National Electronic Data Interchange Transaction Set Implementation Guide

Health Care Claim: Institutional

837

ASC X12N 837 (004010X096)

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 institutional 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 Claims Payment Advice. Should the Secretary adopt the X12N 837 Health Care Claim: Institutional 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: Institutional 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 X12N standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each trading partner must provide these specific requirements separately.

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

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

1.3.1 Terminology

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

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

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

Patient
The term “patient” is intended to convey the case where the Patient loop (Loop ID-2000C) is used. In that case, the patient is not the same person as the subscriber, and the patient is a person (e.g., spouse, children, others) who is covered by the subscriber’s insurance plan. However, it also happens that the patient is sometimes the same person as the subscriber. In that case, all information about the patient/subscriber is carried in the Subscriber loop (Loop ID-2000B). See Section 2.3.2.1, 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 Institutional 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.

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, Property and Casualty, of this Implementation Guide explains these requirements.

1.4.1 UB-92/EMC v.6.0 Mapping

As an aid to UB-92 users during the initial implementation, Appendix F, UB-92 Mapping, provides a map of the UB-92 data elements (in both paper and electronic formats) to the elements' location on the 837. However, the map can not provide one-to-one correspondence due to factors such as the differences between variable and fixed-length records.

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, Introduction to a Business Model for Claims Requiring Coordination of Benefits, 1.4.2.2, Coordination of Benefits Data Models - Detail, and 1.4.2.3, Coordination of Benefits — Correction Detail, for details about the two methods of using the 837 in conjunction with the 835 to achieve electronic COB See Section 4, EDI Transmission Examples for Different Business Uses, for several detailed examples.

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

1.4.2.1 Coordination of Benefits Data Models — Detail

The 837 transaction handles two models of coordinating benefits. Both models are discussed in Section 1.4.2.2, Coordination of Benefits Data Models. See Section 4, EDI Transmission Examples for Different 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 Federal Register for HIPAA rules involving COB.

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

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

Step 2. Upon receipt of the 835, the provider sends a second health care claim transaction (837) to Payer B, the secondary payer. The Subscriber loop (Loop ID-2000B) now contains information about the subscriber who holds the policy

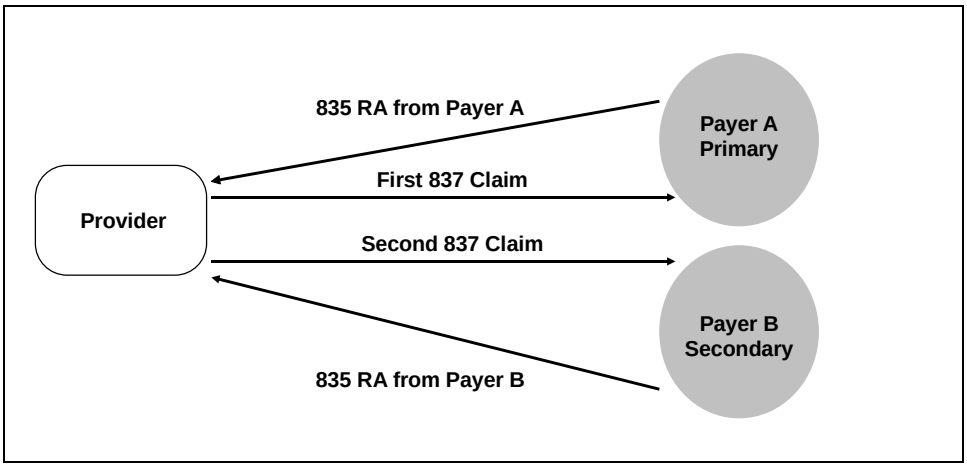


Figure 1. Provider-to-Payer-to-Provider COB Model

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 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 informa-

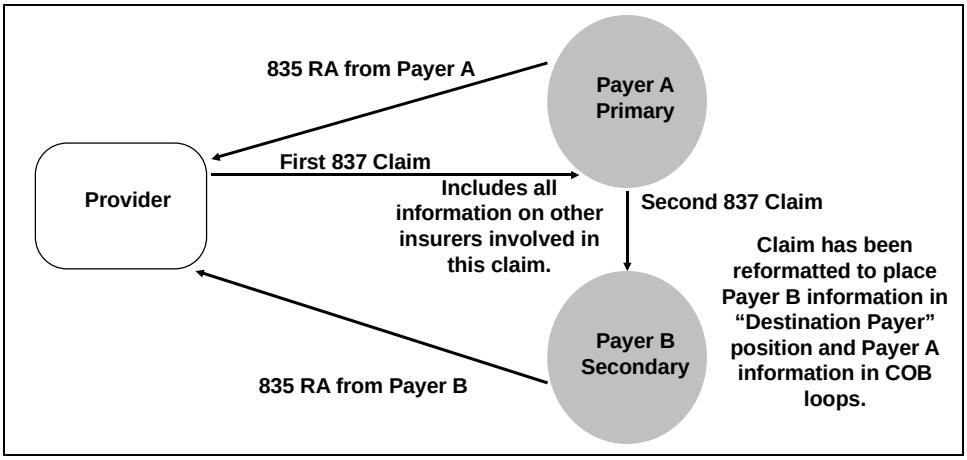


Figure 2. Provider-to-Payer-to-Payer COB Model

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

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

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

1.4.2.1.1 Coordination of Benefits — Claim Level

The destination payer's information is located in Loop ID 2010BC. In addition, any destination payer specific claim information (e.g., referral number), is located in the 2300 loop. All provider identifiers in the 2310 and 2420 loops are specific to the destination payer. Loop ID-2320 occurs once for each payer responsible for the claim, except for the payer receiving the 837 transaction set (destination payer). The destination payer's information is located in Loop ID-2000B.

Loop ID-2320 contains the following:

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

Inside Loop ID-2320, Loop ID-2330 contains the information for the payer and the subscriber. As the claim moves from payer to payer, the destination payer's information in Loop ID-2000B and Loop ID-2010BB must be exchanged with the next payer's information from Loop ID-2320/2330. The table below shows 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 is sent to the secondary payer as follows. BHT02 uses code 00, Original, because this is the first time the secondary payer received this claim.

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

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

CAS*CO*45*20~

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

AMT*D*40~

D = Payer Amount Paid code
40 = Amount

AMT*F2*40~

F2 = Patient Responsibility code
40 = Amount

1.4.2.2.1 Reversal and Correction Method of COB

Corrected Remittance Advice and Claim:

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

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

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

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

Reversal 835:

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

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

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

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

Corrected 835:

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

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

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

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

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

CAS*CO*45*40~

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

Corrected Secondary 837:

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

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

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

CAS*CO*45*40~

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

AMT*D*24~

D = Payer Amount Paid code
24 = Amount

AMT*F2*36~

F2 = Patient Responsibility code
36 = Amount

1.4.3 Service Line Procedure Code Bundling and Unbundling

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

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

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

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

Bundling:

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

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

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

Bundling Example
Hospital A submits procedure code A and B for $100.00 each to a PPO as primary coverage. Each procedure was performed on the same date of service. The PPO's adjudication systems screens the submitted procedures and notes that procedure C covers the services rendered by the hospital 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

SV2*300*HC:A:100*UN*1~

300 = Revenue code
HC = HCPCS qualifier
A = HCPCS procedure code
100 = Submitted charge
UN = Units
1 = Number of units

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

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

CAS*PR*2*20~

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

LX*2~

2 = Service line 2

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

HC = HCPCS qualifier
B = HCPCS procedure code
100 = Submitted charge
UN = Units
1 = Number of units

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

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

CAS*CO*97*100~

CO = Patient Responsibility
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 with COB

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

Unbundling Example

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

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

CAS*OA*93*0~

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

Service Line Level (Loop ID-2400):

LX*1~

1 = Service line 1

SV2*HC:A*200*UN*1N~**

HC = HCPCS qualifier
A = HCPCS code
200 = Submitted charge

UN = Units code
1 = Units billed
N = Not an emergency code

REF*6R*JR001426789~

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

Service Line Adjudication Information: (Loop ID-2430)

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

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

CAS*CO*45*35~

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

SVD*PAYER ID*60*HC:C

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

CAS*CO*45*45~

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

1.4.4 Crosswalking COB Data Elements

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

For the purposes of this discussion there are two types of payers in the 837 (1) the destination payer, i.e., that payer receiving the claim who is defined in the 2010BC 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 2010BC loop. All the information contained in the 2300, 2310, 2400 and 2420 loops (not other sub-loops — just those specific loops) is specific to the destination payer. Information specific to other payers is contained in the 2320, 2330 and 2430 loops. Data that may be specific to a payer are shown in Table 1 below. The table details where this data is carried for the destination payer and where it is carried for any other payers who might be included in the claim for the professional implementation guide.

Example:

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

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

Data Element Name	Destination Payer Location Loop - Segment Element	Other Payer Location Loop - Segment Element
Subscriber Last/Org Name	2010BA | NM103	2330A | NM103
Subscriber First Name	2010BA | NM104	2330A | NM104
Subscriber Middle Name	2010BA | NM105	2330A | NM105
Subscriber Suffix Name	2010BA | NM107	2330A | NM107
Subscriber Identification Number	2010BA | NM108/09	2330A | NM108/09
Subscriber Street Address (1)	2010BA | N301	2330A | N301
Subscriber Street Address (2)	2010BA | N302	2330A | N302
Subscriber City	2010BA | N401	2330A | N401
Subscriber State	2010BA | N402	2330A | N402
Subscriber ZIP Code	2010BA | N403	2330A | N403
Payer Name	2010BC | NM103	2330B | NM103
Payer ID	2010BC | NM108/09	2330B | NM108/09
Patient Identification Number	2010CA | NM108/09	2330C | NM108/09
Relationship of subscriber to patient [2]	2000B | SBR02	2320 | SBR02

Assignment of Benefits Indicator	2300 - CLM08	2320 | OI03
Patient's Signature Source Code	2300 - CLM10	2320 | OI04
Release of Information	2300 - CLM09	2320 | OI06
Prior Authorization or Referral Number - claim level	2300 | REF01/02	2330C | REF01/02 of Prior Auth/Referral REF.
Provider identification number(s) - claim level	2310A-E | REF01/02	2330D-H | REF01/02 of other Payer Provider Identifiers.
Payer specific amounts	NO ELEMENTS[1]	All AMTs in the 2320 loop are specific to the payer identified in the 2330B loop of that iteration of the 2320 loop.
Prior Auth/Referral Number - line level	2400 | REF01/02	2420G | REF01/02 of Prior Authorization or Referral REF
Provider identification number(s) line level	2420A-G | REF01/02	Not Crosswalked

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

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

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

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

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

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

1.5 Property and Casualty

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

2 Data Overview

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

2.1 Overall Data Architecture

Two formats, or views, are used to present the transaction set — the implementation view and the standard view. The implementation view of the transaction set is presented in Section 2.1, Overall Data Architecture. See figure 3, 837 Transaction Set Listing, for the implementation view. Figure 3 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.

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.

Table 1 - Header

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

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

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL			>1
001	HL	Billing/Pay-To Provider Hierarchical Level	R	1	
003	PRV	Billing/Pay-To Provider Specialty Information	S	1	
010	CUR	Foreign Currency Information	S	1	
		LOOP ID - 2010A BILLING PROVIDER NAME			1
015	NM1	Billing Provider Name	R	1	
025	N3	Billing Provider Address	S	1	
	...				

Figure 3. 837 Transaction Set Listing

2.2 Loop Labeling and Use

For the user's convenience, the 837 transaction uses two naming conventions for loops. Loops are labeled with a descriptive name as well as with a shorthand label. Loop ID-2000A BILLING/PAY-TO PROVIDER LEVEL contains information about the billing and pay-to providers. The descriptive name - BILLING/PAY-TO PROVIDER LEVEL - informs the user of the overall focus of the loop. The 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, purchased service provider, service facility location , and supervising provider. These loops are labeled 2310A, 2310B, 2310C, 2310D, and 2310E . Each of these 2310 loops is an equivalent loop. Because they do not specify an HL, it is not necessary to use them in any particular order. In a similar fashion, it is acceptable to send subloops 2010BB, 2010BD, 2010BA, and 2010BC in that order as long as they all belong to the same subloop. However, it is not ac-ceptable to send subloop 2330 before loop 2310 because these are not equivalent subloops.

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

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

2.2.1 Required and Situational Loops

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

The usage designator of a loop's beginning segment indicates the usage of the loop. If a loop is used, the first segment (initial segments) of that loop is required even if it is marked Situational.

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.

2.3 Data Use by Business Use

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

2.3.1 Table 1 — Transaction Control Information

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

Table 1 - Header

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

Figure 4. 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*004010X096~

87 = Functional category
004010X096 = Institutional 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 the transaction set purpose code, BHT02, which indicates an **original transaction** by using data value 00. The submitter's business application system generates the following fields: BHT03, originator's reference number; BHT04, date of transaction creation; and BHT05, time of transaction creation. BHT02 is used to indicate the status of the transaction batch, i.e., is the batch an original transmission or a reissue (resubmitted) batch. BHT06 is used to indicate the type of billed service being sent: fee-for-service (claim) or encounter or a mixed bag of both.

Because the 837 is multi-functional, it is important for the receiver to know which business purpose is served, so the REF in the Header is used. A data value of 87 in REF01 indicates the **functional category,** or type, of 837 being sent. The appropriate value for REF02 is X096.

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 Institutional 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 paitent **Child HL** to the billing provider
Patient HL	**Child HL** to the subscriber HL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 = HL sequence number
1 = parent HL
22 = subscriber

0 = no subordinate HLs to this HL (there is no child HL to this HL - claim level data follows)

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

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

HL*9*7*23*0~ (indicates patient #P4.1 for subscriber #4)

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

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

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

- HLs are numbered sequentially. 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 known that this is the highest hierarchical level for all the contained subordinate levels. The billing provider level is not subordinate to any hierarchical level.
- The data value in data element HL03 describes the hierarchical level entity. For example, when HL03 equals 20, the hierarchical level is the billing provider; when HL03 equals 23, the hierarchical level is the dependent (patient).
- Data element HL04 indicates whether or not subordinate hierarchical levels exist. A value of "1" indicates subsequent hierarchical levels. A value of "0" or absence of a data value indicates 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. Loop ID-1000 instructions directed that anyone who "opened the envelope" of a transaction should include another iteration of Loop ID-1000 so that it would be possible to identify all the entities who had an opportunity to change the data inside the enveloping structure. The audit trail concept is difficult to implement for a variety of reasons, and the developers of this implementation guide do not recommend using Loop ID-1000 as an audit trail in this transaction. Instead, the developers recommend using Loop ID-1000 to record the transaction submitter and the receiver. However, the submitter and receiver concepts are difficult to define accurately. The transaction sub-

mitter 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 submitter and 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 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, Loop ID-1000 — Example 2, 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, demon-

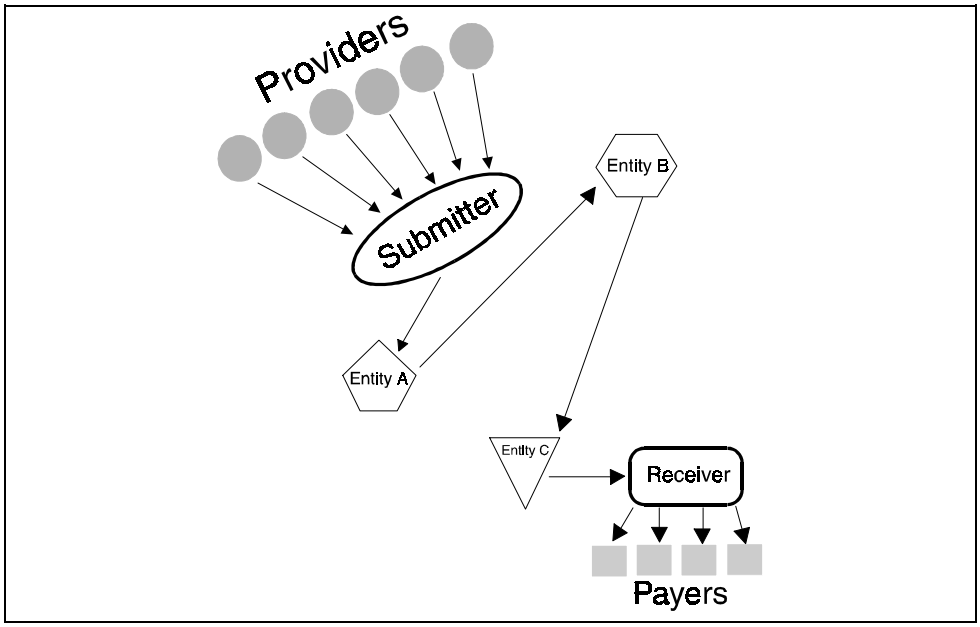


Figure 5. Loop ID-1000 — Example 1

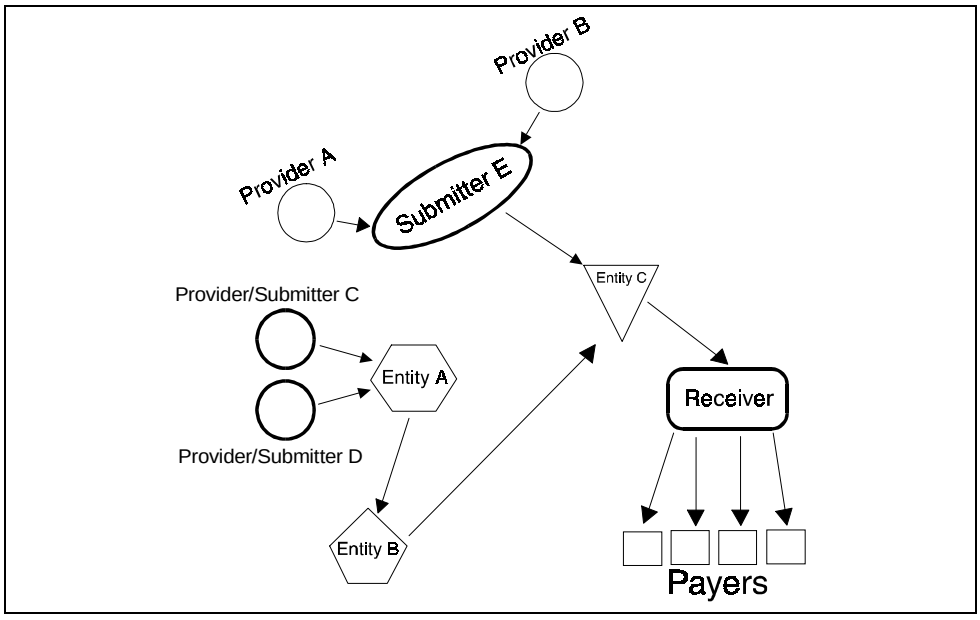


Figure 6. Loop ID-1000 — Example 2

strate 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, 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.

