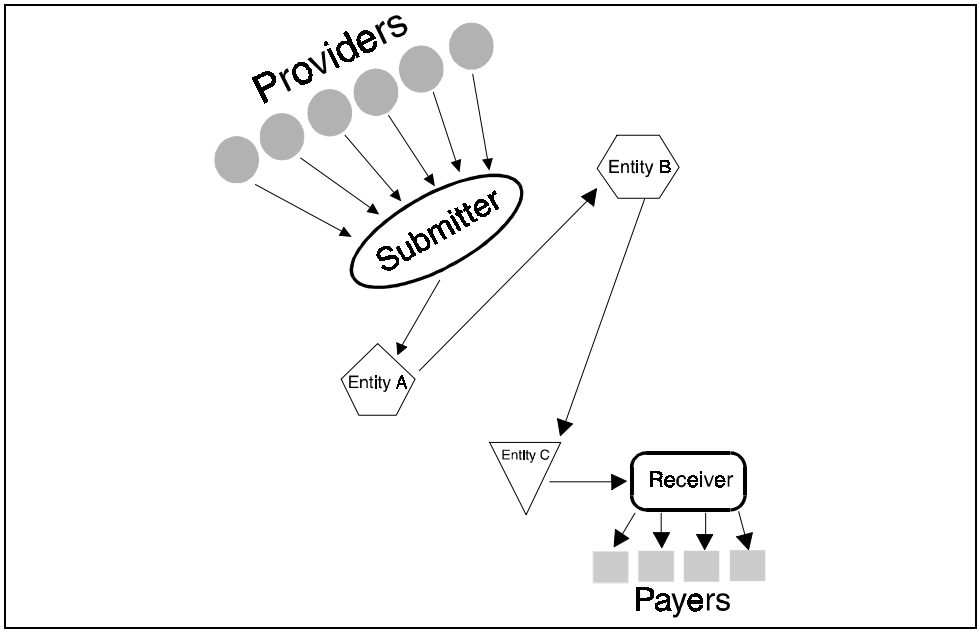


Figure 5. Loop ID-1000 — Example 1

1The original instructions for Loop ID-1000 directed that anyone who "opened the envelope" of the transaction should include another iteration of Loop ID-1000 so that it would be possible to identify all the entities who had an opportunity to change the data inside the enveloping structure.

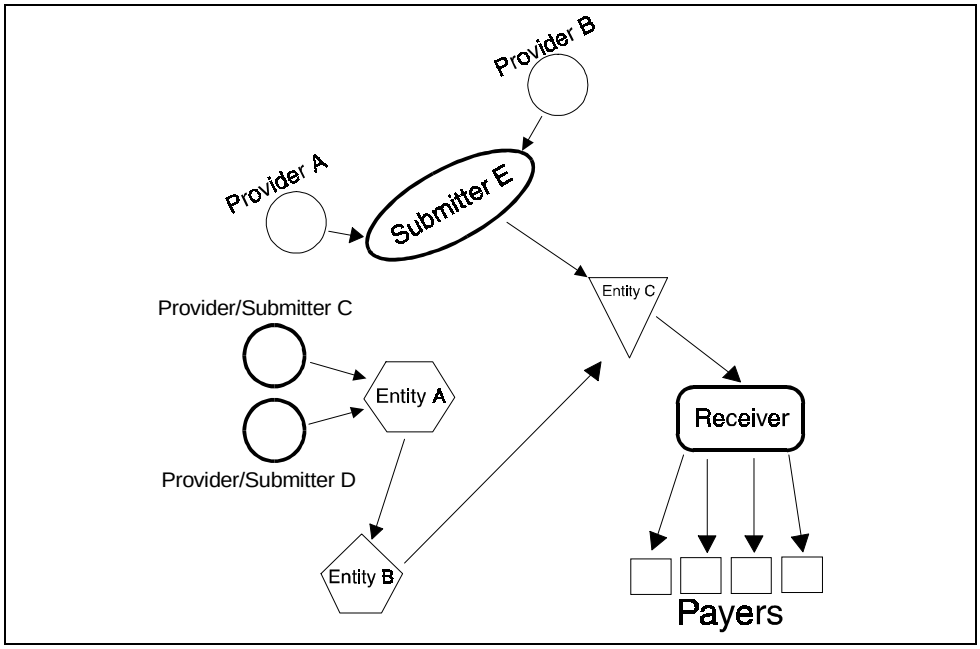


Figure 6. Loop ID-1000 — Example 2

service provider. The submitter could be a billing service, an Automated Clearing House, or another entity who formats the claims into the 837. The original submitter can be thought of as the entity who initially formats the claim data into the ASC X12N transaction and begins the transmission chain, which ultimately ends at the payer. It is possible that the communication between the provider and the submitter is in the form of paper or some other non-standard EDI transaction.

The receiver is more difficult to define. Figure 5, Loop ID-1000 — Example 1, shows that the receiver is not necessarily the destination payer. The receiver is the entity who receives the claim transmission on behalf of perhaps many payer organizations. In figure 5, the receiver can be a Preferred Provider Organization (PPO), a repricer, or any of several other payer-associated entities. These entities can perform a variety of functions for the payer.

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

It is possible that the provider is the submitter, and the payer the receiver. Figure 6, Loop ID-1000 — Example 2, and figure 7, Loop ID-1000 — Example 3, demonstrate alternate types of transmission pathways where the provider and the payer function as submitter and receiver. In figure 6, providers C and D function as submitters because they format their own claim data into an ASC X12N claim transmission package. Providers A and B use submitter E to perform that function and

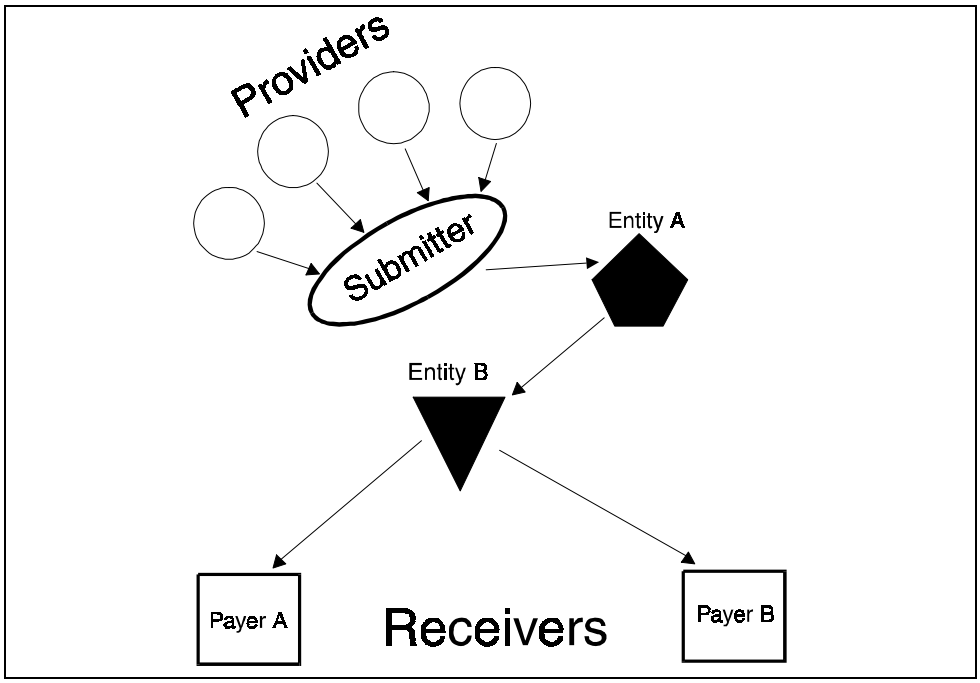


Figure 7. Loop ID-1000 — Example 3

therefore are not submitters. In figure 7, payers A and B function as their own transmission receivers.

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

2.5 The Claim

After the HL structure is defined, the specific claim services are identified in Loop ID-2300. Loop ID-2310 identifies various providers who may have been involved in the health care services being reported in the transaction. Loop ID-2320 identifies all other insurance entities (coordination of benefits). Within Loop ID-2320, Loop ID-2330 identifies all the parties associated with the other insurance entities. Loop ID-2400 is required and identifies service line information. Loop ID-2410 identifies drug information. Loop ID-2420 identifies any service line providers who are different than claim level providers. Loop ID-2430 identifies any service line adjudication information (from a previous payer).

2.6 Interactions with Other Transactions

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

2.6.1 Functional Acknowledgment (997)

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

2.6.2 Unsolicited Claim Status (277)

The Unsolicited Claim Status (277) transaction may be used as the second response to receiving an 837. The 277 transmission may be used to indicate to the provider which claims in an 837 batch were accepted into the adjudication system (i.e., which claims passed the front-end edits) and which claims were rejected before entering the adjudication system. Certain information is taken from the 837 and used in, or crosswalked into, the 277 (e.g., the provider's claim identification number, the amount billed, etc.).

2.6.3 Remittance Advice (835)

Information in the Remittance Advice (835) transaction is generated by the payer's adjudication system. However, in a coordination of benefits (COB) situation where the provider is sending an 837 to a secondary payer, information from the 835 may be included in the secondary 837. As shown in Section 1.4.2.3, Coordination of Benefits — Correction Detail, data from specific segments/elements in the 835 are crosswalked directly into the subsequent 837.

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

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

2.8 Use of Data Segments and Elements Marked "Situational"

Dental claims span an enormous variety of health care dental specialties and payment situations. Because of this, it is difficult to set a single list of data elements that are required for all types of dental health care claims. To meet the divergent needs of dental claim submitters, many data segments and elements included in this implementation guide are marked "situational." Wherever possible, notes have been added to this implementation guide to clarify when to use a particular situational segment or element. For example, a data element may be marked "situational," but the note attached to the element may explain that under certain circumstances the element is "required." If there is not an explanatory note, interpret "situational" to mean "if the information is available and applicable to the claim, the developers of this implementation guide recommend that the information be sent."

3 Transaction Set

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

3.1 Presentation Examples

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

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

Transaction Set Listing

- Implementation
- Standard

Segment Detail

- Implementation
- Standard
- Diagram
- Element Summary

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

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

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

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

835 Health Care Claim Payment/Advice

Table 1 - Header

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

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

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 8. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

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

835 Health Care Claim Payment/Advice

Functional Group ID: **HP**

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

Table 1 - Header

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

Figure 9. Transaction Set Key — Standard

IMPLEMENTATION

Industry Usage

PAYER NAME ← Industry assigned Segment Name

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

Industry Segment Repeat

Usage: SITUATIONAL ← Industry assigned Loop Name

Repeat: 1

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

Industry Notes

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

Example

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

Figure 10. Segment Key — Implementation

STANDARD

N1 Name ← X12 ID and Name

Level: Header ← X12 Level

Position: 080 ← X12 Position Number

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

Requirement: Optional ← X12 Requirement

Max Use: 1 ← X12 Maximum Use

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

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

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

X12 Syntax Notes

Figure 11. Segment Key — Standard

DIAGRAM

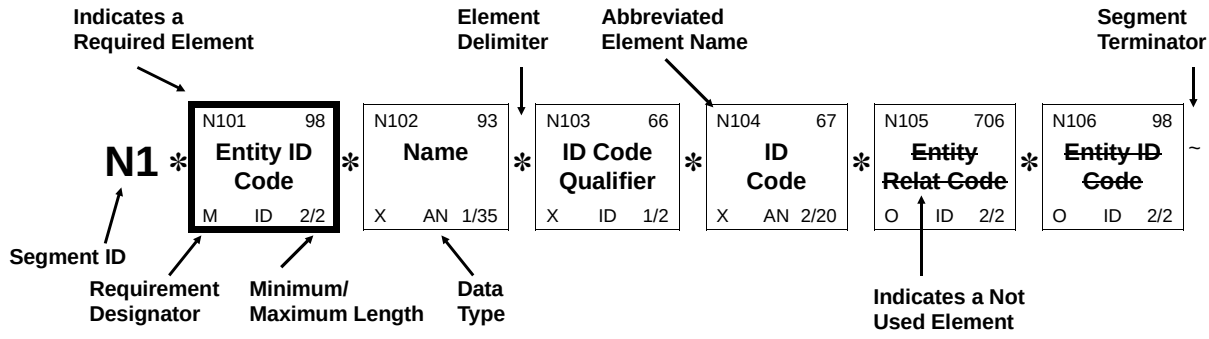
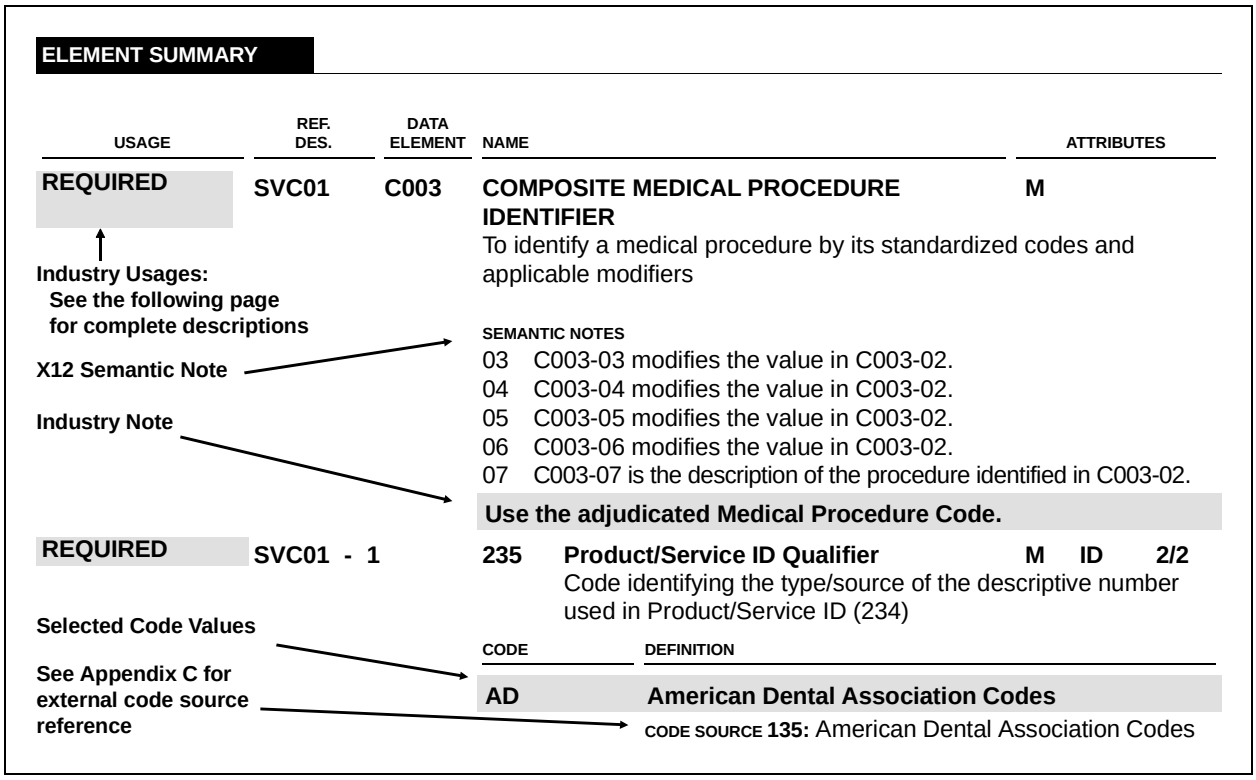


Figure 12. Segment Key — Diagram



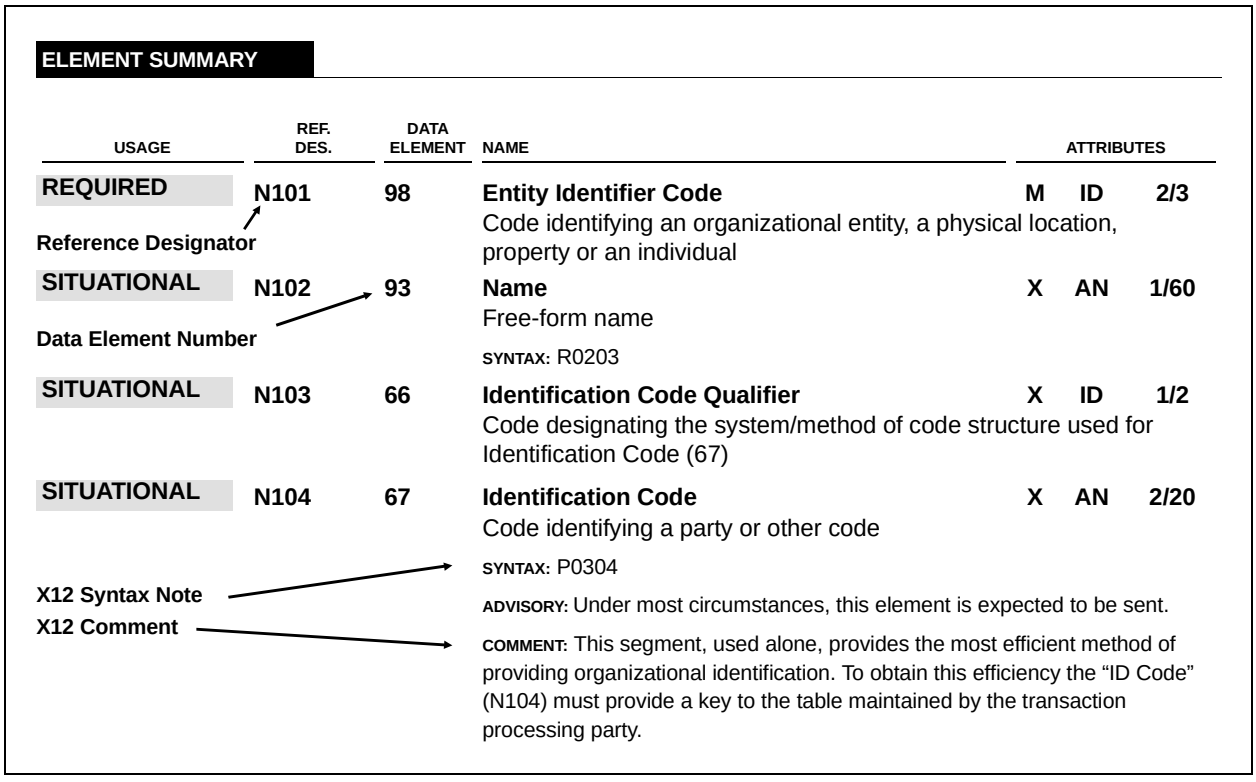


Figure 13. Segment Key — Element Summary

Industry Usages:

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

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

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

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

837 Health Care Claim: Dental

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

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

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

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	005	ST	Transaction Set Header	R	1	
54	010	BHT	Beginning of Hierarchical Transaction	R	1	
57	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
59	020	NM1	Submitter Name	R	1	
62	025	N2	Additional Submitter Name Information	S	1	
63	045	PER	Submitter Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
66	020	NM1	Receiver Name	R	1	
68	025	N2	Receiver Additional Name Information	S	1	

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

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
69	001	HL	Billing/Pay-to Provider Hierarchical Level	R	1	
71	003	PRV	Billing/Pay-to Provider Specialty Information	S	1	
73	010	CUR	Foreign Currency Information	S	1	
			LOOP ID - 2010AA BILLING PROVIDER NAME			1
76	015	NM1	Billing Provider Name	R	1	
79	020	N2	Additional Billing Provider Name Information	S	1	
80	025	N3	Billing Provider Address	R	1	
81	030	N4	Billing Provider City/State/ZIP Code	R	1	
83	035	REF	Billing Provider Secondary Identification Number	S	5	
85	035	REF	Claim Submitter Credit/Debit Card Information	S	8	
			LOOP ID - 2010AB PAY-TO PROVIDER'S NAME			1
87	015	NM1	Pay-to Provider's Name	S	1	
90	020	N2	Additional Pay-to Provider Name Information	S	1	
91	025	N3	Pay-to Provider's Address	R	1	

92	**030**	**N4**	Pay-to Provider City/State/Zip	**R**	**1**	
94	**035**	**REF**	Pay-to Provider Secondary Identification Number	**S**	**5**	

Table 2 - Detail, Subscriber Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			**>1**
96	**001**	**HL**	Subscriber Hierarchical Level	**R**	**1**	
99	**005**	**SBR**	Subscriber Information	**R**	**1**	
			LOOP ID - 2010BA SUBSCRIBER NAME			**1**
103	**015**	**NM1**	Subscriber Name	**R**	**1**	
107	**020**	**N2**	Additional Subscriber Name Information	**S**	**1**	
108	**025**	**N3**	Subscriber Address	**S**	**1**	
109	**030**	**N4**	Subscriber City/State/ZIP Code	**S**	**1**	
111	**032**	**DMG**	Subscriber Demographic Information	**S**	**1**	
113	**035**	**REF**	Subscriber Secondary Identification	**S**	**4**	
115	**035**	**REF**	Property and Casualty Claim Number	**S**	**1**	
			LOOP ID - 2010BB PAYER NAME			**1**
117	**015**	**NM1**	Payer Name	**R**	**1**	
120	**020**	**N2**	Additional Payer Name Information	**S**	**1**	
121	**025**	**N3**	Payer Address	**S**	**1**	
122	**030**	**N4**	Payer City/State/ZIP Code	**S**	**1**	
124	**035**	**REF**	Payer Secondary Identification Number	**S**	**3**	
			LOOP ID - 2010BC CREDIT/DEBIT CARD HOLDER NAME			**1**
126	**015**	**NM1**	Credit/Debit Card Holder Name	**S**	**1**	
129	**020**	**N2**	Additional Credit/Debit Card Holder Name Information	**S**	**1**	
130	**035**	**REF**	Credit/Debit Card Information	**S**	**3**	

Table 2 - Detail, Patient Hierarchical Level

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

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL			**>1**
132	**001**	**HL**	Patient Hierarchical Level	**S**	**1**	
134	**007**	**PAT**	Patient Information	**R**	**1**	
			LOOP ID - 2010CA PATIENT NAME			**1**
136	**015**	**NM1**	Patient Name	**R**	**1**	
139	**020**	**N2**	Additional Name Information	**S**	**1**	
140	**025**	**N3**	Patient Address	**R**	**1**	
141	**030**	**N4**	Patient City/State/ZIP Code	**R**	**1**	
143	**032**	**DMG**	Patient Demographic Information	**R**	**1**	

145	035	REF	Patient Secondary Identification	S	5	
147	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2300 CLAIM INFORMATION			100
149	130	CLM	Claim Information	R	1	
157	135	DTP	Date - Admission	S	1	
158	135	DTP	Date - Discharge	S	1	
160	135	DTP	Date - Referral	S	1	
161	135	DTP	Date - Accident	S	1	
162	135	DTP	Date - Appliance Placement	S	5	
164	135	DTP	Date - Service	S	1	
166	145	DN1	Orthodontic Total Months of Treatment	S	1	
168	150	DN2	Tooth Status	S	35	
170	155	PWK	Claim Supplemental Information	S	10	
173	175	AMT	Patient Amount Paid	S	1	
174	175	AMT	Credit/Debit Card - Maximum Amount	S	1	
175	180	REF	Predetermination Identification	S	5	
177	180	REF	Service Authorization Exception Code	S	1	
179	180	REF	Original Reference Number (ICN/DCN)	S	1	
181	180	REF	Referral Identification	S	1	
183	180	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	1	
185	190	NTE	Claim Note	S	20	
			LOOP ID - 2310A REFERRING PROVIDER NAME			2
187	250	NM1	Referring Provider Name	S	1	
190	255	PRV	Referring Provider Specialty Information	S	1	
192	260	N2	Additional Referring Provider Name Information	S	1	
193	271	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2310B RENDERING PROVIDER NAME			1
195	250	NM1	Rendering Provider Name	S	1	
198	255	PRV	Rendering Provider Specialty Information	R	1	
200	260	N2	Additional Rendering Provider Name Information	S	1	
201	271	REF	Rendering Provider Secondary Identification	S	5	
			LOOP ID - 2310C SERVICE FACILITY LOCATION			1
203	250	NM1	Service Facility Location	S	1	
206	260	N2	Additional Service Facility Location Name Information	S	1	
207	271	REF	Service Facility Location Secondary Identification	S	5	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			10
209	290	SBR	Other Subscriber Information	S	1	
213	295	CAS	Claim Adjustment	S	5	
220	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
221	300	AMT	Coordination of Benefits (COB) Approved Amount	S	1	
222	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	1	
223	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	S	1	
224	300	AMT	Coordination of Benefits (COB) Covered Amount	S	1	
225	300	AMT	Coordination of Benefits (COB) Discount Amount	S	1	
226	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	1	
227	305	DMG	Other Insured Demographic Information	S	1	
229	310	OI	Other Insurance Coverage Information	R	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			1
231	325	NM1	Other Subscriber Name	R	1	
234	330	N2	Additional Other Subscriber Name Information	S	1	
235	332	N3	Other Subscriber Address	S	1	

236	340	N4	Other Subscriber City/State/Zip Code	S	1	
238	355	REF	Other Subscriber Secondary Identification	S	3	
			LOOP ID - 2330B OTHER PAYER NAME			1
240	325	NM1	Other Payer Name	R	1	
242	330	N2	Additional Other Payer Name Information	S	1	
243	345	PER	Other Payer Contact Information	S	2	
246	350	DTP	Claim Paid Date	S	1	
247	355	REF	Other Payer Secondary Identifier	S	3	
249	355	REF	Other Payer Referral Number	S	1	
251	355	REF	Other Payer Claim Adjustment Indicator	S	1	
			LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION			1
253	325	NM1	Other Payer Patient Information	S	1	
255	355	REF	Other Payer Patient Identification	S	3	
			LOOP ID - 2330D OTHER PAYER REFERRING PROVIDER			1
257	325	NM1	Other Payer Referring Provider	S	1	
259	355	REF	Other Payer Referring Provider Identification	S	3	
			LOOP ID - 2330E OTHER PAYER RENDERING PROVIDER			1
261	325	NM1	Other Payer Rendering Provider	S	1	
263	355	REF	Other Payer Rendering Provider Identification	S	3	
			LOOP ID - 2400 LINE COUNTER			50
265	365	LX	Line Counter	R	1	
266	380	SV3	Dental Service	R	1	
271	382	TOO	Tooth Information	S	32	
273	455	DTP	Date - Service	S	1	
275	455	DTP	Date - Prior Placement	S	1	
277	455	DTP	Date - Appliance Placement	S	1	
279	455	DTP	Date - Replacement	S	1	
281	460	QTY	Anesthesia Quantity	S	5	
283	470	REF	Service Predetermination Identification	S	1	
284	470	REF	Referral Number	S	1	
285	470	REF	Line Item Control Number	S	1	
287	475	AMT	Approved Amount	S	1	
288	485	NTE	Line Note	S	10	
			LOOP ID - 2420A RENDERING PROVIDER NAME			1
289	500	NM1	Rendering Provider Name	S	1	
292	505	PRV	Rendering Provider Specialty Information	R	1	
294	510	N2	Additional Rendering Provider Name Information	S	1	
295	525	REF	Rendering Provider Secondary Identification	S	5	
			LOOP ID - 2420B OTHER PAYER REFERRAL NUMBER			1
297	500	NM1	Other Payer Referral Number	S	1	
300	525	REF	Other Payer Referral Number	S	1	
			LOOP ID - 2430 LINE ADJUDICATION INFORMATION			25
301	540	SVD	Line Adjudication Information	S	1	
305	545	CAS	Service Adjustment	S	99	
312	550	DTP	Line Adjudication Date	R	1	
313	555	SE	Transaction Set Trailer	R	1	

STANDARD

837 Health Care Claim

Functional Group ID: HC

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

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

Table 1 - Header

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

Table 2 - Detail

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

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

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

NOTES:

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

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

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

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

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

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

2/365 Loop 2400 contains Service Line information.

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

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

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

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

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

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

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

ST Transaction Set Header

Level: Header

Position: 005

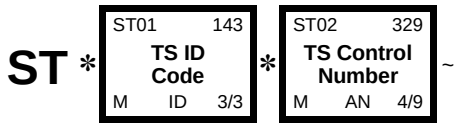
Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

BEGINNING OF HIERARCHICAL TRANSACTION

Usage: **REQUIRED**

Repeat: **1**

Example: **BHT*0019*00*0123*19980108*0932*CH~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 010

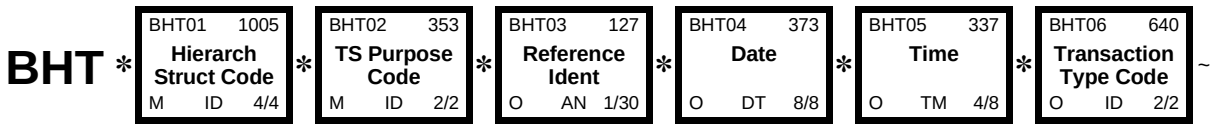
Loop: ____

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

NSF Reference:

AA0-23.0

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

CODE	DEFINITION
00	**Original** **Original transmission are claims/encounters which have never been sent to the receiver. Generally, nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original.**
18	**Reissue** **In the case where a transmission was disrupted, the receiver can request that the batch be sent again. Use ''Reissue'' when resending transmission batches that have been previously sent.**

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

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

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

NSF Reference:

AA0-05.0

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

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

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

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

NSF Reference:

AA0-15.0

Use this date to identify the date on which the submitter created the file.

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

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

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

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

NSF Reference:

AA0-16.0

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

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

Code specifying the type of transaction

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

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

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

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

IMPLEMENTATION

TRANSMISSION TYPE IDENTIFICATION

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. The information carried in this REF is identical to that carried in the GS08. Because the commercial translator community is roughly evenly split on where they look for the implementation guide type, this number is carried in both places.**

Example: **REF*87*004010X097D~**

STANDARD

REF Reference Identification

Level: Header

Position: 015

Loop: ____

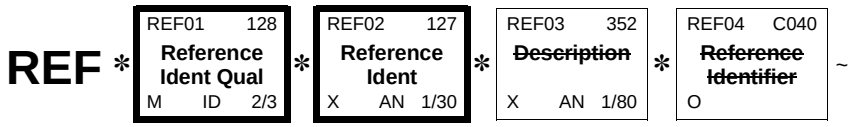
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **87 Functional Category**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Transmission Type Code*** SYNTAX: R0203 **When piloting the transaction set, this value is 004010X097D.** **When sending the transaction set in a production mode, this value is 004010X097.**	**X AN 1/30**

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

IMPLEMENTATION

SUBMITTER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

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

STANDARD

NM1 Individual or Organizational Name

Level: Header

Position: 020

Loop: 1000 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

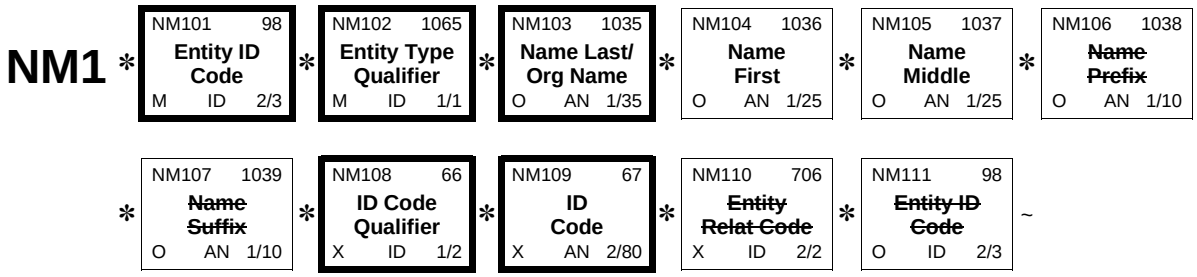
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

ADDITIONAL SUBMITTER NAME INFORMATION

Loop: **1000A — SUBMITTER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N2 Additional Name Information

Level: Header

Position: 025

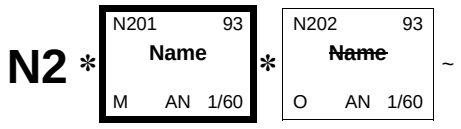
Loop: 1000

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

SUBMITTER CONTACT INFORMATION

Loop: **1000A — SUBMITTER NAME**

Usage: **REQUIRED**

Repeat: **2**

Notes:

1. **This segment is used to identify the EDI contact person.**
2. **Each communication number should always include the area code. The extension, when applicable, should be included in the appropriate PER element immediately after the telephone number (e.g., if the telephone number is included in the PER04, then the extension should be in the PER06).**
3. **When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.**
4. **By definition of the standard, if PER03 is used, PER04 is required.**

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

STANDARD

PER Administrative Communications Contact

Level: Header

Position: 045

Loop: 1000

Requirement: Optional

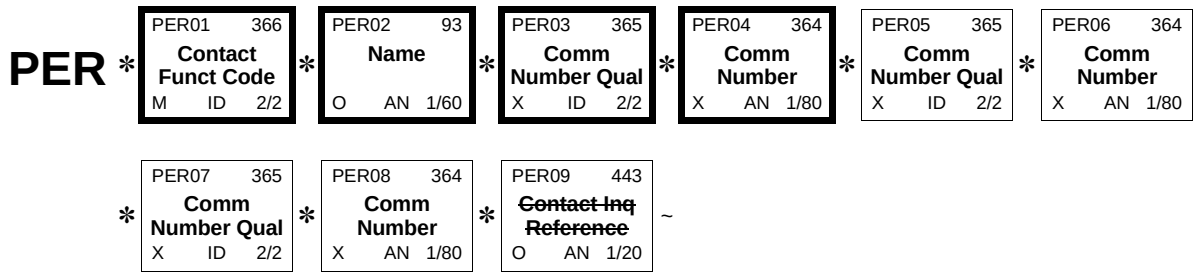
Max Use: 2

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

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

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

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

IMPLEMENTATION

RECEIVER NAME

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

Usage: **REQUIRED**

Repeat: **1**

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

Example: **NM1*40*2*UNION MUTUAL OF OREGON*****46*111222333~**

STANDARD

NM1 Individual or Organizational Name

Level: Header

Position: 020

Loop: 1000 **Repeat:** 10

Requirement: Optional

Max Use: 1

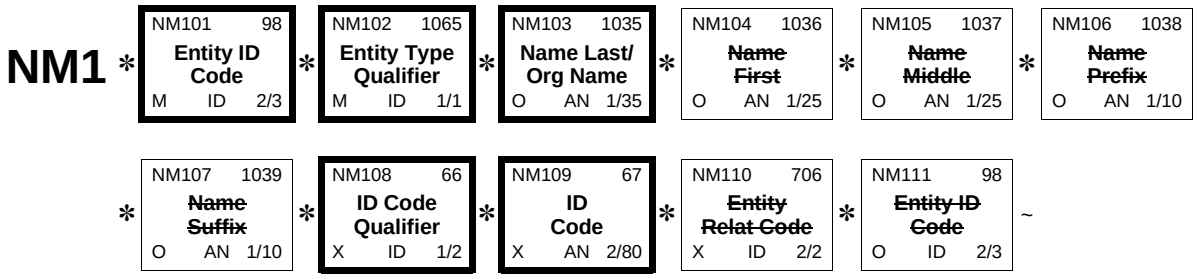
Purpose: To supply the full name of an individual or organizational entity

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

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

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

RECEIVER ADDITIONAL NAME INFORMATION

Loop: **1000B — RECEIVER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2✻ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Header

Position: 025

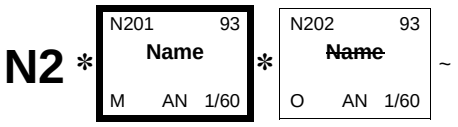
Loop: 1000

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

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

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

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

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

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

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

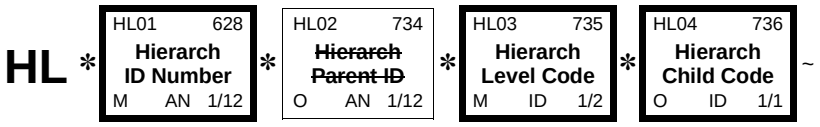
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

Example: **PRV*PT*ZZ*1223S0112Y~**

STANDARD

PRV Provider Information

Level: Detail

Position: 003

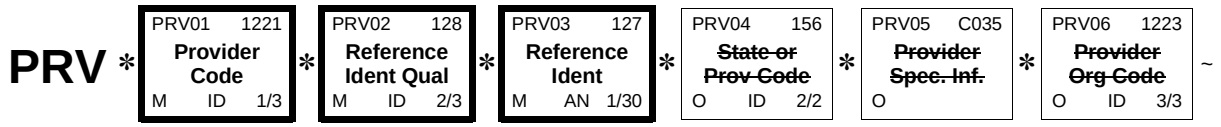
Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

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

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

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

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code*** **NSF Reference:** **BA0-22.0**	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

FOREIGN CURRENCY INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The developers of this implementation guide added the CUR segment to allow billing providers and billing services to submit claims for services provided in foreign countries. The absence of the CUR segment indicates that the claim is submitted in the currency that is normally used by the receiver for processing claims. For example, claims submitted by United States (U.S.) providers to U.S. receivers are assumed to be in U.S. dollars. Claims submitted by Canadian providers to Canadian receivers are assumed to be in Canadian dollars.**

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

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

STANDARD

CUR Currency

Level: Detail

Position: 010

Loop: 2000

Requirement: Optional

Max Use: 1

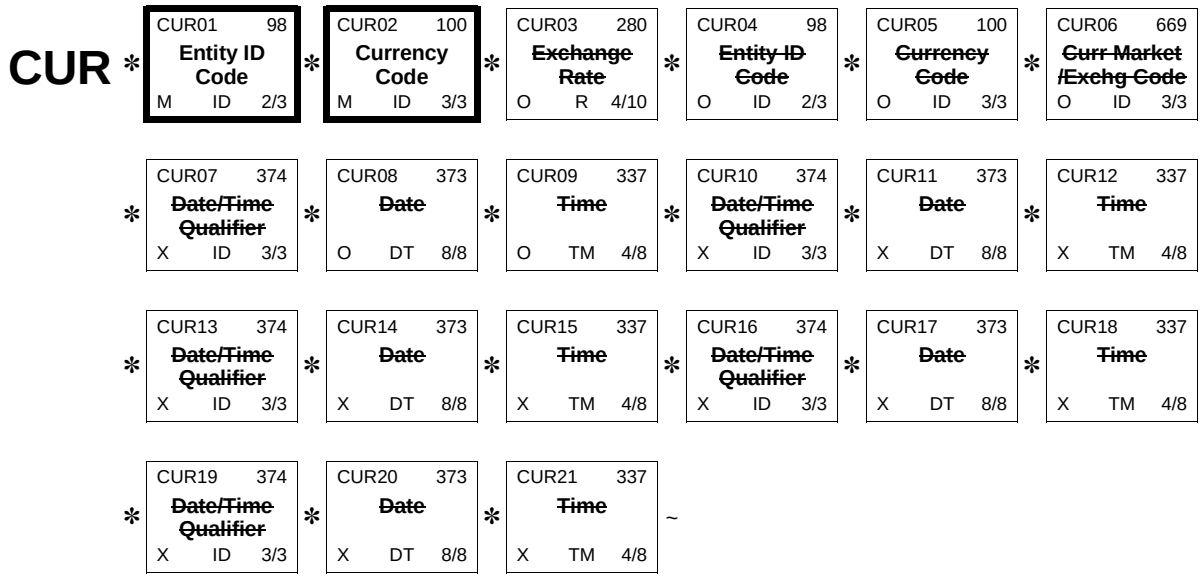
Purpose: To specify the currency (dollars, pounds, francs, etc.) used in a transaction

Syntax:

1. **C0807**
   If CUR08 is present, then CUR07 is required.
2. **C0907**
   If CUR09 is present, then CUR07 is required.
3. **L101112**
   If CUR10 is present, then at least one of CUR11 or CUR12 are required.
4. **C1110**
   If CUR11 is present, then CUR10 is required.
5. **C1210**
   If CUR12 is present, then CUR10 is required.
6. **L131415**
   If CUR13 is present, then at least one of CUR14 or CUR15 are required.
7. **C1413**
   If CUR14 is present, then CUR13 is required.
8. **C1513**
   If CUR15 is present, then CUR13 is required.

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CUR01**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION **85** / **Billing Provider**	**M ID 2/3**
REQUIRED	**CUR02**	**100**	**Currency Code** Code (Standard ISO) for country in whose currency the charges are specified **CODE SOURCE 5:** Countries, Currencies and Funds	**M ID 3/3**
NOT USED	**CUR03**	**280**	**Exchange Rate**	**O R 4/10**
NOT USED	**CUR04**	**98**	**Entity Identifier Code**	**O ID 2/3**
NOT USED	**CUR05**	**100**	**Currency Code**	**O ID 3/3**

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

IMPLEMENTATION

BILLING PROVIDER NAME

Loop: **2010AA — BILLING PROVIDER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

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

Example: **NM1*85*2*DENTAL ASSOCIATES*****34*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

Set Notes:

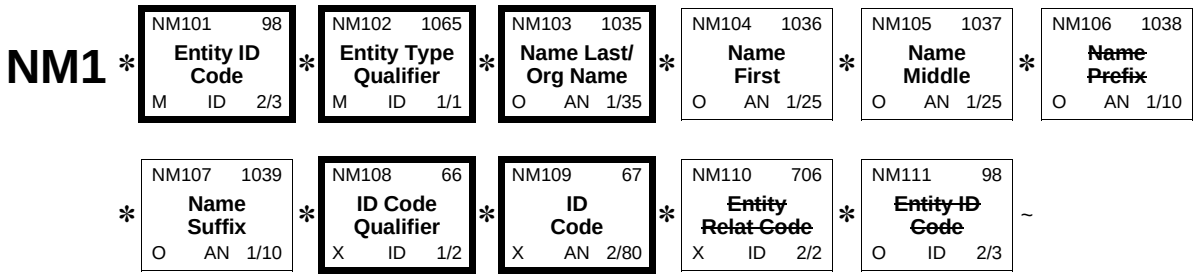
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

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

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Use this code to indicate billing provider, billing submitter and encounter reporting entity.** CODE / DEFINITION **85** — **Billing Provider** **Use this code when the provider is a submitting provider in a capitated environment.**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** — **Person** **2** — **Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Billing Provider Last or Organizational Name*** *ALIAS:* ***Billing Provider Name***	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Billing Provider First Name*** *ALIAS:* ***Billing Provider Name*** **Required if NM102 = 1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Billing Provider Middle Name*** *ALIAS:* ***Billing Provider Name*** **Required if NM102 = 1 and the middle name/initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Billing Provider Name Suffix*** *ALIAS:* ***Billing Provider Name*** **Required if known.**	**O AN 1/10**

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

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

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

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Billing Provider Identifier*** *ALIAS:* ***Billing Provider's Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **BA0-02.0, BA0-06.0, BA0-09.0, BA1-02.0, YA0-02.0, YA0-06.0**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL BILLING PROVIDER NAME INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

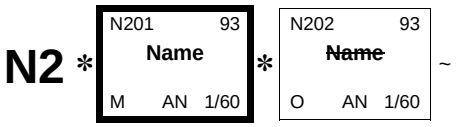
Loop: 2010

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

BILLING PROVIDER ADDRESS

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

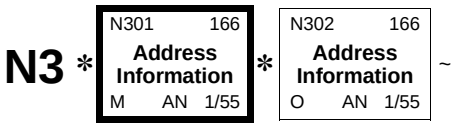
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

BILLING PROVIDER CITY/STATE/ZIP CODE

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

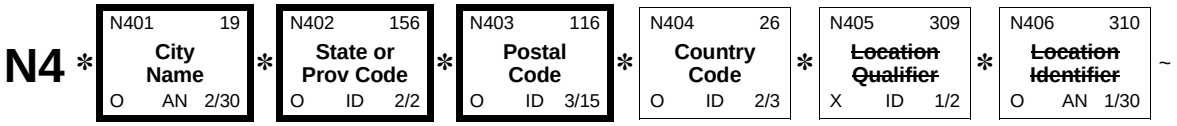
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

BILLING PROVIDER SECONDARY IDENTIFICATION NUMBER

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

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in the NM109.**
2. **If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/NM109 of this loop, then this REF is not used.**
3. **If code "XX - NPI" is used in the NM108/NM109 of this loop, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in this REF.**

Example: **REF*SY*111222333~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

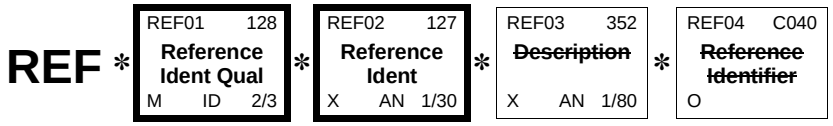
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M ID 2/3
			CODE: 0B — DEFINITION: State License Number	
			1A — Blue Cross Provider Number	
			1B — Blue Shield Provider Number	
			1C — Medicare Provider Number	
			1D — Medicaid Provider Number	
			1E — Dentist License Number	
			1H — CHAMPUS Identification Number	
			EI — Employer's Identification Number	
			G2 — Provider Commercial Number	
			G5 — Provider Site Number	
			LU — Location Number	
			SY — Social Security Number The Social Security Number may not be used for Medicare.	
			TJ — Federal Taxpayer's Identification Number	
REQUIRED	REF02	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Billing Provider Additional Identifier*** *ALIAS:* ***Billing Provider's Secondary Identification Number*** SYNTAX: R0203 **NSF Reference:** **BA0-02.0, BA0-06.0, BA0-08.0, BA0-09.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, CA0-28.0, YA0-06.0**	X AN 1/30
NOT USED	REF03	352	**Description**	X AN 1/80
NOT USED	REF04	C040	**REFERENCE IDENTIFIER**	O

IMPLEMENTATION

CLAIM SUBMITTER CREDIT/DEBIT CARD INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **8**

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

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

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

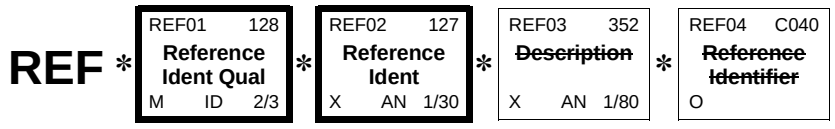
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

IMPLEMENTATION

PAY-TO PROVIDER'S NAME

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

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **If the billing provider and the pay-to provider are the same entity, then it is not necessary to put in the pay-to-provider loop.**
2. **Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**

Example: NM1*87*1*JONES*WILLIAM**XX*0987654321~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

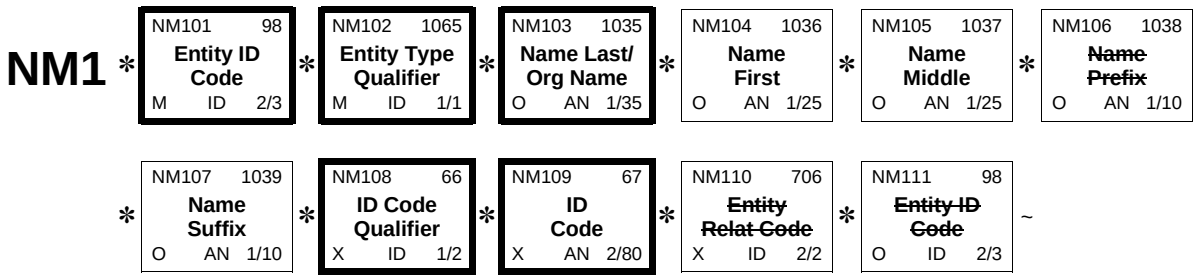
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

NSF Reference:

BA0-21.0

Pay-to Provider Middle Initial

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

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

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

Pay-to Provider Name Suffix

Required if known.

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

SYNTAX: P0809

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

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

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

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

SYNTAX: P0809

NSF Reference:

BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, YA0-06.0

Pay-to Provider's Primary Identification Number

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

IMPLEMENTATION

ADDITIONAL PAY-TO PROVIDER NAME INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

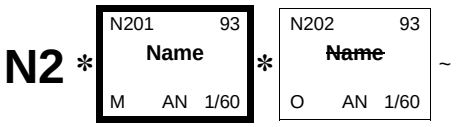
Loop: 2010

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PAY-TO PROVIDER'S ADDRESS

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

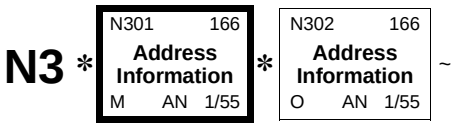
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PAY-TO PROVIDER CITY/STATE/ZIP

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

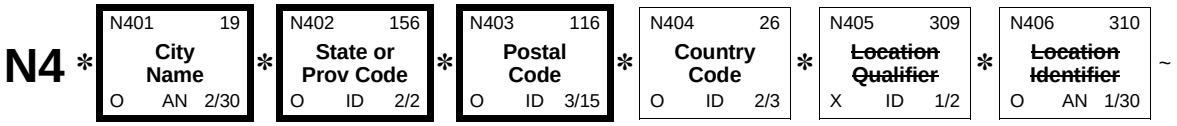
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

PAY-TO PROVIDER SECONDARY IDENTIFICATION NUMBER

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

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in the NM108/109 of this loop.**
2. **If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/NM109 of this loop, then this REF is not used.**
3. **If code" XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in this REF. The number sent is the one which is used in the 1099. If additional numbers are needed in the REF it can be run up to 5 times.**

Example: **REF*SY*111222333~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

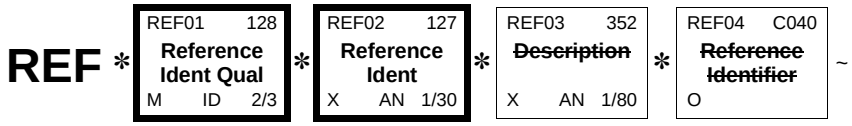
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification	M ID 2/3
			CODE / DEFINITION	
			0B — State License Number	
			1A — Blue Cross Provider Number	
			1B — Blue Shield Provider Number	
			1C — Medicare Provider Number	
			1D — Medicaid Provider Number	
			1E — Dentist License Number	
			1H — CHAMPUS Identification Number	
			EI — Employer's Identification Number	
			G2 — Provider Commercial Number	
			G5 — Provider Site Number	
			LU — Location Number	
			SY — Social Security Number The Social Security Number may not be used for Medicare.	
			TJ — Federal Taxpayer's Identification Number	
REQUIRED	REF02	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Pay-to Provider Identifier*** SYNTAX: R0203 **NSF Reference:** **BA0-02.0, BA0-06.0, BA0-09.0, BA0-10.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, BA0-25.0, BA1-02.0, CA0-28.0, YA0-02.0, YA0-06.0**	X AN 1/30
NOT USED	REF03	352	**Description**	X AN 1/80
NOT USED	REF04	C040	**REFERENCE IDENTIFIER**	O

IMPLEMENTATION

SUBSCRIBER HIERARCHICAL LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

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

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

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

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

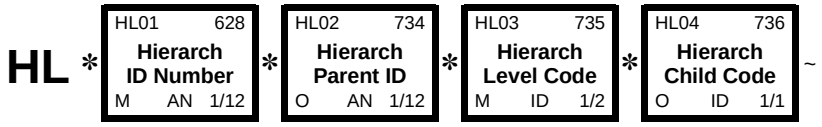
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
22	**Subscriber**

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

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

1	**Additional Subordinate HL Data Segment in This Hierarchical Structure.**

IMPLEMENTATION

SUBSCRIBER INFORMATION

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

Usage: **REQUIRED**

Repeat: **1**

Example: **SBR*P**GRP01020102***6***CI~**

STANDARD

SBR Subscriber Information

Level: Detail

Position: 005

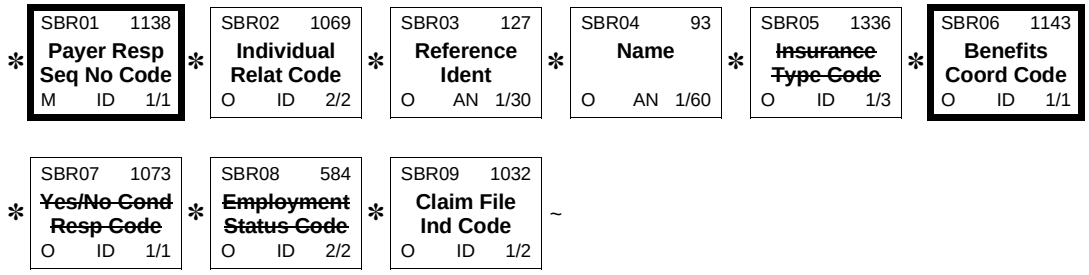
Loop: 2000

Requirement: Optional

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim	**M ID 1/1**

CODE	DEFINITION
P	**Primary** NSF Reference: **DA0-02.0-Pri**
S	**Secondary** NSF Reference: **DA1-02.0-Sec**
T	**Tertiary** **Use to indicate payer of last resort.**

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

SEMANTIC: SBR02 specifies the relationship to the person insured.

NSF Reference:

DA0-17.0

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

CODE	DEFINITION
18	**Self**

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

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

SEMANTIC: SBR03 is policy or group number.

NSF Reference:

DA0-10.0

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

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

INDUSTRY: ***Insured Group Name***

ALIAS: ***Plan Name***

SEMANTIC: SBR04 is plan name.

NSF Reference:

DA0-11.0

Required if the Subscriber's payer identification includes Plan Name.

NOT USED	**SBR05**	**1336**	**Insurance Type Code**	**O**	**ID**	**1/3**
REQUIRED	**SBR06**	**1143**	**Coordination of Benefits Code** Code identifying whether there is a coordination of benefits	**O**	**ID**	**1/1**

CODE	DEFINITION
1	**Coordination of Benefits**
6	**No Coordination of Benefits**

NOT USED	**SBR07**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SBR08**	**584**	**Employment Status Code**	**O**	**ID**	**2/2**

SITUATIONAL **SBR09** **1032** **Claim Filing Indicator Code** **O** **ID** **1/2**
Code identifying type of claim

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

CODE	DEFINITION
09	**Self-pay** NSF Reference: **DA0-05.0 (A)**
11	**Other Non-Federal Programs** **Should be used to indicate that the subscriber is enrolled in a state program.**
12	**Preferred Provider Organization (PPO)**
13	**Point of Service (POS)**
14	**Exclusive Provider Organization (EPO)**
15	**Indemnity Insurance**
16	**Health Maintenance Organization (HMO) Medicare Risk**
17	**Dental Maintenance Organization**
BL	**Blue Cross/Blue Shield** NSF Reference: **CA0-23.0 (G), DA0-05.0 (G), CA0-23.0 (P), DA0-05.0 (P)**
CH	**Champus** NSF Reference: **CA0-23.0 (H), DAO-05.0 (H)**
CI	**Commercial Insurance Co.** NSF Reference: **CA0-23.0 (F), DA0-05.0 (F)**
DS	**Disability**
FI	**Federal Employees Program** NSF Reference: **CA0-23.0 (J), DA0-05.0 (J)**
HM	**Health Maintenance Organization** NSF Reference: **CA0-23.0 (I), DA0-05.0 (I)**
LM	**Liability Medical**
MB	**Medicare Part B** NSF Reference: **CA0-23.0 (C), DA0-05.0 (C)**

MC	**Medicaid** NSF Reference: **CA0-23.0 (D), DA0-05.0 (D)**
MH	**Managed Care Non-HMO** NSF Reference: **DA0-05.0 (N)**
OF	**Other Federal Program** NSF Reference: **CA0-23.0 (E), DA0-05.0 (E)**
SA	**Self-administered Group** NSF Reference: **CA0-23.0 (E), DA0-05.0 (E)**
VA	**Veteran Administration Plan** **Refers to Veteran's Affairs Plan.** NSF Reference: **DA0-05.0 (V)**
WC	**Workers' Compensation Health Claim** NSF Reference: **CA0-23.0(B), DA0-05.0 (B)**
ZZ	**Mutually Defined** **Unknown** NSF Reference: **CA0-23.0 (Z), DA0-05.0 (Z)**

IMPLEMENTATION

SUBSCRIBER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

Example: **NM1*IL*1*DOE*JOHN*T**JR*MI*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

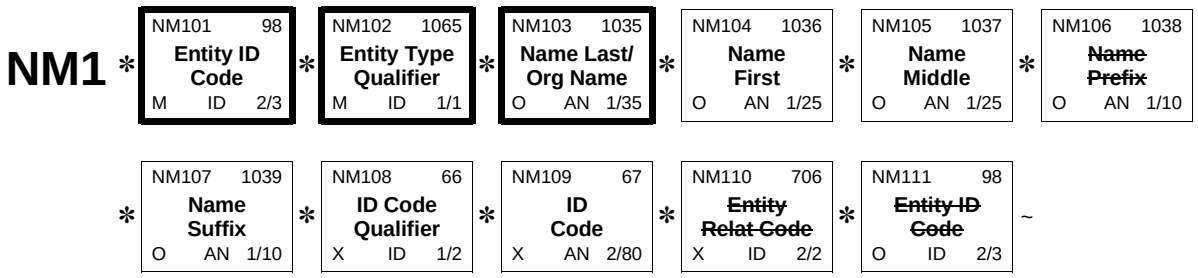
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

INDUSTRY: ***Subscriber Name Suffix***

ALIAS: ***Subscriber's Generation***

NSF Reference:

CA0-07.0, DA0-22.0

Examples: I, II, III, IV, Jr, Sr

Required if known.

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

SYNTAX: P0809

Required if NM102 = 1 (person).

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

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

IMPLEMENTATION

ADDITIONAL SUBSCRIBER NAME INFORMATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

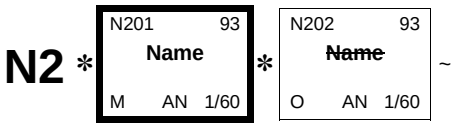
Loop: 2010

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

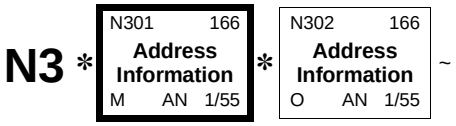
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

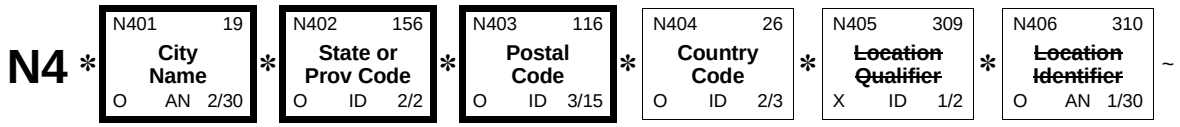
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **DMG*D8*19491117*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 032

Loop: 2010

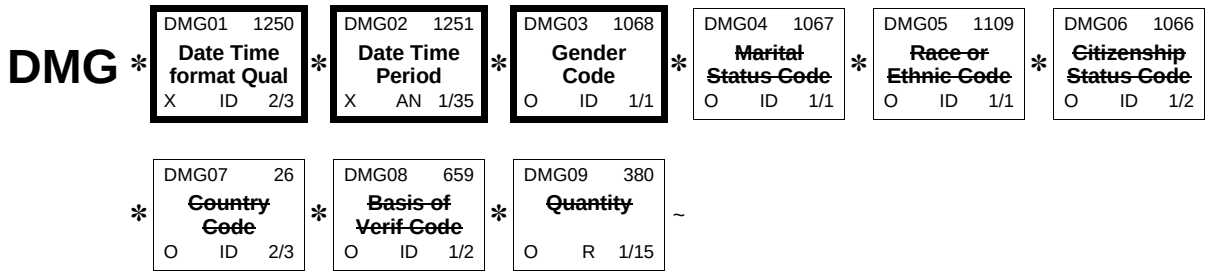
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

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

DIAGRAM



ELEMENT SUMMARY

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

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

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Subscriber Birth Date*** *ALIAS:* ***Date of Birth - Patient*** **SYNTAX:** P0102 **SEMANTIC:** DMG02 is the date of birth. **NSF Reference:** **CA0-08.0, DA0-24.0**	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Subscriber Gender Code*** *ALIAS:* ***Gender - Patient*** **NSF Reference:** **CA0-09.0, DA0-23.0**	**O**	**ID**	**1/1**

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

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

IMPLEMENTATION

SUBSCRIBER SECONDARY IDENTIFICATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **4**

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

Example: **REF*1W*98765~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

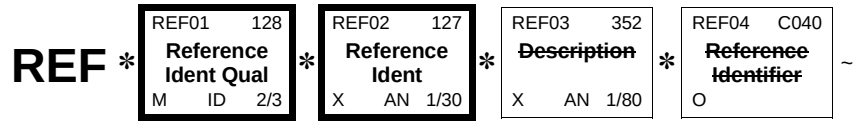
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number** **May not be used when NM108 of this loop has a value of MI.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Service (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**
IG	**Insurance Policy Number**

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

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

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

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

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

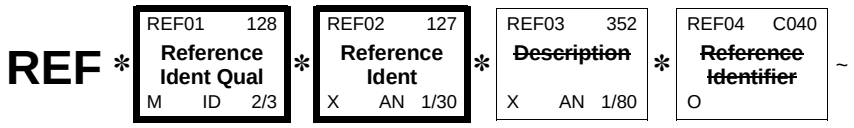
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
Y4	**Agency Claim Number**

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

IMPLEMENTATION

PAYER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

Example: **NM1*PR*2*Union Mutual of Oregon****PI*123123123~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

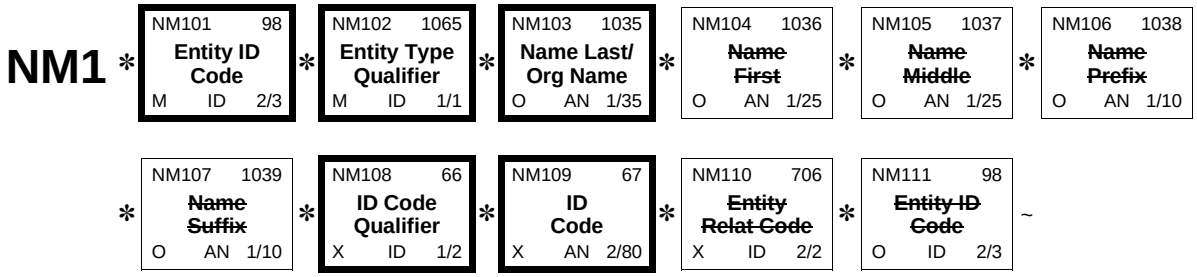
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

ADDITIONAL PAYER NAME INFORMATION

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

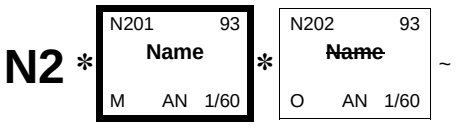
Loop: 2010

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PAYER ADDRESS

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

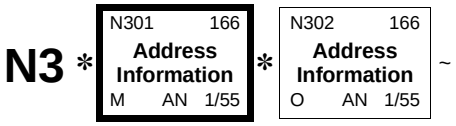
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PAYER CITY/STATE/ZIP CODE

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

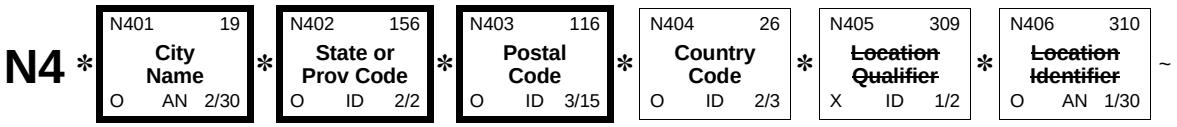
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

PAYER SECONDARY IDENTIFICATION NUMBER

Loop: **2010BB — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

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

Example: **REF*2U*435261708~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

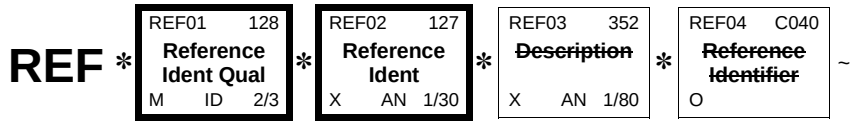
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
2U	**Payer Identification Number** **This code can be used to identify any payer's identification number (the payer can be Medicaid, A commercial payer, TPA, etc.). Whatever number is used has been defined between trading partners.**
FY	**Claim Office Number**

			NF	**National Association of Insurance Commissioners (NAIC) Code**			
				CODE SOURCE **245:** National Association of Insurance Commissioners (NAIC) Code			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Payer Additional Identifier*** SYNTAX: R0203 **NSF Reference:** **DA0-08.0**		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

CREDIT/DEBIT CARD HOLDER NAME

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

Usage: SITUATIONAL

Repeat: 1

Notes:

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

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

Example: NM1*AO*1*SMITH*JANE*L*MI*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

Set Notes:

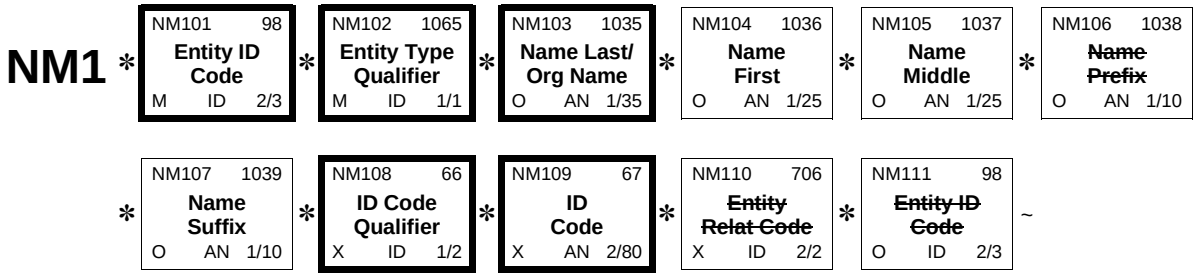
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

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

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

DIAGRAM



ELEMENT SUMMARY

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

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

CODE	DEFINITION
MI	**Member Identification Number**

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

IMPLEMENTATION

ADDITIONAL CREDIT/DEBIT CARD HOLDER NAME INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

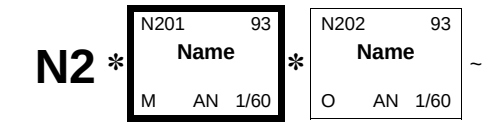
Loop: 2010

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N201**	**93**	**Name** Free-form name	**M**	**AN**	**1/60**
			INDUSTRY: ***Credit or Debit Card Holder Additional Name***			
SITUATIONAL	**N202**	**93**	**Name** Free-form name	**O**	**AN**	**1/60**
			INDUSTRY: ***Credit or Debit Card Holder Additional Name***			
			Required if more than 60 characters are utilized in the Additional Name Segment.			

IMPLEMENTATION

CREDIT/DEBIT CARD INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **3**

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

Example: **REF*BB*11122233334~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

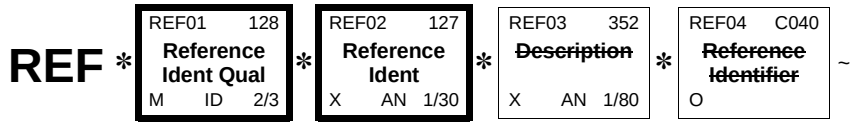
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

PATIENT HIERARCHICAL LEVEL

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This HL is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL.**
2. **Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**
3. **Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the numer of Patient Hierarchical Level loops, there is an implied maximum of 5000.**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

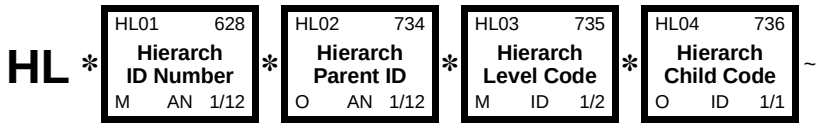
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HL01**	**628**	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be “1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M AN 1/12**
REQUIRED	**HL02**	**734**	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	**O AN 1/12**
REQUIRED	**HL03**	**735**	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information. **The code DEPENDENT is meant to convey that the information in this HL applies to the patient when the subscriber and the patient are not the same person.** CODE — DEFINITION **23 — Dependent**	**M ID 1/2**
REQUIRED	**HL04**	**736**	**Hierarchical Child Code** Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. CODE — DEFINITION **0 — No Subordinate HL Segment in This Hierarchical Structure.**	**O ID 1/1**

IMPLEMENTATION

PATIENT INFORMATION

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

Usage: **REQUIRED**

Repeat: **1**

Example: **PAT*01~**

STANDARD

PAT Patient Information

Level: Detail

Position: 007

Loop: 2000

Requirement: Optional

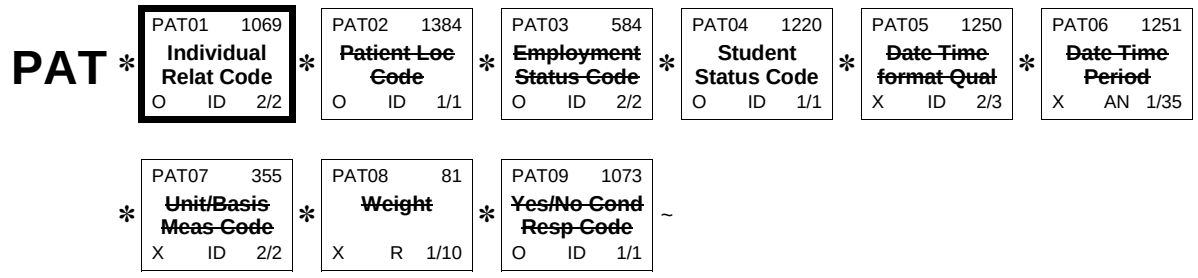
Max Use: 1

Purpose: To supply patient information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
01	**Spouse**
19	**Child**

			20	**Employee**			
			22	**Handicapped Dependent**			
			29	**Significant Other**			
			41	**Injured Plaintiff** **This code value should be used for Property and Casualty claims.**			
			53	**Life Partner**			
			76	**Dependent**			
NOT USED	**PAT02**	**1384**	**Patient Location Code**		**O**	**ID**	**1/1**
NOT USED	**PAT03**	**584**	**Employment Status Code**		**O**	**ID**	**2/2**
SITUATIONAL	**PAT04**	**1220**	**Student Status Code** Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured		**O**	**ID**	**1/1**
			Required to indicate the student status of the patient if 19 years of age or older.				
			CODE	DEFINITION			
			F	**Full-time**			
			N	**Not a Student**			
			P	**Part-time**			
NOT USED	**PAT05**	**1250**	**Date Time Period Format Qualifier**		**X**	**ID**	**2/3**
NOT USED	**PAT06**	**1251**	**Date Time Period**		**X**	**AN**	**1/35**
NOT USED	**PAT07**	**355**	**Unit or Basis for Measurement Code**		**X**	**ID**	**2/2**
NOT USED	**PAT08**	**81**	**Weight**		**X**	**R**	**1/10**
NOT USED	**PAT09**	**1073**	**Yes/No Condition or Response Code**		**O**	**ID**	**1/1**

IMPLEMENTATION

PATIENT NAME

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

Usage: **REQUIRED**

Repeat: **1**

Example: **NM1*QC*1*DOE*SALLY~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

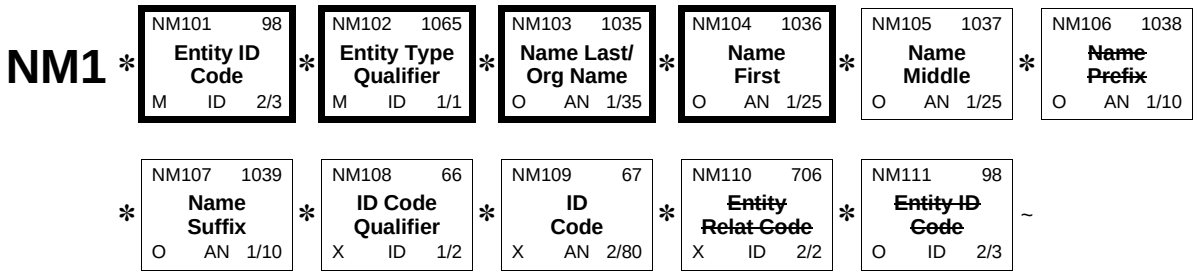
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
QC	**Patient**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M**	**ID**	**1/1**

CODE	DEFINITION
1	**Person**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Patient Last Name*** ***ALIAS:*** ***Patient's Last Name*** **NSF Reference:** **CA0-04.0**	**O**	**AN**	**1/35**
REQUIRED	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Patient First Name*** ***ALIAS:*** ***Patient's First Name*** **NSF Reference:** **CA0-05.0**	**O**	**AN**	**1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:*** ***Patient Middle Name*** ***ALIAS:*** ***Patient's Middle Initial*** **NSF Reference:** **CA0-06.0** **Required if NM102 = 1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name ***INDUSTRY:*** ***Patient Name Suffix*** ***ALIAS:*** ***Patient's Generation*** **NSF Reference:** **CA0-07.0** **Required if known.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **Required if the patient identifier is different than the subscriber identifier.**	**X**	**ID**	**1/2**

CODE	DEFINITION
MI	**Member Identification Number**

			ZZ **Mutually Defined** **The value "ZZ", when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Patient Primary Identifier*** *ALIAS:* ***Patient's Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **DA0-18.0** **Required if the patient identifier is different than the subscriber identifier.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL NAME INFORMATION

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 020

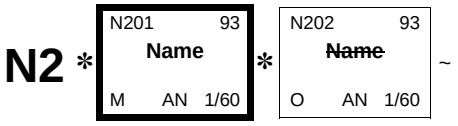
Loop: 2010

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PATIENT ADDRESS

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

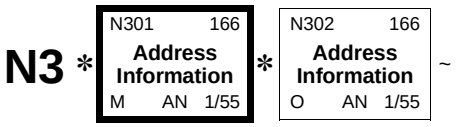
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PATIENT CITY/STATE/ZIP CODE

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

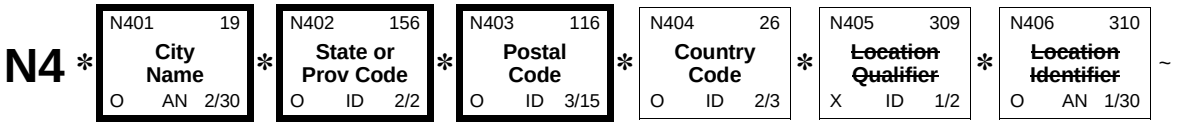
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

PATIENT DEMOGRAPHIC INFORMATION

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

DMG Demographic Information

Level: Detail

Position: 032

Loop: 2010

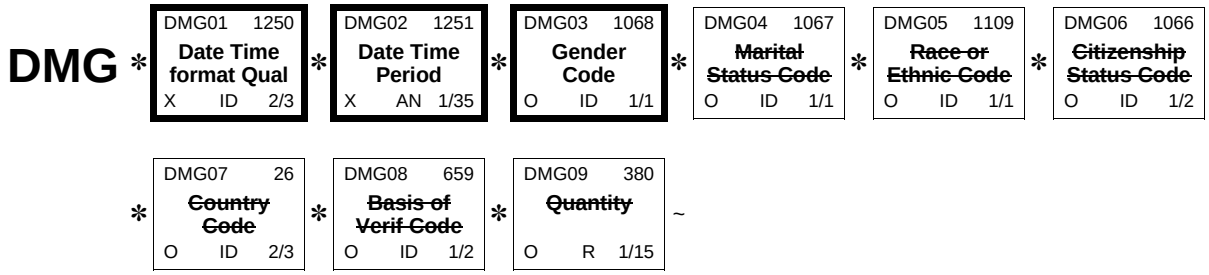
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

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

IMPLEMENTATION

PATIENT SECONDARY IDENTIFICATION

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **5**

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

Example: **REF*1W*98765~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

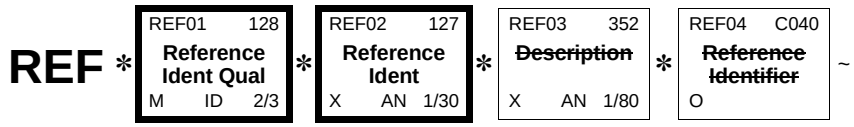
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number**
23	**Client Number**
IG	**Insurance Policy Number**
SY	**Social Security Number** **The Social Security Number may not be used for Medicare.**

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

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

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

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

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

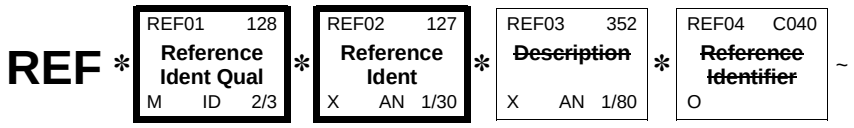
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
Y4	**Agency Claim Number**

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

IMPLEMENTATION

CLAIM INFORMATION

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

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

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

Example: **CLM*013193000001*500***11::1*Y*A*Y*Y~**

STANDARD

CLM Health Claim

Level: Detail

Position: 130

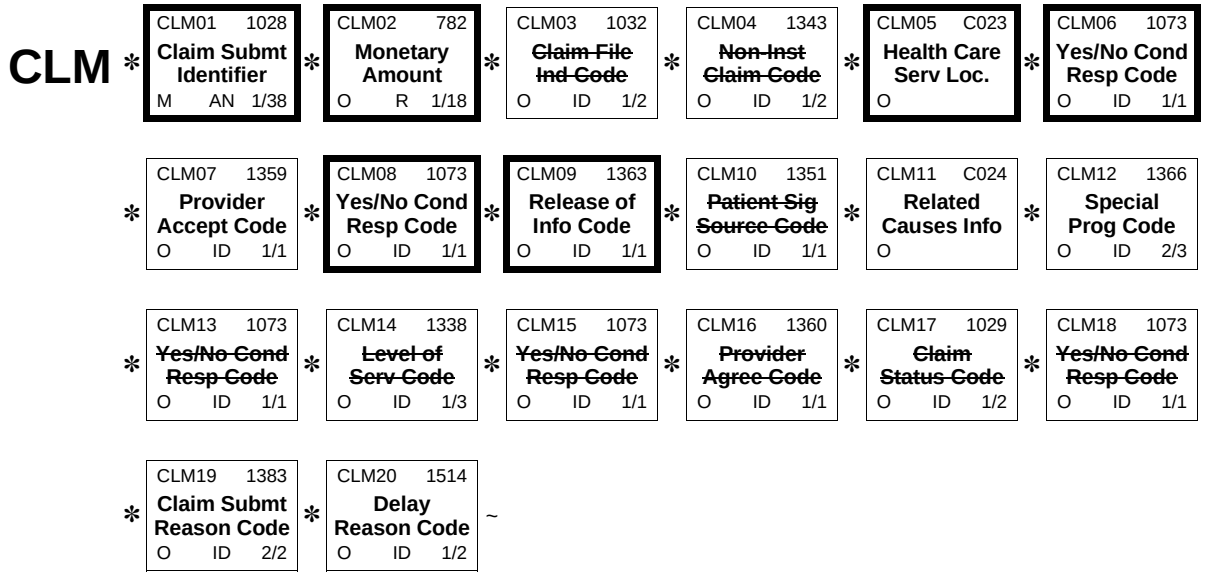
Loop: 2300 **Repeat:** 100

Requirement: Optional

Max Use: 1

Purpose: To specify basic data about the claim

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CLM01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment *INDUSTRY:* ***Patient Account Number*** **NSF Reference:** **CA0-03.0, CB0-03.0, DA0-03.0, DA1-03.0, DA2-03.0, EA0-03.0, EA1-03.0, EA2-03.0, FA0-03.0, FB0-03.0, FB1-03.0, FB2-03.0, FD0-03.0, FE0-03.0, GA0-03.0, GC0-03.0, GD0-03.0, GD1-03.0, GE0-03.0, GP0-03.0, GX0-03.0, GX2-03.0, XA0-03.0** **The number that the submitter transmits in this position is echoed back to the submitter in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim.** **The maximum number of characters to be supported for this field is '20'. A provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond '20' are not required to be stored nor returned by any 837 receiving system.**	**M AN 1/38**

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

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

ALIAS: ***Total Claim Charges***

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

NSF Reference:

XA0-12.0

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

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

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

NSF Reference:

FA0-07.0

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

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

INDUSTRY: ***Facility Type Code***

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

- **11 Office**
- **12 Home**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **31 Skilled Nursing Facility**
- **35 Adult Living Care Facility**

NOT USED	**CLM05 - 2**	**1332**	**Facility Code Qualifier**	**O**	**ID**	**1/2**
REQUIRED	**CLM05 - 3**	**1325**	**Claim Frequency Type Code** Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type	**O**	**ID**	**1/1**

INDUSTRY: ***Claim Submission Reason Code***

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

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

Permissible code values for this subelement:

1 - ORIGINAL (Admit thru Discharge Claim)

6 - CORRECTED (Adjustment of Prior Claim)

7 - REPLACEMENT (Replacement of Prior Claim)

8 - VOID (Void/Cancel of Prior Claim)

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

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

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

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

NSF Reference:

EA0-35.0

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

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

INDUSTRY: ***Medicare Assignment Code***

NSF Reference:

EA0-34.0, FA0-59.0

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

Required for Medicare claims only.