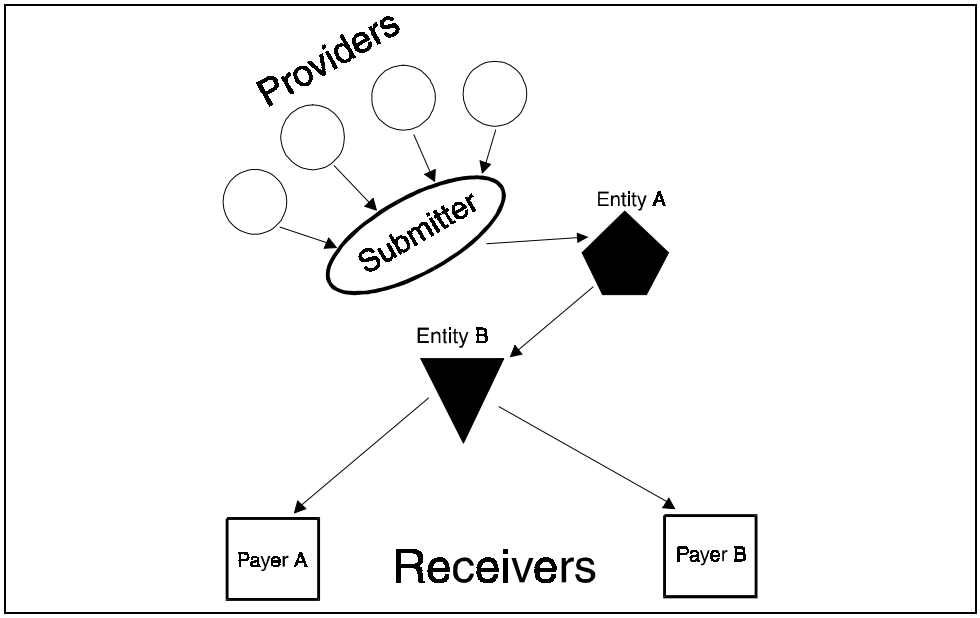


Figure 7. Loop ID-1000 — Example 3

2.5 The Claim

After the HL structure is defined, the specific claim services are identified in Loop ID-2300. Loop ID-2305 identifies services that are specific to home health care. Loop ID-2310 identifies various providers who may have been involved in the health care services being reported in the transaction. Loop ID-2320 identifies all other insurance entities (coordination of benefits). Within Loop ID-2320, Loop ID-2330 identifies all the parties associated with the other insurance entities. Loop ID-2400 is required and identifies service line information. Loop ID-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), and Loop ID-2440 is used to send information from specific forms.

2.6 Interactions with Other Transactions

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

2.6.1 Functional Acknowledgment (997)

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

2.6.2 Unsolicited Claim Status (277)

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

2.6.3 Remittance Advice (835)

Information in the Remittance Advice (835) transaction is generated by the payer's adjudication system. However, in a coordination of benefits (COB) situation where the provider is sending an 837 to a secondary payer, information from the 835 may be included in the secondary 837. As shown 1.4.2.3, 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 they can receive. Some submitters may have the capability and the desire to transmit enormous 837 transactions with thousands of claims contained in them. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. Willing trading partners can agree to set CLM limits higher. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

2.8 Use of Data Segments and Elements Marked “Situational”

Institutional claims span an enormous variety of health care institutional 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 institutional health care claims. To meet the divergent needs of institutional 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

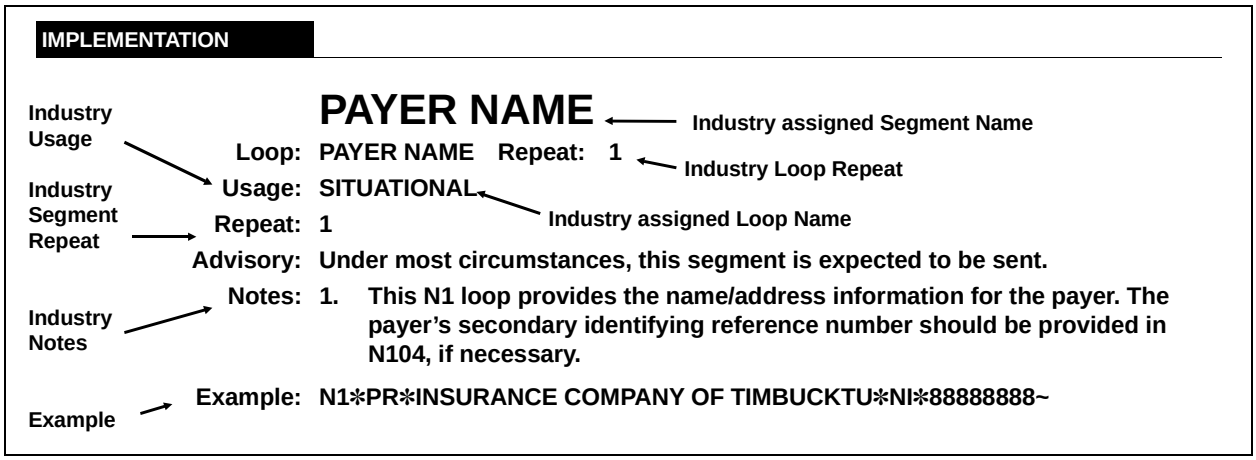


Figure 12. Segment Key — Implementation

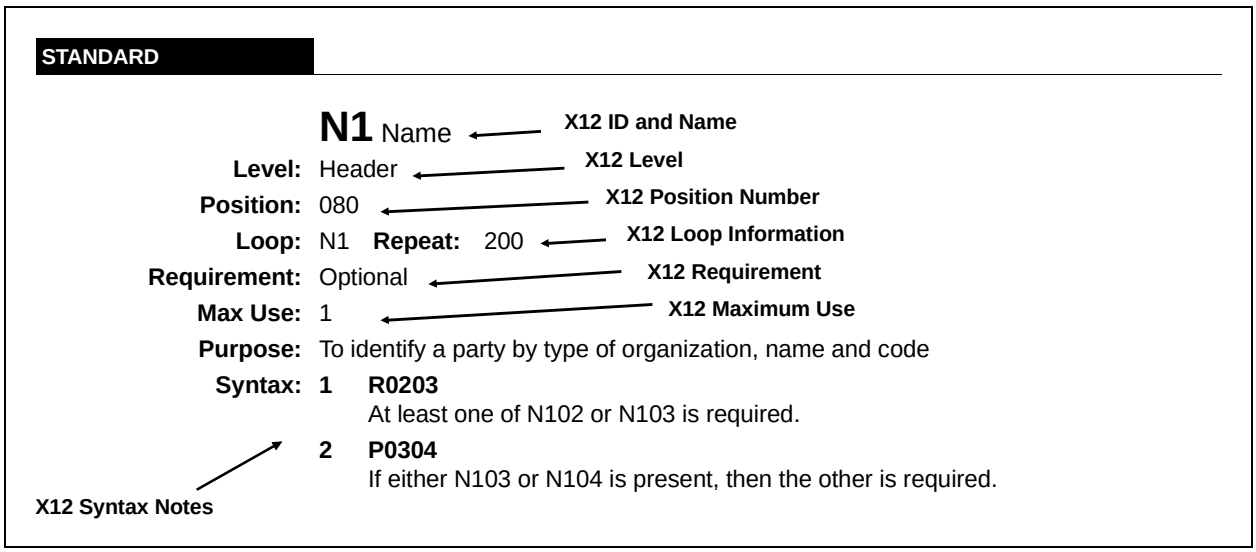


Figure 10. Segment Key — Standard

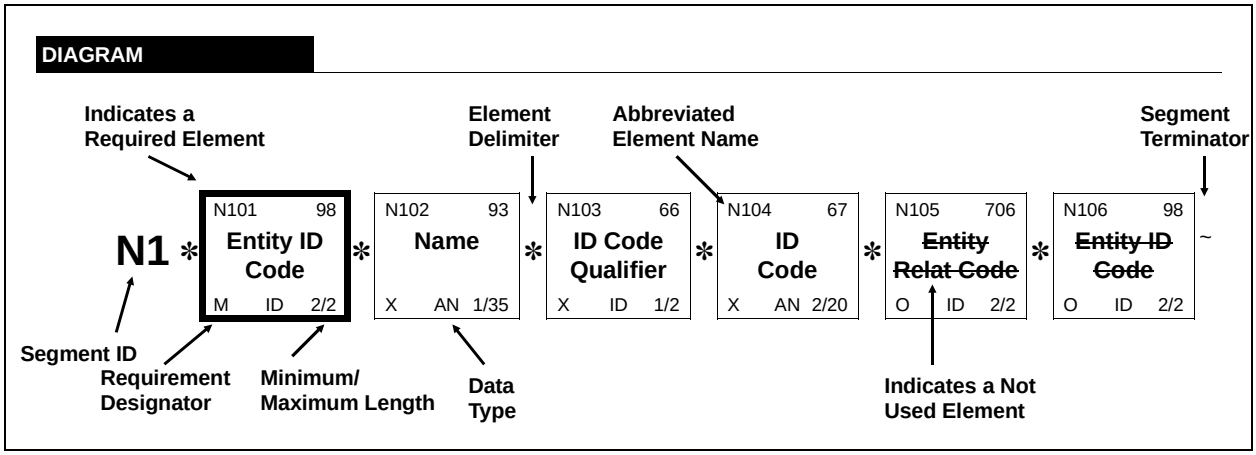
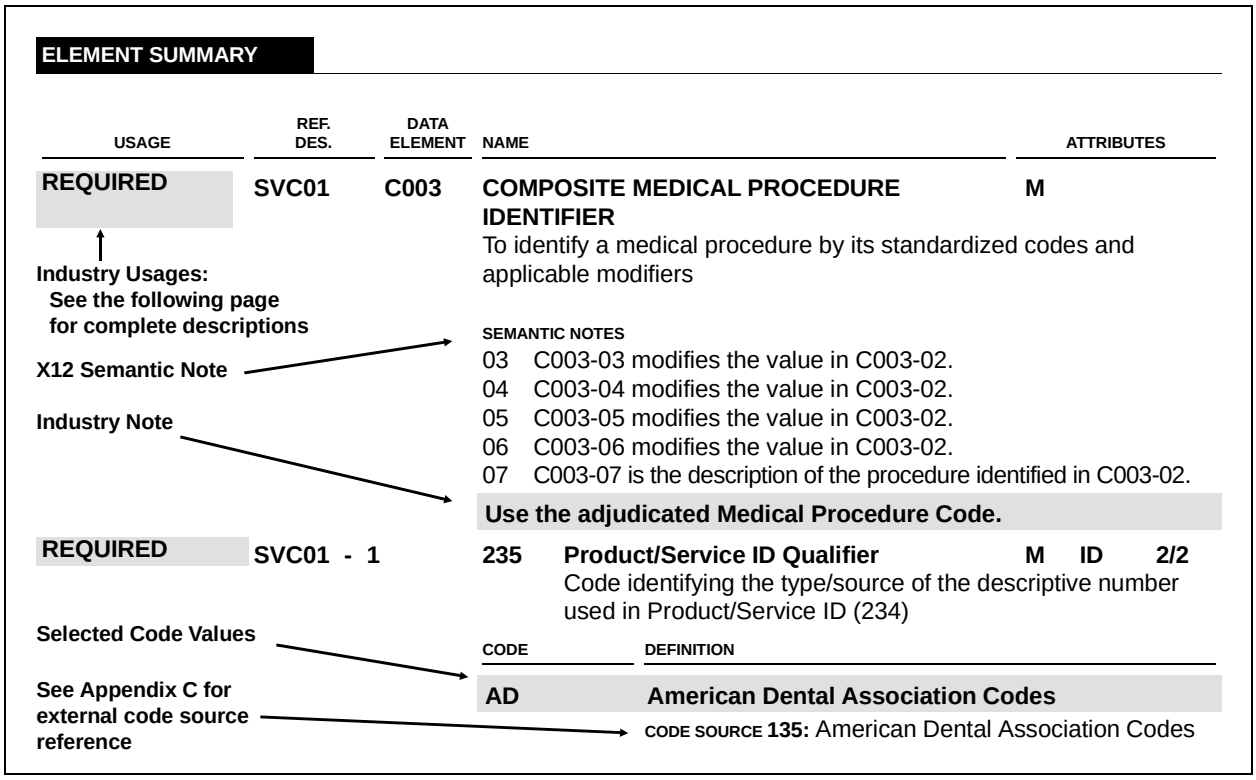


Figure 11. Segment Key — Diagram



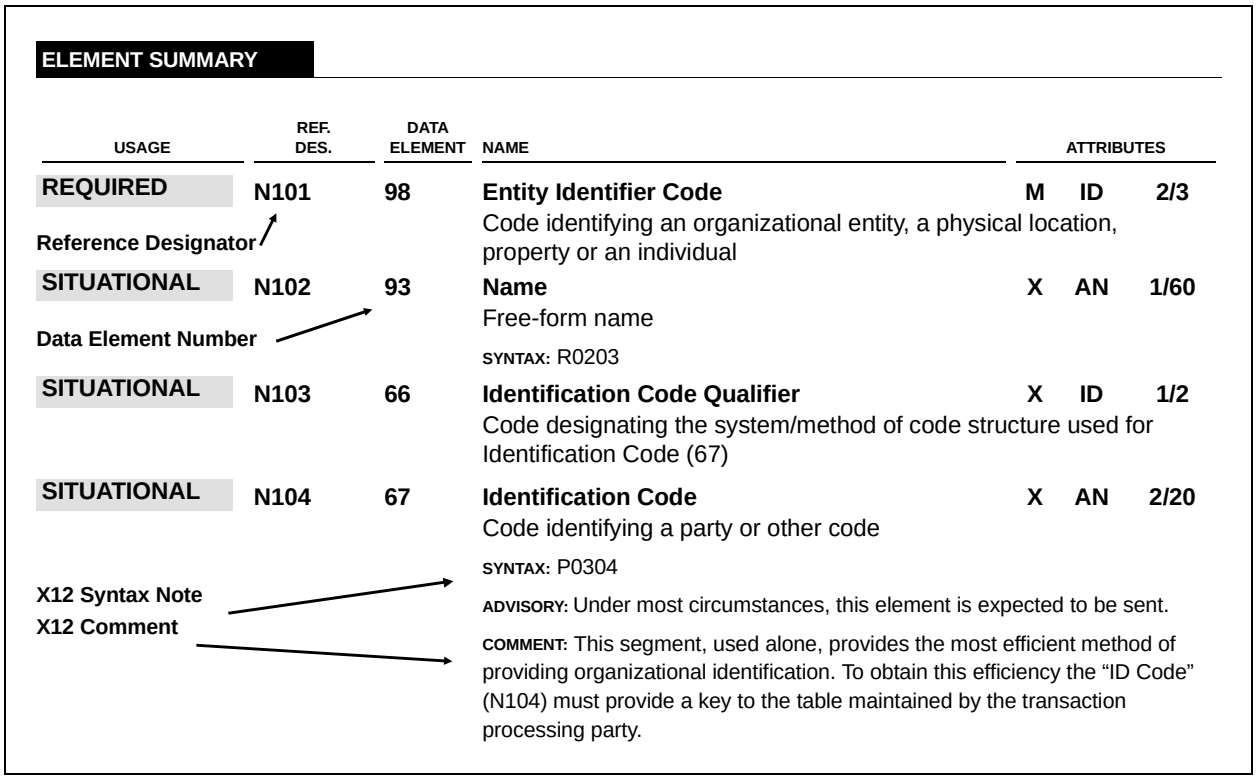


Figure 13. Segment Key — Element Summary

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: Institutional

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
56	005	ST	Transaction Set Header	R	1	
57	010	BHT	Beginning of Hierarchical Transaction	R	1	
60	015	REF	Transmission Type Identification	R	1	
			LOOP ID - 1000A SUBMITTER NAME			1
61	020	NM1	Submitter Name	R	1	
64	045	PER	Submitter EDI Contact Information	R	2	
			LOOP ID - 1000B RECEIVER NAME			1
67	020	NM1	Receiver Name	R	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	025	N3	Billing Provider Address	R	1	
80	030	N4	Billing Provider City/State/ZIP Code	R	1	
82	035	REF	Billing Provider Secondary Identification	S	8	
85	035	REF	Credit/Debit Card Billing Information	S	8	
87	040	PER	Billing Provider Contact Information	S	2	
			LOOP ID - 2010AB PAY-TO PROVIDER NAME			1
91	015	NM1	Pay-To Provider Name	S	1	
94	025	N3	Pay-To Provider Address	R	1	
95	030	N4	Pay-To Provider City/State/ZIP Code	R	1	
97	035	REF	Pay-To Provider Secondary Identification	S	5	

Table 2 - Detail, Subscriber Hierarchical Level

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1
99	001	HL	Subscriber Hierarchical Level	R	1	
101	005	SBR	Subscriber Information	R	1	
106	007	PAT	Patient Information	S	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			1
108	015	NM1	Subscriber Name	R	1	

112	025	N3	Subscriber Address	S	1	
113	030	N4	Subscriber City/State/ZIP Code	S	1	
115	032	DMG	Subscriber Demographic Information	S	1	
117	035	REF	Subscriber Secondary Identification	S	4	
119	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2010BB CREDIT/DEBIT CARD ACCOUNT HOLDER NAME			**1**
121	015	NM1	Credit/Debit Card Account Holder Name	S	1	
124	035	REF	Credit/Debit Card Information	S	2	
			LOOP ID - 2010BC PAYER NAME			**1**
126	015	NM1	Payer Name	R	1	
129	025	N3	Payer Address	S	1	
130	030	N4	Payer City/State/ZIP Code	S	1	
132	035	REF	Payer Secondary Identification	S	3	
			LOOP ID - 2010BD RESPONSIBLE PARTY NAME			**1**
134	015	NM1	Responsible Party Name	S	1	
136	025	N3	Responsible Party Address	R	1	
137	030	N4	Responsible Party City/State/ZIP Code	R	1	