CODE	DEFINITION
A	**Assigned**
C	**Not Assigned**
P	**Patient Refuses to Assign Benefits**

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

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

ALIAS: ***Assignment of Benefits Code***

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

NSF Reference:

DA0-15.0

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

REQUIRED **CLM09** **1363** **Release of Information Code** **O** **ID** **1/1**
Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations

NSF Reference:

EA0-13.0

CODE	DEFINITION
N	**No, Provider is Not Allowed to Release Data**
Y	**Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim**

NOT USED **CLM10** **1351** **Patient Signature Source Code** **O** **ID** **1/1**

SITUATIONAL **CLM11** **C024** **RELATED CAUSES INFORMATION** **O**
To identify one or more related causes and associated state or country information

CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related.

If DTP - Date of Accident (DTP01 = 439) is used, then CLM11 is required.

REQUIRED **CLM11 - 1** **1362** **Related-Causes Code** **M** **ID** **2/3**
Code identifying an accompanying cause of an illness, injury or an accident

INDUSTRY: ***Related Causes Code***

NSF Reference:

EA0-05.0, EA0-04.0

CODE	DEFINITION
AA	**Auto Accident** NSF Reference: **EA0-05.0**
EM	**Employment** NSF Reference: **EA0-04.0**

			OA	**Other Accident** NSF Reference: **EA0-05.0**			
SITUATIONAL	**CLM11 - 2**	**1362**	**Related-Causes Code** Code identifying an accompanying cause of an illness, injury or an accident *INDUSTRY:* ***Related Causes Code*** **NSF Reference:** **EA0-05.0, EA0-04.0** **Used if more than one code applies.**	**O**	**ID**	**2/3**	
			CODE	**DEFINITION**			
			AA	**Auto Accident**			
			EM	**Employment**			
			OA	**Other Accident**			
SITUATIONAL	**CLM11 - 3**	**1362**	**Related-Causes Code** Code identifying an accompanying cause of an illness, injury or an accident *INDUSTRY:* ***Related Causes Code*** **NSF Reference:** **EA0-05.0, EA0-04.0** **Used if more than one code applies.**	**O**	**ID**	**2/3**	
			CODE	**DEFINITION**			
			AA	**Auto Accident**			
			EM	**Employment**			
			OA	**Other Accident**			
SITUATIONAL	**CLM11 - 4**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Auto Accident State or Province Code*** *ALIAS:* ***Accident State*** **CODE SOURCE 22:** States and Outlying Areas of the U.S. **NSF Reference:** **EA0-10.0** **Required if CLM11-1, CLM11-2 or CLM11-3 has a value of "AA".**	**O**	**ID**	**2/2**	
SITUATIONAL	**CLM11 - 5**	**26**	**Country Code** Code identifying the country **CODE SOURCE 5:** Countries, Currencies and Funds **Required if the automobile accident occurred out of the U.S. to identify the country in which the accident occurred.**	**O**	**ID**	**2/3**	

SITUATIONAL	**CLM12**	**1366**	**Special Program Code** Code indicating the Special Program under which the services rendered to the patient were performed	**O**	**ID**	**2/3**

INDUSTRY: ***Special Program Indicator***

NSF Reference:

EA0-43.0

Required if the services were rendered under one of the following circumstances/programs/projects.

CODE	DEFINITION
01	**Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)**
02	**Physically Handicapped Children's Program**
03	**Special Federal Funding**
05	**Disability**

NOT USED	**CLM13**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM14**	**1338**	**Level of Service Code**	**O**	**ID**	**1/3**
NOT USED	**CLM15**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**CLM16**	**1360**	**Provider Agreement Code**	**O**	**ID**	**1/1**
NOT USED	**CLM17**	**1029**	**Claim Status Code**	**O**	**ID**	**1/2**
NOT USED	**CLM18**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
SITUATIONAL	**CLM19**	**1383**	**Claim Submission Reason Code** Code identifying reason for claim submission	**O**	**ID**	**2/2**

ALIAS: ***Predetermination of Benefits Code***

CLM19 is required if the entire claim is being submitted for Predetermination of Benefits.

CODE	DEFINITION
PB	**Predetermination of Dental Benefits**

SITUATIONAL	**CLM20**	**1514**	**Delay Reason Code** Code indicating the reason why a request was delayed	**O**	**ID**	**1/2**

This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed.

Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.

CODE	DEFINITION
1	**Proof of Eligibility Unknown or Unavailable**
2	**Litigation**
3	**Authorization Delays**
4	**Delay in Certifying Provider**

5	Delay in Supplying Billing Forms
6	Delay in Delivery of Custom-made Appliances
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

IMPLEMENTATION

DATE - ADMISSION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required on inpatient visit claims.**

Example: **DTP*435*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

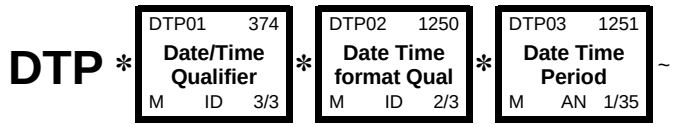
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **435 — Admission**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Related Hospitalization Admission Date*** **NSF Reference:** **EA0-26.0**	**M AN 1/35**

IMPLEMENTATION

DATE - DISCHARGE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required for inpatient claims when the patient was discharged from the facility and the discharge date is known.**

Example: **DTP*096*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

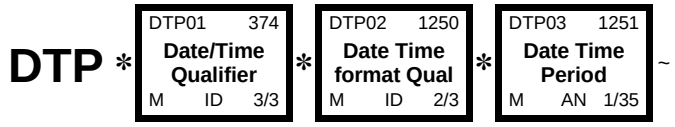
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **096 Discharge**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Discharge or End Of Care Date***

NSF Reference:

EA0-27.0

IMPLEMENTATION

DATE - REFERRAL

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when claim includes a referral.**

Example: **DTP*330*D8*19980617~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

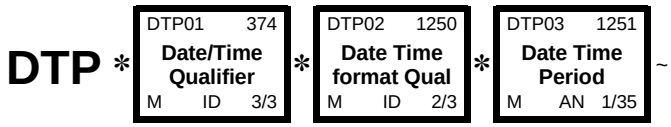
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier***	**M ID 3/3**
			CODE **DEFINITION** **330** **Referral Date**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** **DEFINITION** **D8** **Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Referral Date***	**M AN 1/35**

IMPLEMENTATION

DATE - ACCIDENT

Loop: 2300 — CLAIM INFORMATION

Usage: SITUATIONAL

Repeat: 1

Notes: 1. Required if CLM11-1, CLM11-2 or CLM11-3 = AA, EM or OA.

Example: DTP*439*D8*19980108~

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

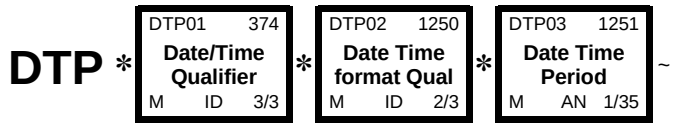
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE: 439 — DEFINITION: Accident	M ID 3/3
REQUIRED	DTP02	1250	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE: D8 — DEFINITION: Date Expressed in Format CCYYMMDD	M ID 2/3
REQUIRED	DTP03	1251	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Accident Date*** **NSF Reference:** EA0-07.0	M AN 1/35

IMPLEMENTATION

DATE - APPLIANCE PLACEMENT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required to report the date orthodontic appliances were placed.**

Example: **DTP*452*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

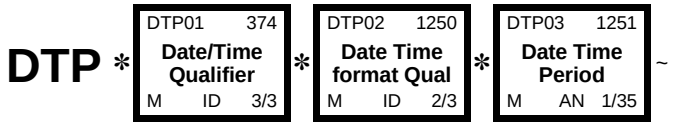
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **452 — Appliance Placement**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Orthodontic Banding Date***

NSF Reference:

FD0-19.0

IMPLEMENTATION

DATE - SERVICE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.**

2. **Required if all of the services on the claim/encounter were performed. This DTP should not be used if the claim is being submitted for Predetermination of Benefits.**

Example: **DTP*472*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

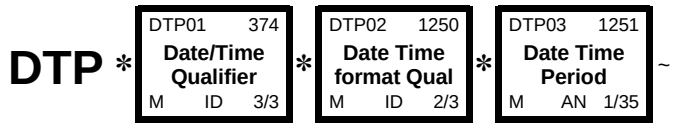
Loop: 2300

Requirement: Optional

Max Use: 150

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **CODE** / **DEFINITION** **472** — **Service**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **CODE** / **DEFINITION** **D8** — **Date Expressed in Format CCYYMMDD**	**M ID 2/3**

			RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**			
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Service Date***		**M**	**AN**	**1/35**

IMPLEMENTATION

ORTHODONTIC TOTAL MONTHS OF TREATMENT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This segment is required to report the total months of orthodontic treatment (DN101), the treatment months remaining for a transfer patient (DN102) or the indication that services on the claim were performed for orthodontic purposes (DN103).**

2. **DN101, DN102 or DN103 must be present if reporting this segment.**

Example: **DN1*36*27~**

STANDARD

DN1 Orthodontic Information

Level: Detail

Position: 145

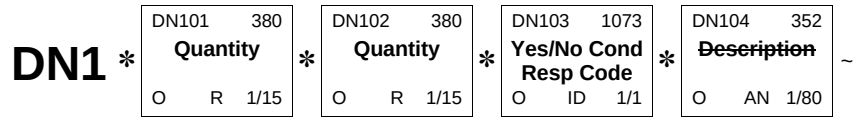
Loop: 2300

Requirement: Optional

Max Use: 1

Purpose: To supply orthodontic information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**DN101**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Orthodontic Treatment Months Count*** *ALIAS:* ***Orthodontic Total Months of Treatment*** SEMANTIC: DN101 is the estimated number of treatment months. **NSF Reference:** **FD0-18.0** **This data element should be used to report the total months of orthodontic treatment.**	**O R 1/15**

SITUATIONAL	**DN102**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Orthodontic Treatment Months Remaining Count***

ALIAS: ***Orthodontic Treatment Months Remaining***

SEMANTIC: DN102 is the number of treatment months remaining.

NSF Reference:

FD0-23.0

This data element should be used to report the treatment months remaining for a transfer patient.

SITUATIONAL	**DN103**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

INDUSTRY: ***Question Response***

SEMANTIC: DN103 is the extra oral traction device indicator. A “Y” value indicates an extra oral traction device; an “N” value indicates no extra oral traction device.

Required to indicate that services reported on the claim are for orthodontic purposes when the DN101 and DN102 are not used.

CODE	DEFINITION
Y	**Yes**

NOT USED	**DN104**	**352**	**Description**	**O**	**AN**	**1/80**

IMPLEMENTATION

TOOTH STATUS

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **35**

Notes: **1. This DN2 segment is used to report a tooth status.**

Example: **DN2*8*E~**

STANDARD

DN2 Tooth Summary

Level: Detail

Position: 150

Loop: 2300

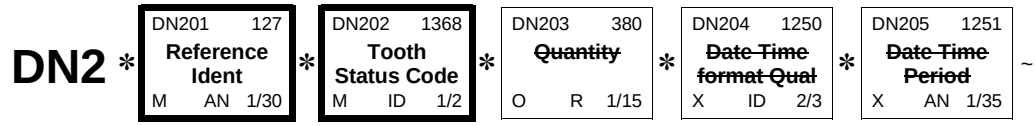
Requirement: Optional

Max Use: 35

Purpose: To specify the status of individual teeth

Syntax: **1. P0405**
If either DN204 or DN205 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DN201**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Tooth Number*** **SEMANTIC:** DN201 is the tooth number. **The National Standard Tooth Numbering System should be used to identify tooth numbers for this data element. See Code Source 135: American Dental Association.**	**M AN 1/30**
REQUIRED	**DN202**	**1368**	**Tooth Status Code** Code specifying the status of the tooth	**M ID 1/2**

CODE	DEFINITION
E	**To Be Extracted**
I	**Impacted**
M	**Missing**

NOT USED	DN203	380	Quantity	O	R	1/15
NOT USED	DN204	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	DN205	1251	Date Time Period	X	AN	1/35

IMPLEMENTATION

CLAIM SUPPLEMENTAL INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **The PWK segment is required if the provider will be sending paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope.**

2. **The PWK segment is required to identify attachments that are sent electronically (PWK02 = EL) but are transmittted in another functional group (e.g., 275) rather than by paper. PWK06 is used to identify the attached electronic documentation. The number in PWK06 would be carried in the TRN of the electronic attachment.**

3. **The PWK can be used to identify paperwork that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but that is not being sent with the claim. Use code AA in PWK02 to convey this specific use of the PWK segment. See code note under PWK02, code AA.**

Example: **PWK*DA*BM***AC*DMN0012~**

STANDARD

PWK Paperwork

Level: Detail

Position: 155

Loop: 2300

Requirement: Optional

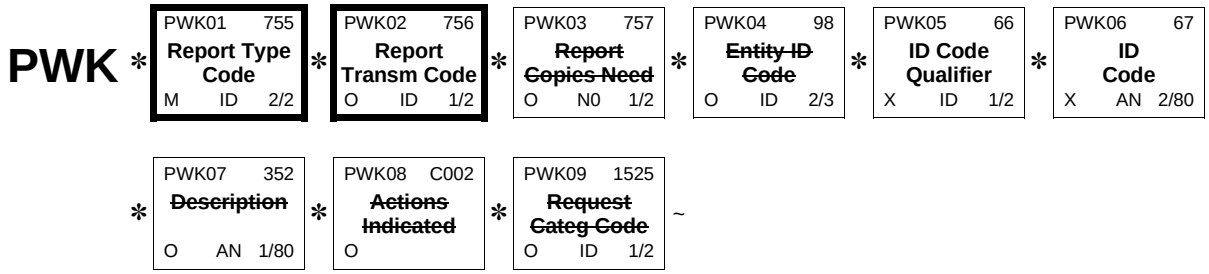
Max Use: 10

Purpose: To identify the type or transmission or both of paperwork or supporting information

Syntax:

1. **P0506**
   If either PWK05 or PWK06 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PWK01	755	**Report Type Code** Code indicating the title or contents of a document, report or supporting item *INDUSTRY:* ***Attachment Report Type Code***	M ID 2/2

NSF Reference:

EA0-41.0

CODE	DEFINITION
B4	Referral Form
DA	Dental Models
DG	Diagnostic Report
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
OB	Operative Note
OZ	Support Data for Claim
P6	Periodontal Charts
RB	Radiology Films
RR	Radiology Reports

REQUIRED	PWK02	756	**Report Transmission Code** Code defining timing, transmission method or format by which reports are to be sent *INDUSTRY:* ***Attachment Transmission Code***	O ID 1/2

NSF Reference:

EA0-40.0

CODE	DEFINITION
AA	Available on Request at Provider Site Paperwork is available on request at the provider's site. This means the paperwork is not being sent with the claim at this time. Rather, it is available to the payer (or appropriate entity) at their request.
BM	By Mail
EL	Electronically Only
EM	E-Mail
FX	By Fax

NOT USED	PWK03	757	**Report Copies Needed**	O N0 1/2
NOT USED	PWK04	98	**Entity Identifier Code**	O ID 2/3

SITUATIONAL	**PWK05**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0506 ADVISORY: Under most circumstances, this element is expected to be sent. COMMENT: PWK05 and PWK06 may be used to identify the addressee by a code number. **Required if PWK02 = EM, EL, BM or FX.**	**X**	**ID**	**1/2**
			CODE / DEFINITION **AC** **Attachment Control Number**			
SITUATIONAL	**PWK06**	**67**	**Identification Code** Code identifying a party or other code INDUSTRY: ***Attachment Control Number*** SYNTAX: P0506 ADVISORY: Under most circumstances, this element is expected to be sent. **The developers of this implementation guide recommend that the sender identify the attachment with a unique attachment control number so that the recipient can match the attachment to the claim.** **Required if PWK02 = EM, EL BM, or FX.**	**X**	**AN**	**2/80**
NOT USED	**PWK07**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**PWK08**	**C002**	**ACTIONS INDICATED**	**O**		
NOT USED	**PWK09**	**1525**	**Request Category Code**	**O**	**ID**	**1/2**

IMPLEMENTATION

PATIENT AMOUNT PAID

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the patient has paid any amount toward the claim.**
2. **Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative.**
3. **The Patient amount Paid indicated in this segment applies to the entire claim. It is recommended that the Patient Amount Paid AMT segment be used at either the line or claim level but not at both.**

Example: **AMT*F5*8.5~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

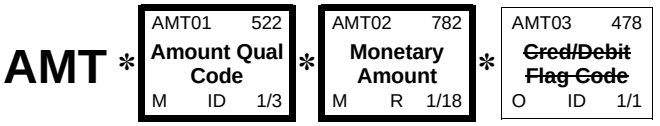
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **F5 — Patient Amount Paid**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Patient Amount Paid*** **NSF Reference:** **XA0-19.0**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

CREDIT/DEBIT CARD - MAXIMUM AMOUNT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Use this segment only for claims that contain credit/debit card information. This segment indicated the maximum amount that can be credited to the account indicated in the 2010BC - Credit/Debit Card Holder Name.**

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

Example: **AMT*MA*500~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

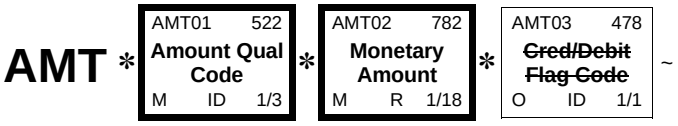
Loop: 2300

Requirement: Optional

Max Use: 40

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			MA — Maximum Amount			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Credit or Debit Card Maximum Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PREDETERMINATION IDENTIFICATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:
1. **Reference numbers at this position apply to the entire claim.**
2. **This REF segment is used to send the Predetermination of Benefits Identification Number for a claim that has been previously predetermined and is now being submitted for payment.**

Example: **REF*G3*13579~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

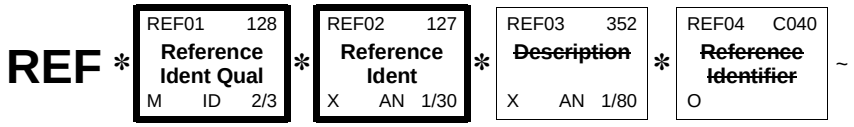
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
G3	**Predetermination of Benefits Identification Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Predetermination of Benefits Identifier*** SYNTAX: R0203 **NSF Reference:** **FD0-26.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

SERVICE AUTHORIZATION EXCEPTION CODE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used only in claims where providers are required by state law (e.g., New York State Medicaid) to obtain authorization for specific services but, for the reasons listed in REF02, performed the services without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.**

Example: **REF*4N*1~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

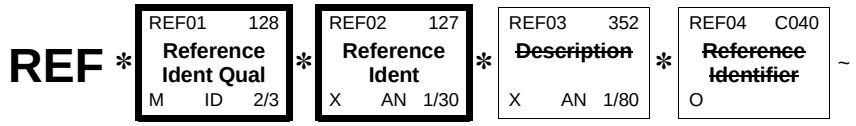
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
4N	**Special Payment Reference Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Service Authorization Exception Code*** SYNTAX: R0203 **Allowable Values for this element are:** **1 Immediate/Urgent Care** **2 Services rendered in a retroactive period** **3 Emergency care** **4 Client as temporary Medicaid** **5 Request from County for second opinion to recipient can work** **6 Request for override pending** **7 Special handling**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

ORIGINAL REFERENCE NUMBER (ICN/DCN)

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when CLM05-3 (Claim Submission Reason code) = "6", "7" or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.**

2. **This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows this is not a duplicate claim.**
   This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.

Example: **REF*F8*R555588~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

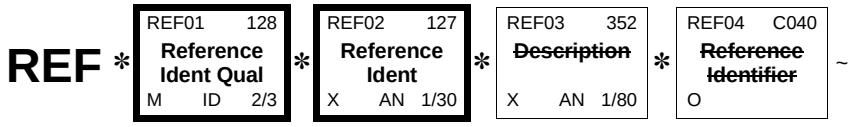
Max Use: 30

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION F8 — Original Reference Number	M	ID	2/3
REQUIRED	REF02	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY: **Claim Original Reference Number*** SYNTAX: R0203 **NSF Reference:** **EA0-47.0**	X	AN	1/30
NOT USED	REF03	352	**Description**	X	AN	1/80
NOT USED	REF04	C040	**REFERENCE IDENTIFIER**	O		

IMPLEMENTATION

REFERRAL IDENTIFICATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.**

2. **Required where services on this claim where a referral is involved. Generally, referral numbers are those numbers assigned by the payer to authorize a service prior to its being performed. The referral number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.**

Example: **REF*9F*12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

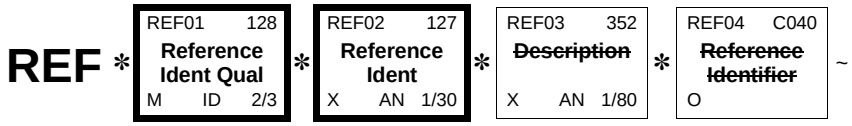
Max Use: 30

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **9F** **Referral Number**	**M**	**ID**	**2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referral Number*** **SYNTAX:** R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLAIM IDENTIFICATION NUMBER FOR CLEARINGHOUSES AND OTHER TRANSMISSION INTERMEDIARIES

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used only by transmission intermediaries (Automated clearinghouses, and others) who need to attach their own unique claim number.**
2. **Although it is possible to send this number, there is no requirement for payers or other transmission intermediaries to return this number in other transactions (835, 277, etc).**
3. **Although this REF is supplied for transmission intermediaries to attach their own unique claim number to a claim/encounter, 837 recipients are not required under HIPAA to return this number in any HIPAA transaction. Trading Partners may voluntarily agree to this interaction if they wish.**

Example: **REF*D9*TJ98UU321~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

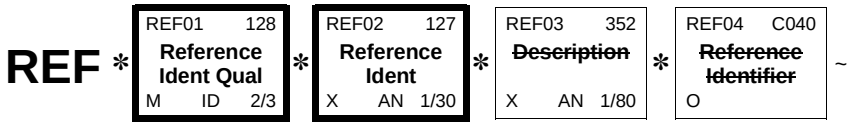
Max Use: 30

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			Number assigned by clearinghouse/van/etc.			
			CODE / DEFINITION			
			D9 Claim Number			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Value Added Network Trace Number*** **SYNTAX:** R0203 **The value carried in this element is limited to a maximum of 20 positions.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

CLAIM NOTE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **20**

Notes:

1. **Required when: (1) State regulations mandate information not identified elsewhere within the claim set; or (2) to report periodontal charting information.**
2. **If this segment is being used to report periodontal charting information, up to 6 measurements per tooth may be reported. The suggested format should be tooth number followed by a measurement for Disto-Lingual, Lingual, Mesio-Lingual, Mesio-Buccal, Buccal or Distal-Buccal. If a tooth has been extracted it should be annotated with "ext" following the tooth number.**
3. **Example of Charting for tooth #'s 5, 6 and 7 (extracted tooth): #5 DL3/L4/ML5/MB4/B4/DB4, #6 DL4/L5/ML5/MB4/B4/DB5, #7 ext**
4. **The following information should also be reported: description of the amount of recession, indication of teeth having furcation involvement and the extent, and the diagnosis.**

Example: **NTE*ADD*#5 DL4/L5/ML6/MB4, #6 L6/ML5/MB4/B5, #7 ext~**

STANDARD

NTE Note/Special Instruction

Level: Detail

Position: 190

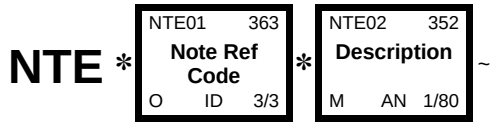
Loop: 2300

Requirement: Optional

Max Use: 20

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NTE01**	**363**	**Note Reference Code** Code identifying the functional area or purpose for which the note applies	**O ID 3/3**
			CODE: **ADD** — DEFINITION: **Additional Information**	
REQUIRED	**NTE02**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Claim Note Text*** **NSF Reference:** **HA0-05.0**	**M AN 1/80**

IMPLEMENTATION

REFERRING PROVIDER NAME

Loop: **2310A — REFERRING PROVIDER NAME Repeat: 2**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **When there is only one referral on the claim, use "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code "DN" in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.**

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

3. **Required if claim involved a referral.**

Example: **NM1*DN*1*SWANSON*HARRY****24*123123123~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

Set Notes:

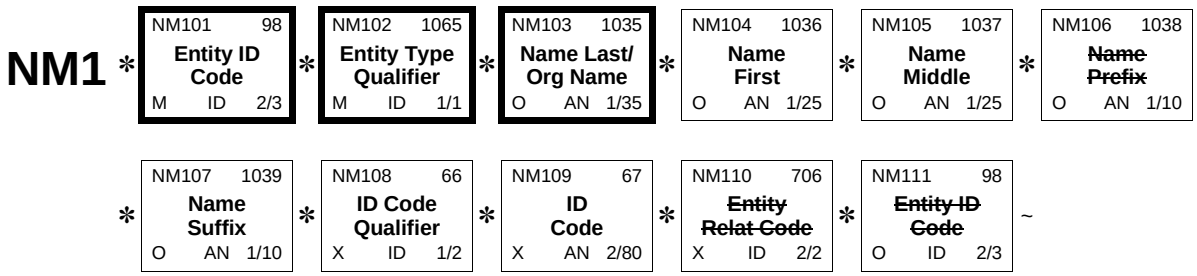
1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

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

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** **DN** — **Referring Provider** **Use on first iteration of this loop. Use if loop is used only once.** **P3** — **Primary Care Provider** **Use only if loop is used twice. Use only on second iteration of this loop.**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. **1** — **Person** **2** — **Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY: Referring Provider Last Name*** **NSF Reference:** **EA0-22.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY: Referring Provider First Name*** **NSF Reference:** **EA0-23.0** **Required if NM102 = 1 (person).**	**O AN 1/25**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Referring Provider Middle Name*** **NSF Reference:** **EA0-24.0** **Required if NM102 = 1 and the middle name/initial of the person is known.**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Referring Provider Name Suffix*** **Required if known.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if the Employer's Identification Number, Social Security Number or National Provider Identifier is known.**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Referring Provider Identifier*** SYNTAX: P0809 **NSF Reference:** **EA0-20.0** **Required if the Employer's Identification Number, Social Security Number or National Provider Identifier is known.** **Referring Provider Primary Identification Number**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

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

IMPLEMENTATION

REFERRING PROVIDER SPECIALTY INFORMATION

Loop: **2310A — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if required under provider-payer contract.**
2. **PRV02 qualifies PRV03.**

Example: **PRV*RF*ZZ*1223E0200Y~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

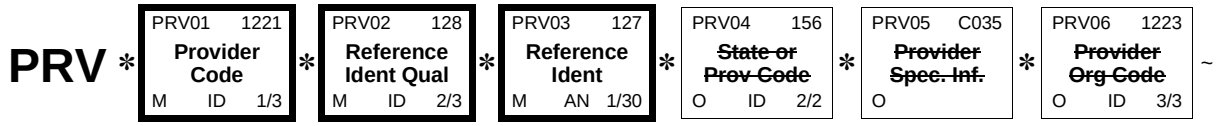
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			RF **Referring**			
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			ZZ **Mutually Defined** **ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ANSI ASC X12N TG2 WG15.**			

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code***	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL REFERRING PROVIDER NAME INFORMATION

Loop: **2310A — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

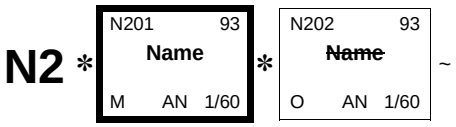
Loop: 2310

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

REFERRING PROVIDER SECONDARY IDENTIFICATION

Loop: **2310A — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:
1. **Required if NM108/NM109 in this loop is not used or if a secondary number is necessary to identify the provider. Until the NPI is mandated for use, this REF may be required if necessary to adjudicate the claim.**

Example: **REF*0B*123123311~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

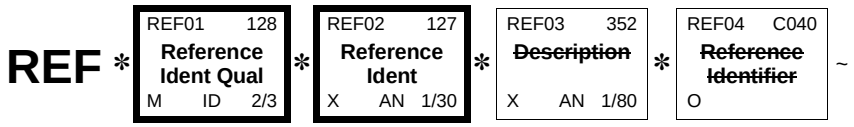
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**

			1E	**Dentist License Number**			
			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The Social Security Number may not be used for Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referring Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

RENDERING PROVIDER NAME

Loop: **2310B — RENDERING PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in the Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of loop ID-2420 with the same value in the NM101.**
2. **Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**
3. **Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops.**

Example: **NM1*82*1*SMITH*BRAD****34*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

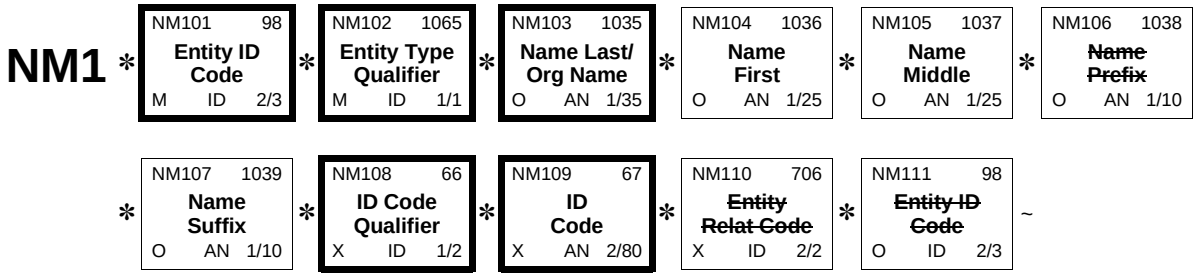
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	M ID 2/3
			The entity identifier in NM101 applies to all segments in Loop ID-2310.	
			CODE / DEFINITION	
			82 Rendering Provider	
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE / DEFINITION	
			1 Person	
			2 Non-Person Entity	
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Rendering Provider Last or Organization Name*** *ALIAS:* ***Rendering Provider Last Name*** **NSF Reference:** **FB1-14.0**	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY:* ***Rendering Provider First Name*** **NSF Reference:** **FB1-15.0** **Required if NM102 = 1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Rendering Provider Middle Name*** **NSF Reference:** **FB1-16.0** **Required when middle name/initial of person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Rendering Provider Name Suffix*** **Required if known.**	O AN 1/10

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

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

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code ***INDUSTRY:*** ***Rendering Provider Identifier*** ***ALIAS:*** ***Rendering Provider's Primary Identification Number*** **SYNTAX:** P0809 **NSF Reference:** **FA0-23.0, FA0-57.0** **NSF Reference: FA0-58.0, FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

RENDERING PROVIDER SPECIALTY INFORMATION

Loop: **2310B — RENDERING PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of the PRV segment with the same value in PRV01.**
2. **PRV02 qualifies PRV03.**

Example: **PRV*PE*ZZ*1223E0200Y~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

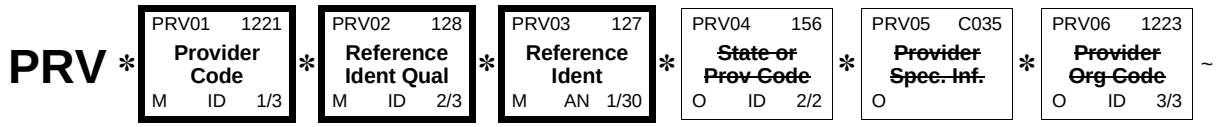
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

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

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

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code*** **NSF Reference:** **FA0-37.0**	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL RENDERING PROVIDER NAME INFORMATION

Loop: **2310B — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

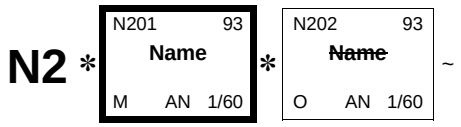
Loop: 2310

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

RENDERING PROVIDER SECONDARY IDENTIFICATION

Loop: **2310B — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NM109.**

Example: **REF*0B*12312321~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

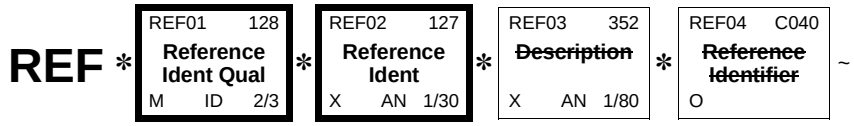
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1E	**Dentist License Number**

			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The Social Security Number may not be used for Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Rendering Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

SERVICE FACILITY LOCATION

Loop: **2310C — SERVICE FACILITY LOCATION** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the service was rendered in Inpatient Hospital, Outpatient Hospital, Skilled Nursing Facility or Adult Living Care Facility (code values 21, 22, 31 or 35 in CLM05-1).**
2. **Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**

Example: **NM1*FA*2*GOOD REST NURSING HOME*****24*1234567789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

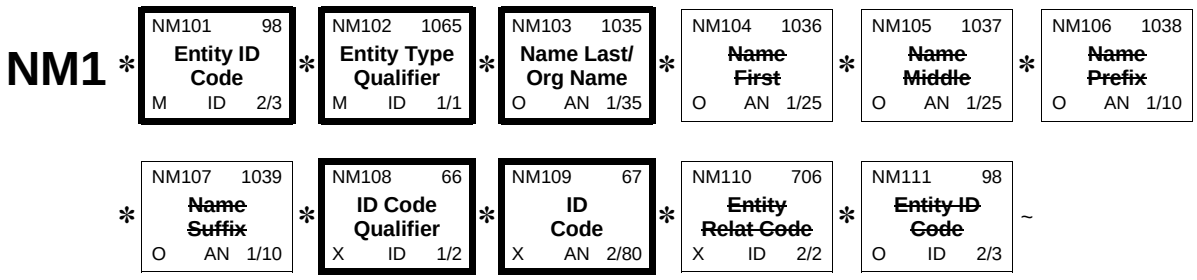
Set Notes:

1. Loop 2310 contains information about the rendering, referring, or attending provider.

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** CODE / DEFINITION **FA** Facility	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION **2** Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Laboratory or Facility Name*** **NSF Reference:** **EA0-37.0** **Facility Name**	O AN 1/35
NOT USED	NM104	1036	**Name First**	O AN 1/25
NOT USED	NM105	1037	**Name Middle**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
NOT USED	NM107	1039	**Name Suffix**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE / DEFINITION **24** Employer's Identification Number **34** Social Security Number **XX** Health Care Financing Administration National Provider Identifier ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***	X ID 1/2
REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code *INDUSTRY: **Laboratory or Facility Primary Identifier*** *ALIAS: **Facility Primary Identification Number*** SYNTAX: P0809	X AN 2/80

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

IMPLEMENTATION

ADDITIONAL SERVICE FACILITY LOCATION NAME INFORMATION

Loop: **2310C — SERVICE FACILITY LOCATION**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 260

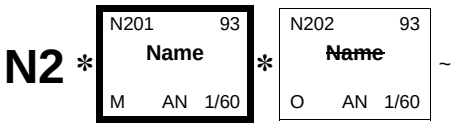
Loop: 2310

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

Loop: **2310C — SERVICE FACILITY LOCATION**

Usage: **SITUATIONAL**

Repeat: **5**

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

Example: **REF*0B*12312321~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

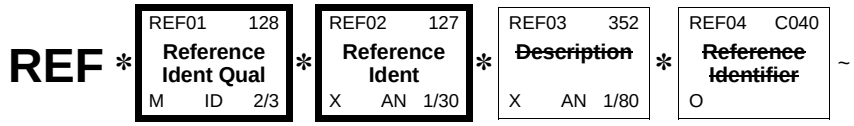
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			TJ	**Federal Taxpayer's Identification Number**		
			X4	**Clinical Laboratory Improvement Amendment Number**		
			X5	**State Industrial Accident Provider Number**		
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Laboratory or Facility Secondary Identifier*** *ALIAS:* ***Laboratory/Facility Secondary Identification Number.*** SYNTAX: R0203 **NSF Reference:** **EA0-53.0, EA1-04.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER SUBSCRIBER INFORMATION

Loop: 2320 — OTHER SUBSCRIBER INFORMATION Repeat: 10

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Required if other payers are known to potentially be involved in paying on this claim.**
2. **Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**
3. **All information contained in the 2320 loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 loop again with its respective 2330 loops.**

Example: SBR*P*01*003450*GOLDEN PLUS***CI~**

STANDARD

SBR Subscriber Information

Level: Detail

Position: 290

Loop: 2320 **Repeat:** 10

Requirement: Optional

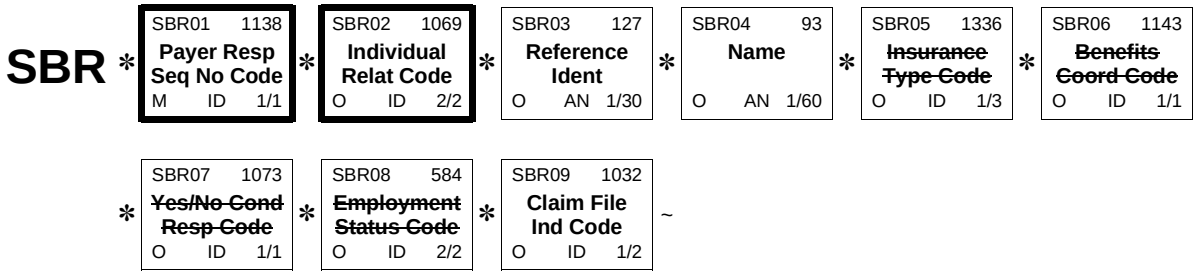
Max Use: 1

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

Set Notes:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SBR01**	**1138**	**Payer Responsibility Sequence Number Code** Code identifying the insurance carrier's level of responsibility for a payment of a claim **NSF Reference:** **DA0-02.0** **P = Primary** **S = Secondary** **T = Tertiary**	**M ID 1/1**
REQUIRED	**SBR02**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities **SEMANTIC:** SBR02 specifies the relationship to the person insured. **NSF Reference:** **DA0-17.0** **Use this code to specify the relationship to the person insured.** **01 = Spouse** **18 = Self** **19 = Child** **20 = Employee** **21 = Unknown** **22 = Handicapped Dependent** **29 = Significant Other** **76 = Dependent**	**O ID 2/2**
SITUATIONAL	**SBR03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier ***INDUSTRY:* *Insured Group or Policy Number*** **SEMANTIC:** SBR03 is policy or group number. **NSF Reference:** **DA0-10.0** **Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).**	**O AN 1/30**

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

INDUSTRY: ***Policy Name***

ALIAS: ***Plan Name***

SEMANTIC: SBR04 is plan name.