Table 2 - Detail, Patient Hierarchical Level

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

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL			**>1**
139	001	HL	Patient Hierarchical Level	S	1	
141	007	PAT	Patient Information	R	1	
			LOOP ID - 2010CA PATIENT NAME			**1**
145	015	NM1	Patient Name	R	1	
148	025	N3	Patient Address	R	1	
149	030	N4	Patient City/State/ZIP Code	R	1	
151	032	DMG	Patient Demographic Information	R	1	
153	035	REF	Patient Secondary Identification Number	S	5	
155	035	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2300 CLAIM INFORMATION			**100**
157	130	CLM	Claim information	R	1	
165	135	DTP	Discharge Hour	S	1	
167	135	DTP	Statement Dates	R	1	
169	135	DTP	Admission Date/Hour	S	1	
171	140	CL1	Institutional Claim Code	S	1	
173	155	PWK	Claim Supplemental Information	S	10	
176	160	CN1	Contract Information	S	1	
178	175	AMT	Payer Estimated Amount Due	S	1	
180	175	AMT	Patient Estimated Amount Due	S	1	
182	175	AMT	Patient Paid Amount	S	1	
184	175	AMT	Credit/Debit Card Maximum Amount	S	1	
185	180	REF	Adjusted Repriced Claim Number	S	1	
186	180	REF	Repriced Claim Number	S	1	

187	180	REF	Claim Identification Number For Clearinghouses and Other Transmission Intermediaries	S	1	
189	180	REF	Document Identification Code	S	1	
191	180	REF	Original Reference Number (ICN/DCN)	S	1	
193	180	REF	Investigational Device Exemption Number	S	1	
195	180	REF	Service Authorization Exception Code	S	1	
197	180	REF	Peer Review Organization (PRO) Approval Number	S	1	
198	180	REF	Prior Authorization or Referral Number	S	2	
200	180	REF	Medical Record Number	S	1	
202	180	REF	Demonstration Project Identifier	S	1	
204	185	K3	File Information	S	10	
205	190	NTE	Claim Note	S	10	
208	190	NTE	Billing Note	S	1	
210	216	CR6	Home Health Care Information	S	1	
218	220	CRC	Home Health Functional Limitations	S	3	
221	220	CRC	Home Health Activities Permitted	S	3	
224	220	CRC	Home Health Mental Status	S	2	
227	231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	R	1	
230	231	HI	Diagnosis Related Group (DRG) Information	S	1	
232	231	HI	Other Diagnosis Information	S	2	
242	231	HI	Principal Procedure Information	S	1	
244	231	HI	Other Procedure Information	S	2	
256	231	HI	Occurrence Span Information	S	2	
267	231	HI	Occurrence Information	S	2	
280	231	HI	Value Information	S	2	
290	231	HI	Condition Information	S	2	
299	231	HI	Treatment Code Information	S	2	
306	240	QTY	Claim Quantity	S	4	
308	241	HCP	Claim Pricing/Repricing Information	S	1	
			LOOP ID - 2305 HOME HEALTH CARE PLAN INFORMATION			**6**
314	242	CR7	Home Health Care Plan Information	S	1	
316	243	HSD	Health Care Services Delivery	S	12	
			LOOP ID - 2310A ATTENDING PHYSICIAN NAME			**1**
321	250	NM1	Attending Physician Name	S	1	
324	255	PRV	Attending Physician Specialty Information	R	1	
326	271	REF	Attending Physician Secondary Identification	S	5	
			LOOP ID - 2310B OPERATING PHYSICIAN NAME			**1**
328	250	NM1	Operating Physician Name	S	1	
331	255	PRV	Operating Physician Specialty Information	S	1	
333	271	REF	Operating Physician Secondary Identification	S	5	
			LOOP ID - 2310C OTHER PROVIDER NAME			**1**
335	250	NM1	Other Provider Name	S	1	
338	255	PRV	Other Provider Specialty Information	R	1	
340	271	REF	Other Provider Secondary Identification	S	5	
			LOOP ID - 2310D REFERRING PROVIDER NAME			**2**
342	250	NM1	Referring Provider Name	S	1	
345	255	PRV	Referring Provider Specialty Information	S	1	
347	271	REF	Referring Provider Secondary Identification	S	5	
			LOOP ID - 2310E SERVICE FACILITY NAME			**1**
349	250	NM1	Service Facility Name	S	1	
352	255	PRV	Service Facility Specialty Information	S	1	
354	265	N3	Service Facility Address	R	1	
355	270	N4	Service Facility City/State/Zip Code	R	1	

357	271	REF	Service Facility Secondary Identification	S	5	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			10
359	290	SBR	Other Subscriber Information	S	1	
365	295	CAS	Claim Level Adjustment	S	5	
371	300	AMT	Payer Prior Payment	S	1	
372	300	AMT	Coordination of Benefits (COB) Total Allowed Amount	S	1	
373	300	AMT	Coordination of Benefits (COB) Total Submitted Charges	S	1	
374	300	AMT	Diagnostic Related Group (DRG) Outlier Amount	S	1	
376	300	AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	S	1	
378	300	AMT	Medicare Paid Amount - 100%	S	1	
380	300	AMT	Medicare Paid Amount - 80%	S	1	
382	300	AMT	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	S	1	
384	300	AMT	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	S	1	
386	300	AMT	Coordination of Benefits (COB) Total Non-covered Amount	S	1	
387	300	AMT	Coordination of Benefits (COB) Total Denied Amount	S	1	
388	305	DMG	Other Subscriber Demographic Information	S	1	
390	310	OI	Other Insurance Coverage Information	R	1	
392	315	MIA	Medicare Inpatient Adjudication Information	S	1	
397	320	MOA	Medicare Outpatient Adjudication Information	S	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			1
400	325	NM1	Other Subscriber Name	R	1	
404	332	N3	Other Subscriber Address	S	1	
406	340	N4	Other Subscriber City/State/ZIP Code	S	1	
408	355	REF	Other Subscriber Secondary Information	S	3	
			LOOP ID - 2330B OTHER PAYER NAME			1
410	325	NM1	Other Payer Name	R	1	
412	332	N3	Other Payer Address	S	1	
413	340	N4	Other Payer City/State/ZIP Code	S	1	
415	350	DTP	Claim Adjudication Date	S	1	
416	355	REF	Other Payer Secondary Identification and Reference Number	S	2	
418	355	REF	Other Payer Prior Authorization or Referral Number	S	1	
			LOOP ID - 2330C OTHER PAYER PATIENT INFORMATION			1
420	325	NM1	Other Payer Patient Information	S	1	
422	355	REF	Other Payer Patient Identification Number	S	3	
			LOOP ID - 2330D OTHER PAYER ATTENDING PROVIDER			1
424	325	NM1	Other Payer Attending Provider	S	1	
426	355	REF	Other Payer Attending Provider Identification	R	3	
			LOOP ID - 2330E OTHER PAYER OPERATING PROVIDER			1
428	325	NM1	Other Payer Operating Provider	S	1	
430	355	REF	Other Payer Operating Provider Identification	R	3	
			LOOP ID - 2330F OTHER PAYER OTHER PROVIDER			1
432	325	NM1	Other Payer Other Provider	S	1	
434	355	REF	Other Payer Other Provider Identification	R	3	
			LOOP ID - 2330G OTHER PAYER REFERRING PROVIDER			2
436	325	NM1	Other Payer Referring Provider	S	1	

438	355	REF	Other Payer Referring Provider Identification	R	3	
			LOOP ID - 2330H OTHER PAYER SERVICE FACILITY PROVIDER			1
440	325	NM1	Other Payer Service Facility Provider	S	1	
442	355	REF	Other Payer Service Facility Provider Identification	R	3	
			LOOP ID - 2400 SERVICE LINE NUMBER			999
444	365	LX	Service Line Number	R	1	
445	375	SV2	Institutional Service Line	R	1	
450	385	SV4	Prescription Number	S	1	
452	420	PWK	Line Supplemental Information	S	5	
456	455	DTP	Service Line Date	S	1	
458	455	DTP	Assessment Date	S	1	
460	475	AMT	Service Tax Amount	S	1	
461	475	AMT	Facility Tax Amount	S	1	
			LOOP ID - 2420A ATTENDING PHYSICIAN NAME			1
462	500	NM1	Attending Physician Name	S	1	
465	505	PRV	Attending Physician Specialty Information	R	1	
467	525	REF	Attending Physician Secondary Identification	S	1	
			LOOP ID - 2420B OPERATING PHYSICIAN NAME			1
469	500	NM1	Operating Physician Name	S	1	
472	505	PRV	Operating Physician Specialty Information	S	1	
474	525	REF	Operating Physician Secondary Identification	S	1	
			LOOP ID - 2420C OTHER PROVIDER NAME			1
476	500	NM1	Other Provider Name	S	1	
479	505	PRV	Other Provider Specialty Information	S	1	
481	525	REF	Other Provider Secondary Identification	S	1	
			LOOP ID - 2420D REFERRING PROVIDER NAME			1
483	500	NM1	Referring Provider Name	S	1	
486	505	PRV	Referring Provider Specialty Information	S	1	
488	525	REF	Referring Provider Secondary Identification	S	1	
			LOOP ID - 2430 SERVICE LINE ADJUDICATION INFORMATION			25
490	540	SVD	Service Line Adjudication Information	S	1	
494	545	CAS	Service Line Adjustment	S	99	
502	550	DTP	Service Adjudication Date	S	1	
503	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

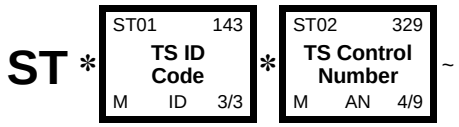
Loop: ____

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 **The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be 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*19960618*0932*CH~**

STANDARD

BHT Beginning of Hierarchical Transaction

Level: Header

Position: 010

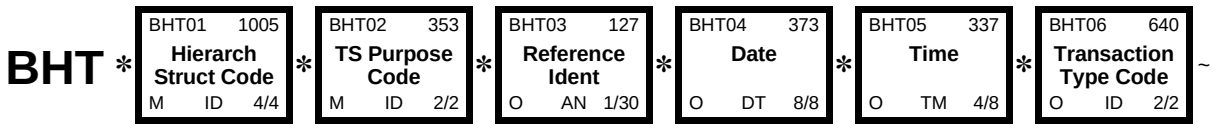
Loop: ____

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

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

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

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

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

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

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

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

Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.

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.

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.

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

REQUIRED	**BHT06**	**640**	**Transaction Type Code** Code specifying the type of transaction	**O**	**ID**	**2/2**

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

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

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 itermediary) for purposes other than adjudication of a claim. Such an entity could be a state health agency which is using the 837 for health data reporting purposes.

CODE	DEFINITION
CH	**Chargeable** **Use this code when the transmission contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction is a claim or encounter, the developers of this implementation guide recommend submitting the transaction as a claim.**
RP	**Reporting** **Use this code to send a batch of encounters.**

IMPLEMENTATION

TRANSMISSION TYPE IDENTIFICATION

Usage: **REQUIRED**

Repeat: **1**

Example: **REF*87*004010X096~**

STANDARD

REF Reference Identification

Level: Header

Position: 015

Loop: ____

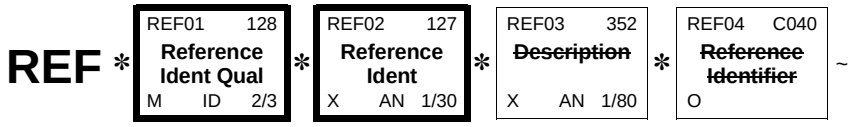
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **87 Functional Category**	**M ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Transmission Type Code*** SYNTAX: R0203 **When this draft is used to pilot the transaction set, this value is 004010X096D. When this draft is used to send the transaction set in a production mode, this value is 004010X096.**	**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, Data Overview, 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.**

Example: **NM1*41*2*ABC Submitter*****46*999999999~**

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

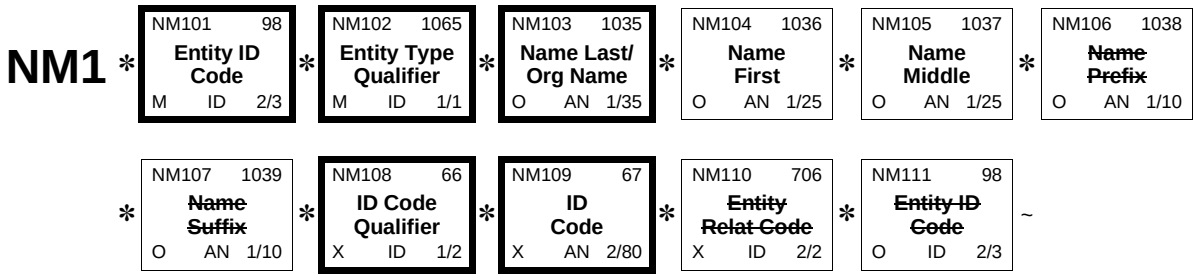
Set Notes:

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***	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 a 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	**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

SUBMITTER EDI CONTACT INFORMATION

Loop: **1000A — SUBMITTER NAME**

Usage: **REQUIRED**

Repeat: **2**

Notes:

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

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

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

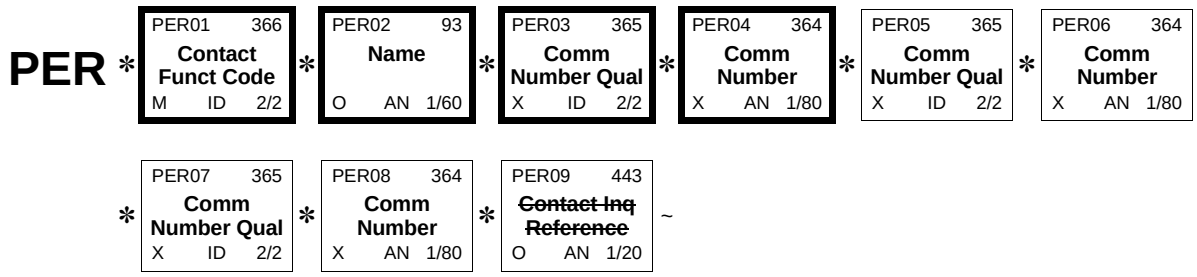
Syntax:

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 / DEFINITION **IC** — **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Submitter 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 when additional contact numbers are to be communicated.** CODE / DEFINITION **ED** — **Electronic Data Interchange Access Number** **EM** — **Electronic Mail** **EX** — **Telephone Extension** **The use of this code indicates it is the extension of the number in PER04.**	**X ID 2/2**

			FX	**Facsimile**			
			TE	**Telephone**			
SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0506 **This data element is required when the submitter needs to convey additional submitter contact information.** **Used when additional contact numbers are to be communicated.**	**X**	**AN**	**1/80**	
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0708 **Used when additional contact numbers are to be communicated.**	**X**	**ID**	**2/2**	
			CODE / DEFINITION				
			ED	**Electronic Data Interchange Access Number**			
			EM	**Electronic Mail**			
			EX	**Telephone Extension** **The use of this code indicates it is the extension of the number in PER06.**			
			FX	**Facsimile**			
			TE	**Telephone**			
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0708 **This data element is required when the submitter needs to convey additional submitter contact information.** **Used when additional contact numbers are to be communicated.**	**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. **See Section 2.4, Loop ID-1000, Data Overview, 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.**

Example: **NM1*40*2*CSC HEALTHCARE*****46*112223333~**

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

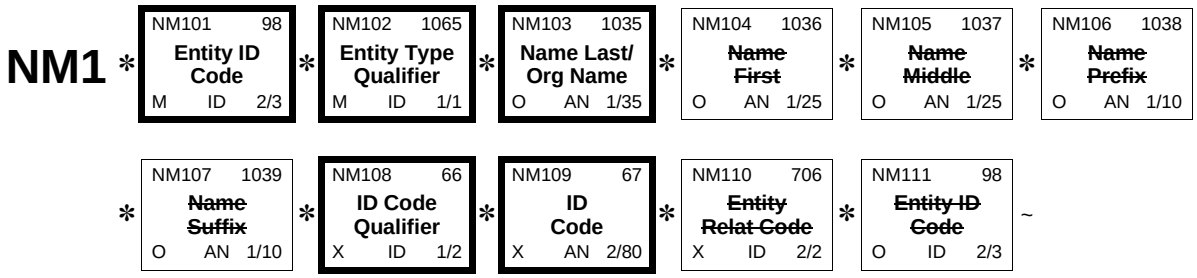
Set Notes:

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 — Receiver	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 2 — 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) *INDUSTRY: **Information Receiver Identification Number*** SYNTAX: P0809 CODE: 46 — 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	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

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-2010BC. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider**

2. **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.**

3. **If the Service Facility Provider is the same entity as the Billing or the Pay-to Provider then do not use Loop 2310E.**

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

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

6. **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.**

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

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

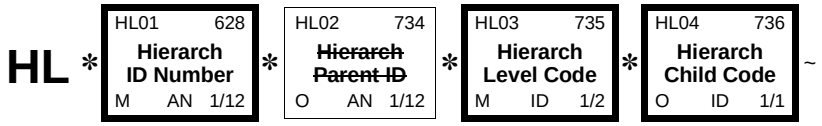
Loop: 2000 **Repeat:** >1

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. **The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).**	**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 Service Facility Provider is the same entity as the BillingProvider and/or the Pay-to Provider. In these cases, the Service Facility Provider is being identified at this level for all subsequent claims in this HL batch and Loop ID-2310E is not used.**
2. **If the Billing or Pay-to Provider is also the Service Facility Provider, and Loop 2310E is not used, this PRV segment is required.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*BI*ZZ*203BA0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 003

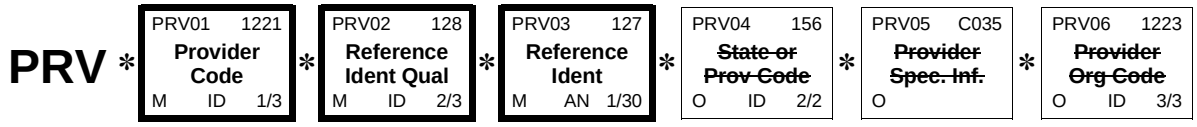
Loop: 2000

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

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

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

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

CODE	DEFINITION
ZZ	**Mutually Defined**

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

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.**

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.

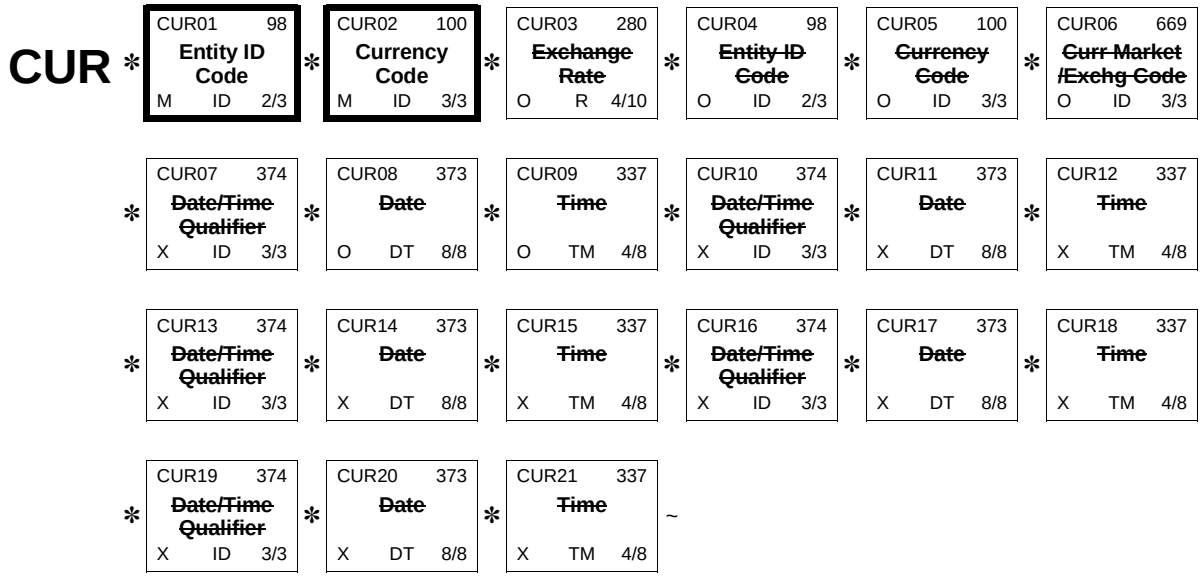
11. **C1816**
    If CUR18 is present, then CUR16 is required.

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: **85** DEFINITION: **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. **Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 nomenclature.**
2. **Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.**

Example: **NM1*85*2*JONES HOSPITAL*****XX*45609312~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

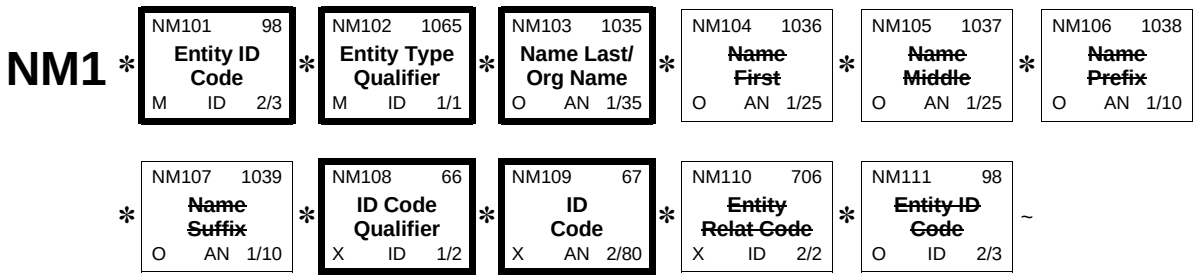
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: 85 — DEFINITION: **Billing Provider** **Use this code to indicate billing provider, billing submitter, and encounter reporting entity.**	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 2 — DEFINITION: **Non-Person Entity**	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Billing Provider Last or Organizational Name*** *ALIAS: **Billing Provider Name*** **UB-92 Reference [UB-92 Name]:** **1, Line 1 [Provider Name, Address and Telephone Number]** **EMC v.6.0 Reference:** **Record Type 10 Field No. 12**	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 **If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.** CODE: 24 — DEFINITION: **Employer's Identification Number** CODE: 34 — DEFINITION: **Social Security Number** CODE: XX — DEFINITION: **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:* ***Billing Provider Identifier*** *ALIAS:* ***Billing Provider Primary ID*** 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

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

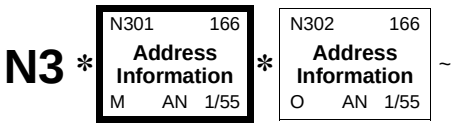
Loop: 2010

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*** **UB-92 Reference [UB-92 Name]:** **1, Line 2 [Provider Name, Address and Telephone Number]** **EMC v.6.0 Reference:** **Record Type 10 Field No. 13**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Billing Provider Address Line*** **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

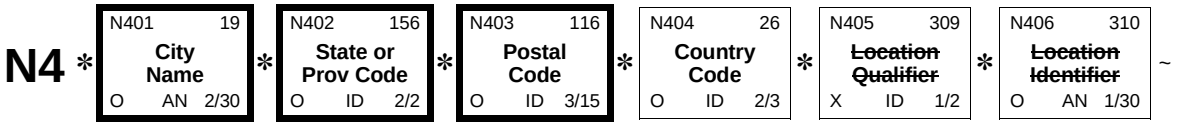
Requirement: Optional

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*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **UB-92 Reference [UB-92 Name]:** **1, Line 3 [Provider Name, Address and Telephone Number]** **EMC v.6.0 Reference:** **Record Type 10 Field No. 14**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**

INDUSTRY: ***Billing Provider State or Province Code***

COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada.

CODE SOURCE 22: States and Outlying Areas of the U.S.

UB-92 Reference [UB-92 Name]:

1, Line 3 [Provider Name, Address and Telephone Number]

EMC v.6.0 Reference:

Record Type 10 Field No. 15

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**

INDUSTRY: ***Billing Provider Postal Zone or ZIP Code***

CODE SOURCE 51: ZIP Code

UB-92 Reference [UB-92 Name]:

1, Line 3 [Provider Name, Address and Telephone Number]

EMC v.6.0 Reference:

Record Type 10 Field No. 16

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**

CODE SOURCE 5: Countries, Currencies and Funds

UB-92 Reference [UB-92 Name]:

1, Line 4, Positions 23-25 [Provider Name, Address and Telephone Number]

EMC v.6.0 Reference:

Record Type 10 Field No. 18

This data element is required when the address is outside of the U.S.

NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

BILLING PROVIDER SECONDARY IDENTIFICATION

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

Usage: **SITUATIONAL**

Repeat: **8**

Notes:

1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.**
2. **If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.**
3. **If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.**

Example: **REF*SY*987654~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

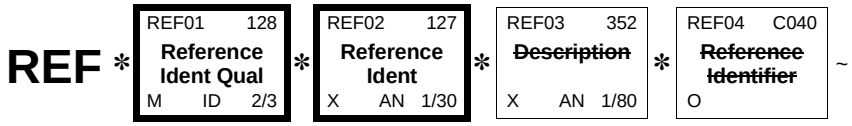
Max Use: 20

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**

Codes 8U, LU, ST, TT, 06, IJ, RB, and EM were added to this implementation guide to support credit/debit card information billing. *See Appendix G, Credit/Debit Card Use,* for details.

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number** UB-92 Reference [UB-92 Name]: **51 (A-C) [Provider Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 9, 10** **Record Type 30 Field No. 24**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number** UB-92 Reference [UB-92 Name]: **51 (A-C) [Provider Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 6** **Record Type 30 Field No. 24**
1D	**Medicaid Provider Number** UB-92 Reference [UB-92 Name]: **51 (A-C) [Provider Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 7**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number** UB-92 Reference [UB-92 Name]: **51 (A-C) [Provider Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 8** **Record Type 30 Field No. 24**
1J	**Facility ID Number**
B3	**Preferred Provider Organization Number**
BQ	**Health Maintenance Organization Code Number**

			EI	**Employer's Identification Number** UB-92 Reference [UB-92 Name]: **5 [Payer Identification]** EMC v.6.0 Reference: **Record Type 10 Field No. 4, 5**			
			FH	**Clinic Number**			
			G2	**Provider Commercial Number** UB-92 Reference [UB-92 Name]: **51 (A-C) [Provider Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 9, 10** **Record Type 30 Field No. 24**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.** UB-92 Reference [UB-92 Name]: **5 [Payer Identification]** EMC v.6.0 Reference: **Record Type 10 Field No. 4, 5**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Billing Provider Additional Identifier*** **SYNTAX:** R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

CREDIT/DEBIT CARD BILLING INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **8**

Notes:

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

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

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

Requirement: Optional

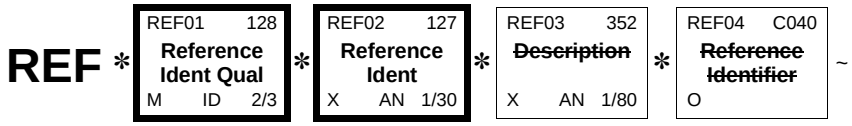
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

IMPLEMENTATION

BILLING PROVIDER CONTACT INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **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).**

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

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 PER05 is used, PER04 is required, and if PER07 is used, PER08 is required.**

Example: **PER*IC*JOHN SMITH*TE*8007775555~**

STANDARD

PER Administrative Communications Contact

Level: Detail

Position: 040

Loop: 2010

Requirement: Optional

Max Use: 2

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

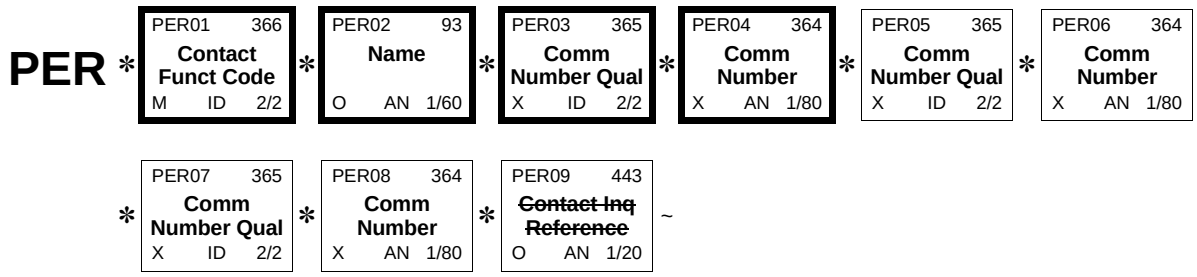
Syntax:

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

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

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named	**M ID 2/2**
			CODE: **IC** — DEFINITION: **Information Contact**	
REQUIRED	**PER02**	**93**	**Name** Free-form name *INDUSTRY:* ***Billing Provider Contact Name***	**O AN 1/60**
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number **SYNTAX:** P0304	**X ID 2/2**
			CODE: **EM** — DEFINITION: **Electronic Mail**	
			CODE: **FX** — DEFINITION: **Facsimile** UB-92 Reference [UB-92 Name]: **1, Line 4, Positions 12-21 [Provider Name, Address and Telephone Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 17**	
			CODE: **TE** — DEFINITION: **Telephone** UB-92 Reference [UB-92 Name]: **1, Line 4, Positions 1-10 [Provider Name, Address and Telephone Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 11**	
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	**X**	**ID**	**2/2**

SYNTAX: P0506

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile** UB-92 Reference [UB-92 Name]: **1, Line 4, Positions 12-21 [Provider Name, Address and Telephone Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 17**
TE	**Telephone** UB-92 Reference [UB-92 Name]: **1, Line 4, Positions 1-10 [Provider Name, Address and Telephone Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 11**

SITUATIONAL	**PER06**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

SYNTAX: P0506

SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X**	**ID**	**2/2**

SYNTAX: P0708

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile** UB-92 Reference [UB-92 Name]: **1, Line 4, Positions 12-21 [Provider Name, Address and Telephone Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 17**
TE	**Telephone** UB-92 Reference [UB-92 Name]: **1, Line 4, Positions 1-10 [Provider Name, Address and Telephone Number]** EMC v.6.0 Reference: **Record Type 10 Field No. 11**

SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X**	**AN**	**1/80**

SYNTAX: P0708

NOT USED	PER09	443	Contact Inquiry Reference	O	AN	1/20

IMPLEMENTATION

PAY-TO PROVIDER NAME

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if the Pay-to Provider is a different entity than the Billing Provider.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**

Example: **NM1*87*2*ELLIS HOSPITAL*****24*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

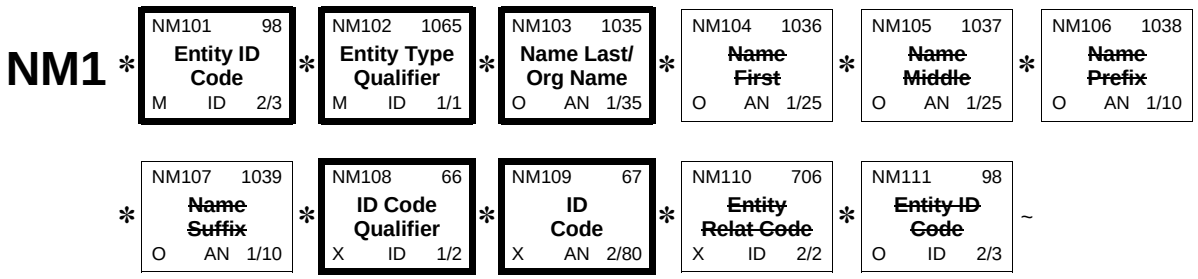
Set Notes:

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: 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: 2 — DEFINITION: Non-Person Entity If this entity is the Service Facility Provider, it is not necessary to use the Service Facility Provider NM1 loop, loop 2310D.	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* ALIAS: *Pay-to Provider Last Name or Organizational 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 If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 5 times. CODE: 24 — DEFINITION: Employer's Identification Number CODE: 34 — DEFINITION: Social Security Number The social security number may not be used for Medicare. CODE: XX — DEFINITION: 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:* ***Pay-to Provider Identifier*** *ALIAS:* ***Pay-to Provider 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

PAY-TO PROVIDER ADDRESS

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

Usage: **REQUIRED**

Repeat: **1**

Example: **N3*2216 N. MAIN STREET*COLDER BUILDING~**

STANDARD

N3 Address Information

Level: Detail

Position: 025

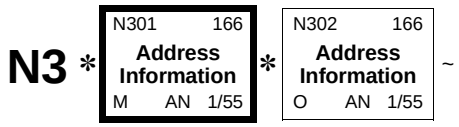
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

PAY-TO PROVIDER CITY/STATE/ZIP CODE

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

Usage: **REQUIRED**

Repeat: **1**

Example: **N4*MADISON* NY*18298~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

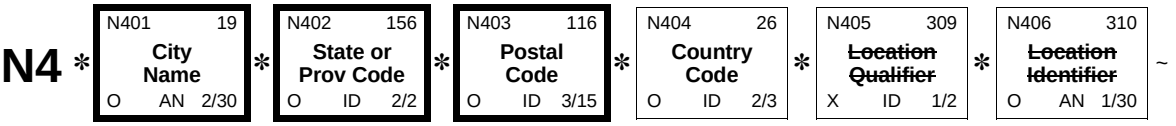
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Pay-to Provider City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Pay-to Provider State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Pay-to Provider Postal Zone or ZIP Code*** *ALIAS:* ***Pay-to Provider Zip Code*** **CODE SOURCE 51:** ZIP Code	**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 outside the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PAY-TO PROVIDER SECONDARY IDENTIFICATION

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

Usage: **SITUATIONAL**

Repeat: **5**

Notes:
1. **Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.**
2. **If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 5 times.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

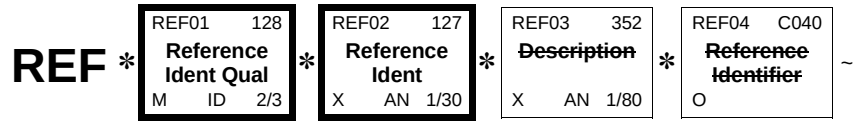
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

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

			1B	**Blue Shield Provider Number**			
			1C	**Medicare Provider Number**			
			1D	**Medicaid Provider Number**			
			1G	**Provider UPIN Number**			
			1H	**CHAMPUS Identification Number**			
			1J	**Facility ID Number**			
			B3	**Preferred Provider Organization Number**			
			BQ	**Health Maintenance Organization Code Number**			
			EI	**Employer's Identification Number**			
			FH	**Clinic Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Pay-to Provider 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

SUBSCRIBER HIERARCHICAL LEVEL

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

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

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

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

Example: **HL*124*123*22*1~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

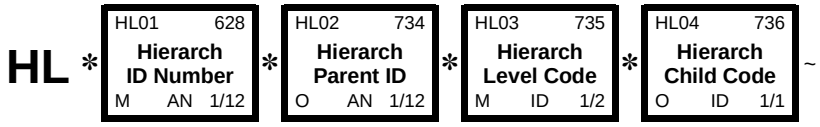
Loop: 2000 **Repeat:** >1

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**

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

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

IMPLEMENTATION

SUBSCRIBER INFORMATION

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

SBR Subscriber Information

Level: Detail

Position: 005

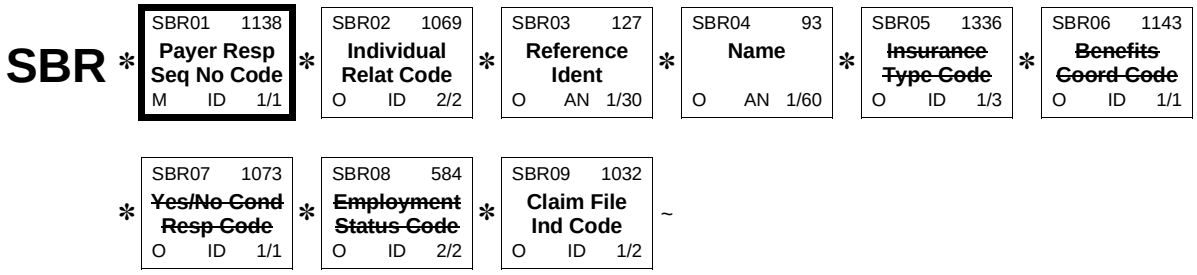
Loop: 2000

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

UB-92 Reference [UB-92 Name]:

50 (A-C) [Payer Identification]
51 (A-C) [Provider Number]
52 (A-C) [Release of Information Certification Indicator]
53 (A-C) [Assignment of Benefits Certification Indicator]
54 (A-C) [Prior Payments - Payers and Patient]
55 (A-C) [Estimated Amount Due]
58 (A-C) [Insured's Name]
59 (A-C) [Patient's Relationship to Insured]
60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]
61 (A-C) [Insured Group Name]
62 (A-C) [Insurance Group Number]
63 (A-C) [Treatment Authorization Code]
64 (A-C) [Employment Status Code of the Insured]
65 (A-C) [Employer Name of the Insured]
66 (A-C) [Employer Location of the Insured]

EMC v.6.0 Reference:

Record Type 30 Field No. 2 (Sequence 01-03)
Record Type 31 Field No. 2 (Sequence 01-03)
Record Type 32 Field No. 2 (Sequence 01-03)
Record Type 40 Field No. 5, 6, 7

CODE	DEFINITION
P	Primary
S	Secondary
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**

ALIAS: ***Patients Relationship to Insured***

SEMANTIC: SBR02 specifies the relationship to the person insured.