Required if the Subscriber's payer identification includes Plan Name.

NOT USED	SBR05	1336	**Insurance Type Code**	O	ID	1/3
NOT USED	SBR06	1143	**Coordination of Benefits Code**	O	ID	1/1
NOT USED	SBR07	1073	**Yes/No Condition or Response Code**	O	ID	1/1
NOT USED	SBR08	584	**Employment Status Code**	O	ID	2/2
SITUATIONAL	SBR09	1032	**Claim Filing Indicator Code** Code identifying type of claim	O	ID	1/2

NSF Reference:

DA0-05.0

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

CODE	DEFINITION
09	Self-pay
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
FI	Federal Employees Program
HM	Health Maintenance Organization
LM	Liability Medical
MB	Medicare Part B
MC	Medicaid

MH	Managed Care Non-HMO
OF	Other Federal Program
SA	Self-administered Group
VA	Veteran Administration Plan Refers to Veteran's Affairs Plan.
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined Unknown

IMPLEMENTATION

CLAIM ADJUSTMENT

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

Usage: SITUATIONAL

Repeat: 5

Notes:

1. **Submitters should use the CAS segment to report claim level adjustments from prior payers that cause the amount paid to differ from the amount originally charged.**

2. **Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, Repeat Loop ID-2320 by repeating the SBR segment and then using the CAS segment again.**

3. **Codes and associated amounts should come from the 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment. See the 835 for definitions of the group codes (CAS01).**

4. **Required if the claim has been adjudicated by payer identified in this loop and has claim level adjustment information.**

5. **To locate the claim adjustment reason codes that are used in CAS02, 05, 08, 11, 14 and 17 see the Washington Publishing Company website: http://www.wpc-edi.com. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.**

6. **There are several NSF fields which are not directly crosswalked from the 837 to NSF, particularly with respect to payer-to-payer COB situations. Below is a list of some of these NSF fields and some suggestions regarding how to handle them in the 837.**
   - **Provider Adjustment Amt (DA3-25.0). This would equal the sum of all the adjustments amounts in CAS03, 06, 09, 12, 15 and 18 at both the claim and the line level. See the 835 for how to balance the CAS adjustments against the total billed amount.**
   - **Beneficiary Liability Amt (FA0-53.0). This amount would equal the sum of all the adjustment amounts in the CAS03, 06, 09, 12, 15 and 18 at both the claim and the line level when CAS01 = PR (patient responsibility).**
   - **Amount Paid to Provider (DA1-33.0). This would be calculated through the use of the CAS codes. Please see the detail on the codes and the discussion of how to use them in the 835 implementation guide.**
   - **Balance Bill Limit Charge (FA0-54.0). This would equal any CAS adjustment where CAS01 = CO and one of the adjustment reason code elements equaled "45".**
   - **Beneficiary Adjustment Amt (DA3-26.0) Amount Paid to Beneficiary (DA1-30.0). The amount paid to the beneficiary is indicated by the use of CAS code "100 - Payment made to patient/insured/responsible party".**
   - **Original Paid Amount (DA3-28.0). The original paid amount can be calculated from the original claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.**

Example: **CAS*PR*1*793~**

Example: **CAS*OA*93*15.06~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 295

Loop: 2320

Requirement: Optional

Max Use: 99

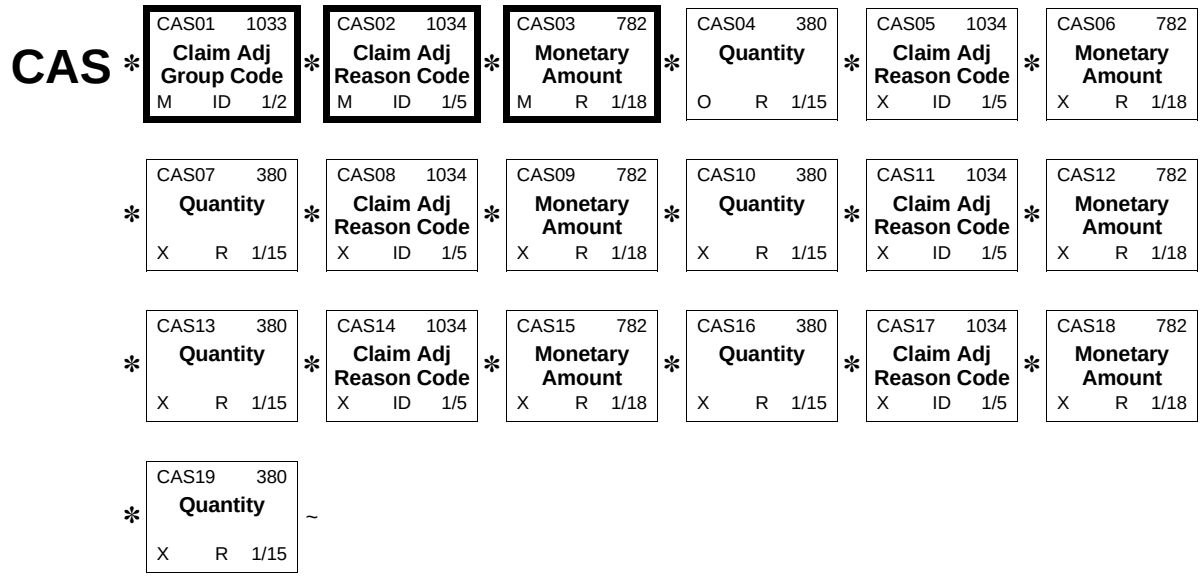
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Syntax:

1. **L050607**
   If CAS05 is present, then at least one of CAS06 or CAS07 are required.
2. **C0605**
   If CAS06 is present, then CAS05 is required.

3. **C0705**
   If CAS07 is present, then CAS05 is required.
4. **L080910**
   If CAS08 is present, then at least one of CAS09 or CAS10 are required.
5. **C0908**
   If CAS09 is present, then CAS08 is required.
6. **C1008**
   If CAS10 is present, then CAS08 is required.
7. **L111213**
   If CAS11 is present, then at least one of CAS12 or CAS13 are required.
8. **C1211**
   If CAS12 is present, then CAS11 is required.
9. **C1311**
   If CAS13 is present, then CAS11 is required.
10. **L141516**
    If CAS14 is present, then at least one of CAS15 or CAS16 are required.
11. **C1514**
    If CAS15 is present, then CAS14 is required.
12. **C1614**
    If CAS16 is present, then CAS14 is required.
13. **L171819**
    If CAS17 is present, then at least one of CAS18 or CAS19 are required.
14. **C1817**
    If CAS18 is present, then CAS17 is required.
15. **C1917**
    If CAS19 is present, then CAS17 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment	**M ID 1/2**

CODE	DEFINITION
CO	**Contractual Obligations**
CR	**Correction and Reversals**
OA	**Other adjustments**
PI	**Payor Initiated Reductions**
PR	**Patient Responsibility**

REQUIRED	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**M ID 1/5**

INDUSTRY: ***Adjustment Reason Code***

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA1-16.0, DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0

REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount	**M R 1/18**

INDUSTRY: ***Adjustment Amount***

SEMANTIC: CAS03 is the amount of adjustment.

COMMENT: When the submitted charges are paid in full, the value for CAS03 should be zero.

NSF Reference:

DA1-09.0, DA1-10.0, DA1-11.0, DA1-12.0, DA1-13.0, DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0

SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity	**O R 1/15**

INDUSTRY: ***Adjustment Quantity***

SEMANTIC: CAS04 is the units of service being adjusted.

Used as needed to show payer adjustments.

SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X ID 1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L050607, C0605, C0705

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA1-17.0, DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SYNTAX: L050607, C0605

SEMANTIC: CAS06 is the amount of the adjustment.

NSF Reference:

DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS07**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L050607, C0705

SEMANTIC: CAS07 is the units of service being adjusted.

Used as needed to show payer adjustments.

SITUATIONAL	**CAS08**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L080910, C0908, C1008

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA1-18.0, DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SYNTAX: L080910, C0908

SEMANTIC: CAS09 is the amount of the adjustment.

NSF Reference:

DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L080910, C1008

SEMANTIC: CAS10 is the units of service being adjusted.

Used as needed to show payer adjustments.

SITUATIONAL	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L111213, C1211, C1311

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SYNTAX: L111213, C1211

SEMANTIC: CAS12 is the amount of the adjustment.

NSF Reference:

DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L111213, C1311

SEMANTIC: CAS13 is the units of service being adjusted.

Used as needed to show payer adjustments.

SITUATIONAL	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L141516, C1514, C1614

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SYNTAX: L141516, C1514

SEMANTIC: CAS15 is the amount of the adjustment.

NSF Reference:

DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L141516, C1614

SEMANTIC: CAS16 is the units of service being adjusted.

Used as needed to show payer adjustments.

SITUATIONAL	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

SYNTAX: L171819, C1817, C1917

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

SYNTAX: L171819, C1817

SEMANTIC: CAS18 is the amount of the adjustment.

NSF Reference:

DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0

Used as needed to show payer adjustments.

SITUATIONAL	**CAS19**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

SYNTAX: L171819, C1917

SEMANTIC: CAS19 is the units of service being adjusted.

Used as needed to show payer adjustments.

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if claim has been adjudicated by payer identified in this loop. It is acceptable to show "0" amount paid.**

Example: **AMT*D*411~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

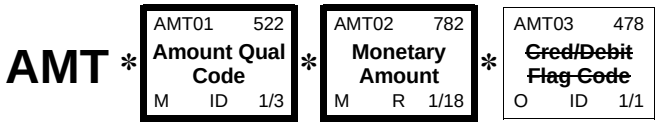
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			D — Payor Amount Paid			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Payer Paid Amount***			
			This amount is a crosswalk from CLP04 in the 835 when doing COB.			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) APPROVED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used only in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.**
2. **The approved amount equals the amount for the total claim that was approved by the payer sending this 837 to another payer.**

Example: **AMT*AAE*500~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

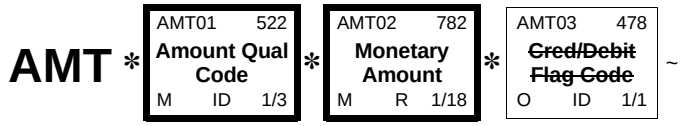
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **AAE** **Approved Amount**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Approved Amount*** **NSF Reference:** **DA1-27.0**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) ALLOWED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used only in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.**
2. **The allowed amount equals the amount for the total claim that was allowed by the payer sending this 837 to another payer.**

Example: **AMT*B6*500~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

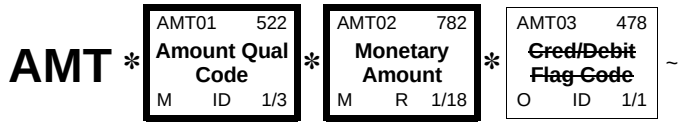
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **B6 — Allowed - Actual**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Allowed Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PATIENT RESPONSIBILITY AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1).**

Example: **AMT*F2*15~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

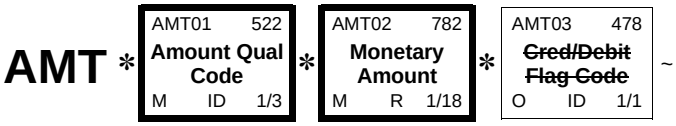
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **F2 — Patient Responsibility - Actual**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Patient Responsibility Amount*** **This amount is a crosswalk from CLP05 in the 835 when doing COB.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) COVERED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used only in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.**
2. **The covered amount equals the amount for the total claim that was covered by the payer sending this 837 to another payer.**

Example: **AMT*AU*203~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

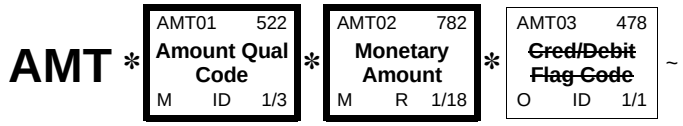
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **AU** **Coverage Amount**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Covered Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) DISCOUNT AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if claim has been adjudicated by the payer indentified in this loop and if this information was included in the remittance advice reporting those adjudication results.**

Example: **AMT*D8*35~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

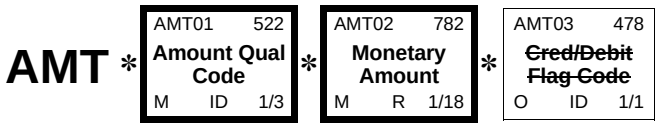
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **D8 — Discount Amount**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY: **Other Payer Discount Amount*** **This amount is a crosswalk from AMT in the 835 (Loop CLP, position 062) when AMT01 = D8.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) PATIENT PAID AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if claim has been adjudicated by the payer indentified in this loop and if this information was included in the remittance advice reporting those adjudication results.**
2. **The amount carried in this segment is the total amount of money paid by the payer to the patient (rather than to the provider) on this claim.**

Example: **AMT*F5*15~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

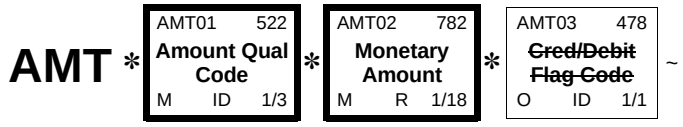
Loop: 2320

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount CODE / DEFINITION **F5 — Patient Amount Paid**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Other Payer Patient Paid Amount*** **This amount is a crosswalk from AMT in the 835 (Loop CLP, position 062) when AMT01 = F5.**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

OTHER INSURED DEMOGRAPHIC INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when 2330A NM102 = 1 (person).**

Example: **DMG*D8*19561105*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 305

Loop: 2320

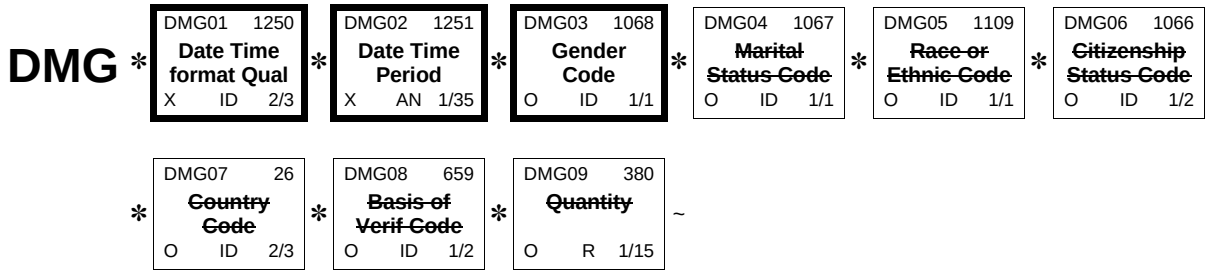
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

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

DIAGRAM



ELEMENT SUMMARY

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

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

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Other Insured Birth Date*** *ALIAS:* ***Subscriber's Date of Birth*** **SYNTAX:** P0102 **SEMANTIC:** DMG02 is the date of birth.	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Other Insured Gender Code*** *ALIAS:* ***Subscriber's Gender***	**O**	**ID**	**1/1**

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

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

IMPLEMENTATION

OTHER INSURANCE COVERAGE INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.**

Example: **OI***Y***Y~**

STANDARD

OI Other Health Insurance Information

Level: Detail

Position: 310

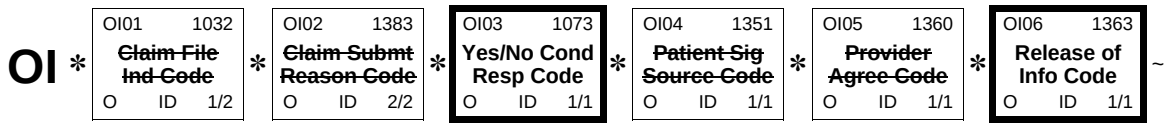
Loop: 2320

Requirement: Optional

Max Use: 1

Purpose: To specify information associated with other health insurance coverage

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
NOT USED	**OI01**	**1032**	**Claim Filing Indicator Code**	**O**	**ID**	**1/2**
NOT USED	**OI02**	**1383**	**Claim Submission Reason Code**	**O**	**ID**	**2/2**
REQUIRED	**OI03**	**1073**	**Yes/No Condition or Response Code** Code indicating a Yes or No condition or response	**O**	**ID**	**1/1**

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

SEMANTIC: OI03 is the assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

NSF Reference:

DA0-15.0

This code is a crosswalk from CLM08 when doing COB.

CODE	DEFINITION
N	**No**

			Y	**Yes**			
NOT USED	**OI04**	**1351**	**Patient Signature Source Code**		**O**	**ID**	**1/1**
NOT USED	**OI05**	**1360**	**Provider Agreement Code**		**O**	**ID**	**1/1**
REQUIRED	**OI06**	**1363**	**Release of Information Code**		**O**	**ID**	**1/1**

Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations

ALIAS: ***Release of Information***

This code is a crosswalk from CLM09 when doing COB.

CODE	DEFINITION
N	**No, Provider is Not Allowed to Release Data**
Y	**Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim**

IMPLEMENTATION

OTHER SUBSCRIBER NAME

Loop: **2330A — OTHER SUBSCRIBER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Submitters are required to send information on all known other subscribers in Loop ID-2330.**
2. **The 2330A loop is required when Loop ID-2320 - Other Subscriber Information, is used. Otherwise, the loop is not used.**

Example: **NM1*IL*1*DOE*JOHN*T**JR*MI*333224444~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

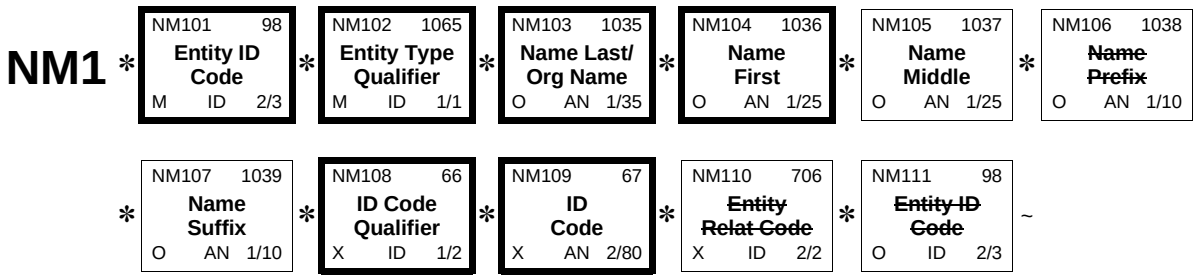
Max Use: 1

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

Set Notes:
1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

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

DIAGRAM



ELEMENT SUMMARY

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

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

CODE	DEFINITION
24	**Employer's Identification Number**
MI	**Member Identification Number**
ZZ	**Mutually Defined** **The value "ZZ", when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

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

IMPLEMENTATION

ADDITIONAL OTHER SUBSCRIBER NAME INFORMATION

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 330

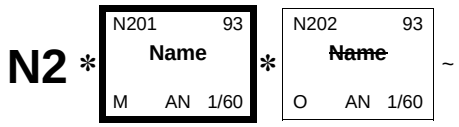
Loop: 2330

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

OTHER SUBSCRIBER ADDRESS

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when information is available.**

Example: **N3*4320 WASHINGTON ST*SUITE 100~**

STANDARD

N3 Address Information

Level: Detail

Position: 332

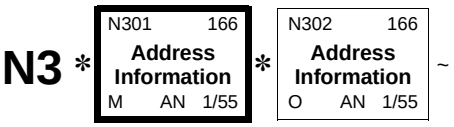
Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

OTHER SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when information is available.**

Example: **N4*PALISADES*OR*23119~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 340

Loop: 2330

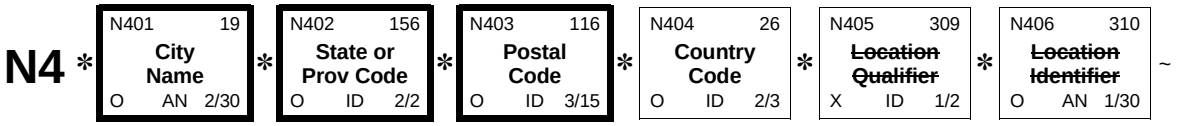
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

OTHER SUBSCRIBER SECONDARY IDENTIFICATION

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

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

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

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

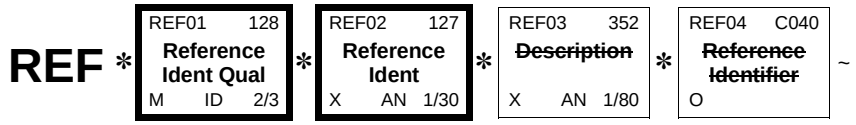
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number**
23	**Client Number**
IG	**Insurance Policy Number**
SY	**Social Security Number** **The Social Security Number may not be used for Medicare.**

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

IMPLEMENTATION

OTHER PAYER NAME

Loop: **2330B — OTHER PAYER NAME** **Repeat:** **1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Submitters are required to send all known information on other payers in this loop ID-2330.**

Example: **NM1*PR*2*UNION MUTUAL OF OREGON*****XV*43~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

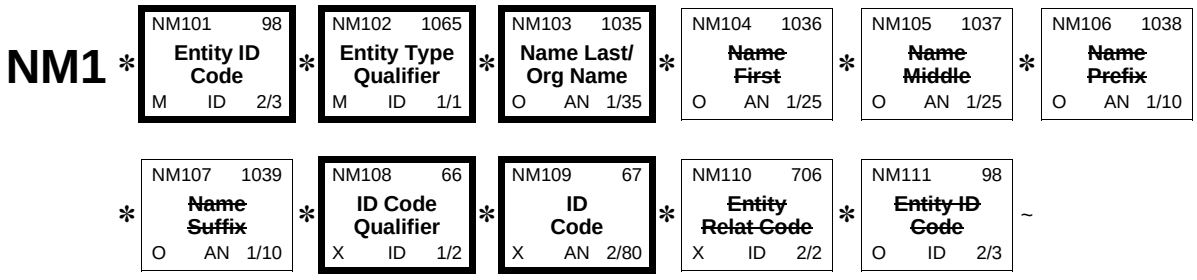
Max Use: 1

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

Set Notes:
1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
PR	**Payer**

REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M**	**ID**	**1/1**

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Other Payer Last or Organization Name*** ***ALIAS:*** ***Other Payer Name*** **NSF Reference:** **DA0-09.0**	**O**	**AN**	**1/35**
NOT USED	**NM104**	**1036**	**Name First**	**O**	**AN**	**1/25**
NOT USED	**NM105**	**1037**	**Name Middle**	**O**	**AN**	**1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O**	**AN**	**1/10**
NOT USED	**NM107**	**1039**	**Name Suffix**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809	**X**	**ID**	**1/2**

CODE	DEFINITION
PI	**Payor Identification**
XV	**Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.***

CODE SOURCE 540: Health Care Financing Administration National PlanID

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code ***INDUSTRY:*** ***Other Payer Primary Identifier*** ***ALIAS:*** ***Other Payer Primary Identification Number*** **SYNTAX:** P0809 **NSF Reference:** **DA0-07.0**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ADDITIONAL OTHER PAYER NAME INFORMATION

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 330

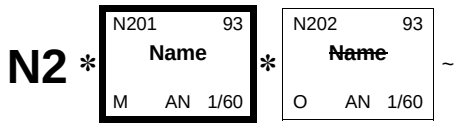
Loop: 2330

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

OTHER PAYER CONTACT INFORMATION

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **This segment is used only in payer-to-payer COB situations. This segment may be completed by a payer who had adjudicated the claim and is passing it on to a secondary payer. It is not completed by submitting providers.**

2. **Each communication number should always include the area code. The extension when applicable, should be included in the appropriate PER element immediately after the telephone number (e.g., if the telephone number is included in PER03, then the extension should be in PER05).**

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

4. **By definition of the standard, if PER03 is used, PER04 is required.**

Example: **PER*IC*SHELLY*TE*5552340000~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 345

Loop: 2330

Requirement: Optional

Max Use: 2

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

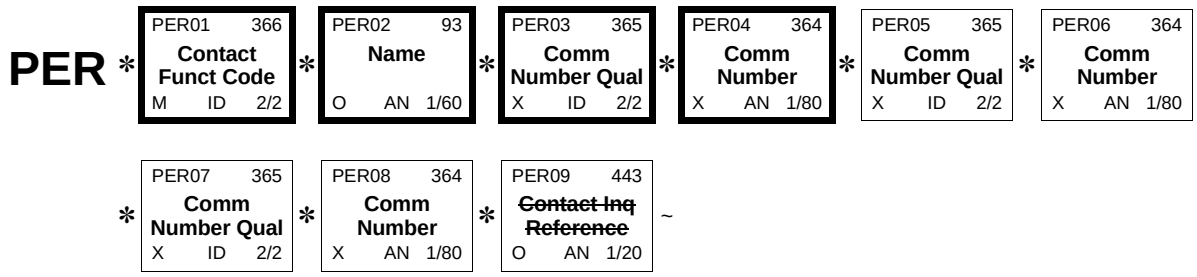
Syntax:

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

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

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			CODE / DEFINITION **IC** — **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Other Payer Contact Name***	**O AN 1/60**
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304 CODE / DEFINITION **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **FX** — **Facsimile** **TE** — **Telephone**	**X ID 2/2**
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0304	**X AN 1/80**
SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0506 **Used only when additional communications numbers need to be transmitted.** CODE / DEFINITION **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **EX** — **Telephone Extension** **FX** — **Facsimile**	**X ID 2/2**

			TE **Telephone**			
SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **Used only when additional communications numbers need to be transmitted.**	**X**	**AN**	**1/80**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Used only when additional communications numbers need to be transmitted.**	**X**	**ID**	**2/2**
			CODE DEFINITION			
			ED **Electronic Data Interchange Access Number**			
			EM **Electronic Mail**			
			EX **Telephone Extension**			
			FX **Facsimile**			
			TE **Telephone**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708 **Used only when additional communications numbers need to be transmitted.**	**X**	**AN**	**1/80**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O**	**AN**	**1/20**

IMPLEMENTATION

CLAIM PAID DATE

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when Loop ID-2430 (Service Adjudication Information) is not used.**

Example: **DTP*573*D8*19991212~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 350

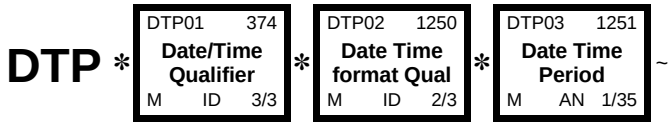
Loop: 2330

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** CODE / DEFINITION **573** — **Date Claim Paid**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** — **Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Date Claim Paid***	**M AN 1/35**

IMPLEMENTATION

OTHER PAYER SECONDARY IDENTIFIER

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in the NM109 of this loop.**
2. **Used when it is necessary to identify the 'other' payer's claim number.**
3. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**
4. **See section 1.4.2 Coordination of Benefits for more information on handling COB in the 837.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

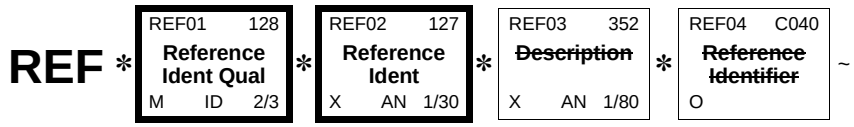
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
2U	**Payer Identification Number**

			D8	**Loss Report Number** **Used to indicate the payer's claim number for this claim for the payer identified in this iteration of the 2330B loop.**			
			F8	**Original Reference Number**			
			FY	**Claim Office Number**			
			NF	**National Association of Insurance Commissioners (NAIC) Code**			
				CODE SOURCE **245:** National Association of Insurance Commissioners (NAIC) Code			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Secondary Identifier*** SYNTAX: R0203 **NSF Reference:** **DA3-29.0** **The DA3-29.0 crosswalk is only used in payer-to-payer COB situations.**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER REFERRAL NUMBER

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used when the payer identified in this loop has given a referral number to this claim. This element is primarily used in payer-to-payer COB situations.**
2. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**

Example: **REF*9F*AB333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

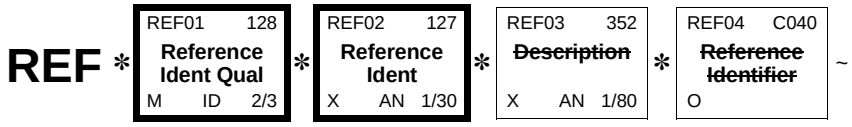
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE — DEFINITION **9F — Referral Number**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY: **Other Payer Prior Authorization or Referral Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O

IMPLEMENTATION

OTHER PAYER CLAIM ADJUSTMENT INDICATOR

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used only in payer-to-payer COB. In that situation, the destination payer is secondary to the payer identified in this loop. Providers/other submitters do not use this segment.**

2. **Required when the payer identified in this loop has previously paid this claim (and indicated so to the destination payer). In this case, the payer identified in this loop has readjudicated the claim and is sending the adjusted payment information to the destination payer. This REF segment is used to indicate that this claim is an adjustment of a previously adjudicated claim. If the claim has not been previously adjudicated this REF is not used.**

3. **There can only be a maximum of three REF segments in any one iteration of the 2330 loop.**

Example: **REF*T4*Y~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

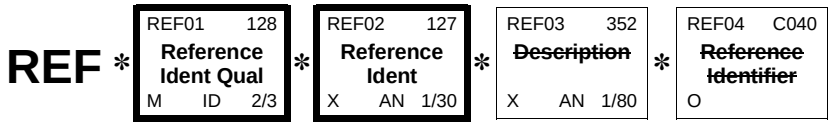
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE: T4 — DEFINITION: Signal Code	M ID 2/3
REQUIRED	REF02	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Claim Adjustment Indicator*** SYNTAX: R0203 **NSF Reference:** **DA3-24.0** **Allowable value is "Y" indicating that the payer in this loop has previously adjudicated this claim and sent a record of that adjudicaton to the destination payer identified in the 2010BB loop. The claim being transmitted in this iteration of the 2300 loop is a readjudicaton version of that claim.**	X AN 1/30
NOT USED	REF03	352	**Description**	X AN 1/80
NOT USED	REF04	C040	**REFERENCE IDENTIFIER**	O

IMPLEMENTATION

OTHER PAYER PATIENT INFORMATION

Loop: **2330C — OTHER PAYER PATIENT INFORMATION** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when it is necessary, in COB situations, to send one or more payer specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330C loop are those patient ID's which belong to non-destination (COB) payers. The patient id(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments.**

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

Example: **NM1*QC*1******MI*6677U801~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

Set Notes:

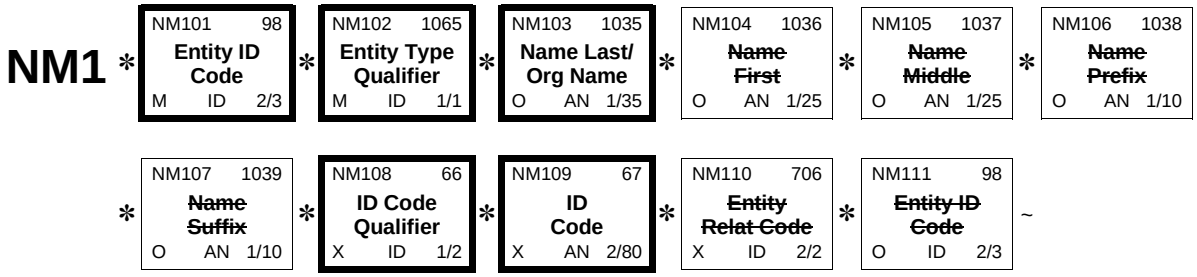
1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

Syntax:

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

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

OTHER PAYER PATIENT IDENTIFICATION

Loop: **2330C — OTHER PAYER PATIENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. Used when a COB payer (listed in 2330B loop) has one or more proprietary patient identification numbers for this claim. The patient (name, DOB, etc.) is identified in the 2010BA and 2010CA loop.**

Example: **REF*AZ*B333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

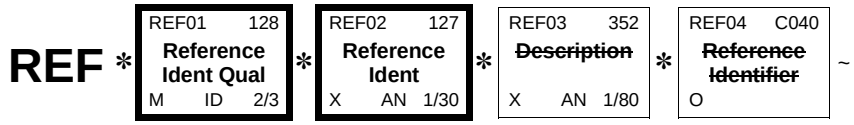
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number**
23	**Client Number**
IG	**Insurance Policy Number**
SY	**Social Security Number** **The Social Security Number may not be used for Medicare.**

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

IMPLEMENTATION

OTHER PAYER REFERRING PROVIDER

Loop: **2330D — OTHER PAYER REFERRING PROVIDER** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*DN*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

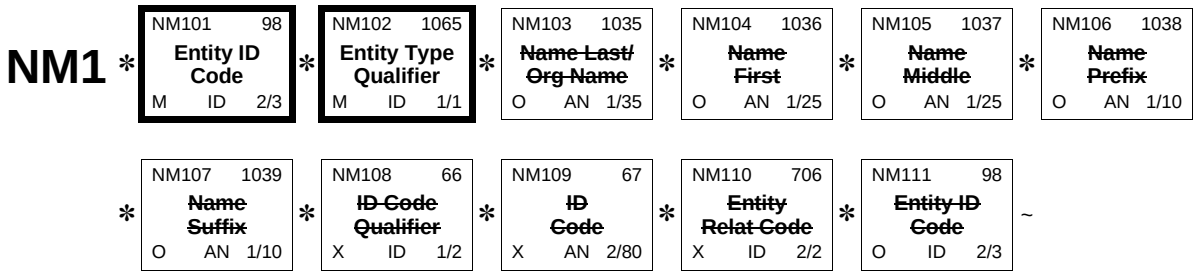
Max Use: 1

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

Set Notes:
1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE / DEFINITION DN — Referring Provider Use on first iteration of this loop. Use if loop is only used once. P3 — Primary Care Provider Use only if loop is used twice. Use only on second iteration of this loop.	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION 1 — Person 2 — Non-Person Entity	M	ID	1/1
NOT USED	NM103	1035	Name Last or Organization Name	O	AN	1/35
NOT USED	NM104	1036	Name First	O	AN	1/25
NOT USED	NM105	1037	Name Middle	O	AN	1/25
NOT USED	NM106	1038	Name Prefix	O	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X	ID	1/2
NOT USED	NM109	67	Identification Code	X	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

IMPLEMENTATION

OTHER PAYER REFERRING PROVIDER IDENTIFICATION

Loop: **2330D — OTHER PAYER REFERRING PROVIDER**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*EI*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

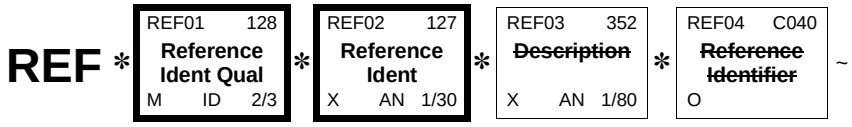
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1E	**Dentist License Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The social Security Number may not be used for Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Referring Provider Identifier*** *ALIAS:* ***Other Payer Referring Provider Identification*** SYNTAX: R0203	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

OTHER PAYER RENDERING PROVIDER

Loop: **2330E — OTHER PAYER RENDERING PROVIDER** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*82*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

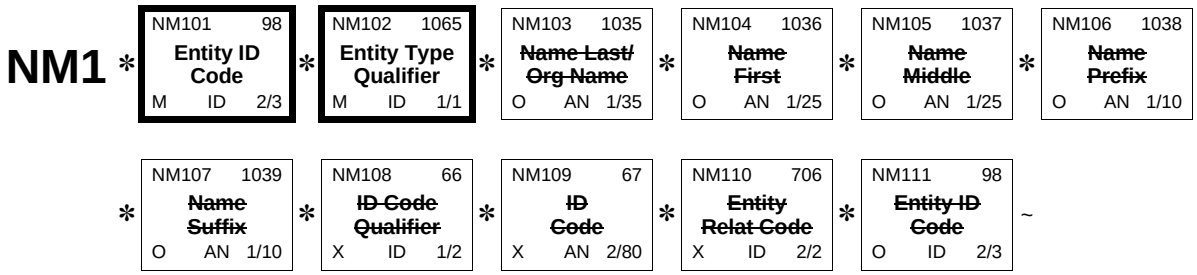
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: 82 — DEFINITION: Rendering Provider	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M	ID	1/1
NOT USED	NM103	1035	Name Last or Organization Name	O	AN	1/35
NOT USED	NM104	1036	Name First	O	AN	1/25
NOT USED	NM105	1037	Name Middle	O	AN	1/25
NOT USED	NM106	1038	Name Prefix	O	AN	1/10
NOT USED	NM107	1039	Name Suffix	O	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X	ID	1/2
NOT USED	NM109	67	Identification Code	X	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O	ID	2/3

IMPLEMENTATION

OTHER PAYER RENDERING PROVIDER IDENTIFICATION

Loop: **2330E — OTHER PAYER RENDERING PROVIDER**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*LU*SLC987~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

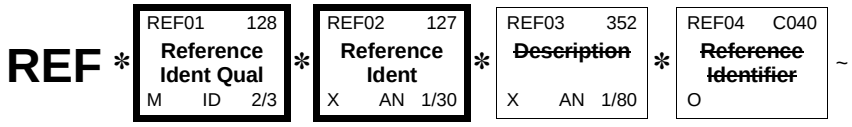
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1E	**Dentist License Number**
1H	**CHAMPUS Identification Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The social Security Number may not be used for Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Rendering Provider Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

LINE COUNTER

Loop: **2400 — LINE COUNTER Repeat: 50**

Usage: **REQUIRED**

Repeat: **50**

Notes:

1. **The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.**
2. **The data in the LX is not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/unbundling in SVC06.**
3. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**

Example: **LX*1~**

STANDARD

LX Assigned Number

Level: Detail

Position: 365

Loop: 2400 **Repeat:** >1

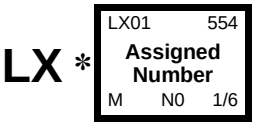
Requirement: Optional

Max Use: 1

Purpose: To reference a line number in a transaction set

Set Notes: **1.** Loop 2400 contains Service Line information.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**LX01**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set *ALIAS:* ***Line Counter*** **NSF Reference:** **FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0** **The service line number is incremented by one for each service line.**	**M**	**N0**	**1/6**

IMPLEMENTATION

DENTAL SERVICE

Loop: **2400 — LINE COUNTER**

Usage: **REQUIRED**

Repeat: **1**

Example: **SV3*AD:D2150*80****1~**

STANDARD

SV3 Dental Service

Level: Detail

Position: 380

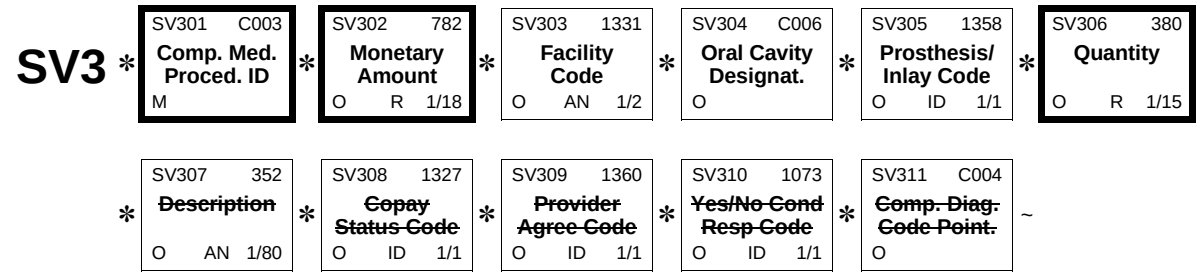
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify the claim service detail for dental work

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SV301**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers	**M**
REQUIRED	**SV301 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**

CODE	DEFINITION
AD	**American Dental Association Codes** **CDT = Current Dental Terminology**

CODE SOURCE 135: American Dental Association Codes

REQUIRED	**SV301 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code***	**M**	**AN**	**1/48**
			NSF Reference: **FA0-09.0**			
SITUATIONAL	**SV301 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN**	**2/2**
			NSF Reference: **FA0-10.0** **Use this modifier for the first procedure code modifier.** **Used at the discretion of the submitter.**			
SITUATIONAL	**SV301 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN**	**2/2**
			NSF Reference: **FA0-11.0** **Use this modifier for the second procedure code modifier.** **Used at the discretion of the submitter.**			
SITUATIONAL	**SV301 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN**	**2/2**
			NSF Reference: **FA0-12.0** **Use this modifier for the third procedure code modifier.** **Used at the discretion of the submitter.**			
SITUATIONAL	**SV301 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***Procedure Code Modifier***	**O**	**AN**	**2/2**
			NSF Reference: **FA0-36.0** **Use this modifier for the fourth procedure code modifier.** **Used at the discretion of the submitter.**			
NOT USED	**SV301 - 7**	**352**	**Description**	**O**	**AN**	**1/80**

REQUIRED **SV302** **782** **Monetary Amount** **O R 1/18**
Monetary amount

INDUSTRY: ***Line Item Charge Amount***

ALIAS: ***Line Charge Amount***

SEMANTIC: SV302 is a submitted charge amount.