UB-92 Reference [UB-92 Name]:

59 (A-C) [Patient's Relationship to Insured]

EMC v.6.0 Reference:

Record Type 30 Field No. 18

Use this code only 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***

ALIAS: ***Group Number***

SEMANTIC: SBR03 is policy or group number.

UB-92 Reference [UB-92 Name]:

62 (A-C) [Insurance Group Number]

EMC v.6.0 Reference:

Record Type 30 Field No. 10 (Sequence 01-03)

Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.

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

INDUSTRY: ***Insured Group Name***

ALIAS: ***Plan Name (Group Name)***

SEMANTIC: SBR04 is plan name.

UB-92 Reference [UB-92 Name]:

61 (A-C) [Insured Group Name]

EMC v.6.0 Reference:

Record Type 30 Field No. 11 (Sequence 01-03)

Used only when no group number is reported in SBR03.

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

EMC v.6.0 Reference:

Record Type 30 Field No. 4 (not all codes map)

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

CODE	DEFINITION
09	**Self-pay** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code A**
10	**Central Certification**
11	**Other Non-Federal Programs**
12	**Preferred Provider Organization (PPO)** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
13	**Point of Service (POS)** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
14	**Exclusive Provider Organization (EPO)** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
15	**Indemnity Insurance**
16	**Health Maintenance Organization (HMO) Medicare Risk**
AM	**Automobile Medical** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
BL	**Blue Cross/Blue Shield** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code G**
CH	**Champus** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code H**
CI	**Commercial Insurance Co.** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code F**
DS	**Disability** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**

HM	**Health Maintenance Organization** **There is no map to EMC v.6.0.** **(Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment)**
LI	**Liability**
LM	**Liability Medical** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
MA	**Medicare Part A** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code C (Same as the qualifier used in CLP06 of 835 Health Care Claim Payment)**
MB	**Medicare Part B** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
MC	**Medicaid** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code D**
OF	**Other Federal Program** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code E**
TV	**Title V** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment**
VA	**Veteran Administration Plan** **Same as the qualifier used in CLP06 of the 835 Health Care Claim Payment.** **Refers to Veterans Affairs Plan.**
WC	**Workers' Compensation Health Claim** EMC v.6.0 Reference: **Record Type 30 Field No. 4 Code B (Same as the qualifier used in CLP06 of 835 Health Care Claim Payment)**
ZZ	**Mutually Defined** **Unknown** **Required value if the HIPAA Individual Identifier is mandated for use. Otherwise, the MI qualifier is used.**

IMPLEMENTATION

PATIENT INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required if the subscriber is the same person as the patient (Loop ID-2000B SBR02=18), and information in this PAT segment (patient weight see PAT07 and PAT08, or Pregnancy Indicator see PAT09) is necessary to file the claim/encounter.**

Example: **PAT*******GR*1768*Y~**

STANDARD

PAT Patient Information

Level: Detail

Position: 007

Loop: 2000

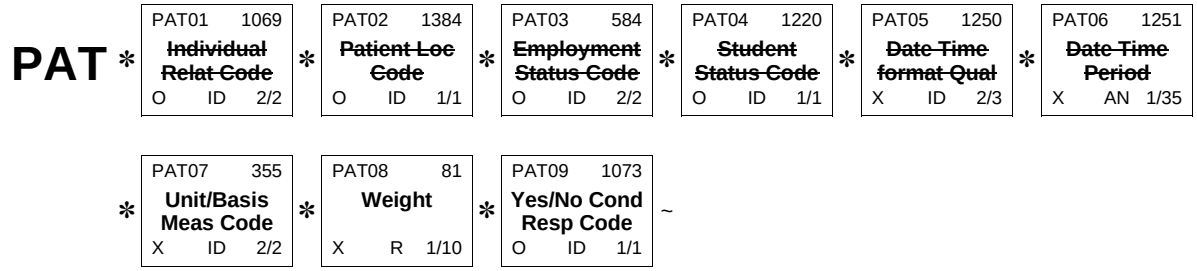
Requirement: Optional

Max Use: 1

Purpose: To supply patient information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
NOT USED	PAT01	1069	Individual Relationship Code	O	ID	2/2
NOT USED	PAT02	1384	Patient Location Code	O	ID	1/1
NOT USED	PAT03	584	Employment Status Code	O	ID	2/2
NOT USED	PAT04	1220	Student Status Code	O	ID	1/1
NOT USED	PAT05	1250	Date Time Period Format Qualifier	X	ID	2/3

NOT USED	**PAT06**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
SITUATIONAL	**PAT07**	**355**	**Unit or Basis for Measurement Code**	**X**	**ID**	**2/2**

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0708

CODE	DEFINITION
GR	**Gram**

This data element is used when the patient's age is less than 29 days old.

SITUATIONAL	**PAT08**	**81**	**Weight**	**X**	**R**	**1/10**

Numeric value of weight

INDUSTRY: ***Patient Weight***

SYNTAX: P0708

SEMANTIC: PAT08 is the patient's weight.

Required on claims/encounters for delivery services to report newborn's birthweight.

SITUATIONAL	**PAT09**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**

Code indicating a Yes or No condition or response

INDUSTRY: ***Pregnancy Indicator***

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

Required when required by state law (e.g., Indiana Medicaid)

CODE	DEFINITION
Y	**Yes**

IMPLEMENTATION

SUBSCRIBER NAME

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

Usage: **REQUIRED**

Repeat: **1**

Notes:

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

Example: **NM1*IL*1*DOE*JOHN*T***MI*739004273~**

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

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**

CODE	DEFINITION
IL	**Insured or Subscriber**

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

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**
2	**Non-Person Entity**

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

INDUSTRY: ***Subscriber Last Name***

UB-92 Reference [UB-92 Name]:

58 (A-C) [Insured's Name]

EMC v.6.0 Reference:

Record Type 30 Field No. 12 (Sequence 01-03)

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

INDUSTRY: ***Subscriber First Name***

UB-92 Reference [UB-92 Name]:

58 (A-C) [Insured's Name]

EMC v.6.0 Reference:

Record Type 30 Field No. 13 (Sequence 01-03)

This data element is required when NM102 equals one (1).

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

INDUSTRY: ***Subscriber Middle Name***

ALIAS: ***Subscriber's Middle Initial***

UB-92 Reference [UB-92 Name]:

58 (A-C) [Insured's Name]

EMC v.6.0 Reference:

Record Type 30 Field No. 14 (Sequence 01-03)

This data element is required when NM102 = 1 and the Middle Name or 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: ***Subscriber Name Suffix***

This data element is required when the NM102 equals one (1) and the name suffix is known. Examples: I, II, III, IV, Jr, Sr.

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

This data element is required when NM102 equals one (1).

MI is also intended to be used in claims submitted to the Indian Health Service/Contract HealthServices (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.

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 Institutional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Medicaid Recipient ID, Health Insurance Claim Number (HIC), etc.**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

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

INDUSTRY: ***Subscriber Primary Identifier***

SYNTAX: P0809

UB-92 Reference [UB-92 Name]:

60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]

EMC v.6.0 Reference:

Record Type 30 Field No. 7 (Sequence 01-03)

This data element is required when NM102 equals one (1).

NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**

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

IMPLEMENTATION

SUBSCRIBER ADDRESS

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is 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

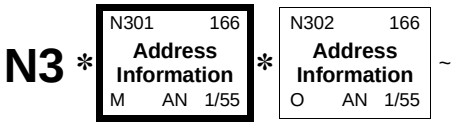
Loop: 2010

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*** **UB-92 Reference [UB-92 Name]:** **84, Line b [Remarks]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 4 (Sequence 01-03)**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Subscriber Address Line*** **EMC v.6.0 Reference:** **Record Type 31 Field No. 5 (Sequence 01-03)** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is 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

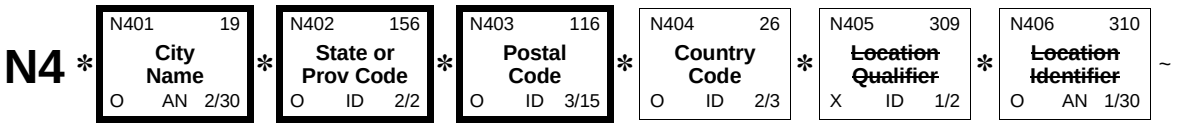
Requirement: Optional

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*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **UB-92 Reference [UB-92 Name]:** **84, Line c [Remarks]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 6 (Sequence 01-03)**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Subscriber State Code*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **UB-92 Reference [UB-92 Name]:** **84, Line c [Remarks]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 7 (Sequence 01-03)**	**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*** CODE SOURCE **51:** ZIP Code **UB-92 Reference [UB-92 Name]:** **84, Line d [Remarks]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 8 (Sequence 01-03)**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country CODE SOURCE **5:** Countries, Currencies and Funds **This data element is required when the address is outside 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. **This segment is required when the Patient is the same person as the Subscriber. (Required when Loop ID 2000B, SBR02- 18 (self)).**

Example: **DMG*D8*19290730*M~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 032

Loop: 2010

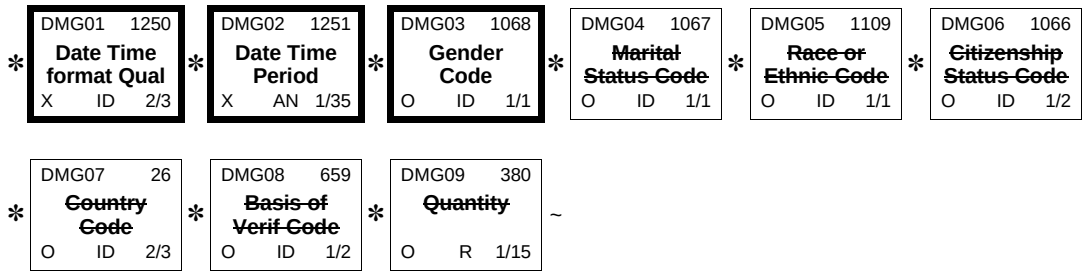
Requirement: Optional

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. **EMC v.6.0 Reference:** **Record Type 20 Field No. 8**	**X**	**AN**	**1/35**
REQUIRED	**DMG03**	**1068**	**Gender Code** Code indicating the sex of the individual *INDUSTRY:* ***Subscriber Gender Code*** *ALIAS:* ***Gender - Patient*** **EMC v.6.0 Reference:** **Record Type 30 Field No. 15**	**O**	**ID**	**1/1**
NOT USED	**DMG04**	**1067**	**Marital Status Code**	**O**	**ID**	**1/1**
NOT USED	**DMG05**	**1109**	**Race or Ethnicity Code**	**O**	**ID**	**1/1**
NOT USED	**DMG06**	**1066**	**Citizenship Status Code**	**O**	**ID**	**1/2**
NOT USED	**DMG07**	**26**	**Country Code**	**O**	**ID**	**2/3**
NOT USED	**DMG08**	**659**	**Basis of Verification Code**	**O**	**ID**	**1/2**
NOT USED	**DMG09**	**380**	**Quantity**	**O**	**R**	**1/15**

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

IMPLEMENTATION

SUBSCRIBER SECONDARY IDENTIFICATION

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **4**

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

Example: **REF*SY*030385074~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

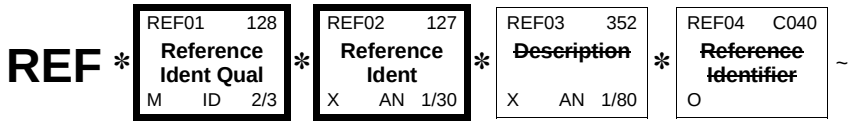
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = MI, this qualifier cannot be used.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**
IG	**Insurance Policy Number**
SY	**Social Security Number**

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

IMPLEMENTATION

PROPERTY AND CASUALTY CLAIM NUMBER

Loop: **2010BA — SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

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

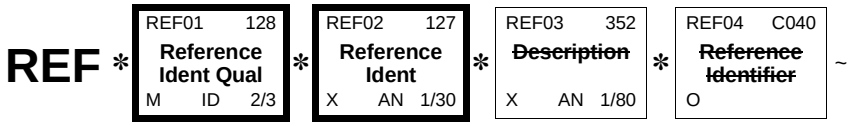
Max Use: 20

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 CODE / DEFINITION **Y4** — **Agency Claim Number** **REQUIRED**	**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:* ***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

CREDIT/DEBIT CARD ACCOUNT HOLDER NAME

Loop: **2010BB — CREDIT/DEBIT CARD ACCOUNT HOLDER NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

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

Example: **NM1*AO*1*DOE*JOHN*T***MI*739004273~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

Set Notes:

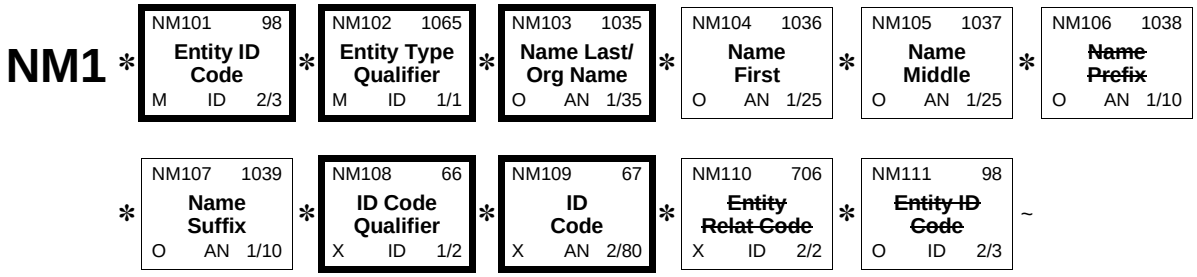
1. Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.

Syntax:

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

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **Code AO was added to this implementation guide to support credit/debit card information billing. See Appendix G, Credit/Debit Card Use, for details.** CODE / DEFINITION **AO** Account Of	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: **Credit or Debit Card Holder Last or Organizational Name*** *ALIAS: **Account Holder Last Name***	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY: **Credit or Debit Card Holder First Name*** *ALIAS: **Account Holder First Name*** **This data element is required when NM102 equals one (1).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Credit or Debit Card Holder Middle Name*** *ALIAS: **Account Holder Middle Initial*** **This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY: **Credit or Debit Card Holder Name Suffix*** **This data element is required when the NM102 equals one (1) and the name suffix is known. Examples: I, II, III, IV, Jr, Sr.**	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

CREDIT/DEBIT CARD INFORMATION

Loop: **2010BB — CREDIT/DEBIT CARD ACCOUNT HOLDER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

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

Example: **REF*AB*030385074~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

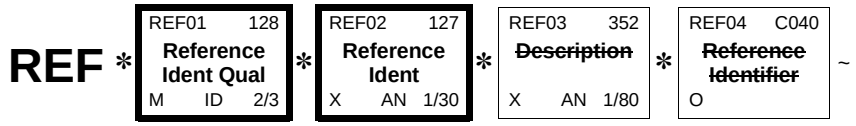
Requirement: Optional

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**

Codes AB and BB were added to this implementation guide to support credit/debit card information billing. See Appendix G, Credit/Debit Card Use, for additional details.

CODE	DEFINITION
AB	**Acceptable Source Purchaser ID**
BB	**Authorization Number**

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

IMPLEMENTATION

PAYER NAME

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

Usage: **REQUIRED**

Repeat: **1**

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

Example: **NM1*PR*2*UNION MUTUAL OF OREGON*****PI*43140~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

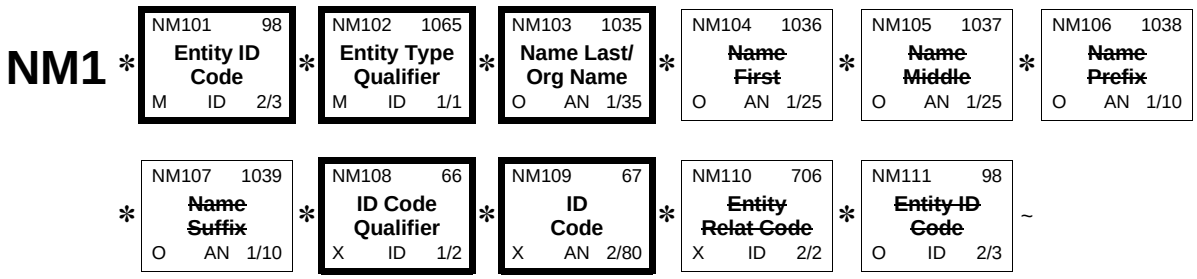
Max Use: 1

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: **PR** — DEFINITION: **Payer**	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: **2** — DEFINITION: **Non-Person Entity**	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Payer Name*** **UB-92 Reference [UB-92 Name]:** **50 (A-C) [Payer Identification]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 8b (Sequence 01-03)** **Record Type 32 Field No. 4 (Sequence 01-03)**	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 **EMC v.6.0 Reference:** **Record Type 30 Field No. 5, 6 (Sequence 01-03)** CODE: **PI** — DEFINITION: **Payor Identification** CODE: **XV** — DEFINITION: **Health Care Financing Administration National PlanID** ***Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.*** CODE SOURCE **540:** Health Care Financing Administration National PlanID	X ID 1/2

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Payer Identifier*** *ALIAS:* ***Primary Payer ID*** 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

PAYER ADDRESS

Loop: **2010BC — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

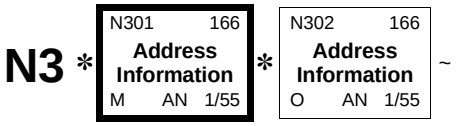
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Payer Address Line*** **EMC v.6.0 Reference:** **Record Type 32 Field No. 5 (Sequence 01-03)**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Payer Address Line*** **EMC v.6.0 Reference:** **Record Type 32 Field No. 6 (Sequence 01-03)** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

PAYER CITY/STATE/ZIP CODE

Loop: **2010BC — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

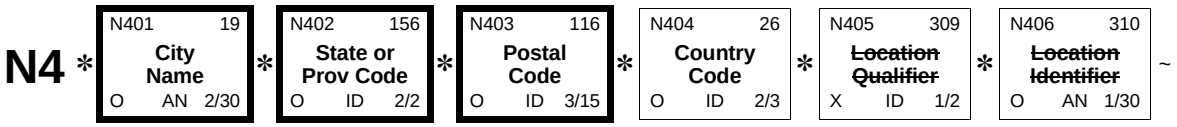
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Payer City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **EMC v.6.0 Reference:** **Record Type 32 Field No. 7 (Sequence 01-03)**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Payer State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **EMC v.6.0 Reference:** **Record Type 32 Field No. 8 (Sequence 01-03)**	**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*** **CODE SOURCE 51:** ZIP Code **EMC v.6.0 Reference:** **Record Type 32 Field No. 9 (Sequence 01-03)**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Payer Country Code*** **CODE SOURCE 5:** Countries, Currencies and Funds **This data element is required when the address is outside of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PAYER SECONDARY IDENTIFICATION

Loop: **2010BC — PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

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

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

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

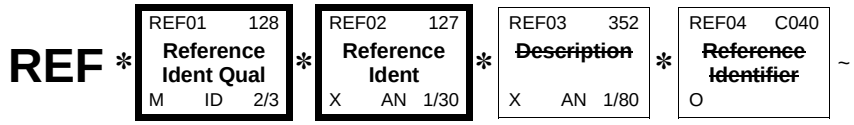
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
2U	**Payer Identification Number** **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 **EMC v.6.0 Reference:** **Record Type 30 Field No. 5, 6 (Sequence 01-03)** **Record Type 31 Field No. 15**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

RESPONSIBLE PARTY NAME

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **In general terms, the responsible party is someone who is not the subscriber/patient but who has financial responsibility for the bill.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
3. **Required for Medicare claims where there is no authorized representative and the provider of medical services has neither the responsible party's signature nor the patient's signature on file.**

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

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 015

Loop: 2010 **Repeat:** 10

Requirement: Optional

Max Use: 1

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

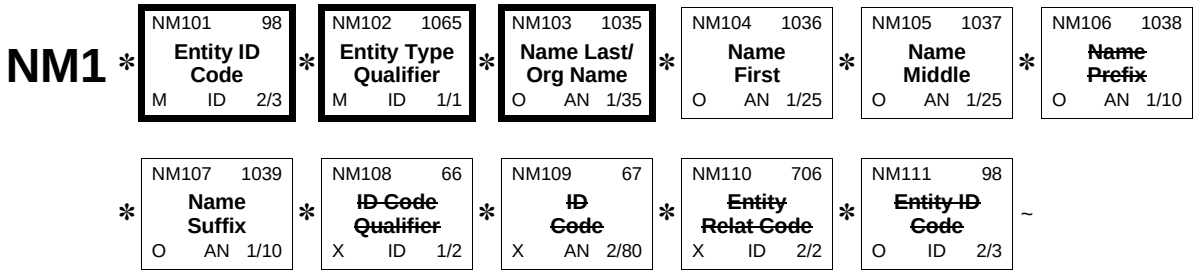
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual CODE: QD — DEFINITION: Responsible Party	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M	ID	1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: Responsible Party Last or Organization Name*	O	AN	1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY: Responsible Party First Name* Required if NM102=1 (person).	O	AN	1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: Responsible Party Middle 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: Responsible Party Suffix Name* *ALIAS: Responsible Party Generation* Required if known.	O	AN	1/10
NOT USED	NM108	66	**Identification Code Qualifier**	X	ID	1/2
NOT USED	NM109	67	**Identification Code**	X	AN	2/80
NOT USED	NM110	706	**Entity Relationship Code**	X	ID	2/2
NOT USED	NM111	98	**Entity Identifier Code**	O	ID	2/3

IMPLEMENTATION

RESPONSIBLE PARTY ADDRESS

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N3 Address Information

Level: Detail

Position: 025

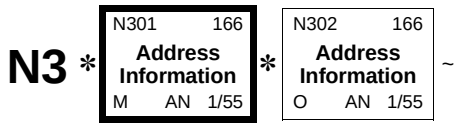
Loop: 2010

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

RESPONSIBLE PARTY CITY/STATE/ZIP CODE

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

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

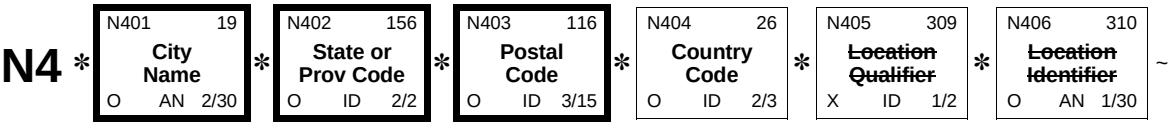
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Responsible Party City Name*** **COMMENT:** A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	**O AN 2/30**
REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Responsible Party State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S.	**O ID 2/2**
REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) *INDUSTRY:* ***Responsible Party Postal Zone or ZIP Code*** *ALIAS:* ***Responsible Party Zip Code*** **CODE SOURCE 51:** ZIP Code	**O ID 3/15**

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Responsible Party Country Code*** **CODE SOURCE 5:** Countries, Currencies and Funds **Required if the address is outside 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 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 HL's subordinate to the Patient HL.**

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

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

Example: **HL*125*124*23*0~**

STANDARD

HL Hierarchical Level

Level: Detail

Position: 001

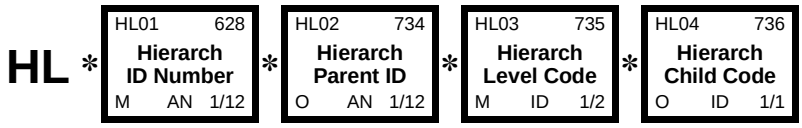
Loop: 2000 **Repeat:** >1

Requirement: Mandatory

Max Use: 1

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HL01	628	**Hierarchical ID Number** A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	M AN 1/12
REQUIRED	HL02	734	**Hierarchical Parent ID Number** Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to COMMENT: HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	O AN 1/12
REQUIRED	HL03	735	**Hierarchical Level Code** Code defining the characteristic of a level in a hierarchical structure COMMENT: HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.	M ID 1/2
			CODE — DEFINITION **23 — Dependent**	
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 only when HL04 has no subordinate levels (HL04 = 0).** 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*19*****01*145~**

STANDARD

PAT Patient Information

Level: Detail

Position: 007

Loop: 2000

Requirement: Optional

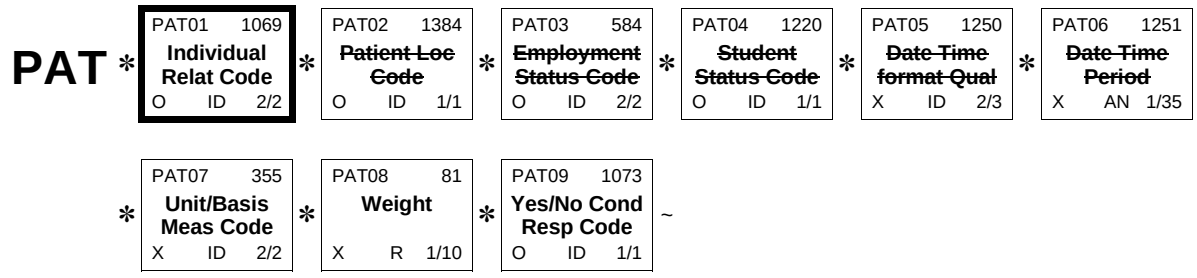
Max Use: 1

Purpose: To supply patient information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PAT01**	**1069**	**Individual Relationship Code** Code indicating the relationship between two individuals or entities	**O ID 2/2**

ALIAS: ***Patients Relationship to Insured***

UB-92 Reference [UB-92 Name]:

59 (A-C) [Patient's Relationship to Insured]

EMC v.6.0 Reference:

Record Type 30 Field No. 18 (Sequence 01-03)

Use this code to specify the patient's relationship to the person insured.

CODE	DEFINITION
01	**Spouse** UB-92 Reference [UB-92 Name]: **59 Code 02 [Spouse]**
04	**Grandfather or Grandmother** UB-92 Reference [UB-92 Name]: **59 Code 19 [Grandparent]**
05	**Grandson or Granddaughter** UB-92 Reference [UB-92 Name]: **59 Code 13 [Grandchild]**
07	**Nephew or Niece** UB-92 Reference [UB-92 Name]: **59 Code 14 [Niece/Nephew]**
10	**Foster Child** UB-92 Reference [UB-92 Name]: **59 Code 06 [Foster Child]**
15	**Ward** **Ward of the Court. This code indicates that the patient is a ward of the insured as a result of a court order.** UB-92 Reference [UB-92 Name]: **59 Code 07 [Ward of the Court]**
17	**Stepson or Stepdaughter** UB-92 Reference [UB-92 Name]: **59 Code 05 [Step Child]**
19	**Child** UB-92 Reference [UB-92 Name]: **59 Code 03 [Natural Child/Insured Financial Responsibility]**

20	**Employee** UB-92 Reference [UB-92 Name]: **59 Code 08 [Employee]**
21	**Unknown** UB-92 Reference [UB-92 Name]: **59 Code 09 [Unknown]**
22	**Handicapped Dependent** UB-92 Reference [UB-92 Name]: **59 Code 10 [Handicapped Dependent]**
23	**Sponsored Dependent** UB-92 Reference [UB-92 Name]: **59 Code 16 [Sponsored Dependent]**
24	**Dependent of a Minor Dependent** UB-92 Reference [UB-92 Name]: **59 Code 17 [Minor Dependent of a Minor Dependent]**
29	**Significant Other**
32	**Mother**
33	**Father**
36	**Emancipated Minor**
39	**Organ Donor** UB-92 Reference [UB-92 Name]: **59 Code 11 [Organ Donor]**
40	**Cadaver Donor** UB-92 Reference [UB-92 Name]: **59 Code 12 [Cadaver Donor]**
41	**Injured Plaintiff** UB-92 Reference [UB-92 Name]: **59 Code 15 [Injured Plaintiff]**
43	**Child Where Insured Has No Financial Responsibility** UB-92 Reference [UB-92 Name]: **59 Code 04 [Natural Child/Insured Does not Have Financial Responsibility]**
53	**Life Partner** UB-92 Reference [UB-92 Name]: **59 Code 20 [Life Partner]**
G8	**Other Relationship**

NOT USED	**PAT02**	**1384**	**Patient Location Code**	**O**	**ID**	**1/1**
NOT USED	**PAT03**	**584**	**Employment Status Code**	**O**	**ID**	**2/2**
NOT USED	**PAT04**	**1220**	**Student Status Code**	**O**	**ID**	**1/1**

NOT USED	**PAT05**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**PAT06**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
SITUATIONAL	**PAT07**	**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	**X**	**ID**	**2/2**

SYNTAX: P0708

This data element is used when the patient's age is less than 29 days old.

CODE	DEFINITION
GR	**Gram**

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

INDUSTRY: ***Patient Weight***

SYNTAX: P0708

SEMANTIC: PAT08 is the patient's weight.

This data element is required when the Patient's Age is less than 29 days old. Patient's Age is calculated as follows: Admission Date - Date of Birth.

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

INDUSTRY: ***Pregnancy Indicator***

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

Required when required by state law (e.g., Indiana Medicaid).

CODE	DEFINITION
Y	**Yes**

IMPLEMENTATION

PATIENT NAME

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

Usage: **REQUIRED**

Repeat: **1**

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

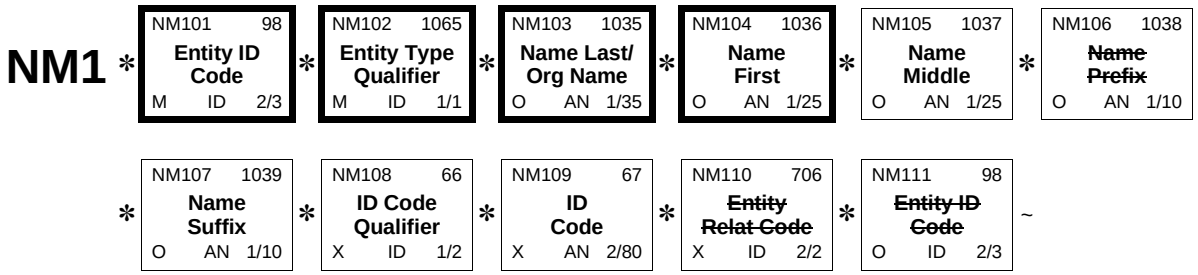
Set Notes:

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	**M ID 2/3**

CODE	DEFINITION
QC	**Patient**

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

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**

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

INDUSTRY: ***Patient Last Name***

UB-92 Reference [UB-92 Name]:

12 [Patient Name]

EMC v.6.0 Reference:

Record Type 20 Field No. 4

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

INDUSTRY: ***Patient First Name***

UB-92 Reference [UB-92 Name]:

12 [Patient Name]

EMC v.6.0 Reference:

Record Type 20 Field No. 5

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

INDUSTRY: ***Patient Middle Name***

UB-92 Reference [UB-92 Name]:

12 [Patient Name]

EMC v.6.0 Reference:

Record Type 20 Field No. 6

This data element is required when NM102 = 1 and the Middle Name or Initial of the person is known.

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

INDUSTRY: ***Patient Name Suffix***

ALIAS: ***Patient's Generation***

This data element is required when the NM102 equals one (1) and the name suffix is known. Examples: I, II, III, IV, Jr, Sr.

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

This data element is required when the Patient's Identifier is different from the Subscriber's Identifier.

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 Institutional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Medicaid Recipient ID, Health Insurance Claim Number (HIC), etc.**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

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

INDUSTRY: ***Patient Primary Identifier***

SYNTAX: P0809

UB-92 Reference [UB-92 Name]:

60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]

EMC v.6.0 Reference:

Record Type 30 Field No. 7

This data element is required when the Patients ID is different from the Subscribers ID.

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

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

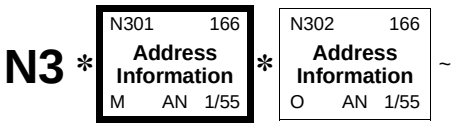
Loop: 2010

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*** **UB-92 Reference [UB-92 Name]:** **13 [Patient Address]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 12**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Patient Address Line*** **UB-92 Reference [UB-92 Name]:** **13 [Patient Address]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 13** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

PATIENT CITY/STATE/ZIP CODE

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 030

Loop: 2010

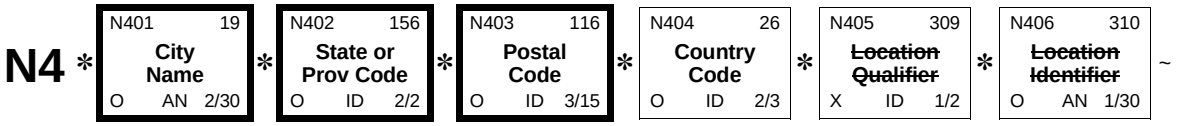
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N401**	**19**	**City Name** Free-form text for city name *INDUSTRY:* ***Patient City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **UB-92 Reference [UB-92 Name]:** **13 [Patient Address]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 14**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Patient State Code*** **COMMENT:** N402 is required only if city name (N401) is in the U.S. or Canada. **CODE SOURCE 22:** States and Outlying Areas of the U.S. **UB-92 Reference [UB-92 Name]:** **13 [Patient Address]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 15**	**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*** **CODE SOURCE 51:** ZIP Code **UB-92 Reference [UB-92 Name]:** **13 [Patient Address]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 16**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country **CODE SOURCE 5:** Countries, Currencies and Funds **This data element is required when the address is outside of the U.S.**	**O**	**ID**	**2/3**
NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

PATIENT DEMOGRAPHIC INFORMATION

Loop: **2010CA — PATIENT NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

DMG Demographic Information

Level: Detail

Position: 032

Loop: 2010

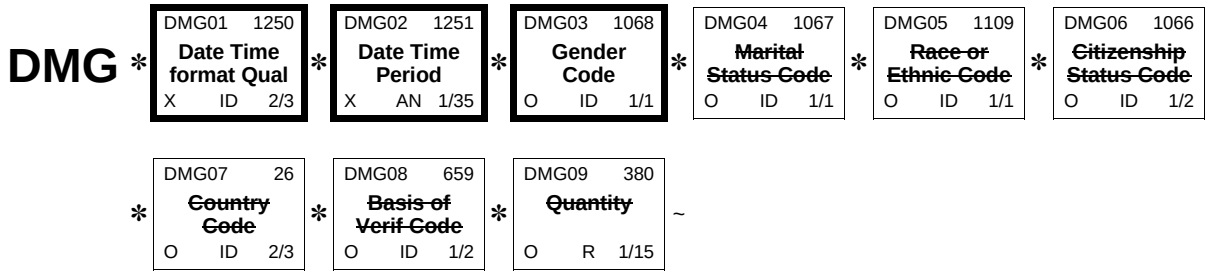
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

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

DIAGRAM



ELEMENT SUMMARY

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

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

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

INDUSTRY: ***Patient Birth Date***

ALIAS: ***Patient's Date of Birth***

SYNTAX: P0102

SEMANTIC: DMG02 is the date of birth.