NSF Reference:

FA0-13.0

Zero "0" is an acceptable value for this element.

SITUATIONAL **SV303** **1331** **Facility Code Value** **O AN 1/2**
Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format

INDUSTRY: ***Facility Type Code***

SEMANTIC: SV303 is the place of service code representing the location where the dental treatment was rendered.

Required if the Place of Service is different than the Place of Service reported in the CLM segment in the 2300 loop.

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

- **11 Office**
- **12 Home**
- **21 Inpatient Hospital**
- **22 Outpatient Hospital**
- **31 Skilled Nursing Facility**
- **35 Adult Living Care Facility**

SITUATIONAL **SV304** **C006** **ORAL CAVITY DESIGNATION** **O**
To identify one or more areas of the oral cavity

Required to report areas of the mouth that are being treated.

REQUIRED **SV304 - 1** **1361** **Oral Cavity Designation Code** **M ID 1/3**
Code Identifying the area of the oral cavity in which service is rendered

NSF Reference:

FD0-62.0

CODE	DEFINITION
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant

		20	**Upper Left Quadrant**
		30	**Lower Left Quadrant**
		40	**Lower Right Quadrant**
		L	**Left**
		R	**Right**

SITUATIONAL **SV304 - 2** **1361** **Oral Cavity Designation Code** **O ID 1/3**
Code Identifying the area of the oral cavity in which service is rendered

NSF Reference:

FD0-62.0

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

SITUATIONAL **SV304 - 3** **1361** **Oral Cavity Designation Code** **O ID 1/3**
Code Identifying the area of the oral cavity in which service is rendered

NSF Reference:

FD0-62.0

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

SITUATIONAL **SV304 - 4** **1361** **Oral Cavity Designation Code** **O ID 1/3**
Code Identifying the area of the oral cavity in which service is rendered

NSF Reference:

FD0-62.0

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

SITUATIONAL **SV304 - 5** **1361** **Oral Cavity Designation Code** **O ID 1/3**
Code Identifying the area of the oral cavity in which service is rendered

NSF Reference:

FD0-62.0

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

SITUATIONAL	**SV305**	**1358**	**Prosthesis, Crown or Inlay Code** Code specifying the placement status for the dental work	**O**	**ID**	**1/1**

INDUSTRY: ***Prosthesis, Crown, or Inlay Code***

NSF Reference:

FD0-13.0

Required to indicate the placement status of the prosthetic on this line.

CODE	DEFINITION
I	**Initial Placement**
R	**Replacement** **If the SV305 = R, then the DTP segment in the 2400 loop for Prior Placement is Required.**

REQUIRED	**SV306**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Procedure Count***

SEMANTIC: SV306 is the number of procedures.

NSF Reference:

FA0-18.0

Number of procedures

NOT USED	**SV307**	**352**	**Description**	**O**	**AN**	**1/80**
NOT USED	**SV308**	**1327**	**Copay Status Code**	**O**	**ID**	**1/1**
NOT USED	**SV309**	**1360**	**Provider Agreement Code**	**O**	**ID**	**1/1**
NOT USED	**SV310**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV311**	**C004**	**COMPOSITE DIAGNOSIS CODE POINTER**	**O**		

IMPLEMENTATION

TOOTH INFORMATION

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **32**

Notes: **1. Required to report tooth number and/or tooth surface related to this procedure line.**

Example: **TOO*JP*12*L:O~**

STANDARD

TOO Tooth Identification

Level: Detail

Position: 382

Loop: 2400

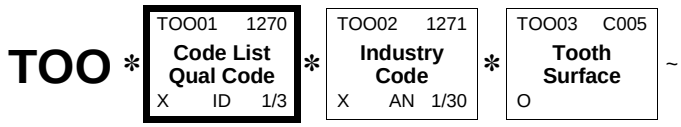
Requirement: Optional

Max Use: 32

Purpose: To identify a tooth by number and, if applicable, one or more tooth surfaces

Syntax: **1. P0102**
If either TOO01 or TOO02 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TOO01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list SYNTAX: P0102	**X ID 1/3**

CODE	DEFINITION
JP	**National Standard Tooth Numbering System** CODE SOURCE **135:** American Dental Association Codes

SITUATIONAL **TOO02** **1271** **Industry Code** **X** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Tooth Code***

ALIAS: ***Tooth Number***

SYNTAX: P0102

NSF Reference:

FD0-05.0, FD0-07.0, FD0-09.0, FD0-11.0

See Appendix C for code source 135: American Dental Association Codes.

SITUATIONAL **TOO03** **C005** **TOOTH SURFACE** **O**
To identify one or more tooth surface codes

Required if the procedure code requires tooth surface codes.

REQUIRED **TOO03 - 1** **1369** **Tooth Surface Code** **M** **ID** **1/2**
Code identifying the area of the tooth that was treated

NSF Reference:

FD0-06.0, FD0-08.0, FD0-10.0, FD0-12.0

CODE	DEFINITION
B	**Buccal**
D	**Distal**
F	**Facial**
I	**Incisal**
L	**Lingual**
M	**Mesial**
O	**Occlusal**

SITUATIONAL **TOO03 - 2** **1369** **Tooth Surface Code** **O** **ID** **1/2**
Code identifying the area of the tooth that was treated

Additional tooth surface codes can be carried in TOO03-2 through TOO03-5. The code values are the same as in TOO03-1.

Required to report a second tooth surface.

SITUATIONAL **TOO03 - 3** **1369** **Tooth Surface Code** **O** **ID** **1/2**
Code identifying the area of the tooth that was treated

Required to report a third tooth surface.

SITUATIONAL **TOO03 - 4** **1369** **Tooth Surface Code** **O** **ID** **1/2**
Code identifying the area of the tooth that was treated

Required to report a fourth tooth surface.

SITUATIONAL **TOO03 - 5** **1369** **Tooth Surface Code** **O** **ID** **1/2**
Code identifying the area of the tooth that was treated

Required to report a fifth tooth surface.

IMPLEMENTATION

DATE - SERVICE

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the service date is different than the service date reported at the DTP segment in the 2300 loop.**

Example: **DTP*472*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

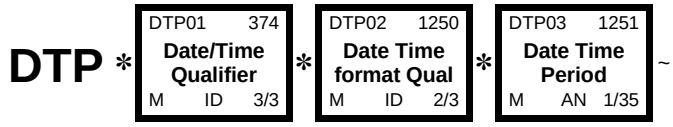
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE **DEFINITION**	
			472 Service	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**M ID 2/3**
			SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	
			CODE **DEFINITION**	
			D8 Date Expressed in Format CCYYMMDD	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Service Date***

NSF Reference:

FA0-05.0, FA0-06.0

IMPLEMENTATION

DATE - PRIOR PLACEMENT

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if the services performed are prosthetic services that were previously placed.**
2. **If the SV305 data element = "R - Replacement" the Prior Placement date is required.**

Example: **DTP*441*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

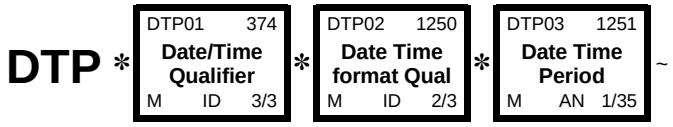
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier***	**M ID 3/3**
			CODE / **DEFINITION** **441** / **Prior Placement**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **NSF Reference:** **FD0-14.0**	**M ID 2/3**
			CODE / **DEFINITION** **D8** / **Date Expressed in Format CCYYMMDD**	

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Prior Placement Date***	**M**	**AN**	**1/35**

IMPLEMENTATION

DATE - APPLIANCE PLACEMENT

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if the orthodontic appliance placement date is different than the orthodontic appliance placement date in the DTP segment in the 2300 loop.**

Example: **DTP*452*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

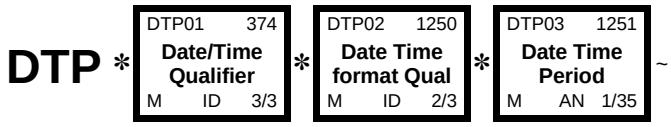
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **452 — Appliance Placement**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **NSF Reference:** **FD0-19.0** **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Orthodontic Banding Date***	**M**	**AN**	**1/35**

IMPLEMENTATION

DATE - REPLACEMENT

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This DTP segment should be used to report the date an orthodontic appliance was replaced.**

Example: **DTP*446*D8*19980108~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

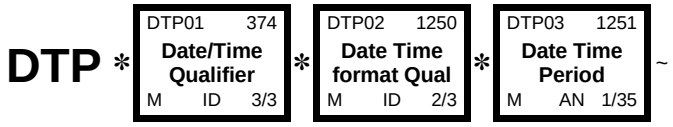
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **446 — Replacement**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. **NSF Reference:** **FD0-22.0** **D8 — Date Expressed in Format CCYYMMDD**	**M ID 2/3**

REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M**	**AN**	**1/35**

INDUSTRY: ***Replacement Date***

IMPLEMENTATION

ANESTHESIA QUANTITY

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:
1. **Required on anesthesia service lines if one or more extenuating circumstances, coded in the QTY01, was present at the time of service.**

Example: **QTY*BF*3~**

STANDARD

QTY Quantity

Level: Detail

Position: 460

Loop: 2400

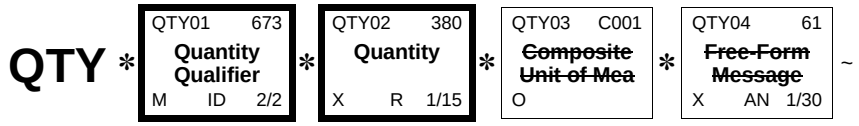
Requirement: Optional

Max Use: 5

Purpose: To specify quantity information

Syntax:
1. **R0204**
   At least one of QTY02 or QTY04 is required.
2. **E0204**
   Only one of QTY02 or QTY04 may be present.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**M ID 2/2**

CODE	DEFINITION
BF	**Age Modifying Units**
EM	**Emergency Modifying Units**
HM	**Use of Hypothermia**
HO	**Use of Hypotension**
HP	**Use of Hyperbaric Pressurization**
P3	**Physical Status III**

			P4	**Physical Status IV**			
			P5	**Physical Status V**			
			SG	**Swan-Ganz**			
REQUIRED	**QTY02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Anesthesia Unit Count*** SYNTAX: R0204, E0204		**X**	**R**	**1/15**
NOT USED	**QTY03**	**C001**	**COMPOSITE UNIT OF MEASURE**		**O**		
NOT USED	**QTY04**	**61**	**Free-Form Message**		**X**	**AN**	**1/30**

IMPLEMENTATION

SERVICE PREDETERMINATION IDENTIFICATION

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment shoud be used to send the line level Predetermination of Benefits Identification Number for a service that was previously predetermined and is now being submitted for payment.**

Example: **REF*G3*MCN12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

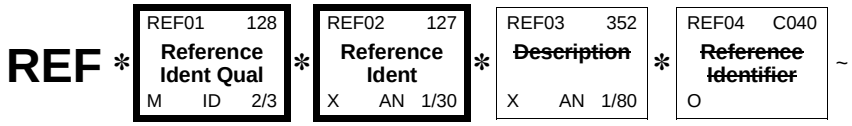
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION	
			G3 — Predetermination of Benefits Identification Number	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Predetermination of Benefits Identifier*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

REFERRAL NUMBER

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if service line involved a referral number that is different than the number reported at the claim level (loop ID-2300).**

Example: **REF*9F*123456567~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

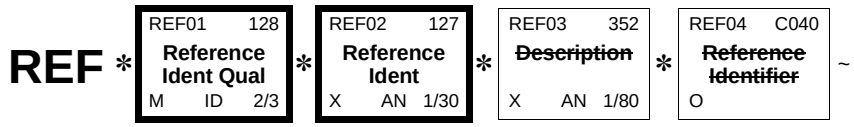
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE — DEFINITION **9F — Referral Number**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referral Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

LINE ITEM CONTROL NUMBER

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required if it is necessary to send a line control or inventory number. It is strongly suggested that providers send this number, particularly if the provider automatically posts their remittance advice. Payers are required to return this number in the remittance advice transaction (835) if the provider sends it to them in the 837.**

Example: **REF*6R*543211~**

STANDARD

REF Reference Identification

Level: Detail

Position: 470

Loop: 2400

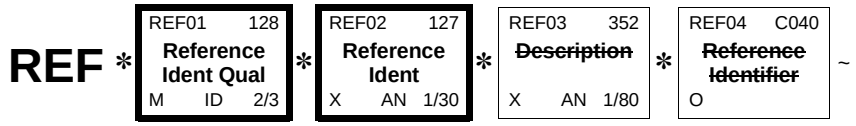
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
6R	**Provider Control Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Line Item Control Number*** SYNTAX: R0203 **NSF Reference:** **FA0-04.4, FB0-04.0, FB1-04.0, FB2-04.0, FD0-04.0, FE0-04.0, HA0-04.0**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

APPROVED AMOUNT

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used only in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.**
2. **The approved amount equals the amount for the service line that was approved by the payer sending this 837 to another payer.**

Example: **AMT*AAE*300~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

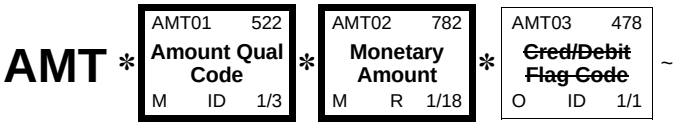
Loop: 2400

Requirement: Optional

Max Use: 15

Purpose: To indicate the total monetary amount

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			AAE — Approved Amount			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Approved Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

LINE NOTE

Loop: **2400 — LINE COUNTER**

Usage: **SITUATIONAL**

Repeat: **10**

Notes: **1. Required if the submitter used a "Not Otherwise Classified" (NOC) or a "By Report" procedure code or to report the following information on this service line: Date of Initial Impression, Date of Initial Preparation Crown, Initial Preparation Crown Tooth Number or Initial Endodontic Treatment.**

Example: **NTE*ADD*PATIENT IS HANDICAPPED AND REQUIRED BEHAVIORAL MANAGEMENT TO COMPLETE TREATMENT~**

STANDARD

NTE Note/Special Instruction

Level: Detail

Position: 485

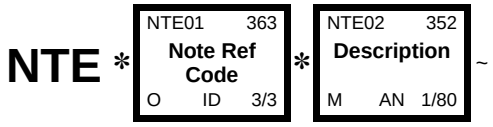
Loop: 2400

Requirement: Optional

Max Use: 10

Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NTE01**	**363**	**Note Reference Code** Code identifying the functional area or purpose for which the note applies	**O ID 3/3**
			CODE / DEFINITION **ADD — Additional Information**	
REQUIRED	**NTE02**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Claim Note Text*** **NSF Reference:** **HA0-05.0**	**M AN 1/80**

IMPLEMENTATION

RENDERING PROVIDER NAME

Loop: **2420A — RENDERING PROVIDER NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.**

2. **Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering Provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider that what is given in the 2010AA/AB loop.**

Example: **NM1*82*1*DICE*LINDA****34*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

Set Notes:

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

Syntax:

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

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

DIAGRAM

NM1 * NM101 98 **Entity ID Code** M ID 2/3 * NM102 1065 **Entity Type Qualifier** M ID 1/1 * NM103 1035 **Name Last/ Org Name** O AN 1/35 * NM104 1036 **Name First** O AN 1/25 * NM105 1037 **Name Middle** O AN 1/25 * NM106 1038 ~~**Name Prefix**~~ O AN 1/10

* NM107 1039 **Name Suffix** O AN 1/10 * NM108 66 **ID Code Qualifier** X ID 1/2 * NM109 67 **ID Code** X AN 2/80 * NM110 706 ~~**Entity Relat Code**~~ X ID 2/2 * NM111 98 ~~**Entity ID Code**~~ O ID 2/3 ~

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			The entity identifier in NM101 applies to all segments in Loop ID-2420.	
			CODE / DEFINITION	
			82 Rendering Provider	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M ID 1/1**
			CODE / DEFINITION	
			1 Person	
			2 Non-Person Entity	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:*** ***Rendering Provider Last or Organization Name*** **NSF Reference:** **FB1-14.0**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:*** ***Rendering Provider First Name*** **NSF Reference:** **FB1-15.0** **Required if NM102 = 1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:*** ***Rendering Provider Middle Name*** **NSF Reference:** **FB1-16.0** **Required if NM102 = 1 and the middle name/initial of the person is known.**	**O AN 1/25**
NOT USED	**NM106**	**1038**	**Name Prefix**	**O AN 1/10**
SITUATIONAL	**NM107**	**1039**	**Name Suffix** Suffix to individual name ***INDUSTRY:*** ***Rendering Provider Name Suffix*** **ADVISORY:** Under most circumstances, this element is not sent. **Required if known.**	**O AN 1/10**

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

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

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Rendering Provider Identifier*** *ALIAS:* ***Rendering Provider Primary Identification Number*** SYNTAX: P0809 **NSF Reference:** **FA0-23.0**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

RENDERING PROVIDER SPECIALTY INFORMATION

Loop: **2420A — RENDERING PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. PRV02 qualifies PRV03.**

Example: **PRV*PE*ZZ*1223P0300Y~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

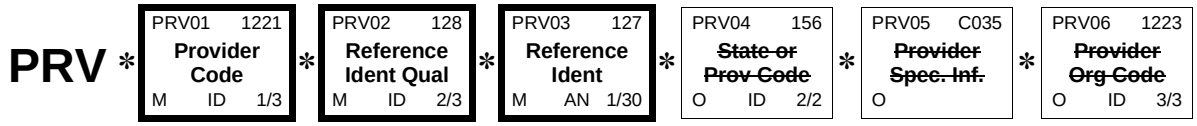
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**PRV01**	**1221**	**Provider Code** Code indentifying the type of provider	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			PE — **Performing**			
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE / DEFINITION			
			ZZ — **Mutually Defined** **ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ANSI ASC X12N TG2 WG15.**			

REQUIRED	**PRV03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Provider Taxonomy Code*** *ALIAS:* ***Provider Specialty Code***	**M**	**AN**	**1/30**
NOT USED	**PRV04**	**156**	**State or Province Code**	**O**	**ID**	**2/2**
NOT USED	**PRV05**	**C035**	**PROVIDER SPECIALTY INFORMATION**	**O**		
NOT USED	**PRV06**	**1223**	**Provider Organization Code**	**O**	**ID**	**3/3**

IMPLEMENTATION

ADDITIONAL RENDERING PROVIDER NAME INFORMATION

Loop: **2420A — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **N2*ADDITIONAL NAME INFORMATION~**

STANDARD

N2 Additional Name Information

Level: Detail

Position: 510

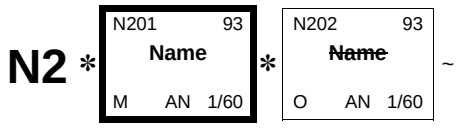
Loop: 2420

Requirement: Optional

Max Use: 2

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

RENDERING PROVIDER SECONDARY IDENTIFICATION

Loop: **2420A — RENDERING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

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

Example: **REF*0B*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

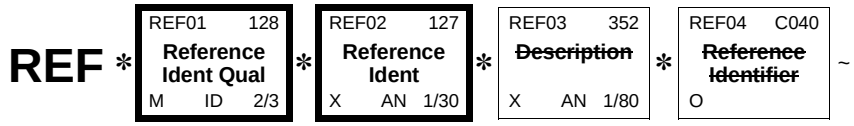
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1E	**Dentist License Number**

			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The Social Security Number may not be used for Medicare.**			
			TJ	**Federal Taxpayer's Identification Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Rendering Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER PAYER REFERRAL NUMBER

Loop: **2420B — OTHER PAYER REFERRAL NUMBER** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when it is necessary, in COB situations, to send a payer specific line level referral number. The payer-specific numbers carried in the REF in this loop belong to the non-destination (COB) payer.**

2. **The strategy in using this loop is to use NM109 to identify which payer referral number carried in the REF of this loop belongs to. For example, if there are two COB payers (non-destination payers) who have additional referral numbers for this service line the data string for the 2420C loop would look like this:**

   NM1*PR*2*PAYER1***PI*PAYER #1 ID~ (This payer ID would be identified in an iteration of the loop 2330B in it's own 2320 loop)**
   REF*9F*AAAAAAA~
   NM1*PR*2*PAYER2***PI*PAYER #2 ID~ (This payer ID would be identified in an iteration of the loop 2330B in it's own 2320 loop)**
   REF*9F*2*BBBBBB~

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

Example: **NM1*PR*2*PAYER1*****PI*111222333~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

Set Notes:

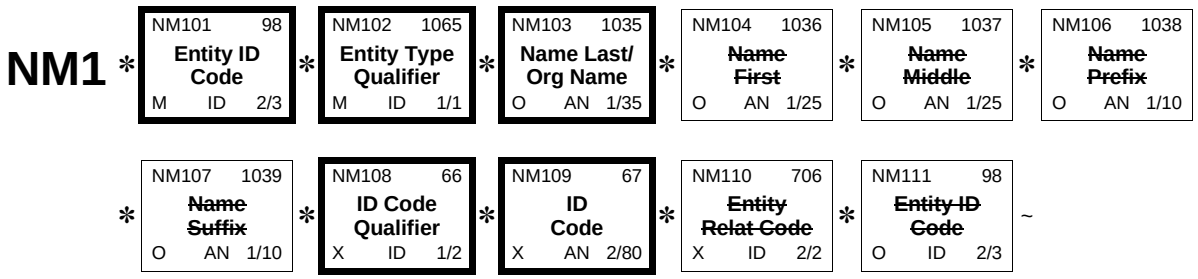
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Syntax:

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

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

DIAGRAM



ELEMENT SUMMARY

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

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Payer Referral Number*** *ALIAS:* ***Other Payer Referral Identification*** SYNTAX: P0809 **Must match corresponding Other Payer Identifier in NM109 in 2330B loop(s).**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

OTHER PAYER REFERRAL NUMBER

Loop: **2420B — OTHER PAYER REFERRAL NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when COB Payer (listed in 2330B loop) has one or more line-level referral numbers for this service line.**

Example: **REF*9F*AB333-Y6~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

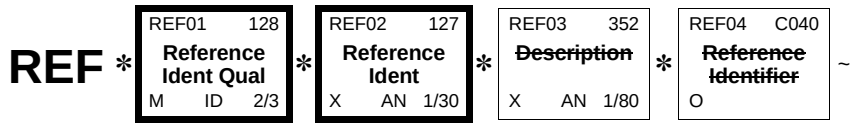
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **9F — Referral Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Prior Authorization or Referral Number*** SYNTAX: R0203	**X AN 1/30**
NOT USED	**REF03**	**352**	**Description**	**X AN 1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**

IMPLEMENTATION

LINE ADJUDICATION INFORMATION

Loop: 2430 — LINE ADJUDICATION INFORMATION Repeat: 25

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **To show unbundled lines: If, in the original claim, line 3 is unbundled into (for examples) 2 additional lines, then the SVD for line 3 is used 3 times: once for the original adjustment to line 3 and then two more times for the additional unbundled lines. If a line item control number (REF01 = 6R) exists for the line, that number may be used in SVD06 instead of the LX number when a line is unbundled.**

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

3. **Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.**

Example: SVD*43*55*AD:D03301~**

STANDARD

SVD Service Line Adjudication

Level: Detail

Position: 540

Loop: 2430 **Repeat:** >1

Requirement: Optional

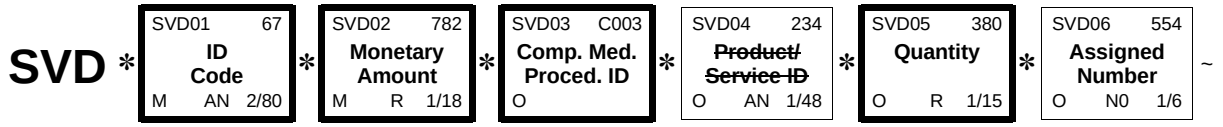
Max Use: 1

Purpose: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

Set Notes:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SVD01**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Payer Primary Identifier*** *ALIAS:* ***Payer Identification Code*** **SEMANTIC:** SVD01 is the payer identification code. **This number shown matches NM109 in the Loop ID-2330B Identifying other payer.** **Crosswalked from 004010 835 Loop 1000A N104 (if PlanID is used) or REF02.**	**M AN 2/80**
REQUIRED	**SVD02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Service Line Paid Amount*** *ALIAS:* ***Amount Paid for This Service Line*** **SEMANTIC:** SVD02 is the amount paid for this service line. **NSF Reference:** **FA0-52.0** **Zero "0" is an acceptable value for this element.** **The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations.** **Crosswalked from 004010 835 SVC03.**	**M R 1/18**
REQUIRED	**SVD03**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers **This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transaction.** **Crosswalked from 004010 835 SVC01.**	**O**
REQUIRED	**SVD03 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**

CODE	DEFINITION
AD	**American Dental Association Codes** **CODE SOURCE 135:** American Dental Association Codes
ZZ	**Mutually Defined** **Jurisdictionally Defined Procedure and Suppply Codes (used for Worker's Compensation claims).**

REQUIRED	**SVD03 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code***	**M AN 1/48**

SITUATIONAL	**SVD03 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Use this modifier for the first procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
SITUATIONAL	**SVD03 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Use this modifier for the second procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
SITUATIONAL	**SVD03 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Use this modifier for the third procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
SITUATIONAL	**SVD03 - 6**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners	**O**	**AN**	**2/2**
			Use this modifier for the fourth procedure code modifier.			
			Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.			
SITUATIONAL	**SVD03 - 7**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Procedure Code Description*** **Required if SVC01-7 was returned in the 835 transaction.**	**O**	**AN**	**1/80**
NOT USED	**SVD04**	**234**	**Product/Service ID**	**O**	**AN**	**1/48**
REQUIRED	**SVD05**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Paid Service Unit Count*** **SEMANTIC:** SVD05 is the paid units of service. **Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units. Crosswalked from 004010 835 SVC05.**	**O**	**R**	**1/15**

SITUATIONAL	**SVD06**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set	**O**	**N0**	**1/6**

INDUSTRY: ***Bundled or Unbundled Line Number***

ALIAS: ***Bundled/Unbundled Line Number***

COMMENT: SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.

Use the line item control number (REF01 = 6R) or the LX from this transaction which points to the bundled line. Required if payer bundled the service line.

IMPLEMENTATION

SERVICE ADJUSTMENT

Loop: **2430 — LINE ADJUDICATION INFORMATION**

Usage: **SITUATIONAL**

Repeat: **99**

Notes:

1. **Required if the payer identified in loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.**

2. **Mapping CAS information into a flat file format may involve reading specific Claim Adjustment Reason Codes and then mapping the subsequent Monetary Amount and/or Quantity elements to specified fields in the flat file.**

3. **There are some NSF COB elements which are covered through the use of the CAS segment. Please see the claim level CAS segment for a note on handling those crosswalks at the claim level. Some of that information may apply at the line level. Further information is given below which is more specific to line level issues.**

   Balance bill limiting charge (FA0-54.0). The adjustment for this information would be conveyed in a CAS amount element if the provider billed for more than they were allowed under contract.

4. **The Claim Adjustment Reason codes are located on the Washington Publishing Company web site: http://www.wpc-edi.com.**

Example: **CAS*PR*1*793~**

Example: **CAS*OA*93*0~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 545

Loop: 2430

Requirement: Optional

Max Use: 99

Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Syntax:

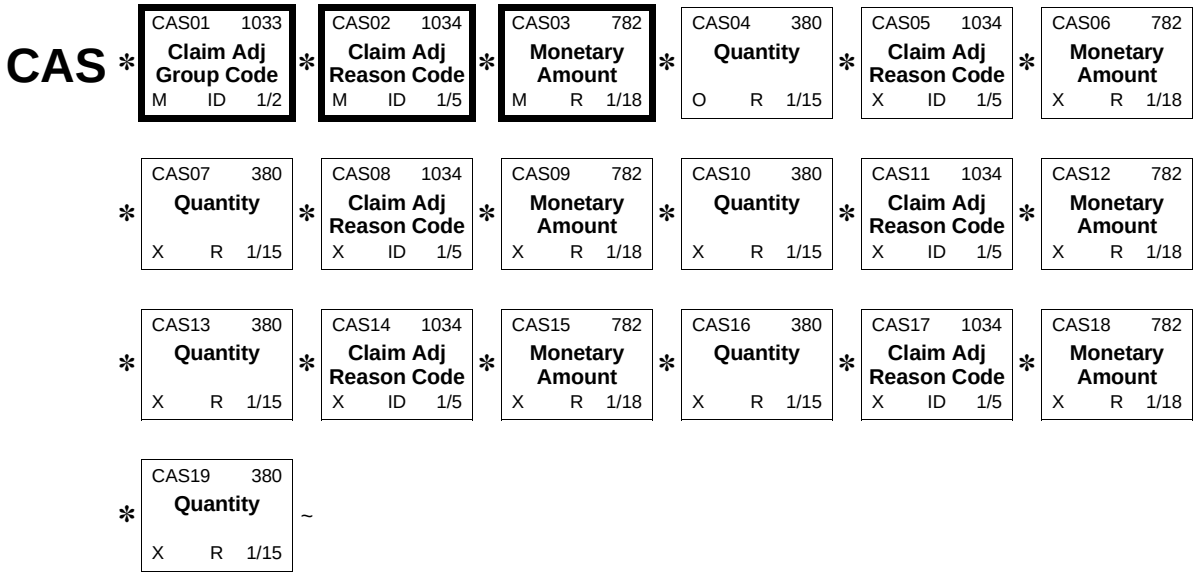
1. **L050607**
   If CAS05 is present, then at least one of CAS06 or CAS07 are required.

2. **C0605**
   If CAS06 is present, then CAS05 is required.

3. **C0705**
   If CAS07 is present, then CAS05 is required.

4. **L080910**
   If CAS08 is present, then at least one of CAS09 or CAS10 are required.
5. **C0908**
   If CAS09 is present, then CAS08 is required.
6. **C1008**
   If CAS10 is present, then CAS08 is required.
7. **L111213**
   If CAS11 is present, then at least one of CAS12 or CAS13 are required.
8. **C1211**
   If CAS12 is present, then CAS11 is required.
9. **C1311**
   If CAS13 is present, then CAS11 is required.
10. **L141516**
    If CAS14 is present, then at least one of CAS15 or CAS16 are required.
11. **C1514**
    If CAS15 is present, then CAS14 is required.
12. **C1614**
    If CAS16 is present, then CAS14 is required.
13. **L171819**
    If CAS17 is present, then at least one of CAS18 or CAS19 are required.
14. **C1817**
    If CAS18 is present, then CAS17 is required.
15. **C1917**
    If CAS19 is present, then CAS17 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment *ALIAS:* ***Adjustment Group Code***	**M**	**ID**	**1/2**

CODE	DEFINITION
CO	**Contractual Obligations**
CR	**Correction and Reversals**
OA	**Other adjustments**
PI	**Payor Initiated Reductions**
PR	**Patient Responsibility**

REQUIRED	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** *ALIAS:* ***Adjustment Reason Code - Line Level*** **CODE SOURCE 139:** Claim Adjustment Reason Code **NSF Reference:** **FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0** **Use the Claim Adjustment Reason code list (see Appendix C).**	**M**	**ID**	**1/5**
REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Adjustment Amount*** *ALIAS:* ***Adjusted Amount - Line Level*** **SEMANTIC:** CAS03 is the amount of adjustment. **COMMENT:** When the submitted charges are paid in full, the value for CAS03 should be zero. **NSF Reference:** **FA0-027.0, FA0-28.0, FA0-35.0, FA0-48.0, FB0-06.0, FB0-07.0, FB0-08.0, FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0** **Use this amount for the adjustment amount.**	**M**	**R**	**1/18**
SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** *ALIAS:* ***Adjusted Units - Line Level*** **SEMANTIC:** CAS04 is the units of service being adjusted. **Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.**	**O**	**R**	**1/15**

SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L050607, C0605, C0705

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L050607, C0605

SEMANTIC: CAS06 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

SITUATIONAL	**CAS07**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L050607, C0705

SEMANTIC: CAS07 is the units of service being adjusted.

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

SITUATIONAL	**CAS08**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L080910, C0908, C1008

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L080910, C0908

SEMANTIC: CAS09 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L080910, C1008

SEMANTIC: CAS10 is the units of service being adjusted.

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

SITUATIONAL	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L111213, C1211, C1311

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L111213, C1211

SEMANTIC: CAS12 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L111213, C1311

SEMANTIC: CAS13 is the units of service being adjusted.

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

SITUATIONAL	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L141516, C1514, C1614

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L141516, C1514

SEMANTIC: CAS15 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L141516, C1614

SEMANTIC: CAS16 is the units of service being adjusted.

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

SITUATIONAL	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**ID**	**1/5**

INDUSTRY: ***Adjustment Reason Code***

ALIAS: ***Adjustment Reason Code - Line Level***

SYNTAX: L171819, C1817, C1917

CODE SOURCE 139: Claim Adjustment Reason Code

NSF Reference:

FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount	**X**	**R**	**1/18**

INDUSTRY: ***Adjustment Amount***

ALIAS: ***Adjusted Amount - Line Level***

SYNTAX: L171819, C1817

SEMANTIC: CAS18 is the amount of the adjustment.

NSF Reference:

FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

SITUATIONAL	**CAS19**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Adjusted Units - Line Level***

SYNTAX: L171819, C1917

SEMANTIC: CAS19 is the units of service being adjusted.

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

IMPLEMENTATION

LINE ADJUDICATION DATE

Loop: **2430 — LINE ADJUDICATION INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **DTP*573*D8*19961131~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 550

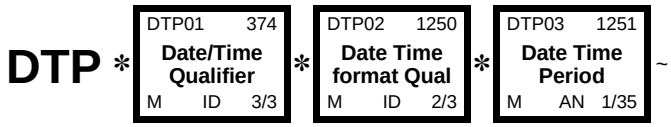
Loop: 2430

Requirement: Optional

Max Use: 9

Purpose: To specify any or all of a date, a time, or a time period

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time *INDUSTRY:* ***Date Time Qualifier*** **573** = **Date Claim Paid**	**M ID 3/3**
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. **D8** = **Date Expressed in Format CCYYMMDD**	**M ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Adjudication or Payment Date***	**M AN 1/35**

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*211*987654~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 555

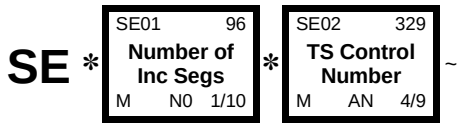
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments *INDUSTRY:* ***Transaction Segment Count***	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set *ALIAS:* ***Transaction Set Control Number*** **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.**	**M AN 4/9**

4 EDI Transmission Examples for Different Business Uses

4.1 Dental

4.1.1 Example 1

The patient is a different person than the subscriber. The payer is a commercial health insurance company.