UB-92 Reference [UB-92 Name]:

14 [Patient Birthdate]

EMC v.6.0 Reference:

Record Type 20 Field No. 8 (MMDDCCYY)

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

INDUSTRY: ***Patient Gender Code***

UB-92 Reference [UB-92 Name]:

15 [Patient Sex]

EMC v.6.0 Reference:

Record Type 20 Field No. 7

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

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

IMPLEMENTATION

PATIENT SECONDARY IDENTIFICATION NUMBER

Loop: **2010CA — PATIENT NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. This segment is required when an additional identification number is needed.**

Example: **REF*A6*030385074~**

STANDARD

REF Reference Identification

Level: Detail

Position: 035

Loop: 2010

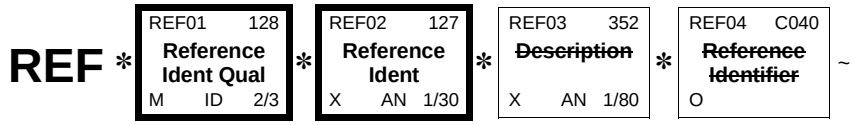
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = MI, this qualifier cannot be used.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**
IG	**Insurance Policy Number**

			SY **Social Security Number** **The social security number may not be used for Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***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. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 4.2, Property and Casualty, for additional information about property and casualty claims.**

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

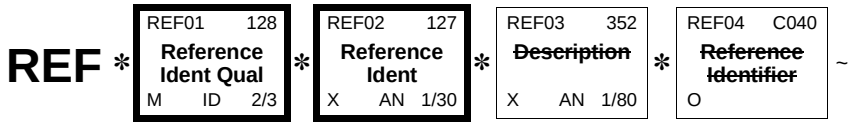
Max Use: 20

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

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

Example: **CLM*01319300001*500***11:A:1*Y*A*Y*Y***02******N~**

STANDARD

CLM Health Claim

Level: Detail

Position: 130

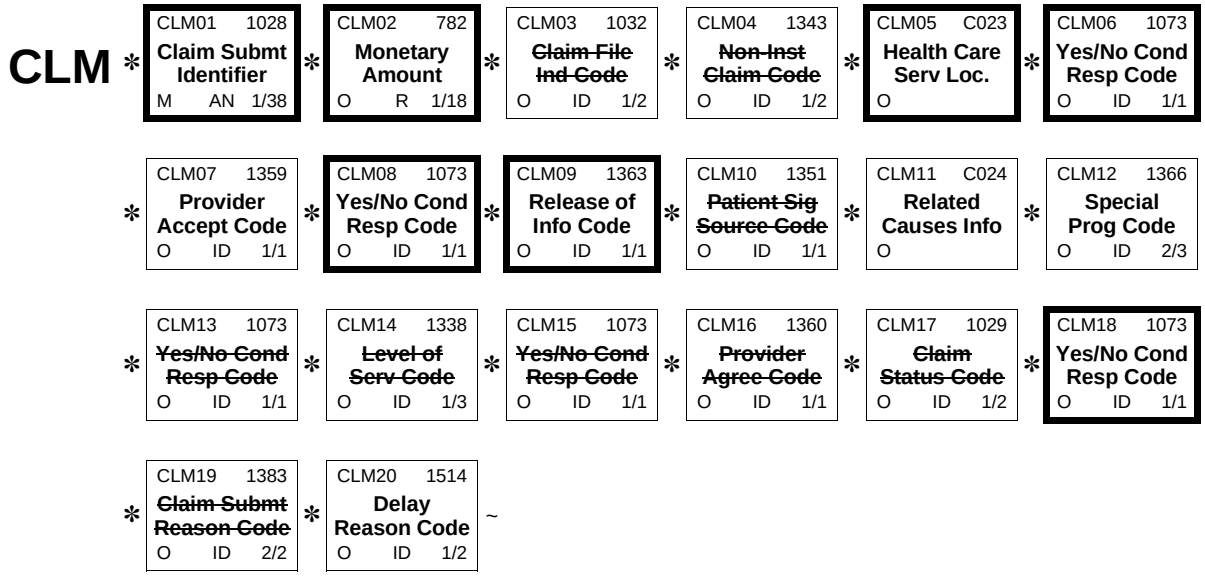
Loop: 2300 **Repeat:** 100

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*** *ALIAS:* ***Patient Control Number*** **UB-92 Reference [UB-92 Name]:** **3 [Patient Control Number]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 3** **The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the patient account number or the claim number in the billing provider's system.** **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 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.

UB-92 Reference [UB-92 Name]:

47 (Revenue Code 001) This amount is the total of the SV2 segments, with the exception of Revenue Code 001. [Total Charges (by Revenue Code Category)]

EMC v.6.0 Reference:

Record Type 90 Field No. 13 (Total of Field No. 13 and Field No. 15. This amount is the total of the SV2 segments, with the exception of Revenue Code 001.)

Use this element to indicate the total amount of all submitted charges of service segments for this claim.

Zero 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: ***Type of Bill***

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***

UB-92 Reference [UB-92 Name]:

4, Positions 1-2 [Type of Bill]

EMC v.6.0 Reference:

Record Type 40 Field No. 4, Positions 1-2

Record Type 10 Field No. 2, Positions 1-2

Record Type 95 Field No. 5, Position 1-2 (Batch Control)

REQUIRED	CLM05 - 2	1332	**Facility Code Qualifier** Code identifying the type of facility referenced	O	ID	1/2

CODE	DEFINITION
A	**Uniform Billing Claim Form Bill Type**

CODE SOURCE **236:** Uniform Billing Claim Form Bill Type

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 Frequency Code***

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

UB-92 Reference [UB-92 Name]:

4, Position 3 [Type of Bill]

EMC v.6.0 Reference:

Record Type 40 Field No. 4, Position 3

Record Type 10 Field No. 2, Position 3

Record Type 95 Field No. 5, Position 3 (Batch Control)

REQUIRED **CLM06** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**

Code indicating a Yes or No condition or response

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

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

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

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***

CLM07 indicates whether the provider accepts Medicare assignment.

CODE	DEFINITION
A	**Assigned**
C	**Not Assigned**

REQUIRED **CLM08** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**

Code indicating a Yes or No condition or response

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

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

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

UB-92 Reference [UB-92 Name]:

53 (A-C) [Assignment of Benefits Certification Indicator]

EMC v.6.0 Reference:

Record Type 30 Field No. 17 (Sequence 01-03)

Use this value as an assignment of benefits indicator. Use a "Y" value to indicate that the insured or authorized person authorizes benefits to be assigned to the provider. Use an "N" value to indicate that benefits have not been assigned to the provider.

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

UB-92 Reference [UB-92 Name]:

52 (A-C) [Release of Information Certification Indicator]

EMC v.6.0 Reference:

Record Type 30 Field No. 16 (Sequence 01-03)

CODE	DEFINITION
A	**Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization**
I	**Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes**
M	**The Provider has Limited or Restricted Ability to Release Data Related to a Claim** UB-92 Reference [UB-92 Name]: **52 Code R [Restricted or Modified Release]** EMC v.6.0 Reference: **Record Type 30 Field No. 16 Code R**
N	**No, Provider is Not Allowed to Release Data** UB-92 Reference [UB-92 Name]: **52 Code N [No Release]**
O	**On file at Payor or at Plan Sponsor**
Y	**Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim** UB-92 Reference [UB-92 Name]: **52 Code Y [Yes]**

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

ALIAS: ***Property & Casualty Related Cause Codes***

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

It is suggested that users code Related Causes in the Occurrence Code Information HI segment.

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***

CODE	DEFINITION
AA	**Auto Accident**

AB	**Abuse**
AP	**Another Party Responsible**
EM	**Employment**
OA	**Other Accident**

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

INDUSTRY: ***Related Causes Code***

This element is required when an additional Related Cause Code is applicable. Related Cause Code must not be duplicated.

CODE	DEFINITION
AA	**Auto Accident**
AB	**Abuse**
AP	**Another Party Responsible**
EM	**Employment**
OA	**Other Accident**

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

INDUSTRY: ***Related Causes Code***

See CLM11-2

This element is required when an additional Related Cause Code is applicable. Related Cause Code must not be duplicated.

CODE	DEFINITION
AA	**Auto Accident**
AB	**Abuse**
AP	**Another Party Responsible**
EM	**Employment**
OA	**Other Accident**

SITUATIONAL **CLM11 - 4** **156** **State or Province Code** **O** **ID** **2/2**
Code (Standard State/Province) as defined by appropriate government agency

INDUSTRY: ***Auto Accident State or Province Code***

CODE SOURCE 22: States and Outlying Areas of the U.S.

This data element is required to be present when CLM11-1, CLM11-2 or CLM11-3 equals 'AA'.

SITUATIONAL **CLM11 - 5** **26** **Country Code** **O** **ID** **2/3**
Code identifying the country

CODE SOURCE **5:** Countries, Currencies and Funds

This data element is required to be present when CLM11-4 is present and the accident occured outside of the U.S.

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

INDUSTRY: ***Special Program Indicator***

ALIAS: ***Special Program Code***

Required if the services were rendered under one of the following circumstances, programs or 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**
07	**Induced Abortion - Danger to Life**
08	**Induced Abortion - Rape or Incest**
09	**Second Opinion or Surgery**

NOT USED **CLM13** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**

NOT USED **CLM14** **1338** **Level of Service Code** **O** **ID** **1/3**

NOT USED **CLM15** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**

NOT USED **CLM16** **1360** **Provider Agreement Code** **O** **ID** **1/1**

NOT USED **CLM17** **1029** **Claim Status Code** **O** **ID** **1/2**

REQUIRED **CLM18** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Explanation of Benefits Indicator***

ALIAS: ***Explanation of Benefits (EOB) Indicator***

SEMANTIC: CLM18 is explanation of benefit (EOB) indicator. A "Y" value indicates that a paper EOB is requested; an "N" value indicates that no paper EOB is requested.

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

NOT USED **CLM19** **1383** **Claim Submission Reason Code** **O** **ID** **2/2**

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

Delay Reason Code

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

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

CODE	DEFINITION
1	Proof of Eligibility Unknown or Unavailable
2	Litigation
3	Authorization Delays
4	Delay in Certifying Provider
5	Delay in Supplying Billing Forms
6	Delay in Delivery of Custom-made Appliances
7	Third Party Processing Delay
8	Delay in Eligibility Determination
9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
10	Administration Delay in the Prior Approval Process
11	Other

IMPLEMENTATION

DISCHARGE HOUR

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. **This segment is required on all final inpatient claims/encounters.**

Example: **DTP*096*TM*1130~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

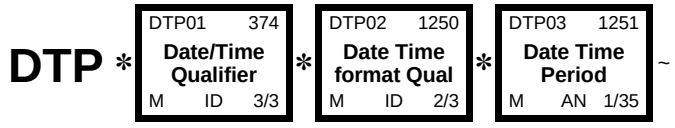
Loop: 2300

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 **TM Time Expressed in Format HHMM**	**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 Hour***

UB-92 Reference [UB-92 Name]:

21 [Discharge Hour]

EMC v.6.0 Reference:

Record Type 20 Field No. 22

IMPLEMENTATION

STATEMENT DATES

Loop: **2300 — CLAIM INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Example: **DTP*434*RD8*19981209-19981214~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

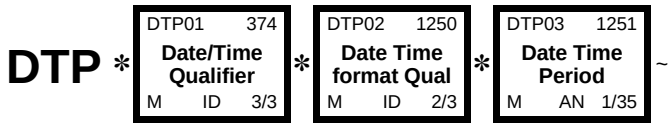
Loop: 2300

Requirement: Optional

Max Use: 150

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**
			INDUSTRY: ***Date Time Qualifier***	
			CODE / **DEFINITION** **434** — **Statement**	
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**	
			RD8 — **Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **Use RD8 in DTP02 if it is necessary to indicate begin/end for from/to statement dates.**	

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: ***Statement From or To Date***

UB-92 Reference [UB-92 Name]:

6 (From) and (Through) [Statement Covers Period]

EMC v.6.0 Reference:

Record Type 20 Field No. 19, 20

IMPLEMENTATION

ADMISSION DATE/HOUR

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. **This segment is required on all Inpatient claims.**

Example: **DTP*435*DT*199610131242~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 135

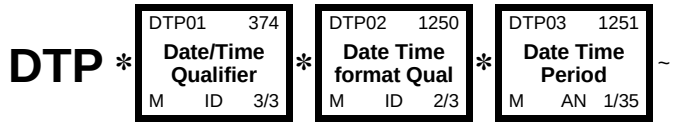
Loop: 2300

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 **DT** — **Date and Time Expressed in Format CCYYMMDDHHMM**	**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: ***Admission Date and Hour***

UB-92 Reference [UB-92 Name]:

17 [Admission/Start of Care Date]

18 [Admission Hour]

EMC v.6.0 Reference:

Record Type 20 Field No. 17 (Admission Date)

Record Type 20 Field No. 18 (Admission Hour)

IMPLEMENTATION

INSTITUTIONAL CLAIM CODE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when reporting hospital based admission and Medicare outpatient registrations on claims/encounters. It may be used when provider wishes to communicate this information on non-Medicare outpatient claims/encounters.**

Example: **CL1*1*7*30~**

STANDARD

CL1 Claim Codes

Level: Detail

Position: 140

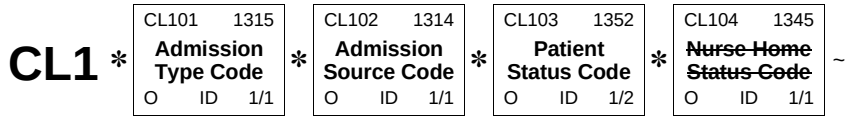
Loop: 2300

Requirement: Optional

Max Use: 1

Purpose: To supply information specific to hospital claims

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**CL101**	**1315**	**Admission Type Code** Code indicating the priority of this admission **CODE SOURCE 231:** Admission Type Code **UB-92 Reference [UB-92 Name]:** **19 [Type of Admission]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 10** **Required when patient is being admitted to the hospital for inpatient services.**	**O ID 1/1**

SITUATIONAL	**CL102**	**1314**	**Admission Source Code** Code indicating the source of this admission CODE SOURCE **230:** Admission Source Code **UB-92 Reference [UB-92 Name]:** **20 [Source of Admission]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 11** **Required for all inpatient admissions. Required on Medicare outpatient registrations for diagnostic testing services.**	**O**	**ID**	**1/1**
SITUATIONAL	**CL103**	**1352**	**Patient Status Code** Code indicating patient status as of the “statement covers through date” CODE SOURCE **239:** Patient Status Code **UB-92 Reference [UB-92 Name]:** **22 [Patient Status]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 21** **This element is required for inpatient claims/encounters.**	**O**	**ID**	**1/2**
NOT USED	**CL104**	**1345**	**Nursing Home Residential Status Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

CLAIM SUPPLEMENTAL INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

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

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

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

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

STANDARD

PWK Paperwork

Level: Detail

Position: 155

Loop: 2300

Requirement: Optional

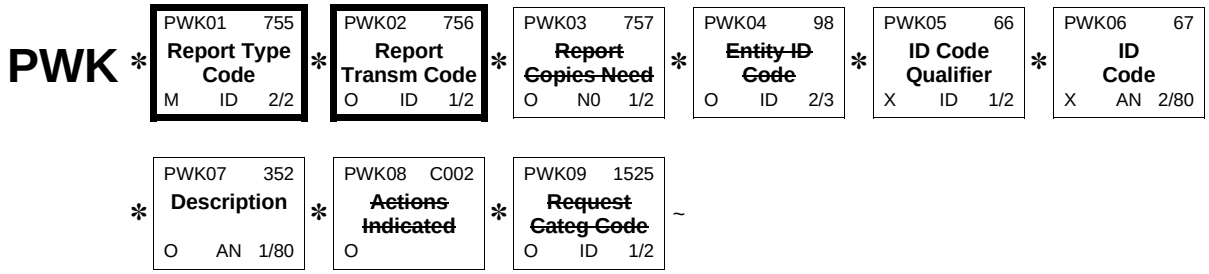
Max Use: 10

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	M ID 2/2

INDUSTRY: ***Attachment Report Type Code***

CODE	DEFINITION
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
CT	Certification
DA	Dental Models
DG	Diagnostic Report
DS	Discharge Summary
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
MT	Models
NN	Nursing Notes
OB	Operative Note
OZ	Support Data for Claim
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report

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

INDUSTRY: ***Attachment Transmission Code***

CODE	DEFINITION
AA	**Available on Request at Provider Site** **Paperwork is available at the provider's site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at his or her 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 **COMMENT:** PWK05 and PWK06 may be used to identify the addressee by a code number. **This data element is required when PWK02 DOES NOT equal 'AA'. Can be used when PWK02 equals 'AA' if the Provider wants to send a document control number for an attachment remaining at the Providers office.** CODE DEFINITION **AC** **Attachment Control Number**	**X**	**ID**	**1/2**
SITUATIONAL	**PWK06**	**67**	**Identification Code** Code identifying a party or other code ***INDUSTRY:*** ***Attachment Control Number*** **SYNTAX:** P0506 **Required if PWK02 equals BM, EL, EM or FX.**	**X**	**AN**	**2/80**
SITUATIONAL	**PWK07**	**352**	**Description** A free-form description to clarify the related data elements and their content ***INDUSTRY:*** ***Attachment Description*** **ADVISORY:** Under most circumstances, this element is not sent. **COMMENT:** PWK07 may be used to indicate special information to be shown on the specified report. **This data element is used to add any additional information about the attachment described in this segment.**	**O**	**AN**	**1/80**
NOT USED	**PWK08**	**C002**	**ACTIONS INDICATED** **ADVISORY:** Under most circumstances, this composite is not sent.	**O**		
NOT USED	**PWK09**	**1525**	**Request Category Code**	**O**	**ID**	**1/2**

IMPLEMENTATION

CONTRACT INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The developers of this implementation guide recommend that for non-capitated situations, contract information be maintained in the receiver's files and not be transmitted with each claim whenever possible. It is recommended that submitters always include CN1 for encounters that include only capitated services.**

2. **Required if the provider is contractually obligated to provide contract information on this claim.**