SUBSCRIBER: Jane Smith
KEY INSURANCE COMPANY ID#: SSN
SSN: 111-22-3333

PATIENT: Ted Smith
PATIENT ADDRESS: 236 N. Main St., Miami, FL, 33413
SEX: M
DOB: 05/01/73
PATIENT RELATIONSHIP: Child

DESTINATION PAYER: Insurance Company XYZ

RECEIVER: Insurance Company XYZ
ETIN#: 66783JJT

SUBMITTER: Premier Billing Service
ETIN#: TGJ23

BILLING PROVIDER: Dental Associates
TIN: 587654321
ADDRESS: 234 Seaway St., Miami, FL, 33111

RENDERING PROVIDER: Dr. Ben Kildare
SSN: 999996666

PATIENT ACCOUNT NUMBER: 2-640-3774
DOS: 02091999
POS=Office
SERVICES RENDERED: Two surface amalgam on tooth #12 (mesial and occlusal surfaces) and prophy.
CHARGES: amalgam = $100.00, prophy = $50.00.

ELECTRONIC ROUTE: VAN submits claim on behalf of billing provider (submitter) to Insurance Company XYZ (receiver).
VAN CLAIM IDENTIFICATION NUMBER: 17312345600006351.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	HEADER ST TRANSACTION SET CONTROL NUMBER ST*837*3456~
2	BHT TRANSACTION SET HIERACHY AND CONTROL INFORMATION BHT*0019*00*0123*19990210*1023*CH~
3	REF TRANMISSION TYPE INDENTIFICATION REF*87*004010X097~
4	1000A SUBMITTER NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*TGJ23~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*7176149999~
6	1000B RECEIVER NM1 RECEIVER NM1*40*2*INSURANCE COMPANY XYZ*****46*66783JJT~
7	2000A BILLING/PAY-TO PROVIDER HL LOOP Hierarchical Level 1 HL*1**20*1~
8	2010AA BILLING PROVIDER NM1 BILLING PROVIDER NAME NM1*85*2*DENTAL ASSOCIATES*****34*587654321~
9	N3 BILLING PROVIDER ADDRESS N3*234 SEAWAY ST~
10	N4 BILLING PROVIDER'S CITY N4*MIAMI*FL*33111~
11	2000B SUBSCRIBER HL LOOP Hierarchical Level 2 HL*2*1*22*1~
12	SBR SUBSCRIBER INFORMATION SBR*P*****6***CI~
13	2010BA SUBSCRIBER NM1 SUBSCRIBER'S NAME NM1*IL*1*SMITH*JANE****MI*111223333~
14	2010BB SUBSCRIBER/PAYER NM1 PAYER'S NAME NM1*PR*2*INSURANCE COMPANY XYZ*****PI*66783JJT~

SEG #	LOOP SEGMENT/ELEMENT STRING
15	2000C PATIENT'S HL LOOP Hierarchical Level 3 HL*3*2*23*0~
16	PAT PATIENT INFORMATION PAT*19~
17	2010CA PATIENT NM1 PATIENT'S NAME NM1*QC*1*SMITH*TED~
18	N3 PATIENT'S ADDRESS N3*236 N MAIN ST~
19	N4 PATIENT'S CITY N4*MIAMI*FL*33413~
20	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
21	2300 CLAIM CLM Health CLAIM INFORMATION CLM*26403774*150***11::1*Y**Y*Y~
22	DTP DATE - SERVICE DATE DTP*472*D8*19990209~
23	REF VAN CLAIM NUMBER REF*D9*17312345600006351~
24	2310C RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****34*123456789~
25	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~
26	2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~
27	SV3 DENTAL SERVICE SV3*AD:D2150*100****1~
28	TOO TOOTH NUMBER/SURFACES TOO*JP*12*M:0~
29	2400 SERVICE LINE LX SERVICE LINE NUMBER LX*2~
30	SV3 DENTAL SERVICE SV3*AD:D1110*50****1~
31	TRAILER SE TRANSACTION SET TRAILER SE*31*3456~

Complete Data String:

```
ST*837*3456~
BHT*0019*00*0123*19990210*1023*CH~
REF*87*004010X097~
NM1*41*2*PREMIER BILLING SERVICE*****46*TGJ23~
PER*IC*JERRY*TE*7176149999~
NM1*40*2*INSURANCE COMPANY XYZ*****46*66783JJT~
HL*1**20*1~
NM1*85*2*DENTAL ASSOCIATES*****34*587654321~
N3*234 SEAWAY ST~
N4*MIAMI*FL*33111~
HL*2*1*22*1~
SBR*P*****6***CI~
NM1*IL*1*SMITH*JANE****MI*111223333~
NM1*PR*2*INSURANCE COMPANY XYZ*****PI*66783JJT~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*SMITH*TED~
N3*236 N MAIN ST~
N4*MIAMI*FL*33413~
DMG*D8*19730501*M~
CLM*26403774*150***11::1*Y**Y*Y~
DTP*472*D8*19990209~
REF*D9*17312345600006351~
NM1*82*1*KILDARE*BEN****34*999996666~
PRV*PE*ZZ*122300000N~
LX*1~
SV3*AD:D2150*100****1~
TOO*JP*12*M:0~
LX*2~
SV3*AD:D1110*50****1~
SE*31*3456~
```

4.1.2 Example 2

Coordination of benefits; the patient is not the subscriber; payers are commercial health insurance companies.

SUBSCRIBER FOR PAYER A: Jane Smith
DOB: 05/01/43
PAYER A ID NUMBER: JS00111223333

SUBSCRIBER FOR PAYER B: Jack Smith
DOB: 10/22/43
PAYER B ID NUMBER: T55TY666

PATIENT: Ted Smith
ADDRESS: 236 N. Main St., Miami, FL, 33413
SEX: M
DOB: 05/01/73
PATIENT RELATIONSHIP: Child

SUBMITTER: Premier Billing Service
ETIN#: 567890

DESTINATION PAYER A: (Receiver) Key Insurance Company
PAYER A ADDRESS: 3333 Ocean St., South Miami, FL, 33000
PAYER A ID NUMBER: (TIN) 999996666

DESTINATION PAYER B (Receiver): Great Prairies Health
PAYER B ADDRESS: 4456 South Shore Blvd., Chicago, IL 44444
ETIN#: 123456789

BILLING PROVIDER: Dental Associates
ADDRESS: 234 Seaway St., Miami, FL, 33111
TIN: 587654321

RENDERING PROVIDER: Dr. Ben Kildare
SSN: 123454321

PATIENT ACCOUNT NUMBER: 2-640-3774
DOS=02/09/99
POS=Office
SERVICES RENDERED: Root Canal treatment for tooth #5 at $200.00.

ELECTRONIC ROUTE: VAN submits claim on behalf of billing provider to Payer A (receiver) (Example 2A) who adjudicates the claim. Payer A transmits back an 835 to the billing provider. The VAN then submits a second claim on behalf of the billing provider to Payer B (receiver) (Example 2B)

VAN CLAIM IDENTIFICATION NUMBER FOR PAYER A: 111222333444.
VAN CLAIM IDENTIFICATION NUMBER FOR PAYER B: 444333222111.

Example 2.A - Claim to Payer A From Billing Provider

SEG #	LOOP SEGMENT/ELEMENT STRING
1	HEADER ST TRANSACTION SET CONTROL NUMBER ST*837*0002~

SEG #	LOOP SEGMENT/ELEMENT STRING
2	BHT TRANSACTION SET HIERACHY AND CONTROL INFORMATION BHT*0019*00*0123*19990210*1023*CH~
3	REF TRANMISSION TYPE INDENTIFICATION REF*87*004010X097~
4	1000A SUBMITTER NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*567890~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*7176149999~
6	1000B RECEIVER NM1 RECEIVER NM1*40*2*KEY INSURANCE COMPANY*****46*999996666~
7	2000A BILLING/PAY-TO PROVIDER HL LOOP Hierarchical Level 1 HL*1**20*1~
8	2010AA BILLING PROVIDER NM1 BILLING PROVIDER NAME NM1*85*2*DENTAL ASSOCIATES*****34*587654321~
9	N3 BILLING PROVIDER ADDRESS N3*234 SEAWAY ST~
10	N4 BILLING PROVIDER CITY N4*MIAMI*FL*33111~
11	2000B SUBSCRIBER HL LOOP Hierarchical Level 2 HL*2*1*22*1~
12	SBR SUBSCRIBER INFORMATION SBR*P*****6***CI~
13	2010BA SUBSCRIBER NM1 SUBSCRIBER’S NAME NM1*IL*1*SMITH*JANE****MI*JS00111223333~
14	2010BB SUBSCRIBER/PAYER NM1 PAYER NAME NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~
15	2000C PATIENT HL LOOP Hierarchical Level 3 HL*3*2*23*0~
16	PAT PATIENT INFORMATION PAT*19~

SEG #	LOOP SEGMENT/ELEMENT STRING
17	2010CA PATIENT NM1 PATIENT'S NAME NM1*QC*1*SMITH*TED~
18	N3 PATIENT'S ADDRESS N3*236 N MAIN ST~
19	N4 PATIENT'S CITY N4*MIAMI*FL*33413~
20	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
21	2300 CLAIM CLM Health CLAIM INFORMATION CLM*26403774*200***11::1*Y**Y*Y~
22	DTP DATE - SERVICE DATE DTP*472*D8*19990209~
23	REF VAN CLAIM NUMBER REF*D9*111222333444~
24	2310 RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****34*123454321~
25	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~
26	2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~
27	SV3 DENTAL SERVICE SV3*AD:D3320*200****1~
28	TOO TOOTH NUMBER SURFACE(S) TOO*JP*5~
29	TRAILER SE TRANSACTION SET TRAILER SE*29*0002~

Complete Data String:

ST*837*0002~
BHT*0019*00*0123*19990210*1023*CH~
REF*87*004010X097~
NM1*41*2*PREMIER BILLING SERVICE***46*567890~**
PER*IC*JERRY*TE*7176149999~
NM1*40*2*KEY INSURANCE COMPANY***46*999996666~**
HL*120*1~**
NM1*85*2*DENTAL ASSOCIATES***34*587654321~**

```
N3*234 SEAWAY ST~
N4*MIAMI*FL*33111~
HL*2*1*22*1~
SBR*P*****6***CI~
NM1*IL*1*SMITH*JANE****MI*JS00111223333~
NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*SMITH*TED~
N3*236 N MAIN ST~
N4*MIAMI*FL*33413~
DMG*D8*19730501*M~
CLM*26403774*200***11::1*Y**Y*Y~
DTP*472*D8*19990209~
REF*D9*111222333444~
NM1*82*1*KILDARE*BEN****34*123454321~
PRV*PE*ZZ*122300000N~
LX*1~
SV3*AD:D3320*200****1~
TOO*JP*5~
SE*29*0002~
```

Payer A returned an electronic remittance advice (835) to the billing provider with the following amounts and claim adjustment reason codes:

SUBMITTED CHARGES (CLP003): 200.00
AMOUNT PAID (CLP04): 150.00
PATIENT RESPONSIBILITY (CLP05): 50.00

The CAS at the claim level was:
CAS*PR*1*50*1~ (INDICATES A $50.00 DEDUCTIBLE PAYMENT IS DUE FROM PATIENT).

See the introduction for a discussion on cross walking 835 to 837.

Example 2.B - Claim to Payer B From Billing Provider

SEG #	LOOP SEGMENT/ELEMENT STRING
1	HEADER ST TRANSACTION SET CONTROL NUMBER ST*837*0123~
2	BHT TRANSACTION SET HIERACHY AND CONTROL INFORMATION BHT*0019*00*0123*19990220*1023*CH~
3	REF TRANMISSION TYPE INDENTIFICATION REF*87*004010X097~

SEG #	LOOP SEGMENT/ELEMENT STRING
4	1000A SUBMITTER NM1 SUBMITTER NM1*41*2*PREMIER BILLING SERVICE*****46*567890~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*7176149999~
6	1000B RECEIVER NM1 RECEIVER NM1*40*2*GREAT PRAIRIES HEALTH*****46*123456789~
7	2000A BILLING/PAY-TO PROVIDER HL LOOP Hierarchical Level 1 HL*1**20*1~
	2010AA BILLING PROVIDER
8	NM1 BILLING PROVIDER NAME NM1*85*2*DENTAL ASSOCIATES*****34*587654321~
9	N3 BILLING PROVIDER ADDRESS N3*234 SEAWAY ST~
10	N4 BILLING PROVIDER CITY N4*MIAMI*FL*33111~
11	2000B SUBSCRIBER HL LOOP Hierarchical Level 2 HL*2*1*22*1~
12	SBR SUBSCRIBER INFORMATION SBR*S*****1***CI~
13	2010BA SUBSCRIBER NM1 SUBSCRIBER'S NAME NM1*IL*1*SMITH*JACK****MI*T55TY666~
14	2010BB SUBSCRIBER/PAYER NM1 PAYER NAME NM1*PR*2*GREAT PRAIRIES HEALTH*****PI*123456789~
15	2000C PATIENT'S HL LOOP Hierarchical Level 3 HL*3*2*23*0~
16	PAT PATIENT INFORMATION PAT*19~
17	2010CA PATIENT NM1 PATIENT'S NAME NM1*QC*1*SMITH*TED
18	N3 PATIENT'S ADDRESS N3*236 N MAIN ST~

SEG #	LOOP SEGMENT/ELEMENT STRING
19	N4 PATIENT'S CITY N4*MIAMI*FL*33413~
20	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19730501*M~
	2300 CLAIM
21	CLM Health CLAIM INFORMATION CLM*26403774*200***11::1*Y**Y*Y~
22	DTP DATE - SERVICE DATE DTP*472*19990209~
23	REF VAN CLAIM NUMBER REF*D9*444333222111~
24	2310 RENDERING PROVIDER NM1 RENDERING PROVIDER'S NAME NM1*82*1*KILDARE*BEN****34*123454321~
25	PRV RENDERING PROVIDER INFORMATION PRV*PE*ZZ*122300000N~
26	2320 OTHER SUBSCRIBER INFORMATION SBR SUBSCRIBER INFORMATION - OTHER PAYERS SBR*P*19*******CI~
27	CAS CLAIM LEVEL ADJUSTMENTS AND AMOUNTS CAS*PR*1*50*1~
28	AMT COB - PAYER AMOUNT PAID ON CLAIM AMT*D*150~
29	AMT COB - PATIENT RESPONSIBILITY AMT*F2*50~
30	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~
31	OI OTHER INSURANCE COVERAGE INFORMATION OI***Y***Y~
32	2300A OTHER INSURED NAME NM1 OTHER NAME NM1*IL*1*SMITH*JANE****MI*JS00111223333~
33	N3 OTHER SUBSCRIBER'S ADDRESS N3*236 N MAIN ST~
34	N4 OTHER SUBSCRIBER'S CITY N4*MIAMI*FL*33413~
35	2300B OTHER PAYER NAME NM1 OTHER PAYER NAME NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~

SEG #	LOOP SEGMENT/ELEMENT STRING

```
36   2400 SERVICE LINE
     LX SERVICE LINE NUMBER
     LX*1~

37   SV3 DENTAL SERVICE
     SV3*AD:D3320*200****1~

38   TOO TOOTH NUMBER/SURFACE(S)
     TOO*JP*5~

39   TRAILER
     SE TRANSACTION SET TRAILER
     SE*39*0123~
```

Complete Data String:

```
ST*837*0123~
BHT*0019*00*0123*19990210*1023*CH~
REF*87*004010X097~
NM1*41*2*PREMIER BILLING SERVICE*****46*567890~
PER*IC*JERRY*TE*7176149999~
NM1*40*2*GREAT PRAIRIES HEALTH*****46*123456789~
HL*1**20*1~
NM1*85*2*DENTAL ASSOCIATES*****34*587654321~
N3*234 SEAWAY ST~
N4*MIAMI*FL*33111~
HL*2*1*22*1~
SBR*S*****1***CI~
NM1*IL*1*SMITH*JACK****MI*T55TY666~
NM1*PR*2*GREAT PRAIRIES HEALTH*****PI*123456789~
HL*3*2*23*0~
PAT*19~
NM1*QC*1*SMITH*TED~
N3*236 N MAIN ST~
N4*MIAMI*FL*33413~
DMG*D8*19730501*M~
CLM*26403774*200***11::1*Y**Y*Y~
DTP*472*19990209~
REF*D9*444333222111~
NM1*82*1*KILDARE*BEN*****34*123454321~
PRV*PE*ZZ*122300000N~
SBR*P*19*******CI~
CAS*PR*1*50*1~
AMT*D*150~
AMT*F2*50~
```

```
DMG*D8*19430501*F~
OI***Y***Y~
NM1*IL*1*SMITH*JANE****MI*JS001112223333~
N3*236 N MAIN ST~
N4*MIAMI*FL*33413~
NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~
LX*1~
SV3*AD:D3320*200****1~
TOO*JP*5~
SE*39*0123~
```

4.1.3 Example 3

Predetermination of benefits, the patient is the subscriber, the payer is a commercial payer.

SUBSCRIBER: Jane Smith
Address: 236 N. Main St., Miami, FL 33413
Sex: F
DOB: 05/01/43
Payer ID #: SSN
SSN: 111-22-3333

PATIENT: Jane Smith

SUBMITTER: ABC Clearinghouse
ETIN#: ABC123

DESTINATION PAYER: (Receiver) Key Insurance Company
Payer TIN: 999996666

BILLING PROVIDER: Dr. John Doe
Address: 123 Tooth Drive, Miami, FL. 33411
TIN#: 587654321

RENDERING PROVIDER: Dr. John Doe

PATIENT ACCOUNT NUMBER: SMITH878
POS = Office
Service Predetermined: Single crown on tooth #13 at $750.00.
This is the initial placement of the crown.
Radiograph is being sent to the payer in the mail.

ELECTRONIC PATH: VAN submits the claim on behalf of the billing provider to the payer who adjudicates the claim. VAN Claim # 123123123.

SEG #	LOOP SEGMENT/ELEMENT STRING
1	HEADER ST TRANSACTION SET CONTROL NUMBER ST*837*0321~
2	BHT TRANSACTION SET HEIRARCH AND CONTROL INFORMATION BHT*0019*00*0123*19990217*1023*CH~

SEG #	LOOP SEGMENT/ELEMENT STRING
3	REF TRANSMISSION TYPE IDENTIFICATION REF*87*004010X097~
4	1000A SUBMITTER NM1 SUBMITTER NM1*41*2*ABC CLEARINGHOUSE*****46*ABC123~
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JERRY*TE*7176149999~
6	1000B RECEIVER NM1 RECEIVER NM1*40*2*KEY INSURANCE COMPANY*****46*999996666~
7	2000A BILLING/PAY-TO PROVIDER HL LOOP HEIRARCHICAL LEVEL 1 HL*1**20*1~
8	PRV BILLING PROVIDER INFORMATION PRV*BI*ZZ*122300000N~
9	2010AA BILLING PROVIDER NM1 BILLING PROVIDER NM1*85*1*JOHN*DOE*****34*587654321~
10	N3 BILLING PROVIDER ADDRESS N3*123 TOOTH DRIVE~
11	N4 BILLING PROVIDER CITY N4*MIAMI*FL*33411~
12	2000B SUBSCRIBER HL LOOP HIERARCHICAL LEVEL 2 HL*2*1*22*1~
13	SBR SUBSCRIBER INFORMATION SBR*P*18****6***CI~
14	2010BA SUBSCRIBER NAME NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****MI*111223333~
15	N3 SUBSCRIBER ADDRESS N3*236 N MAIN STREET~
16	N4 SUBSCRIBER CITY N4*MIAMI*FL*33413~
17	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19430501*F~

SEG #	LOOP SEGMENT/ELEMENT STRING
18	2010BB SUBSCRIBER/PAYER NM1 PAYER NAME NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~
19	2300 CLAIM CLM HEALTH CLAIM INFORMATION CLM*SMITH878*750***11::1*Y**Y*Y**********PB~
20	PWK CLAIM SUPPLEMENTAL INFORMATION PWK*RB*BM***AC*SMITHJANE11122333~
21	REF VAN CLAIM NUMBER REF*D9*123123123~
22	2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~
23	SV3 DENTAL SERVICE SV3*AD:D2750*750***I*1~
24	TOO TOOTH NUMBER/SURFACE(S) TOO*JP*13~
25	TRAILER SE TRANSACTION SET TRAILER SE*25*0321~

Complete Data String:

ST*837*0321~
BHT*0019*00*0123*19990217*1023*CH~
REF*87*004010X097~
NM1*41*2*ABC CLEARINGHOUSE***46*ABC123~**
PER*IC*JERRY*TE*7176149999~
NM1*40*2*KEY INSURANCE COMPANY***46*999996666~**
HL*120*1~**
PRV*BI*ZZ*122300000N~
NM1*85*1*JOHN*DOE***34*587654321~**
N3*123 TOOTH DRIVE~
N4*MIAMI*FL*33411~
HL*2*1*22*1~
SBR*P*18**6***CI~**
NM1*IL*1*SMITH*JANE**MI*111223333~**
N3*236 N MAIN STREET~
N4*MIAMI*FL*33413~
DMG*D8*19430501*F~
NM1*PR*2*KEY INSURANCE COMPANY***PI*999996666~**
CLM*SMITH878*750*11::1*Y**Y*Y**********PB~**

```
PWK*RB*BM***AC*SMITHJANE11122333~
REF*D9*123123123~
LX*1~
SV3*AD:D2750*750***I*1~
TOO*JP*13~
SE*25*0321~
```

4.1.4 Example 4

Orthodontic treatment plan, patient is not the subscriber, the payer is a commercial payer.

SUBSCRIBER: Jane Smith
Payer ID#: SSN
SSN: 111-22-3333

PATIENT: Ted Smith
Patient Address: 236 N. Main St., Miami, FL. 33413
Sex: M
DOB: 05/01/85

SUBMITTER: Dr. John Doe
ETIN#: 940001

DESTINATION PAYER: (Receiver) Key Insurance Company
Payer TIN: 999996666

BILLING PROVIDER: Dr. John Doe
Address: 123 Tooth Drive, Miami, FL. 33411
TIN: 587654321

RENDERING PROVIDER: Dr. John Doe

PATIENT ACCOUNT NUMBER: SMITH788
POS: Office
Services: Treatment plan for orthodontic care: 36 month at $4,000. Banding date 2/15/99.

ELECTRONIC PATH: Billing provider submits claim directly to the payer.

SEG #	LOOP SEGMENT/ELEMENT STRING	
1	HEADER	
	ST TRANSACTION SET CONTROL NUMBER	
	ST*837*0322~	
2	BHT TRANSACTION SET HEIRARCH AND CONTROL INFORMATION	
	BHT*0019*00*0123*19990217*1023*CH~	
3	REF TRANSMISSION TYPE IDENTIFICATION	
	REF*87*004010X097~	
4	NM1 SUBMITTER	
	NM1*41*1*JOHN DOE*****46*940001~	

SEG #	LOOP SEGMENT/ELEMENT STRING
5	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*SALLY*TE*7175555555~
6	1000B RECEIVER NM1 RECEIVER NM1*40*2*KEY INSURANCE COMPANY*****46*999996666~
7	2000A BILLING/PAY-TO PROVIDER HL LOOP HEIRARCHICAL LEVEL 1 HL*1**20*1~
8	PRV BILLING PROVIDER INFORMATION PRV*BI*ZZ*122300000N~
9	2010AA BILLING PROVIDER NM1 BILLING PROVIDER NM1*85*1*JOHN*DOE*****34*587654321~
10	N3 BILLING PROVIDER ADDRESS N3*123 TOOTH DRIVE~
11	N4 BILLING PROVIDER CITY N4*MIAMI*FL*33411~
12	2000B SUBSCRIBER HL LOOP HIERARCHICAL LEVEL 2 HL*2*1*22*1~
13	SBR SUBSCRIBER INFORMATION SBR*P*****6***CI~
14	2010BA SUBSCRIBER NAME NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JANE****MI*111223333~
15	2010BB SUBSCRIBER/PAYER NM1 PAYER NAME NM1*PR*2*KEY INSURANCE COMPANY*****PI*999996666~
16	2000C PATIENT HL LOOP HIERARCHICAL LEVEL 3 HL*3*2*23*0~
17	PAT PATIENT INFORMATION PAT*19~
18	2010CA NM1 PATIENT NAME NM1*QC*1*SMITH*TED~
19	N3 PATIENT ADDRESS N3*236 N MAIN ST~
20	N4 PATIENT CITY N4*MIAMI*FL*33413~

SEG #	LOOP SEGMENT/ELEMENT STRING
21	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19850501*M~
22	2300 CLAIM CLM HEALTH CLAIM INFORMATION CLM*SMITH788*4000***11::1*Y**Y*Y~
23	DTP APPLIANCE PLACEMENT DATE DTP*452*D8*19990215~
23	DN1 ORTHODONTIC TOTAL MONTHS OF TREATMENT DN1*36~
24	2400 SERVICE LINE LX SERVICE LINE NUMBER LX*1~
25	SV3 DENTAL SERVICE SV3*AD:D8080*4000****1~
26	TRAILER SE TRANSACTION SET TRAILER SE*26*0322~

Complete Data String:

ST*837*0322~
BHT*0019*00*0123*19990217*1023*CH~
REF*87*004010X097~
NM1*41*1*JOHN DOE***46*940001~**
PER*IC*SALLY*TE*7175555555~
NM1*40*2*KEY INSURANCE COMPANY***46*999996666~**
HL*120*1~**
PRV*BI*ZZ*122300000N~
NM1*85*1*JOHN*DOE***34*587654321~**
N3*123 TOOTH DRIVE~
N4*MIAMI*FL*33411~
HL*2*1*22*1~
SBR*P***6***CI~**
NM1*IL*1*SMITH*JANE**MI*111223333~**
NM1*PR*2*KEY INSURANCE COMPANY***PI*999996666~**
HL*3*2*23*0~
PAT*19~
NM1*QC*1*SMITH*TED~
N3*236 N MAIN ST~
NR*MIAMI*FL*33413~
DMG*D8*19850501*M~

```
CLM*SMITH788*4000***11::1*Y**Y*Y~
DTP*452*D8*19990215~
DN1*36~
LX*1~
SV3*AD:D8080*4000****1~
SE*26*0322~
```

4.2 Property and Casualty

Healthcare Bill to Property & Casualty Payer The requirements for submitting of Healthcare bills to Property & Casualty payers to ensure prompt processing, meet jurisdictional requirements, and avoid potential fined and penalties are presented here.

837 Transaction Set

Bills resulting from accident or occupationally-related injuries and illnesses should be submitted to a Property & Casualty (P&C) payer. Because coverage is triggered by a specific event, certain information is critical for the payment process. Unlike health insurance where each bill is an individual claim, for P&C a bill is a piece of information that needs to be associated with an event. The ensuing P&C claim includes both the bill information as well as the information on the event that caused the injury of illness. Information concerning the event is necessary to associate a medical bill with the P&C claim. P&C is generally governed by State Insurance Regulations, Departments of Labor, Workers' Compensation Boards, or other Jurisdictionally defined entities, which often mandates compliance with Jurisdiction-specific procedures.

The Business Need: Provider to P&C Payer Bill Transmission

- The date of accident/occurrence/onset of symptoms (Date of Loss/Injury) is a critical piece of information and should be transmitted in the "Date - Accident" DTP segment within Loop ID-2300 (Claim Loop). This segment triggers the applicability of P&C for consideration of payment for the health care provided.
- A unique identification number, referred to in P&C as a claim number, is required to be transmitted along with the bill information to expedite the adjudication of the bill for payment. This information can be transmitted in the REF segment of Loop ID- 2010BA if the patient is the subscriber or in the REF segment of Loop ID-2010CA if the patient is not the subscriber.
- If no claim number is assigned or available, then the subscriber's policy number should be transmitted along with the date of loss. The REF segment of the subscriber loop (loop ID 2010BA) should be used to transmit the policy number.
- In the case of a work-related injury or illness, if no claim number or policy number is available, then it is necessary to include the employer's information (at a minimum name, address, and telephone number) in the NM1 segment of the subscriber loop (Loop ID-2010BA) and the patient's name and social security number in the NM1 segment of the patient loop (Loop ID-2010CA).
- Because most P&C coverage is based upon fee-for-service arrangements, it is necessary to itemize the services provided on a line-by-line basis. Each service line should be transmitted in its own SV3 segment in the Service Line Number loop (Loop ID-2400) for clarity.

4.2.1 Example 1

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company. The claim type is Workers' Compensation.

DATE OF ACCIDENT: 02/12/97

SUBSCRIBER: Jen & Barry's Ice Cream Shoppe
POLICY NUMBER: WC-96-2222-L
INSURANCE COMPANY: Basket & Roberts Insurance Company
CLAIM NUMBER: W9-1234-99

PATIENT: Penny Plump
PATIENT ADDRESS: 265 Double Dip Lane, Sugar Cone, VT, 55544
SEX: F
DOB: 02/11/77

DESTINATION PAYER/RECEIVER: Basket & Roberts Insurance Company
PAYER ID: 345345345
ETIN# SJ431

SUBMITTER: Speedy Billing Service
ETIN#: 333119999
CONTACT: Sam Speedy 815-555-4444

BILLING PROVIDER: Dental Associates
EIN: 331330001
ADDRESS: 837 Professional Drive, Pistachio, VT, 55557
TELEPHONE: 617-555-3210

RENDERING PROVIDER: Dr. Sam Sweettooth
SSN: 431334703

PATIENT ACCOUNT NUMBER: 888-22-8888

CASE: Patient is an employee of Subscriber. She slipped and hit her tooth on the freezer case.

SERVICES RENDERED: Office visit, x-ray
CHARGES: X-rays = $40.00, Stabilization of Accidentally Evulsed Tooth = $230.00. Total Charges = $270.00

ELECTRONIC ROUTE: Billing Service (submitter) to Payer (receiver).

SEG #	LOOP SEGMENT/ELEMENT STRING
	HEADER
1	ST Transaction Set Header ST*837*873401~
2	BHT Beginning of Hierarchical Transaction BHT*0019*00*0124*19970411*0724*CH~
3	REF Transmission Type Identification REF*87*004010X097~

SEG #	LOOP SEGMENT/ELEMENT STRING
	LOOP 1000A - Submitter
4	NM1 Submitter Name NM1*41*2*SPEEDY BILLING SERVICE*****46*SJ431~
5	PER Submitter EDI Contact Information PER*IC*SAM SPEEDY*TE*8155554444~
	LOOP 1000B Receiver Name
6	NMI Receiver Name NM1*40*2*BASKET & ROBERTS INSURANCE COMPANY*****46*345345345~
	LOOP 2000A Billing/Pay-To Provider HL
7	HL Billing Provider HL*1**20*1~
	LOOP 2010AA Billing Provider
8	NM1 Billing Provider Name NM1*85*2*DENTAL ASSOCIATES*****34*331330001~
9	N3 Billing Provider Address N3*1 837 PROFESSIONAL DRIVE~
10	N4 Billing Provider City/State/Zip Code N4*PISTACHIO*VT*55557~
	LOOP 2000B Subscriber HL
11	HL Subscriber HL HL*2*1*22*1~
12	SBR Subscriber Information SBR*P*****6***WC~
	LOOP 2010BA Subscriber
13	NM1 Subscriber Name NM1*IL*2*JEN & BARRY’S ICE CREAM SHOPPE*****MI*WC962222L~
	LOOP 2010BB Payer
14	NM1 Payer Name NM1*PR*2*BASKET & ROBERTS INSURANCE COMPANY*****XV*345345345~
	LOOP 2000C Patient HL
15	HL - Patient HL HL*3*2*23*0~
16	PAT Patient Information PAT*20~
	LOOP 2010CA Patient
17	NM1 Patient Name NM1*QC*1*PLUMP*PENNY~

SEG #	LOOP SEGMENT/ELEMENT STRING
18	N3 Patient Address N3*265 DOUBLE DIP LANE~
19	N4 Patient City/State/Zip Code N4*SUGAR CONE*VT*55544~
20	DMG Patient Demographic Information DMG*D8*19770211*F~
21	REF Property and Casualty Claim Number REF*Y4*W9123499~
	LOOP 2300 Claim
22	CLM Claim Information CLM*888228888*270***11::1*Y**Y*Y**EM~
23	DTP Accident DTP*439*D8*19970212~
24	DTP Service DTP*472*D8*19970212~
25	LOOP 2310B Rendering Provider NM1 Rendering Provider Name NM1*82*1*SWEETTOOTH*SAM****34*331330001~
26	PRV Rendering Provider Specialty Information PRV*PE*ZZ*122300000N~
	LOOP 2400 Service Line
27	LX Service Line Counter LX*1~
28	SV3 Dental Service SV3*AD:D0230*40****4~
	LOOP 2400 Service Line
29	LX Service Line Counter LX*2~
30	SV3 Dental Service SV3*AD:D7270*230****1~
31	TOO Tooth Information TOO*JP*8~
	TRAILER
32	SE Transaction Set Trailer SE*32*873401~

Complete Data String:

```
ST*837*873401~
BHT*0019*00*0124*19970411*0724*CH~
REF*87*004010X097~
NM1*41*2*SPEEDY BILLING SERVICE*****46*SJ431~
PER*IC*SAM SPEEDY*TE*8155554444~
NM1*40*2*BASKET & ROBERTS INSURANCE COM-
PANY*****46*345345345~
HL*1**20*1~
NM1*85*2*DENTAL ASSOCIATES*****34*331330001~
N3*1 837 PROFESSIONAL DRIVE~
N4*PISTACHIO*VT*55557~
HL*2*1*22*1~
SBR*P*****6***WC~
NM1*IL*2*JEN & BARRY'S ICE CREAM
SHOPPE****MI*WC962222L~
NM1*PR*2*BASKET & ROBERTS INSURANCE COM-
PANY*****XV*345345345~
HL*3*2*23*0~
PAT*20~
NM1*QC*1*PLUMP*PENNY~
N3*265 DOUBLE DIP LANE~
N3*265 DOUBLE DIP LANE~
DMG*D8*19770211*F~
REF*Y4*W9123499~
CLM*888228888*270***11::1*Y**Y*Y**EM~
DTP*439*D8*19970212~
DTP*472*D8*19970212~
NM1*82*1*SWEETTOOTH*SAM****34*331330001~
PRV*PE*ZZ*122300000N~
LX*1~
SV3*AD:D0230*40****4~
LX*2~
SV3*AD:D7270*230****1~
TOO*JP*8~
SE*32*873401~
```

4.2.2 Example 2

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company. The claim type is automobile.

DATE OF ACCIDENT: 02/1/97

SUBSCRIBER: Hal Howling
POLICY NUMBER: B999-777-91G
INSURANCE COMPANY: Heisman Insurance Company
CLAIM NUMBER: 32-3232-32

PATIENT: D.J. Dimpson
PATIENT ADDRESS: 32 Buffalo Run, Rocking Horse, CA, 99666
SEX: M
DOB: 06/01/48

DESTINATION PAYER/RECEIVER: Heisman Insurance Company
PAYER ID: 999888777
ETIN#: VT334

BILLING PROVIDER/SUBMITTER: Dental Associates
TIN: 579999999
NATIONAL PROVIDER IDENTIFIER: 591PD123
ADDRESS: 10 1/2 Shoemaker Street, Cobbler, CA, 99997
TELEPHONE: 212-555-7987

RENDERING PROVIDER: Dr. Bruno Moglie SSN: 224873702

PATIENT ACCOUNT NUMBER: 900-00-0032

CASE: The patient was a passenger in the subscriber's automobile and hit his mouth on the dashboard when the automobile struck a tree. Patient lost two front teeth.

SERVICES RENDERED: Interim Partial Denture and x-ray.
CHARGES: Interim Partial Upper Denture = $350.00, X-ray = $40.00
Total charges = $390.00
DOS=02/2/97

ELECTRONIC ROUTE: Billing provider (submitter) to payer (receiver).

SEG #	LOOP SEGMENT/ELEMENT STRING
	HEADER
1	ST Transaction Set Header
	ST*837*873501~
2	BHT Beginning of Hierarchical Transaction
	BHT*0019*00*0125*19970411*1524*CH~
3	REF Transmission Type Identification
	REF*87*004010X097~
	LOOP 1000A - Submitter
4	NM1 Submitter Name
	NM1*41*2*DENTAL ASSOCIATES*****46*579999999~
5	PER Submitter EDI Contact Information
	PER*IC*SYDNEY SNOW*TE*2125557987~

SEG #	LOOP SEGMENT/ELEMENT STRING
	LOOP 1000B Receiver Name
6	NMI Receiver Name NM1*40*2*HEISMAN INSURANCE COMPANY*****46*555667777~
	LOOP 2000A Billing/Pay-To Provider HL
7	HL – Billing Provider HL*1**20*1~
	LOOP 2010AA Billing Provider
8	NM1 Billing Provider Name NM1*85*2*DENTAL ASSOCIATES*****XX*591PD123~
9	N3 Billing Provider Address N3*10 1/2 SHOEMAKER STREET~
10	N4 Billing Provider City/State/Zip Code N4*COBBLER*CA*99997~
11	REF Billing Provider Secondary Identification REF*TJ*579999999~
	LOOP 2000B Subscriber HL
12	HL – Subscriber HL HL*2*1*22*1~
13	SBR Subscriber Information SBR*P*****6***LM~
	LOOP 2010BA Subscriber
14	NM1 Subscriber Name NM1*IL*1*HOWLING*HAL****MI*B99977791G~
	LOOP 2010BB Payer
15	NM1 Payer Name NM1*PR*2*HEISMAN INSURANCE COMPANY*****XV*999888777~
	LOOP 2000C Patient HL
16	HL – Patient HL HL*3*2*23*0~
17	PAT Patient Information PAT*41~
	LOOP 2010CA Patient
18	NM1 Patient Name NM1*QC*1*DIMPSON*D*J***34*567324788~
19	N3 Patient Address N3*32 BUFFALO RUN~
20	N4 Patient City/State/Zip Code N4*ROCKING HORSE*CA*99666~

SEG #	LOOP SEGMENT/ELEMENT STRING
21	DMG Patient Demographic Information DMG*D8*19480601*M~
22	REF Property and Casualty Claim Number REF*Y4*32323232~
	LOOP 2300 Claim
23	CLM Claim Information CLM*900000032*390***11::1*Y**Y*Y**AA:::CA~
24	DTP Accident DTP*439*D8*19970201~
25	DTP Service DTP*472*D8*19970202~
	LOOP 2310B Rendering Provider
26	NM1 Rendering Provider Name NM1*82*1*MOGLIE*BRUNO****34*224873702~
27	PRV Rendering Provider Specialty Information PRV*PE*ZZ*122300000N~
	LOOP 2400 Service Line
28	LX Service Line Counter LX*1~
29	SV3 Dental Service SV3*AD:D0330*40****1~
	LOOP 2400 Service Line
30	LX Service Line Counter LX*2~
31	SV3 Dental Service SV3*AD:D5820*350***I*1~
32	TOO Tooth Information TOO*JP*8~
33	TOO Tooth Information TOO*JP*9~
34	TOO Tooth Information TOO*JP*13~
	TRAILER
35	SE Transaction Set Trailer SE*35*873501~

Complete Data String:

```
ST*837*873501~
BHT*0019*00*0125*19970411*1524*CH~
REF*87*004010X097~
NM1*41*2*DENTAL ASSOCIATES*****46*579999999~
NM1*40*2*HEISMAN INSURANCE COM-
PANY*****46*555667777~
HL*1**20*1~
NM1*85*2*DENTAL ASSOCIATES*****XX*591PD123~
N3*10 1/2 SHOEMAKER STREET~
N4*COBBLER*CA*99997~
REF*TJ*579999999~
HL*2*1*22*1~
SBR*P*****6***LM~
NM1*IL*1*HOWLING*HAL****MI*B99977791G~
NM1*PR*2*HEISMAN INSURANCE COM-
PANY*****XV*999888777~
HL*3*2*23*0~
PAT*41~
NM1*QC*1*DIMPSON*D*J***34*567324788~
N3*32 BUFFALO RUN~
N4*ROCKING HORSE*CA*99666~
DMG*D8*19480601*M~
REF*Y4*32323232~
CLM*900000032*390***11::1*Y**Y*Y**AA:::CA~
DTP*439*D8*19970201~
DTP*472*D8*19970202~
NM1*82*1*MOGLIE*BRUNO****34*224873702~
PRV*PE*ZZ*122300000N~
LX*1~
SV3*AD:D0330*40****1~
LX*2~
SV3*AD:D5820*350***I*1~
TOO*JP*8~
TOO*JP*9~
TOO*JP*13~
SE*35*873501~
```

A ASC X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

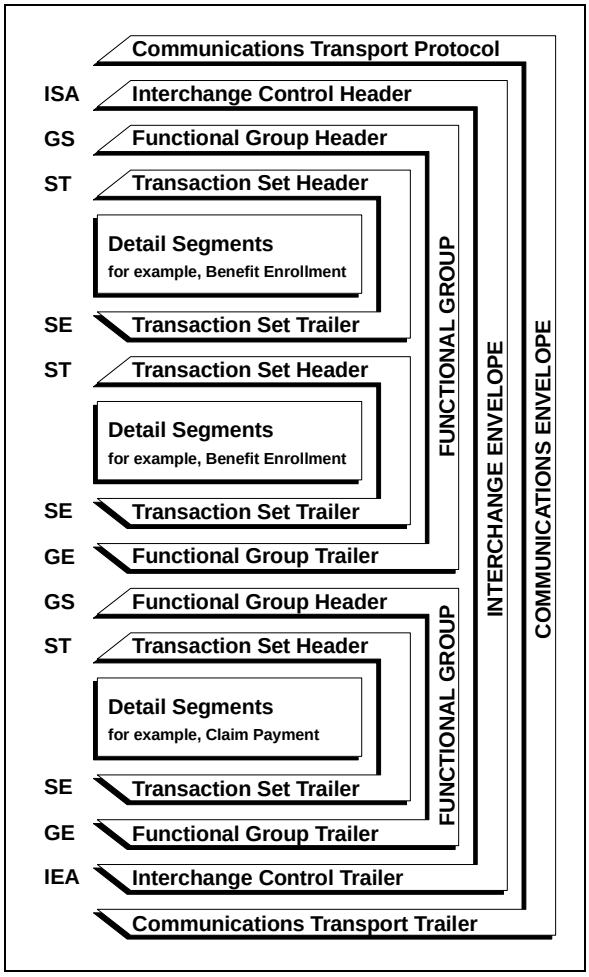


Figure A1. Transmission Control Schematic

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer. Figure A1, Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions and Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. The data element is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in figure A2, Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure A2. Basic Character Set

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in figure A3, Extended Character Set.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

Figure A3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears

in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the matrix A1, Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix A1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in matrix A2, Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix A2. Extended Control Set

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in matrix A3, Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

Matrix A3. Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element can result in errors in translation programs. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

A.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See A.1.3.8, Condition Designator.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member.

This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 3.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List	

Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table A5. Condition Designator

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number

and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

- **ST** Transaction Set Header, starts a transaction set.
  - **LS** Loop Header, starts a bounded loop of data segments but is not part of the loop.
    - **LS** Loop Header, starts an inner, nested, bounded loop.
    - **LE** Loop Trailer, ends an inner, nested bounded loop.
  - **LE** Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
- **SE** Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See figure A1, Transmission Control Schematic.

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat

an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by ">1."

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See figure A1, Transmission Control Schematic.

A.1.4 Envelopes and Control Structures

A.1.4.1 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products, if these fields are different the interchange will be "suspended" in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written trading partner agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. The ISA12 does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An Interchange Acknowledgment can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a "yes" condition in data element ISA14 would be the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrep-

ancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix B, EDI Control Directory, for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

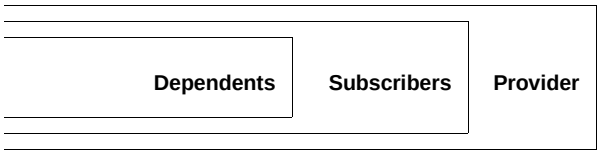
Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. For health care, this unit identification can be used to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be used for debugging purposes during problem resolution. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. Appendix B provides guidance for the value for this data element. The GS08 does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix B, EDI Control Directory, for a complete detailing of the functional group header and trailer.

A.1.4.3 HL Structures

The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide. The following diagram, from transaction set 837, illustrates a typical hierarchy.



Each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims. Each guide states what levels are available, the level's requirement, a repeat value, and whether that level has subordinate levels within a transmission.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although recommended by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

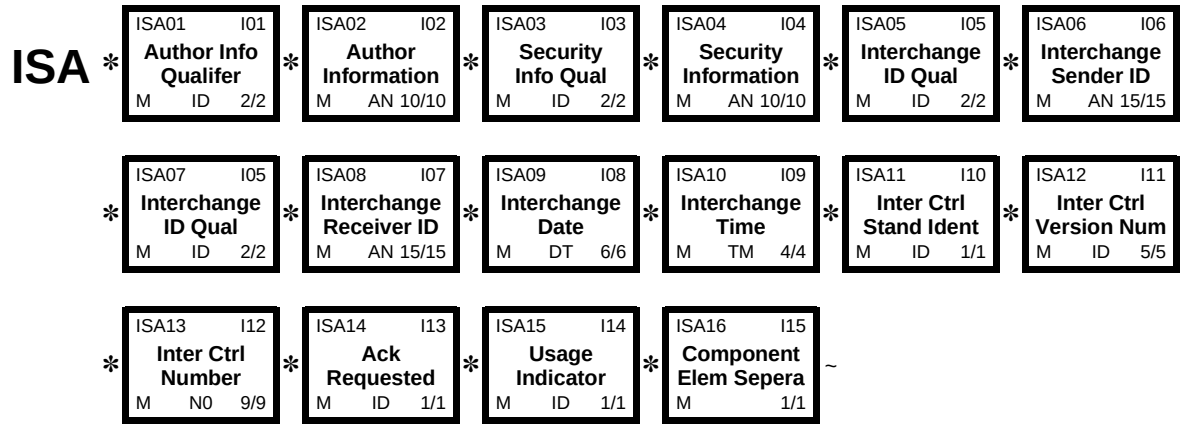
Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID..* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00401* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**
			CODE / **DEFINITION** **00** — **No Authorization Information Present (No Meaningful Information in I02)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION.** **03** — **Additional Data Identification**	
REQUIRED	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M ID 2/2**
Code to identify the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M AN 10/10**
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121: Health Industry Identification Number**
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**

			14	**Duns Plus Suffix**		
			20	**Health Industry Number (HIN)**		
				CODE SOURCE **121: Health Industry Identification Number**		
			27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			30	**U.S. Federal Tax Identification Number**		
			33	**National Association of Insurance Commissioners Company Code (NAIC)**		
			ZZ	**Mutually Defined**		
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID**		**M**	**AN**	**15/15**
			Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them				
REQUIRED	**ISA09**	**I08**	**Interchange Date**		**M**	**DT**	**6/6**
			Date of the interchange				
			The date format is YYMMDD.				
REQUIRED	**ISA10**	**I09**	**Interchange Time**		**M**	**TM**	**4/4**
			Time of the interchange				
			The time format is HHMM.				
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier**		**M**	**ID**	**1/1**
			Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer				
			CODE	DEFINITION			
			U	**U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number**		**M**	**ID**	**5/5**
			This version number covers the interchange control segments				
			CODE	DEFINITION			
			00401	**Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number**		**M**	**N0**	**9/9**
			A control number assigned by the interchange sender				
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M** **ID** **1/1**
Code sent by the sender to request an interchange acknowledgment (TA1)

See Section A.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Acknowledgment Requested**
1	**Interchange Acknowledgment Requested**

REQUIRED **ISA15** **I14** **Usage Indicator** **M** **ID** **1/1**
Code to indicate whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M** **1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

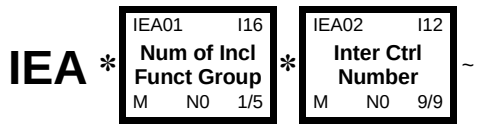
Example: IEA*1*000000905~

STANDARD

IEA Interchange Control Trailer

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

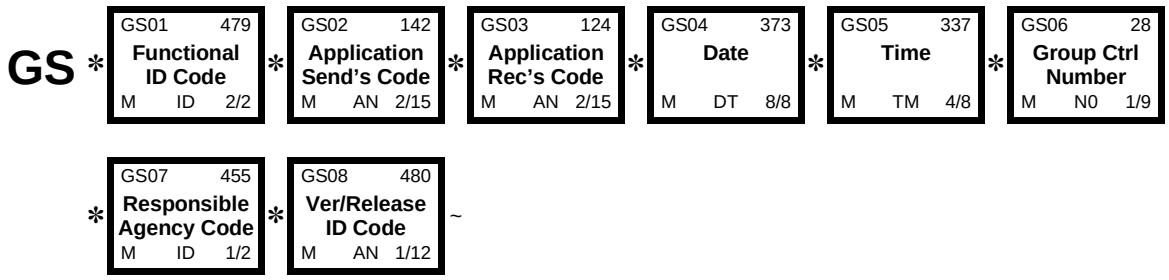
Example: GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X097~

STANDARD

GS Functional Group Header

Purpose: To indicate the beginning of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**GS01**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **CODE** / **DEFINITION** **HC** — **Health Care Claim (837)**	**M ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission. Codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M DT 8/8**
REQUIRED	**GS05**	**337**	**Time** Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) **SEMANTIC:** GS05 is the group time. **Use this time for the creation time. The recommended format is HHMM.**	**M TM 4/8**

REQUIRED **GS06** **28** **Group Control Number** **M N0 1/9**
Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

REQUIRED **GS07** **455** **Responsible Agency Code** **M ID 1/2**
Code used in conjunction with Data Element 480 to identify the issuer of the standard

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M AN 1/12**
Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE	DEFINITION
004010X097	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

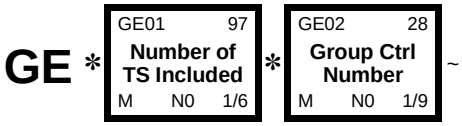
Example: **GE*1*1~**

STANDARD

GE Functional Group Trailer

Purpose: To indicate the end of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M**	**N0**	**1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**
2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in this Appendix.**

Example: **TA1*000000905*940101*0100*A*000~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M N0 9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.	
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.	
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M DT 6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)	
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M TM 4/4**
			This is the time of the original interchange being acknowledged. (HHMM)	

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M ID 1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.
E	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.
R	The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.

REQUIRED **TA105** **I18** **Interchange Note Code** **M ID 3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported.
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use of the 997 transaction is subject to trading partner agreement or accepted usage and is neither mandated nor prohibited in this Appendix.**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

Requirement: Mandatory

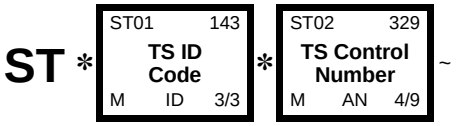
Max Use: 1

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

Set Notes:

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE** **DEFINITION** **997** **Functional Acknowledgment**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.** **Use the corresponding value in SE02 for this transaction set.**	**M AN 4/9**

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HC*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

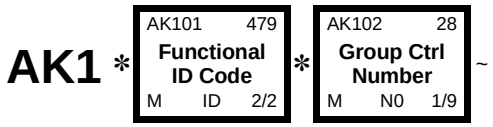
Max Use: 1

Purpose: To start acknowledgment of a functional group

Set Notes:

1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **SEMANTIC:** AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.	**M**	**ID**	**2/2**
			CODE / **DEFINITION** **HC** **Health Care Claim (837)**			
REQUIRED	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.	**M**	**N0**	**1/9**

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **AK2 — TRANSACTION SET RESPONSE HEADER** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when communicating information about a transaction set within the functional group identified in AK1.**

Example: **AK2*837*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

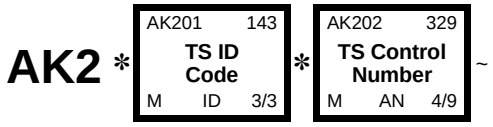
Requirement: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Set Notes:
1. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged. **CODE** / **DEFINITION** **837** **Health Care Claim**	**M ID 3/3**
REQUIRED	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **SEMANTIC:** AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.	**M AN 4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when there are errors to report in a transaction.**

Example: **AK3*NM1*37*2010BB*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

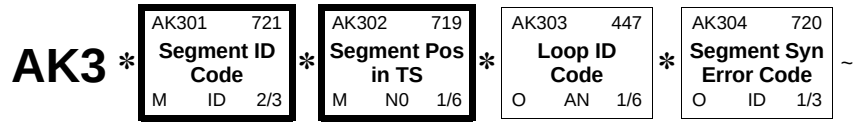
Requirement: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Set Notes: **1.** The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) **CODE SOURCE 77:** X12 Directories **This is the two or three characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

SITUATIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/6**
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Use this code to identify a loop within the transaction set that is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

SITUATIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a segment

This code is required if an error exists.

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **SITUATIONAL**

Repeat: **99**

Notes: **1. Used when there are errors to report in a data element or composite data structure.**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

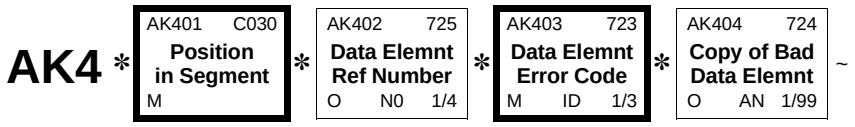
Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
SITUATIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error	**O N0 1/2**
			Used when an error occurs in a composite data element and the composite data element position can be determined.	

SITUATIONAL **AK402** **725** **Data Element Reference Number** **O** **N0** **1/4**

Reference number used to locate the data element in the Data Element Dictionary

ADVISORY: Under most circumstances, this element is expected to be sent.

CODE SOURCE 77: X12 Directories

The Data Element Reference Number for this data element is 725. For example, all reference numbers are found with the segment descriptions in this guide.

REQUIRED **AK403** **723** **Data Element Syntax Error Code** **M** **ID** **1/3**

Code indicating the error found after syntax edits of a data element

CODE	DEFINITION
1	Mandatory data element missing
2	Conditional required data element missing.
3	Too many data elements.
4	Data element too short.
5	Data element too long.
6	Invalid character in data element.
7	Invalid code value.
8	Invalid Date
9	Invalid Time
10	Exclusion Condition Violated

SITUATIONAL **AK404** **724** **Copy of Bad Data Element** **O** **AN** **1/99**

This is a copy of the data element in error

SEMANTIC: In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.

Used to provide copy of erroneous data to the original submitter, but this is not used if the error reported in an invalid character.

IMPLEMENTATION

TRANSACTION SET RESPONSE TRAILER

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **REQUIRED**

Repeat: **1**

Example: **AK5*E*5~**

STANDARD

AK5 Transaction Set Response Trailer

Level: Header

Position: 060

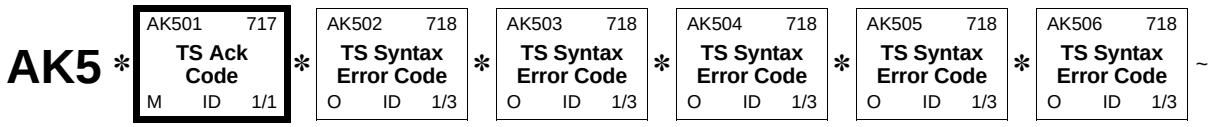
Loop: AK2

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection and report errors in a transaction set

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK501**	**717**	**Transaction Set Acknowledgment Code** Code indicating accept or reject condition based on the syntax editing of the transaction set	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted But Errors Were Noted**
M	**Rejected, Message Authentication Code (MAC) Failed**
R	**Rejected** **ADVISED**
W	**Rejected, Assurance Failed Validity Tests**
X	**Rejected, Content After Decryption Could Not Be Analyzed**

SITUATIONAL **AK502** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

This code is required if an error exists.

CODE	DEFINITION
1	Transaction Set Not Supported
2	Transaction Set Trailer Missing
3	Transaction Set Control Number in Header and Trailer Do Not Match
4	Number of Included Segments Does Not Match Actual Count
5	One or More Segments in Error
6	Missing or Invalid Transaction Set Identifier
7	Missing or Invalid Transaction Set Control Number
8	Authentication Key Name Unknown
9	Encryption Key Name Unknown
10	Requested Service (Authentication or Encrypted) Not Available
11	Unknown Security Recipient
12	Incorrect Message Length (Encryption Only)
13	Message Authentication Code Failed
15	Unknown Security Originator
16	Syntax Error in Decrypted Text
17	Security Not Supported
23	Transaction Set Control Number Not Unique within the Functional Group
24	S3E Security End Segment Missing for S3S Security Start Segment
25	S3S Security Start Segment Missing for S3E Security End Segment
26	S4E Security End Segment Missing for S4S Security Start Segment
27	S4S Security Start Segment Missing for S4E Security End Segment

SITUATIONAL **AK503** **718** **Transaction Set Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a transaction set

Use the same codes indicated in AK502.

SITUATIONAL	**AK504**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK505**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			
SITUATIONAL	**AK506**	**718**	**Transaction Set Syntax Error Code** Code indicating error found based on the syntax editing of a transaction set	**O**	**ID**	**1/3**
			Use the same codes indicated in AK502.			

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK9*A*1*1*1~**

STANDARD

AK9 Functional Group Response Trailer

Level: Header

Position: 070

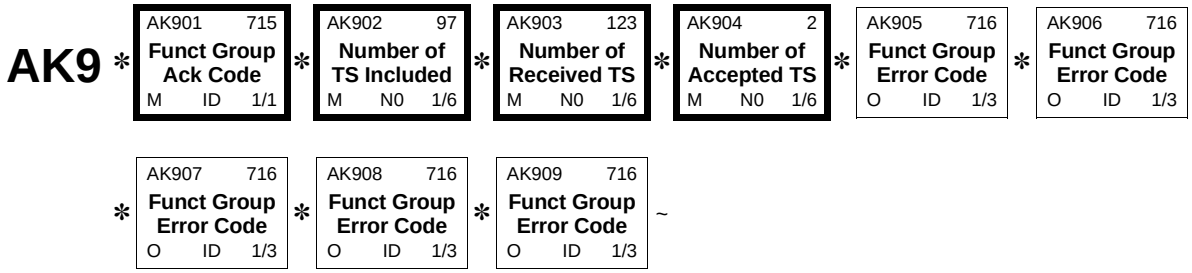
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK901**	**715**	**Functional Group Acknowledge Code** Code indicating accept or reject condition based on the syntax editing of the functional group COMMENT: If AK901 contains the value “A” or “E”, then the transmitted functional group is accepted.	**M ID 1/1**

CODE	DEFINITION
A	**Accepted** **ADVISED**
E	**Accepted, But Errors Were Noted.**
M	**Rejected, Message Authentication Code (MAC) Failed**

			P	**Partially Accepted, At Least One Transaction Set Was Rejected** **ADVISED**			
			R	**Rejected** **ADVISED**			
			W	**Rejected, Assurance Failed Validity Tests**			
			X	**Rejected, Content After Decryption Could Not Be Analyzed**			
REQUIRED	**AK902**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**	
			This is the value in the original GE01.				
REQUIRED	**AK903**	**123**	**Number of Received Transaction Sets** Number of Transaction Sets received	**M**	**N0**	**1/6**	
REQUIRED	**AK904**	**2**	**Number of Accepted Transaction Sets** Number of accepted Transaction Sets in a Functional Group	**M**	**N0**	**1/6**	
SITUATIONAL	**AK905**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			This code is required if an error exists.				

CODE	DEFINITION
1	**Functional Group Not Supported**
2	**Functional Group Version Not Supported**
3	**Functional Group Trailer Missing**
4	**Group Control Number in the Functional Group Header and Trailer Do Not Agree**
5	**Number of Included Transaction Sets Does Not Match Actual Count**
6	**Group Control Number Violates Syntax**
10	**Authentication Key Name Unknown**
11	**Encryption Key Name Unknown**
12	**Requested Service (Authentication or Encryption) Not Available**
13	**Unknown Security Recipient**
14	**Unknown Security Originator**
15	**Syntax Error in Decrypted Text**
16	**Security Not Supported**
17	**Incorrect Message Length (Encryption Only)**
18	**Message Authentication Code Failed**

			23	**S3E Security End Segment Missing for S3S Security Start Segment**			
			24	**S3S Security Start Segment Missing for S3E End Segment**			
			25	**S4E Security End Segment Missing for S4S Security Start Segment**			
			26	**S4S Security Start Segment Missing for S4E Security End Segment**			
SITUATIONAL	**AK906**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK907**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK908**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				
SITUATIONAL	**AK909**	**716**	**Functional Group Syntax Error Code** Code indicating error found based on the syntax editing of the functional group header and/or trailer	**O**	**ID**	**1/3**	
			Use the same codes indicated in AK905.				

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*27*1234~**

STANDARD

SE Transaction Set Trailer

Level: Header

Position: 080

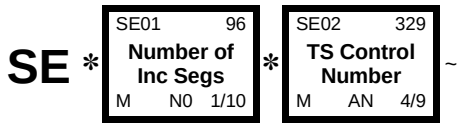
Loop: ____

Requirement: Mandatory

Max Use: 1

Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments	**M N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	**M AN 4/9**
			The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.	

C External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

235/CH, 26, 100

SOURCE

Codes for Representation of Names of Countries, ISO 3166-(Latest Release)
Codes for Representation of Currencies and Funds, ISO 4217-(Latest Release)

AVAILABLE FROM

American National Standards Institute
11 West 42nd Street, 13th Floor
New York, NY 10036

ABSTRACT

This international standard provides a two-letter alphabetic code for representing the names of countries, dependencies, and other areas of special geopolitical interest for purposes of international exchange and general directions for the maintenance of the code. The standard is intended for use in any application requiring expression of entitles in coded form. Most currencies are those of the geopolitical entities that are listed in ISO 3166, Codes for the Representation of Names of Countries. The code may be a three-character alphabetic or three-digit numeric. The two leftmost characters of the alphabetic code identify the currency authority to which the code is assigned (using the two character alphabetic code from ISO 3166, if applicable). The rightmost character is a mnemonic derived from the name of the major currency unit or fund. For currencies not associated with a single geographic entity, a specially-allocated two-character alphabetic code, in the range XA to XZ identifies the currency authority. The rightmost character is derived from the name of the geographic area concerned, and is mnemonic to the extent possible. The numeric codes are identical to those assigned to the geographic entities listed in ISO 3166. The range 950-998 is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166.

22 States and Outlying Areas of the U.S.

SIMPLE DATA ELEMENT/CODE REFERENCES

66/SJ, 771/009, 235/A5, 156

SOURCE

National Zip Code and Post Office Directory

AVAILABLE FROM

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT

Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S.

Microfiche available from NTIS (same as address above).
The Canadian Post Office lists the following as “official” codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT - Yukon

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

66/16, 309/PQ, 309/PR, 309/PS, 771/010, 116

SOURCE

National ZIP Code and Post Office Directory, Publication 65

The USPS Domestic Mail Manual

AVAILABLE FROM

U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT

The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two rightmost digits identify a local delivery area. In the nine-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

77 X12 Directories

SIMPLE DATA ELEMENT/CODE REFERENCES

721, 725

SOURCE

X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM

Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT

The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

121 Health Industry Identification Number

SIMPLE DATA ELEMENT/CODE REFERENCES

128/HI, 66/21, I05/20, 1270/HI

SOURCE

Health Industry Number Database

AVAILABLE FROM

Health Industry Business Communications Council
5110 North 40th Street
Phoenix, AZ 85018

ABSTRACT

The HIN is a coding system, developed and administered by the Health Industry Business Communications Council, that assigns a unique code number to hospitals and other provider organizations - the customers of health industry manufacturers and distributors.

131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD

SOURCE

International Classification of Diseases, 9th Revision, Clincal Modification (ICD-9-CM)

AVAILABLE FROM

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities

1968 Green Road
Ann Arbor, MI 48105

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

135 American Dental Association Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/AD, 1270/JO, 1270/JP

SOURCE

Current Dental Terminology (CDT) Manual

AVAILABLE FROM

Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

ABSTRACT

The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1034

SOURCE

National Health Care Claim Payment/Advice Committee Bulletins

AVAILABLE FROM

www.wpc-edi.com
Washington Publishing Company
PMB 161
5284 Randolph Road
Rockville, MD 20852-2116

ABSTRACT

Bulletins describe standard codes and messages that detail the reason why an adjustment was made to a health care claim payment by the payer.

235 Claim Frequency Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1325

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Position 3

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

237 Place of Service from Health Care Financing Administration Claim Form

SIMPLE DATA ELEMENT/CODE REFERENCES

1332/B

SOURCE

Electronic Media Claims National Standard Format

AVAILABLE FROM

www.hcfa.gov/medicare/poscode.htm
Health Care Financing Administration
Center for Health Plans and Providers
7500 Security Blvd.
Baltimore, MD 21244-1850
Contact: Patricia Gill

ABSTRACT

A variety of codes indicating place where service was rendered.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/NF

SOURCE

National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM

National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT

Codes that uniquely identify each insurance company.

540 Health Care Financing Administration National PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV

SOURCE

PlanID Database

AVAILABLE FROM

Health Care Financing Administration
Center for Beneficiary Services
Administration Group
Division of Membership Operations
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

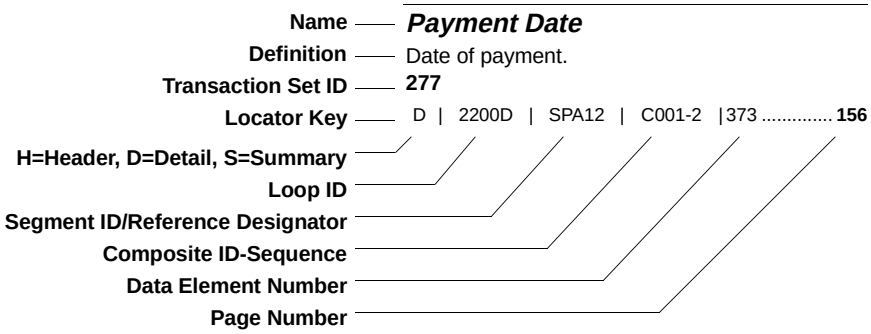
The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

D Change Summary

This is the first ASC X12N implementation guide for the 837. In future guides, this section will contain a summary of all changes since the previous guide.

E Data Element Name Index

This appendix contains an alphabetic listing of data elements used in this implementation guide. Consult the Data Element Dictionary for the complete list. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.



Accident Date

Date of the accident related to charges or to the patient's current condition, diagnosis, or treatment referenced in the transaction.

D | 2300 | DTP03 | - | 1251 ..... **161**

Additional Submitter Name

Additional name information for the receiver or submitter of the transaction.

H | 1000A | N201 | - | 93 ..... **62**

Adjudication or Payment Date

Date of payment or denial determination by previous payer.

D | 2430 | DTP03 | - | 1251 ..... **312**

Adjustment Amount

Adjustment amount for the associated reason code.

D | 2320 | CAS03 | - | 782 ..... **216**
D | 2320 | CAS06 | - | 782 ..... **217**
D | 2320 | CAS09 | - | 782 ..... **217**
D | 2320 | CAS12 | - | 782 ..... **218**
D | 2320 | CAS15 | - | 782 ..... **218**
D | 2320 | CAS18 | - | 782 ..... **219**
D | 2430 | CAS03 | - | 782 ..... **307**
D | 2430 | CAS06 | - | 782 ..... **308**
D | 2430 | CAS09 | - | 782 ..... **309**
D | 2430 | CAS12 | - | 782 ..... **309**
D | 2430 | CAS15 | - | 782 ..... **310**
D | 2430 | CAS18 | - | 782 ..... **311**

Adjustment Quantity

Numeric quantity associated with the related reason code for coordination of benefits.

D | 2320 | CAS04 | - | 380 ..... **216**
D | 2320 | CAS07 | - | 380 ..... **217**
D | 2320 | CAS10 | - | 380 ..... **217**
D | 2320 | CAS13 | - | 380 ..... **218**
D | 2320 | CAS16 | - | 380 ..... **219**
D | 2320 | CAS19 | - | 380 ..... **219**
D | 2430 | CAS04 | - | 380 ..... **307**
D | 2430 | CAS07 | - | 380 ..... **308**
D | 2430 | CAS10 | - | 380 ..... **309**
D | 2430 | CAS13 | - | 380 ..... **310**
D | 2430 | CAS16 | - | 380 ..... **310**
D | 2430 | CAS19 | - | 380 ..... **311**

Adjustment Reason Code

Code that indicates the reason for the adjustment.

D | 2320 | CAS02 | - | 1034 ..... **216**
D | 2320 | CAS05 | - | 1034 ..... **216**
D | 2320 | CAS08 | - | 1034 ..... **217**
D | 2320 | CAS11 | - | 1034 ..... **218**
D | 2320 | CAS14 | - | 1034 ..... **218**
D | 2320 | CAS17 | - | 1034 ..... **219**
D | 2430 | CAS02 | - | 1034 ..... **307**
D | 2430 | CAS05 | - | 1034 ..... **308**
D | 2430 | CAS08 | - | 1034 ..... **308**
D | 2430 | CAS11 | - | 1034 ..... **309**
D | 2430 | CAS14 | - | 1034 ..... **310**
D | 2430 | CAS17 | - | 1034 ..... **311**

Allowed Amount

The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment.

D | 2320 | AMT02 | - | 782 ..... **222**

Amount Qualifier Code

Code to qualify amount.

D | 2300 | AMT01 | - | 522 ..... **173**
D | 2300 | AMT01 | - | 522 ..... **174**
D | 2320 | AMT01 | - | 522 ..... **220**
D | 2320 | AMT01 | - | 522 ..... **221**
D | 2320 | AMT01 | - | 522 ..... **222**
D | 2320 | AMT01 | - | 522 ..... **223**
D | 2320 | AMT01 | - | 522 ..... **224**
D | 2320 | AMT01 | - | 522 ..... **225**
D | 2320 | AMT01 | - | 522 ..... **226**

Anesthesia Unit Count

Number of anesthesia units provided to patient

Approved Amount

Amount approved.

Assigned Number

Number assigned for differentiation within a transaction set.

Attachment Control Number

Identification number of attachment related to the claim.

Attachment Report Type Code

Code to specify the type of attachment that is related to the claim.

Attachment Transmission Code

Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.

Auto Accident State or Province Code

State or Province where auto accident occurred.

Benefits Assignment Certification Indicator

A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

Billing Provider Additional Identifier

Identifies another or additional distinguishing code number associated with the billing provider.

Billing Provider Additional Name

Additional names or characters for the billing provider or billing entity for the transaction.

Billing Provider Address Line

Address line of the billing provider or billing entity address.

Billing Provider City Name

City of the billing provider or billing entity

Billing Provider Credit Card Identifier

Identification number for credit card processing for the billing provider or billing entity

Billing Provider First Name

First name of the billing provider or billing entity

Billing Provider Identifier

Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.

Billing Provider Last or Organizational Name

Last name or organization name of the provider billing or billing entity for services.

Billing Provider Middle Name

The middle name of the billing provider or billing entity

Billing Provider Name Suffix

Suffix, including generation, for the name of the provider or billing entity submitting the claim.

Billing Provider Postal Zone or ZIP Code

Postal zone code or ZIP code for the provider or billing entity billing for services.

Billing Provider State or Province Code

State or province for provider or billing entity billing for services.

Bundled or Unbundled Line Number

Identification of line item bundled or unbundled by non-destination (COB) payer in payment of benefits.

D	2430	SVD06	-	554		**304**

Claim Adjustment Group Code

Code identifying the general category of payment adjustment.

D	2320	CAS01	-	1033		**216**
D	2430	CAS01	-	1033		**307**

Claim Filing Indicator Code

Code identifying type of claim or expected adjudication process.

D	2000B	SBR09	-	1032		**101**
D	2320	SBR09	-	1032		**211**

Claim Note Text

Narrative text providing additional information related to the claim.

D	2300	NTE02	-	352		**186**
D	2400	NTE02	-	352		**288**

Claim Original Reference Number

Number assigned by a processor to identify a claim.

D	2300	REF02	-	127		**180**

Claim Submission Reason Code

Code identifying reason for claim submission

D	2300	CLM05	C023-3	1325		**151**
D	2300	CLM19	-	1383		**155**

Claim or Encounter Identifier

Code indicating whether the transaction is a claim or reporting encounter information.

H		BHT06	-	640		**56**

Code List Qualifier Code

Code identifying a specific industry code list.

D	2400	TOO01	-	1270		**271**

Communication Number

Complete communications number including country or area code when applicable

H	1000A	PER04	-	364		**64**
H	1000A	PER06	-	364		**65**
H	1000A	PER08	-	364		**65**
D	2330B	PER04	-	364		**244**
D	2330B	PER06	-	364		**245**
D	2330B	PER08	-	364		**245**

Communication Number Qualifier

Code identifying the type of communication number

H	1000A	PER03	-	365		**64**
H	1000A	PER05	-	365		**65**
H	1000A	PER07	-	365		**65**
D	2330B	PER03	-	365		**244**
D	2330B	PER05	-	365		**244**
D	2330B	PER07	-	365		**245**

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

H	1000A	PER01	-	366		**64**
D	2330B	PER01	-	366		**244**

Coordination of Benefits Code

Code identifying whether there is a coordination of benefits

D	2000B	SBR06	-	1143		**100**

Country Code

Code indicating the geographic location.

D	2010AA	N404	-	26		**82**
D	2010AB	N404	-	26		**93**
D	2010BA	N404	-	26		**110**
D	2010CA	N404	-	26		**142**
D	2300	CLM11	C024-5	26		**154**
D	2330A	N404	-	26		**237**

Covered Amount

Amount determined to be covered by the payer who adjudicated the claim.

D	2320	AMT02	-	782		**224**

Credit or Debit Card Authorization Number

Credit/Debit card authorization number used to authorize use of card for payment for billed charges.

D	2010BC	REF02	-	127		**130**

Credit or Debit Card Holder Additional Name

Additional name information for the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BC	N201	-	93		**129**
D	2010BC	N202	-	93		**129**

Credit or Debit Card Holder Last or Organizational Name

Last name or organization name of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BC	NM103	-	1035		**127**

Credit or Debit Card Holder Middle Name

Middle name of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BC	NM105		-	1037	**127**

Credit or Debit Card Holder Name Suffix

Name suffix of the person or entity who has a credit card that could be used as payment for the billed charges.

D	2010BC	NM107		-	1039	**127**

Credit or Debit Card Maximum Amount

Dollar limit for a credit or debit card

D	2300	AMT02		-	782	**174**

Credit or Debit Card Number

Credit/Debit card number that may be used to pay for billed charges.

D	2010BC	NM109		-	67	**128**

Currency Code

Code for country in whose currency the charges are specified.

D	2000A	CUR02		-	100	**74**

Date Claim Paid

Code indicating the date the claim was paid.

D	2330B	DTP03		-	1251	**246**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format

D	2010BA	DMG01		-	1250	**111**
D	2010CA	DMG01		-	1250	**143**
D	2300	DTP02		-	1250	**157**
D	2300	DTP02		-	1250	**158**
D	2300	DTP02		-	1250	**160**
D	2300	DTP02		-	1250	**161**
D	2300	DTP02		-	1250	**162**
D	2300	DTP02		-	1250	**164**
D	2320	DMG01		-	1250	**227**
D	2330B	DTP02		-	1250	**246**
D	2400	DTP02		-	1250	**273**
D	2400	DTP02		-	1250	**275**
D	2400	DTP02		-	1250	**277**
D	2400	DTP02		-	1250	**279**
D	2430	DTP02		-	1250	**312**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

D	2300	DTP01		-	374	**157**
D	2300	DTP01		-	374	**158**
D	2300	DTP01		-	374	**160**
D	2300	DTP01		-	374	**161**
D	2300	DTP01		-	374	**162**
D	2300	DTP01		-	374	**164**
D	2330B	DTP01		-	374	**246**
D	2400	DTP01		-	374	**273**
D	2400	DTP01		-	374	**275**
D	2400	DTP01		-	374	**277**
D	2400	DTP01		-	374	**279**
D	2430	DTP01		-	374	**312**

Delay Reason Code

Code indicating the reason why a request was delayed.

D	2300	CLM20		-	1514	**155**

Discharge or End Of Care Date

Date that the patient was discharged from inpatient care or care/treatment ended.

D	2300	DTP03		-	1251	**159**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual

H	1000A	NM101		-	98	**60**
H	1000B	NM101		-	98	**67**
D	2000A	CUR01		-	98	**74**
D	2010AA	NM101		-	98	**77**
D	2010AB	NM101		-	98	**88**
D	2010BA	NM101		-	98	**104**
D	2010BB	NM101		-	98	**118**
D	2010CA	NM101		-	98	**136**
D	2310A	NM101		-	98	**188**
D	2310B	NM101		-	98	**196**
D	2310C	NM101		-	98	**204**
D	2330A	NM101		-	98	**232**
D	2330B	NM101		-	98	**240**
D	2330C	NM101		-	98	**254**
D	2330D	NM101		-	98	**258**
D	2330E	NM101		-	98	**262**
D	2420A	NM101		-	98	**290**
D	2420B	NM101		-	98	**298**

Entity Type Qualifier

Code qualifying the type of entity

H	1000A	NM102		-	1065	**60**
H	1000B	NM102		-	1065	**67**
D	2010AA	NM102		-	1065	**77**
D	2010AB	NM102		-	1065	**88**
D	2010BA	NM102		-	1065	**104**
D	2010BB	NM102		-	1065	**118**
D	2010BC	NM104		-	1036	**127**
D	2010CA	NM102		-	1065	**137**
D	2310A	NM102		-	1065	**188**
D	2310B	NM102		-	1065	**196**
D	2310C	NM102		-	1065	**204**
D	2330A	NM102		-	1065	**232**
D	2330B	NM102		-	1065	**241**
D	2330C	NM102		-	1065	**254**
D	2330D	NM102		-	1065	**258**
D	2330E	NM102		-	1065	**262**
D	2420A	NM102		-	1065	**290**
D	2420B	NM102		-	1065	**298**

Facility Type Code

Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format.

D	2300	CLM05	C023-1	1331	.....	**151**
D	2400	SV303	-	1331	.....	**268**

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

D	2000A	HL04	-	736	.....	**70**
D	2000B	HL04	-	736	.....	**97**
D	2000C	HL04	-	736	.....	**133**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

D	2000A	HL01	-	628	.....	**70**
D	2000B	HL01	-	628	.....	**97**
D	2000C	HL01	-	628	.....	**133**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

D	2000A	HL03	-	735	.....	**70**
D	2000B	HL03	-	735	.....	**97**
D	2000C	HL03	-	735	.....	**133**

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.

D	2000B	HL02	-	734	.....	**97**
D	2000C	HL02	-	734	.....	**133**

Hierarchical Structure Code

Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

H		BHT01	-	1005	.....	**54**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67)

H	1000A	NM108	-	66	.....	**60**
H	1000B	NM108	-	66	.....	**67**
D	2010AA	NM108	-	66	.....	**78**
D	2010AB	NM108	-	66	.....	**89**
D	2010BA	NM108	-	66	.....	**105**
D	2010BB	NM108	-	66	.....	**118**
D	2010BC	NM108	-	66	.....	**128**
D	2010CA	NM108	-	66	.....	**137**
D	2300	PWK05	-	66	.....	**172**
D	2310A	NM108	-	66	.....	**189**
D	2310B	NM108	-	66	.....	**197**
D	2310C	NM108	-	66	.....	**204**
D	2330A	NM108	-	66	.....	**233**
D	2330B	NM108	-	66	.....	**241**
D	2330C	NM108	-	66	.....	**254**
D	2420A	NM108	-	66	.....	**291**
D	2420B	NM108	-	66	.....	**298**

Individual Relationship Code

Code indicating the relationship between two individuals or entities

D	2000B	SBR02	-	1069	.....	**100**
D	2000C	PAT01	-	1069	.....	**134**
D	2320	SBR02	-	1069	.....	**210**

Insured Group Name

Name of the group or plan through which the insurance is provided to the insured.

D	2000B	SBR04	-	93	.....	**100**

Insured Group or Policy Number

The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

D	2000B	SBR03	-	127	.....	**100**
D	2320	SBR03	-	127	.....	**210**

Laboratory or Facility Name

Name of laboratory or other facility performing Laboratory testing on the claim where the health care service was performed/rendered.

D	2310C	NM103	-	1035	.....	**204**

Laboratory or Facility Name Additional Text

Additional name information identifying the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D	2310C	N201	-	93	.....	**206**

Laboratory or Facility Primary Identifier

Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.

D	2310C	NM109	-	67	.....	**204**

Laboratory or Facility Secondary Identifier

Additional identifier for the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D	2310C	REF02	-	127	.....	**208**

Line Item Charge Amount

Charges related to this service.

D	2400	SV302	-	782	.....	**268**

Line Item Control Number

Identifier assigned by the submitter/provider to this line item.

D | 2400 | REF02 | - | 127 ..... **286**

Location Qualifier

Code identifying type of location.

D | 2010BC | NM101 | - | 98 ..... **127**

Loop Identifier Code

The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE.

D | 2010BC | NM102 | - | 1065 ..... **127**

Medicare Assignment Code

An indication, used by Medicare or other government programs, that the provider accepted assignment.

D | 2300 | CLM07 | - | 1359 ..... **152**

Note Reference Code

Code identifying the functional area or purpose for which the note applies.

D | 2300 | NTE01 | - | 363 ..... **186**
D | 2400 | NTE01 | - | 363 ..... **288**

Oral Cavity Designation Code

Code identifying an oral cavity involved in the service.

D | 2400 | SV304 | C006-1 | 1361 ..... **268**
D | 2400 | SV304 | C006-2 | 1361 ..... **269**
D | 2400 | SV304 | C006-3 | 1361 ..... **269**
D | 2400 | SV304 | C006-4 | 1361 ..... **269**
D | 2400 | SV304 | C006-5 | 1361 ..... **269**

Originator Application Transaction Identifier

An identification number that identifies a transaction within the originator's applications system.

H | | BHT03 | - | 127 ..... **55**

Orthodontic Banding Date

Date that Orthodontic bands were applied.

D | 2300 | DTP03 | - | 1251 ..... **163**
D | 2400 | DTP03 | - | 1251 ..... **278**

Orthodontic Treatment Months Count

Estimated Number of Treatment Months for Orthodontic Treatment

D | 2300 | DN101 | - | 380 ..... **166**

Orthodontic Treatment Months Remaining Count

Number of Treatment Months Remaining for Orthodontic Treatment

D | 2300 | DN102 | - | 380 ..... **167**

Other Insured Additional Identifier

Number providing additional identification of the other insured.

D | 2330A | REF02 | - | 127 ..... **239**

Other Insured Additional Name

Additional name information for the other insured.

D | 2330A | N201 | - | 93 ..... **234**

Other Insured Address Line

Address line of the additional insured individual's mailing address.

D | 2330A | N301 | - | 166 ..... **235**
D | 2330A | N302 | - | 166 ..... **235**

Other Insured Birth Date

The birth date of the additional insured individual.

D | 2320 | DMG02 | - | 1251 ..... **228**

Other Insured City Name

The city name of the additional insured individual.

D | 2330A | N401 | - | 19 ..... **236**

Other Insured First Name

The first name of the additional insured individual.

D | 2330A | NM104 | - | 1036 ..... **232**

Other Insured Gender Code

A code to specify the sex of the additional insured individual.

D | 2320 | DMG03 | - | 1068 ..... **228**

Other Insured Identifier

An identification number, assigned by the third party payer, to identify the additional insured individual.

D | 2330A | NM109 | - | 67 ..... **233**

Other Insured Last Name

The last name of the additional insured individual.

D | 2330A | NM103 | - | 1035 ..... **232**

Other Insured Middle Name

The middle name of the additional insured individual.

D | 2330A | NM105 | - | 1037 ..... **232**

Other Insured Name Suffix

The suffix to the name of the additional insured individual.

D | 2330A | NM107 | - | 1039 ..... **232**

Other Insured Postal Zone or ZIP Code

The Postal ZIP code of the additional insured individual's mailing address.

D | 2330A | N403 | - | 116..... **237**

Other Insured State Code

The state code of the additional insured individual's mailing address.

D | 2330A | N402 | - | 156 ..... **237**

Other Payer Additional Name Text

Additional name information for the other payer organization.

D | 2330B | N201 | - | 93 ..... **242**

Other Payer Claim Adjustment Indicator

Indicates the other payer has made a previous claim adjustment to this claim.

D | 2330B | REF02 | - | 127 ..... **252**

Other Payer Contact Name

Name of other payer contact.

D | 2330B | PER02 | - | 93 ..... **244**

Other Payer Discount Amount

Amount determined by other payer to be subject to discount provisions.

D | 2320 | AMT02 | - | 782 ..... **225**

Other Payer Last or Organization Name

The name of the other payer organization.

D | 2330B | NM103 | - | 1035 ..... **241**
D | 2420B | NM103 | - | 1035 ..... **298**

Other Payer Patient Last Name

The non-destination (COB) payer's patient's last name.

D | 2330C | NM103 | - | 1035 ..... **254**

Other Payer Patient Paid Amount

Amount reported by other payer as paid by the patient

D | 2320 | AMT02 | - | 782 ..... **226**

Other Payer Patient Primary Identifier

The non-destination (COB) payer's patient's primary identification number.

D | 2330C | NM109 | - | 67 ..... **254**
D | 2330C | REF02 | - | 127 ..... **256**

Other Payer Primary Identifier

An identification number for the other payer.

D | 2330B | NM109 | - | 67 ..... **241**
D | 2430 | SVD01 | - | 67 ..... **302**

Other Payer Prior Authorization or Referral Number

The non-destination (COB) payer's prior authorization or referral number.

D | 2330B | REF02 | - | 127 ..... **249**
D | 2420B | REF02 | - | 127 ..... **300**

Other Payer Referral Number

The non-destination (COB) payer's service line level referral number.

D | 2420B | NM109 | - | 67 ..... **299**

Other Payer Referring Provider Identifier

The non-destination (COB) payer's referring provider identifier.

D | 2330D | REF02 | - | 127 ..... **260**

Other Payer Rendering Provider Identifier

The non-destination (COB) payer's rendering provider identifier.

D | 2330E | REF02 | - | 127 ..... **264**

Other Payer Secondary Identifier

Additional identifier for the other payer organization

D | 2330B | REF02 | - | 127 ..... **248**

Paid Service Unit Count

Units of service paid by the payer for coordination of benefits.

D | 2430 | SVD05 | - | 380 ..... **303**

Patient Account Number

Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim.

D | 2300 | CLM01 | - | 1028 ..... **150**

Patient Additional Name

Additional name information for the patient.

D | 2010CA | N201 | - | 93 ..... **139**

Patient Address Line

Address line of the street mailing address of the patient.

D | 2010CA | N301 | - | 166 ..... **140**
D | 2010CA | N302 | - | 166 ..... **140**

Patient Amount Paid

The amount the provider has received from the patient (or insured) toward payment of this claim.

D | 2300 | AMT02 | - | 782 ..... **173**

Patient Birth Date

Date of birth of the patient.

D | 2010CA | DMG02 | - | 1251 ..... **144**

Patient City Name

The city name of the patient.

D | 2010CA | N401 | - | 19 ..... **141**

Patient First Name

The first name of the individual to whom the services were provided.

D | 2010CA | NM104 | - | 1036 ..... **137**

Patient Gender Code

A code indicating the sex of the patient.

D | 2010CA | DMG03 | - | 1068 ..... **144**

Patient Last Name

The last name of the individual to whom the services were provided.

D | 2010CA | NM103 | - | 1035 ..... **137**

Patient Middle Name

The middle name of the individual to whom the services were provided.

D | 2010CA | NM105 | - | 1037 ..... **137**

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

D | 2010CA | NM107 | - | 1039 ..... **137**

Patient Postal Zone or ZIP Code

The ZIP Code of the patient.

D | 2010CA | N403 | - | 116..... **142**

Patient Primary Identifier

Identifier assigned by the payer to identify the patient

D | 2010CA | NM109 | - | 67 ..... **138**

Patient Responsibility Amount

The amount determined to be the patient's responsibility for payment..

D | 2320 | AMT02 | - | 782 ..... **223**

Patient Secondary Identifier

Additional identifier assigned to the patient by the payer.

D | 2010CA | REF02 | - | 127 ..... **146**

Patient State Code

The State Postal Code of the patient.

D | 2010CA | N402 | - | 156 ..... **142**

Pay-to Provider Additional Name

Additional name information for the provider to receive payment.

D | 2010AB | N201 | - | 93 ..... **90**

Pay-to Provider Address Line

Address line of the provider to receive payment

D | 2010AB | N301 | - | 166 ..... **91**
D | 2010AB | N302 | - | 166 ..... **91**

Pay-to Provider City Name

City name of the provider to receive payment.

D | 2010AB | N401 | - | 19 ..... **92**

Pay-to Provider First Name

First name of the provider to receive payment.

D | 2010AB | NM104 | - | 1036 ..... **88**

Pay-to Provider Identifier

Identification number for the provider or organization that will receive payment.

D | 2010AB | NM109 | - | 67 ..... **89**
D | 2010AB | REF02 | - | 127 ..... **95**

Pay-to Provider Last or Organizational Name

Last or organizational name of the provider to receive payment.

D | 2010AB | NM103 | - | 1035 ..... **88**

Pay-to Provider Middle Name

The middle name of the pay-to provider.

D | 2010AB | NM105 | - | 1037 ..... **89**

Pay-to Provider Name Suffix

The suffix, including generation, of the provider that will receive payment.

D | 2010AB | NM107 | - | 1039 ..... **89**

Pay-to Provider Postal Zone or ZIP Code

Postal ZIP code of the provider to receive payment

D | 2010AB | N403 | - | 116..... **93**

Pay-to Provider State Code

State of the provider to receive payment.

D | 2010AB | N402 | - | 156 ..... **93**

Payer Additional Identifier

Additional identifier for the payer.

D | 2010BB | REF02 | - | 127 ..... **125**

Payer Additional Name

Additional name information for the payer.

D | 2010BB | N201 | - | 93 ..... **120**

Payer Address Line

Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N301 | - | 166 ..... **121**
D | 2010BB | N302 | - | 166 ..... **121**

Payer City Name

The City Name of the Payer's claim mailing address for this particular payer ID and claim office.

D | 2010BB | N401 | - | 19 ..... **122**

Payer Identifier

Number identifying the payer organization.

D | 2010BB | NM109 | - | 67 .....**118**

Payer Name

Name identifying the payer organization.

D | 2010BB | NM103 | - | 1035 .....**118**

Payer Paid Amount

The amount paid by the payer on this claim.

D | 2320 | AMT02 | - | 782 ..... **220**

Payer Postal Zone or ZIP Code

The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N403 | - | 116..... **123**
D | 2010BB | N404 | - | 26 ..... **123**

Payer Responsibility Sequence Number Code

Code identifying the insurance carrier's level of responsibility for a payment of a claim

D | 2000B | SBR01 | - | 1138..... **99**
D | 2320 | SBR01 | - | 1138..... **210**

Payer State Code

State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.

D | 2010BB | N402 | - | 156 ..... **123**

Policy Name

The name of the policy providing coverage.

D | 2320 | SBR04 | - | 93 .....**211**

Predetermination of Benefits Identifier

Identifier or authorization number assigned to Predetermination of Benefits.

D | 2300 | REF02 | - | 127 ..... **176**
D | 2400 | REF02 | - | 127 ..... **283**

Prior Placement Date

The date of Prior Placement of the Prosthesis, Crown or Inlay, if any reason for service is replacement.

D | 2400 | DTP03 | - | 1251 ..... **276**

Procedure Code

Code identifying the procedure, product or service.

D | 2400 | SV301 | C003-2 | 234 ..... **267**
D | 2430 | SVD03 | C003-2 | 234 ..... **302**

Procedure Code Description

Description clarifying the Product/Service Procedure Code and related data elements.

D | 2430 | SVD03 | C003-7 | 352 ..... **303**

Procedure Count

Number of Procedures

D | 2400 | SV306 | - | 380 ..... **270**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

D | 2400 | SV301 | C003-3 | 1339 ..... **267**
D | 2400 | SV301 | C003-4 | 1339 ..... **267**
D | 2400 | SV301 | C003-5 | 1339 ..... **267**

D	2400	SV301	C003-6	1339		**267**
D	2430	SVD03	C003-3	1339		**303**
D	2430	SVD03	C003-4	1339		**303**
D	2430	SVD03	C003-5	1339		**303**
D	2430	SVD03	C003-6	1339		**303**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

D	2400	SV301	C003-1	235		**266**
D	2430	SVD03	C003-1	235		**302**

Property Casualty Claim Number

Identification number for property casualty claim associated with the services identified on the bill.

D	2010BA	REF02	-	127		**116**
D	2010CA	REF02	-	127		**148**

Prosthesis, Crown, or Inlay Code

Code Specifying the Placement Status for the Dental Work

D	2400	SV305	-	1358		**270**

Provider Code

Code identifying the type of provider.

D	2000A	PRV01	-	1221		**71**
D	2310A	PRV01	-	1221		**190**
D	2310B	PRV01	-	1221		**198**
D	2420A	PRV01	-	1221		**292**

Provider Taxonomy Code

Code designating the provider type, classification, and specialization.

D	2000A	PRV03	-	127		**72**
D	2310A	PRV03	-	127		**191**
D	2310B	PRV03	-	127		**199**
D	2420A	PRV03	-	127		**293**

Provider or Supplier Signature Indicator

An indicater that the provider of service reported on this claim acknowledges the performance of the service and authorizes payment, and that a signature is on file in the provider's office.

D	2300	CLM06	-	1073		**152**

Quantity Qualifier

Code specifying the type of quantity

D	2400	QTY01	-	673		**281**

Question Response

A yes/no question response.

D	2300	DN103	-	1073		**167**

Receiver Additional Name

Additional name information for the receiver.

H	1000B	N201	-	93		**68**

Receiver Name

Name of organization receiving the transaction.

H	1000B	NM103	-	1035		**67**

Receiver Primary Identifier

Primary identification number for the receiver of the transaction.

H	1000B	NM109	-	67		**67**

Reference Identification Qualifier

Code qualifying the reference identification

H		REF01	-	128		**57**
D	2000A	PRV02	-	128		**72**
D	2010AA	REF01	-	128		**84**
D	2010AA	REF01	-	128		**85**
D	2010AB	REF01	-	128		**95**
D	2010BA	REF01	-	128		**113**
D	2010BA	REF01	-	128		**115**
D	2010BB	REF01	-	128		**124**
D	2010BC	REF01	-	128		**130**
D	2010CA	REF01	-	128		**145**
D	2010CA	REF01	-	128		**147**
D	2300	REF01	-	128		**175**
D	2300	REF01	-	128		**177**
D	2300	REF01	-	128		**180**
D	2300	REF01	-	128		**182**
D	2300	REF01	-	128		**184**
D	2310A	PRV02	-	128		**190**
D	2310A	REF01	-	128		**193**
D	2310B	PRV02	-	128		**199**
D	2310B	REF01	-	128		**201**
D	2310C	REF01	-	128		**207**
D	2330A	REF01	-	128		**238**
D	2330B	REF01	-	128		**247**
D	2330B	REF01	-	128		**249**
D	2330B	REF01	-	128		**252**
D	2330C	REF01	-	128		**255**
D	2330D	REF01	-	128		**259**
D	2330E	REF01	-	128		**263**
D	2400	REF01	-	128		**283**
D	2400	REF01	-	128		**284**
D	2400	REF01	-	128		**285**
D	2420A	PRV02	-	128		**292**
D	2420A	REF01	-	128		**295**
D	2420B	REF01	-	128		**300**

Referral Date

Date of referral.

D	2300	DTP03	-	1251		**160**

Referral Number

Referral authorization number.

D	2300	REF02	-	127		**182**
D	2400	REF02	-	127		**284**

Referring Provider First Name

The first name of provider who referred the patient to the provider of service on this claim.

D	2310A	NM104	-	1036		**188**

Referring Provider Identifier

The identification number for the referring physician.

D | 2310A | NM109 | - | 67 ..... **189**

Referring Provider Last Name

The Last Name of Provider who referred the patient to the provider of service on this claim.

D | 2310A | NM103 | - | 1035 ..... **188**

Referring Provider Middle Name

Middle name of the provider who is referring patient for care.

D | 2310A | NM105 | - | 1037 ..... **189**

Referring Provider Name Additional Text

Additional name information identifying the referring provider.

D | 2310A | N201 | - | 93 ..... **192**

Referring Provider Name Suffix

Suffix to the name of the provider referring the patient for care.

D | 2310A | NM107 | - | 1039 ..... **189**

Referring Provider Secondary Identifier

Additional identification number for the provider referring the patient for service.

D | 2310A | REF02 | - | 127 ..... **194**

Related Causes Code

Code identifying an accompanying cause of an illness, injury, or an accident.

D | 2300 | CLM11 | C024-1 | 1362 ..... **153**
D | 2300 | CLM11 | C024-2 | 1362 ..... **154**
D | 2300 | CLM11 | C024-3 | 1362 ..... **154**

Related Hospitalization Admission Date

The date the patient was admitted for inpatient care related to current service.

D | 2300 | DTP03 | - | 1251 ..... **157**

Release of Information Code

Code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations.

D | 2300 | CLM09 | - | 1363 ..... **153**
D | 2320 | OI06 | - | 1363 ..... **230**

Rendering Provider First Name

The first name of the provider who performed the service.

D | 2310B | NM104 | - | 1036 ..... **196**
D | 2420A | NM104 | - | 1036 ..... **290**

Rendering Provider Identifier

The identifier assigned by the Payor to the provider who performed the service.

D | 2310B | NM109 | - | 67 ..... **197**
D | 2420A | NM109 | - | 67 ..... **291**

Rendering Provider Last or Organization Name

The last name or organization of the provider who performed the service

D | 2310B | NM103 | - | 1035 ..... **196**
D | 2420A | NM103 | - | 1035 ..... **290**

Rendering Provider Middle Name

Middle name of the provider who has provided the services to the patient.

D | 2310B | NM105 | - | 1037 ..... **196**
D | 2420A | NM105 | - | 1037 ..... **290**

Rendering Provider Name Additional Text

Additional name information identifying the rendering provider.

D | 2310B | N201 | - | 93 ..... **200**
D | 2420A | N201 | - | 93 ..... **294**

Rendering Provider Name Suffix

Name suffix of the provider who has provided the services to the patient.

D | 2310B | NM107 | - | 1039 ..... **196**
D | 2420A | NM107 | - | 1039 ..... **290**

Rendering Provider Secondary Identifier

Additional identifier for the provider providing care to the patient.

D | 2310B | REF02 | - | 127 ..... **202**
D | 2420A | REF02 | - | 127 ..... **296**

Replacement Date

Replacement Date for appliance or prosthesis

D | 2400 | DTP03 | - | 1251 ..... **280**

Service Authorization Exception Code

Code identifying the service authorization exception.

D | 2300 | REF02 | - | 127 ..... **178**

Service Date

Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.

D | 2300 | DTP03 | - | 1251 ..... **165**
D | 2400 | DTP03 | - | 1251 ..... **274**

Service Line Paid Amount

Amount paid by the indicated payer for a service line

D | 2430 | SVD02 | - | 782 ..... **302**

Special Program Indicator

A code indicating the Special Program under which the services rendered to the patient were performed.

D | 2300 | CLM12 | - | 1366 ..... **155**

Student Status Code

Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured

D | 2000C | PAT04 | - | 1220 ..... **135**

Submitter Contact Name

Name of the person at the submitter organization to whom inquiries about the transaction should be directed.

H | 1000A | PER02 | - | 93 ..... **64**

Submitter First Name

The first name of the person submitting the transaction or receiving the transaction, as identified by the preceding identification code.

H | 1000A | NM104 | - | 1036 ..... **60**

Submitter Identifier

Code or number identifying the entity submitting the claim.

H | 1000A | NM109 | - | 67 ..... **61**

Submitter Last or Organization Name

The last name or the organizational name of the entity submitting the transaction

H | 1000A | NM103 | - | 1035 ..... **60**

Submitter Middle Name

The middle name of the person submitting the transaction

H | 1000A | NM105 | - | 1037 ..... **60**

Subscriber Address Line

Address line of the current mailing address of the insured individual or subscriber to the coverage.

D | 2010BA | N301 | - | 166 ..... **108**
D | 2010BA | N302 | - | 166 ..... **108**

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG02 | - | 1251 .....**112**

Subscriber City Name

The City Name of the insured individual or subscriber to the coverage

D | 2010BA | N401 | - | 19 ..... **109**

Subscriber First Name

The first name of the insured individual or subscriber to the coverage

D | 2010BA | NM104 | - | 1036 ..... **104**

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG03 | - | 1068 .....**112**

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage

D | 2010BA | NM103 | - | 1035 ..... **104**

Subscriber Middle Name

The middle name of the subscriber to the indicated coverage or policy.

D | 2010BA | NM105 | - | 1037 ..... **104**

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

D | 2010BA | NM107 | - | 1039 ..... **105**

Subscriber Postal Zone or ZIP Code

The ZIP Code of the insured individual or subscriber to the coverage

D | 2010BA | N403 | - | 116.....**110**

Subscriber Primary Identifier

Primary identification number of the subscriber to the coverage.

D | 2010BA | NM109 | - | 67 ..... **106**

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage

D | 2010BA | N402 | - | 156 .....**110**

Subscriber Supplemental Description

Text information clarifying subscriber additional information

D | 2010BA | N201 | - | 93 ..... **107**

Subscriber Supplemental Identifier

Identifies another or additional distinguishing code number associated with the subscriber.

D | 2010BA | REF02 | - | 127 ..... **114**

Tooth Code

An indication of the tooth on which services were performed or will be performed.

D | 2400 | TOO02 | - | 1271 ..... **272**

Tooth Number

Standard identification number of a tooth.

D | 2300 | DN201 | - | 127 ..... **168**

Tooth Status Code

Code specifying the status of a tooth

D | 2300 | DN202 | - | 1368 ..... **168**

Tooth Surface Code

The surface(s) of the tooth on which services were performed or will be performed.

D | 2400 | TOO03 | C005-1 | 1369 ..... **272**
D | 2400 | TOO03 | C005-2 | 1369 ..... **272**
D | 2400 | TOO03 | C005-3 | 1369 ..... **272**
D | 2400 | TOO03 | C005-4 | 1369 ..... **272**
D | 2400 | TOO03 | C005-5 | 1369 ..... **272**

Total Claim Charge Amount

The sum of all charges included within this claim.

D | 2300 | CLM02 | - | 782 ..... **151**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

D | | SE01 | - | 96 ..... **313**

Transaction Set Control Number

The unique identification number within a transaction set.

H | | ST02 | - | 329 ..... **53**
D | | SE02 | - | 329 ..... **313**

Transaction Set Creation Date

Identifies the date the submitter created the transaction

H | | BHT04 | - | 373 ..... **55**

Transaction Set Creation Time

Time file is created for transmission.

H | | BHT05 | - | 337 ..... **56**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H | | ST01 | - | 143 ..... **53**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

H | | BHT02 | - | 353 ..... **55**

Transmission Type Code

Code identifying the type of transaction or transmission included in the transaction set.

H | | REF02 | - | 127 ..... **57**

Value Added Network Trace Number

Unique Identification number for a transaction assigned by a Value Added Network, Clearinghouse, or other transmission entity.

D | 2300 | REF02 | - | 127 ..... **184**

F NSF Mapping

Truncation: Because payer processing is often predicated on flat file data content and field lengths, payers will accept the maximum ANSI ASC X12 field lengths established by the implementation guide, but may only process the maximum flat file field lengths, thus resulting in some truncation.

Mappings: The 837 is a variable length record designed for wire transmissions and is not suitable for use in an application program. Therefore mappings to and from the national standard format flat file have been provided to assist users in the translation of the 837 for applications system processing. The requirement to engage in this standard flat file translation step may vary by payer.

F.1 X12N-NSF Map

This is a list of all the NSF fields referred to in the body of the 837 professional implementation guide listed by: **Loop ID | Reference Designator | Composite ID-Composite Sequence | Data Element Number / Code Value**

F.2 ADA Dental Claim Form 2000 Mapping

ADA Form Locator 1 Dentist's pre-treatment estimate	
2300 | CLM19 | 1383 / PB	153
ADA Form Locator 1 Dentist's statement of actual services	N/A
ADA Form Locator 1 Specialty "END"	
2000A | PRV03 | 127 / 1223E0200Y	70
ADA Form Locator 1 Specialty "OPY" 2	
000A | PRV03 | 127 / 1223P0106Y	70
ADA Form Locator 1 Specialty "ORT"	
2000A | PRV03 | 127 / 1223X0400Y	70
ADA Form Locator 1 Specialty "OSY"	
2000A | PRV03 | 127 / 1223S0112Y	70
ADA Form Locator 1 Specialty "PDT"	
2000A | PRV03 | 127 / 1223P0300Y	70
ADA Form Locator 1 Specialty "PED"	
2000A | PRV03 | 127 / 1223P0221Y	70
ADA Form Locator 1 Specialty "PHD"	
2000A | PRV03 | 127 / 1223D0001Y	70
ADA Form Locator 1 Specialty "PST"	
2000A | PRV03 | 127 / 1223P0700Y	70
ADA Form Locator 2 Medicaid Claim	N/A
ADA Form Locator 2 EPSDT	
2300 | CLM12 | 1366/011	153
ADA Form Locator 2 Prior Authorization #	
2300 | REF02 (REF01 = G3)	174
ADA Form Locator 3 Carrier Name	
2010BB | NM103	116
ADA Form Locator 4 Carrier Address	
2010BB | N301	119
ADA Form Locator 5 Carrier City	
2010BB | N401	120
ADA Form Locator 6 Carrier State	
2010BB | N402	121
ADA Form Locator 7 Carrier Zip	
2010BB | N403	121
ADA Form Locator 8 Patient Last Name	
2010CA | NM103	135
2010BA | NM103	102
ADA Form Locator 8 Patient First Name	
2010CA | NM104	135
2010BA | NM104	102
ADA Form Locator 8 Patient Middle Name	
2010CA | NM105	135
2010BA | NM105	102
ADA Form Locator 9 Patient Address	
2010CA | N301	138
2010BA | N301	106
ADA Form Locator 10 Patient City	
2010CA | N401	139
2010BA | N401	107
ADA Form Locator 11 Patient State	
2010CA | N402	140
2010BA | N402	108
ADA Form Locator 12 Patient Date of Birth	
2010CA | DMG02	142
2010BA | DMG02	110
ADA Form Locator 13 Patient ID#	
2010CA | NM109	136
2010BA | NM109	104
2010CA | REF02	144
2010BA | REF02	112
ADA Form Locator 14 Patient Sex	
2010CA | DMG03	142
2010BA | DMG03	110
ADA Form Locator 15 Patient Phone Number	N/A
ADA Form Locator 16 Patient Zip Code	
2010CA | N403	140
2010BA | N403	108
ADA Form Locator 17 Relationship to Subscriber/Empl (Self) 2000B | SBR02 | 1069/18	98
ADA Form Locator 17 Relationship to Subscriber/Empl (Spouse)	
2000C | PAT01 | 1069/01	132
ADA Form Locator 17 Relationship to Subscriber/Empl (Child)	
2000C | PAT01 | 1069/19	132
ADA Form Locator 17 Relationship to Subscriber/Empl (Other)	
2000C | PAT01 | 1069	132
ADA Form Locator 18 Employer / School	N/A
ADA Form Locator 19 Subscriber / Empl ID#/SSN#	
2010BA | NM109	104
2010BA | REF02	112
ADA Form Locator 20 Employer Name	N/A
ADA Form Locator 21 Group #	
2000B | SBR03	98

ADA Form Locator 59
Carrier %
2320 | AMT02 (AMT01 = AU) 223

ADA Form Locator 59
Carrier pays N/A

ADA Form Locator 59
Patient pays
2320 | AMT02 (AMT01 = F2) 222

ADA Form Locator 60
Missing Teeth
2300 | DN201 (DN202 = E) 166
2300 | DN201 (DN202 = M) 166

ADA Form Locator 61
Remarks for unusual services
2300 | NTE02 184

ADA Form Locator 62
Treating Dentist Signature
2310B | NM103 194
2310B | NM104 (if NM102 = 1) 194
2310B | NM105 (if NM102 = 1) 194
2420A | NM103 288
2420A | NM104 (if NM102 = 1) 288
2420A | NM105 (if NM102 = 1) 288

ADA Form Locator 62
Treating Dentist License #
2310B | REF02 (REF01 = 0B) 200
2310B | REF02 (REF01 = 1E) 200
2420A | REF02 (REF01 = 0B) 294
2420A | REF02 (REF01 = 1E) 294

ADA Form Locator 62
Treating Dentist Signature Date N/A

ADA Form Locator 63
Treating Dentist Address N/A

ADA Form Locator 64
Treating Dentist City N/A

ADA Form Locator 64
Treating Dentist State N/A

ADA Form Locator 64
Treating Dentist Zip Code N/A

G Credit/Debit Card Use

G.1 Credit/Debit Card Scenario 837 Transaction Set

A business scenario using credit/debit cards as an alternate payment vehicle for the patient portion of post-adjudicated claims is defined in this appendix. This scenario does not apply to all health care business environments using the 837. Implementers of this option must ensure that no current federal or state privacy regulations are violated. The use of this payment option is currently prohibited in conjunction with federal health plans such ac Medicaid, CHAMPUS/TRICARE, VA, etc. This capability, which can be used to improve the provider's accounts receivable situation, is applicable only when trading partners agree to the opportunities and constraints defined in the following business scenario. The scenario has been included as an appendix to this 837 implementation guide after several years of work, as well as presentations and review with the appropriate ANSI X12N committees, including the 837 work group, the 835 work group, and work group 11 (business modeling).

The Business Need: Patient to Provider Payment Options

Providers today can offer patients a variety of service payment options when the patient's portion of the cost is known either before or at the time of service. Examples of payment options include cash, check, and billing (i.e., being billed). Another option, which is the topic of this appendix, is to use a patient's credit or debit card when the amount of the co-payment or service charge is known. Providers typically have a credit card terminal that is connected through a dial-up phone line to their credit card processing network.

The business need of increasing cash flow and providing payment options to a patient reflects a new use of a patient's credit/debit card as an option for payment of the patient/subscriber portion of a claim when that amount is not known at the time of service. This new payment option is being requested to:

- improve patient payment flexibility
- potentially reduce provider billing costs
- provide faster access to monies due from patients, and improve accounts receivable management

Before using this flexible payment option, the provider, value-added network, and/or an intermediary have to form a partnership where credit/debit card transactions are accepted as part of the reimbursement process. These agreements must comply with all current federal and state privacy regulations.

The patient/subscriber also must choose to use his or her credit/debit card for a future yet-to-be-determined amount. The patient/subscriber would provide his or her consent up to a maximum amount allowing the provider/ value-added network to bill the credit card after the claim has been adjudicated. This patient consent form also authorizes the transmission of credit/debit card information over a health care EDI network. The consent form must identify how the transaction will be used, and who will receive the information . It authorizes the service providers to use the account number in this transaction as described. The concept of pre-

authorized payment is currently in use in other industries, and customer acceptance of this type of payment vehicle has increased.

To implement this payment alternative, the patient's/subscriber's credit or debit card information would be carried in the 837, along with selected provider information. This information involves approximately 200 characters of data for each instance of credit or debit card use.

The provider's claims submission system would be enhanced to incorporate the required credit/debit card information into the 837 transaction. The 837 would then be transmitted to the Automated Clearing House/ processor/payer for claim adjudication. After the claim is adjudicated and coordination of benefits issues are resolved, the payer pays his or her portion of the claim and returns its explanation in an 835.

At this point, the value-added network could determine the amount to be applied to the patient's credit or debit card, and initiate a credit or debit card transaction to complete the claim payment. The amount charged to the patient's credit or debit card would then be reported to the provider in a separate transaction.

- Figure G1, Scenario: Patient Uses a Credit/Debit Card, depicts an example of how credit/debit card information could be transmitted using the standard 837 methodology.

Business Process Flow for Credit/Debit Card Payment Alternative for Post-adjudicated Claims

A. The provider/Automated Clearing House agrees to accept credit or debit cards.

B. The subscriber signs a consent form to pre-authorize charges up to a maximum amount and authorizes the use of their account number in this network.

C. The patient incurs the charges.

D. The provider submits an 837, including some claims containing credit or debit card information.

E. The Automated Clearing House notes the credit or debit card option and information, and passes the claim to the payer.

F. The payer adjudicates the claim and determines the coordination of benefits (COB). If no COB is involved, the payer returns the adjudicated claim to the Automated Clearing House or provider with the 835.

G. The Automated Clearing House creates the credit or debit card transaction(s), as appropriate, to close out the claim payment.

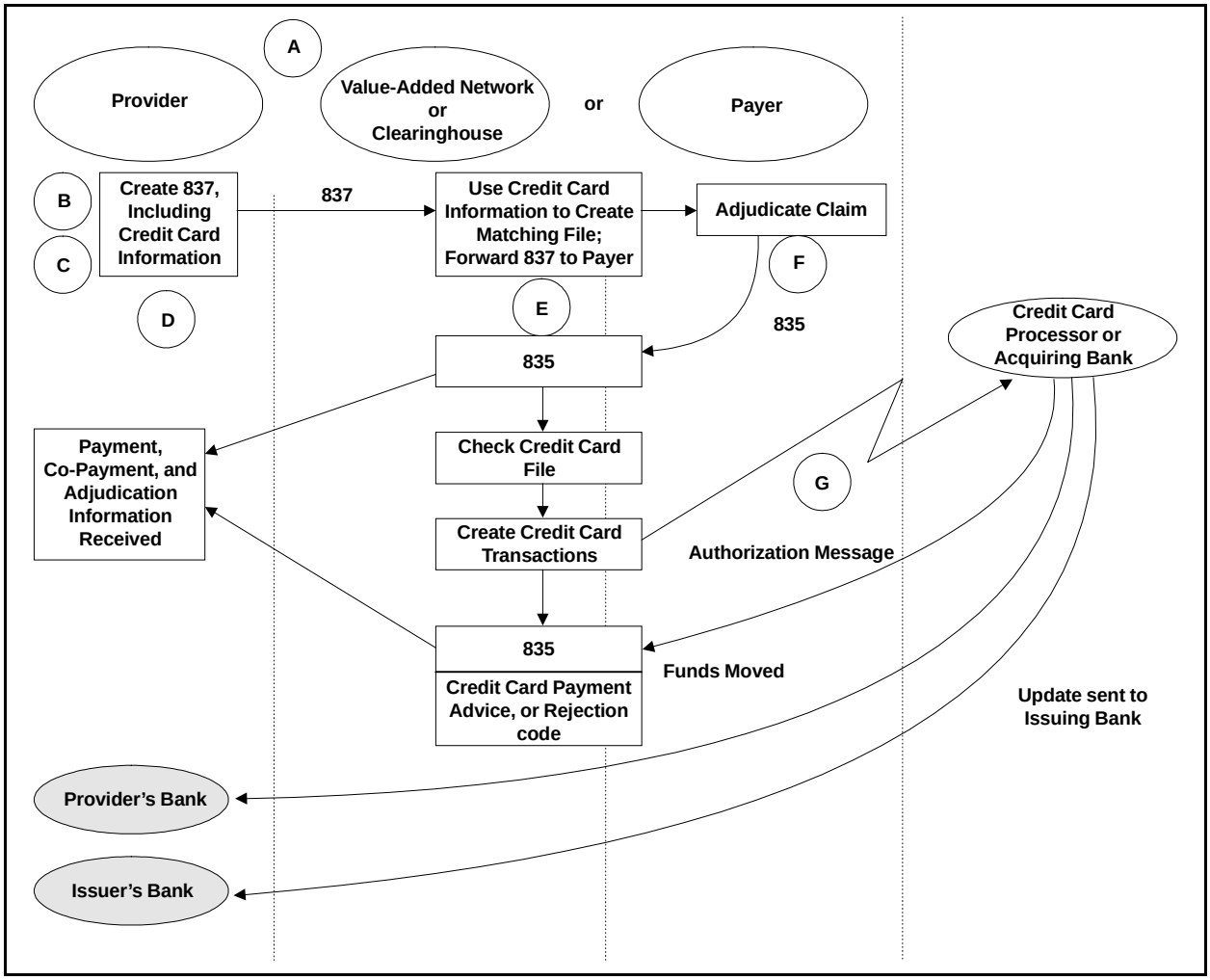


Figure G1. Scenario: Patient Uses a Credit/Debit Card (Patient payment amount unknown)

Credit/Debit Card Information

This is a map of only the additional information necessary to carry credit/debit card information. Loop ID-2010BF carries only information about the person whose credit/debit card is being used in the transaction. This person may or may not be the subscriber.

Table	Loop	Position	Seg't ID	Data Element	Qualifier	Description
2	2010AA	035	REF01	128	8U	Bank Assigned Security ID
					LU	Location Number
					ST	Store Number
					TT	Terminal Code
					06	Systems Number
					IJ	SIC
					RB	Rate Code
					EM	Electronic Payment Reference Number
2	2110BC	055	NM101	98	AO	Account of
2	2110BC	085	REF01	128	AB	Acceptable Source Purchaser ID; method used to identify cardholder
					BB	Authorization Number; card read or data manually entered
2	2300	175	AMT01	522	MA	Maximum Amount
2	2300	180	REF01	128	E4	Charge Card Number

H X12N Name Index

This is an alphabetical list of all segment and element names. It has been included in this Implementation Guide to assist users in locating specific data elements.