Example: **CN1*02*550~**

STANDARD

CN1 Contract Information

Level: Detail

Position: 160

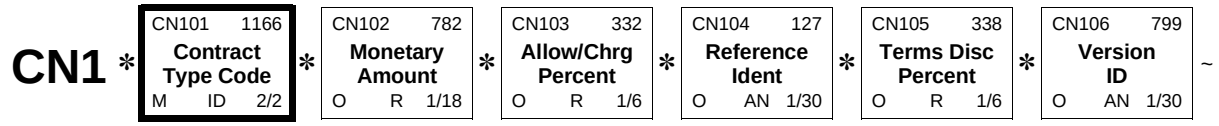
Loop: 2300

Requirement: Optional

Max Use: 1

Purpose: To specify basic data about the contract or contract line item

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CN101**	**1166**	**Contract Type Code** Code identifying a contract type	**M ID 2/2**

CODE	DEFINITION
01	**Diagnosis Related Group (DRG)**
02	**Per Diem**
03	**Variable Per Diem**
04	**Flat**
05	**Capitated**
06	**Percent**

			09 Other			
SITUATIONAL	**CN102**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Contract Amount*** **SEMANTIC:** CN102 is the contract amount. **Required if provider is contractually obligated to provide this information on the claim.**	**O**	**R**	**1/18**
SITUATIONAL	**CN103**	**332**	**Percent** Percent expressed as a percent *INDUSTRY:* ***Contract Percentage*** *ALIAS:* ***Allowance or Charge Percent*** **SEMANTIC:** CN103 is the allowance or charge percent. **Required if provider is contractually obligated to provide this information on the claim.**	**O**	**R**	**1/6**
SITUATIONAL	**CN104**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Contract Code*** **SEMANTIC:** CN104 is the contract code. **Required if provider is contractually obligated to provide this information on the claim.**	**O**	**AN**	**1/30**
SITUATIONAL	**CN105**	**338**	**Terms Discount Percent** Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date *INDUSTRY:* ***Terms Discount Percentage*** **Required if provider is contractually obligated to provide this information on the claim.**	**O**	**R**	**1/6**
SITUATIONAL	**CN106**	**799**	**Version Identifier** Revision level of a particular format, program, technique or algorithm *INDUSTRY:* ***Contract Version Identifier*** **SEMANTIC:** CN106 is an additional identifying number for the contract. **Required if provider is contractually obligated to provide this information on the claim.**	**O**	**AN**	**1/30**

IMPLEMENTATION

PAYER ESTIMATED AMOUNT DUE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The amounts in this segment at the claim level Loop ID-2300 apply to all service lines unless overridden in the AMT segment in Loop ID-2400. An amount is considered to be overridden if the value in AMT01 is the same in both the claim level AMT segment and the service line level AMT segment.**

2. **This segment is required when the Payer Estimated Amount Due is applicable to this claim.**

Example: **AMT*C5*14523.1~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

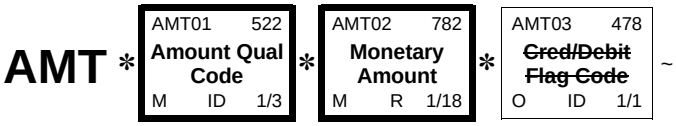
Loop: 2300

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
C5	**Claim Amount Due - Estimated**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Estimated Claim Due Amount***			
			UB-92 Reference [UB-92 Name]:			
			55 (A-C) [Estimated Amount Due]			
			EMC v.6.0 Reference:			
			Record Type 30 Field No. 26			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PATIENT ESTIMATED AMOUNT DUE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The amounts in this segment at the claim level Loop ID-2300 apply to all service lines unless overridden in the AMT segment in Loop ID-2400. An amount is considered to be overridden if the value in AMT01 is the same in both the claim level AMT segment and the service line level AMT segment.**

2. **This segment is required when the Patient Responsibility Amount is applicable to this claim.**

Example: **AMT*F3*123~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

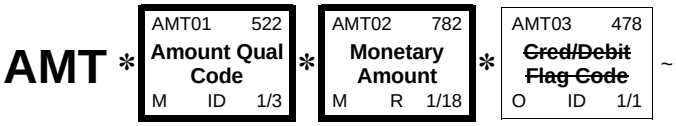
Loop: 2300

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**	
			F3 / **Patient Responsibility - Estimated**	

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Patient Responsibility Amount*** **UB-92 Reference [UB-92 Name]:** **55, Patient Line [Estimated Amount Due]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 24**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PATIENT PAID AMOUNT

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The amounts in this segment at the claim level Loop ID-2300 apply to all service lines unless overridden in the AMT segment in Loop ID-2400. An amount is considered to be overridden if the value in AMT01 is the same in both the claim level AMT segment and the service line level AMT segment.**

2. **This segment is required when the Patient Paid Amount is applicable to this claim.**

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

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

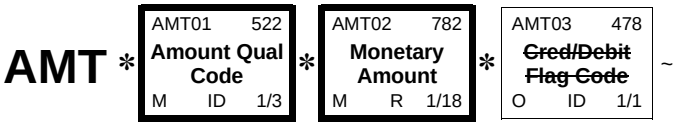
Loop: 2300

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	**M ID 1/3**

CODE	DEFINITION
F5	**Patient Amount Paid**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Patient Amount Paid*** **UB-92 Reference [UB-92 Name]:** **54, Line P [Prior Payments - Payers and Patient]** **EMC v.6.0 Reference:** **Record Type 20 Field No. 23**	**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 indicates the maximum amount that can be credited to the account indicated in 2010BB - CREDIT/DEBIT CARD ACCOUNT HOLDER NAME.**

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

Example: **AMT*MA*25~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 175

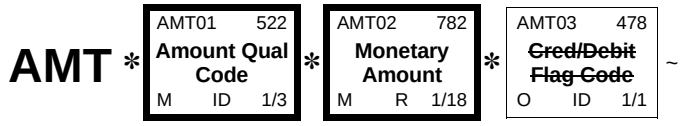
Loop: 2300

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

ADJUSTED REPRICED CLAIM NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Reference numbers at this position apply to the entire claim.**
2. **This segment is required when Repricers need to attach their own claim identification number to a previously adjusted (resubmitted) claim they are processing.**

Example: **REF*9C*XDE1234579~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

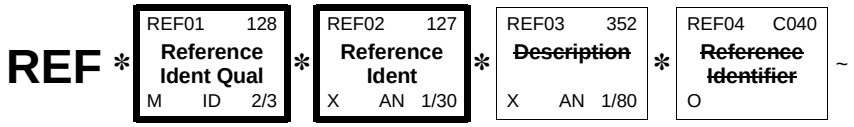
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

IMPLEMENTATION

REPRICED CLAIM NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Reference numbers at this position apply to the entire claim.**
2. **This segment is required when the Repricers need to attach their own claim identification to a claim they are processing.**

Example: **REF*9A*3456749387~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

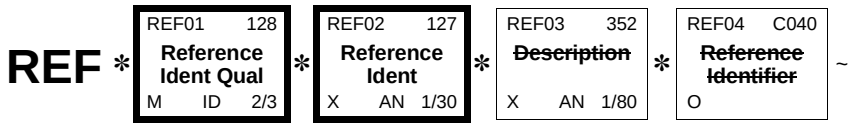
Requirement: Optional

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 **9A** — **Repriced Claim Reference Number**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Repriced Claim Reference Number*** SYNTAX: R0203	**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 (Value-Added Networks, Automated Clearing Houses, and others) who need to attach their own unique claim number.**
2. **This number can be used to facilitate front-end acknowledgements such as the 277 Health Care Payer Unsolicited Claim Status.**

Example: **REF*D9*4373649430ABES~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

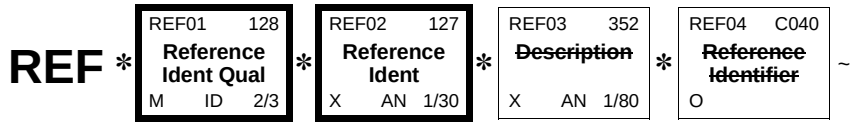
Requirement: Optional

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	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

DOCUMENT IDENTIFICATION CODE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Reference numbers at this position apply to the entire claim.**
2. **This segment is used to convey submittal of HCFA-485 and HCFA-486 data OR HCFA-486 data only.**

Example: **REF*DD*96234007932~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

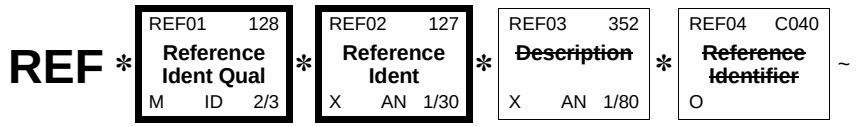
Requirement: Optional

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 **DD — Document Identification Code**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Document Control Identifier*** SYNTAX: R0203 **EMC v.6.0 Reference:** **Record Type 71 Field No. 4**	**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. **Reference numbers at this position apply to the entire claim.**
2. **This segment is used to convey the control number assigned to the original bill by the payer to identify a unique claim.**

Example: **REF*F8*1234636854~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

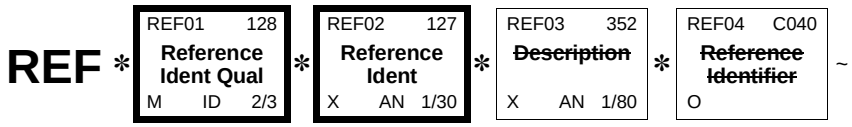
Requirement: Optional

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
F8	**Original 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:* ***Claim Original Reference Number*** SYNTAX: R0203 **UB-92 Reference [UB-92 Name]:** **37 (A-C) [Internal Control Number (ICN)/ Document Control Number (DCN)]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 14 (Sequence 01-03)**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

INVESTIGATIONAL DEVICE EXEMPTION NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required only on claims involving an FDA assigned investigational device exemption (IDE) number. Only one IDE per claim is to be reported.**

Example: **REF*LX*432907~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

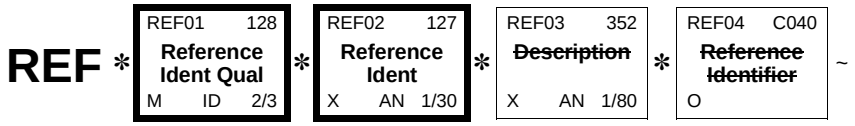
Requirement: Optional

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 **LX** — **Qualified Products List**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Investigational Device Exemption Identifier*** SYNTAX: R0203 **EMC v.6.0 Reference:** **Record Type 34 Field No. 5**	**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 service without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.**

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

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

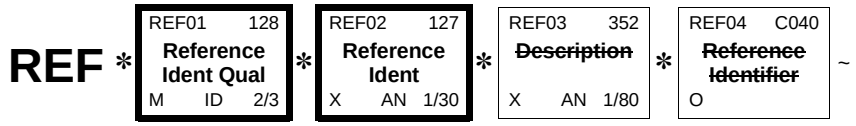
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

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

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Service Authorization Exception Code*** SYNTAX: R0203 **Allowable values for this element are:** **1 Immediate/Urgent Care** **2 Services Rendered in a Retroactive Period** **3 Emergency Care** **4 Client as Temporary Medicaid** **5 Request from County for Second Opinion to Recipient can Work** **6 Request for Override Pending** **7 Special Handling**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

PEER REVIEW ORGANIZATION (PRO) APPROVAL NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when an external Peer Review Organization assigns an Approval Number to services deemed medically necessary by that organization.**

Example: **REF*G4*284746~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

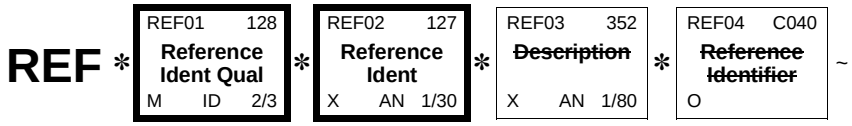
Requirement: Optional

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	
			G4 — Peer Review Organization (PRO) Approval Number	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Peer Review 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

PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BC loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.**

Example: **REF*G1*200398~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

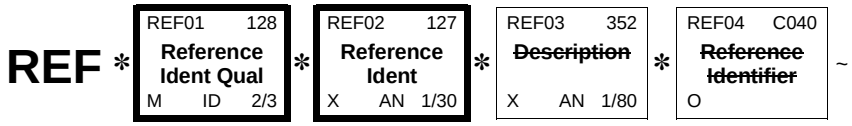
Max Use: 30

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
9F	**Referral Number**
G1	**Prior Authorization Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prior Authorization Number*** SYNTAX: R0203 **UB-92 Reference [UB-92 Name]:** **63 (A-C) [Treatment Authorization Code]** **EMC v.6.0 Reference:** **Record Type 40 Field No. 5, 6, 7 (Treatment Authorization Number)**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

MEDICAL RECORD NUMBER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if provider needs to identify for future inquiries the actual medical record of the patient identified in either Loop ID - 2010BA or 2010CA for this episode of care.**
2. **Used if provider will utilize this information in a 276 - Claim Status Inquiry in order to receive and process a 277 -Claim Status Response.**

Example: **REF*EA*1230484376R~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

Requirement: Optional

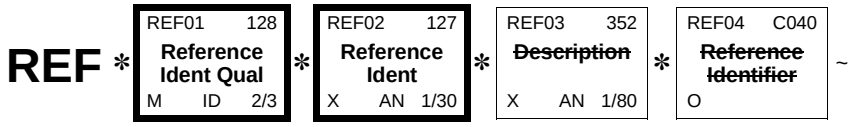
Max Use: 30

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
EA	**Medical Record 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:* ***Medical Record Number*** SYNTAX: R0203 **EMC v.6.0 Reference:** **Record Type 20 Field No. 25 (Medical Record Number)**	**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**	**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**	**O**		

IMPLEMENTATION

DEMONSTRATION PROJECT IDENTIFIER

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required on claims/encounters where a demonstration project is being billed/reported. This information is specific to the destination payer reported in the 2010BC loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.**

Example: **REF*P4*THJ1222~**

STANDARD

REF Reference Identification

Level: Detail

Position: 180

Loop: 2300

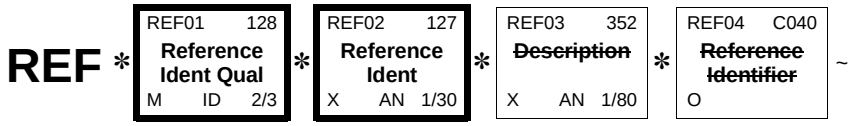
Requirement: Optional

Max Use: 30

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M ID 2/3**
			CODE / DEFINITION **P4 — Project Code**	
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Demonstration Project Identifier*** SYNTAX: R0203	**X AN 1/30**

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

IMPLEMENTATION

FILE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **At the time of publication K3 segments have no specific use. However, they have been included in this implementation guide to be used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority.**

2. **This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement, and X12N determines that there is no method to meet the requirement. Only then may the state require the temporary use of the K3 to meet the requirement. X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee.**

STANDARD

K3 File Information

Level: Detail

Position: 185

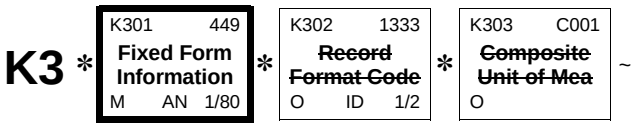
Loop: 2300

Requirement: Optional

Max Use: 10

Purpose: To transmit a fixed-format record or matrix contents

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**K301**	**449**	**Fixed Format Information** Data in fixed format agreed upon by sender and receiver	**M**	**AN**	**1/80**
NOT USED	**K302**	**1333**	**Record Format Code**	**O**	**ID**	**1/2**
NOT USED	**K303**	**C001**	**COMPOSITE UNIT OF MEASURE**	**O**		

IMPLEMENTATION

CLAIM NOTE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **10**

Notes:

1. **Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400. Information is considered to be overridden when the value in NTE01 in Loop ID-2400 is the same as the value in NTE01 in Loop ID-2300.**

   The developers of this implementation guide discourage using narrative information within the 837. Trading partners who require narrative information with claims are encouraged to codify that information within the X12 environment.

2. **Home Health Corresponding Data**
   This segment is used to convey Home Health narrative information from the forms ''Home Health Certification and Plan of Treatment'' and ''Medical Update and Patient Information.''

3. **Required only when provider deems it necessary to transmit information not otherwise supported in this implementation.**

Example: **NTE*NTR*PATIENT REQUIRES TUBE FEEDING~**

STANDARD

NTE Note/Special Instruction

Level: Detail

Position: 190

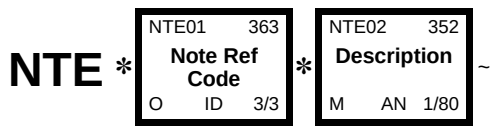
Loop: 2300

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**

EMC v.6.0 Reference:

Record Type 73 Field No. 5

CODE	DEFINITION
ALG	**Allergies** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48517**
DCP	**Goals, Rehabilitation Potential, or Discharge Plans** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48522**
DGN	**Diagnosis Description**
DME	**Durable Medical Equipment (DME) and Supplies** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48514**
MED	**Medications** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48510**
NTR	**Nutritional Requirements** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48516**
ODT	**Orders for Disciplines and Treatments** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48521**
RHB	**Functional Limitations, Reason Homebound, or Both** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48617**
RLH	**Reasons Patient Leaves Home** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48621**
RNH	**Times and Reasons Patient Not at Home** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48620**
SET	**Unusual Home, Social Environment, or Both** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48619**

			SFM	**Safety Measures** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48515**			
			SPT	**Supplementary Plan of Treatment** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48521**			
			UPI	**Updated Information** EMC v.6.0 Reference: **Record Type 73 Field No. 5 Code 48616**			
REQUIRED	**NTE02**	**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Claim Note Text*** **UB-92 Reference [UB-92 Name]:** **84 [Remarks]** **EMC v.6.0 Reference:** **Record Type 73 Field No. 6**		**M**	**AN**	**1/80**

IMPLEMENTATION

BILLING NOTE

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **This segment is used to convey additional information necessary to adjudicate the claim.**

2. **Required when: (1) State regulations mandate information not identified elsewhere within the claim set; or (2) in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.**

Example: **NTE*ADD*NO LIABILITY, PATIENT FELL AT HOME~**

STANDARD

NTE Note/Special Instruction

Level: Detail

Position: 190

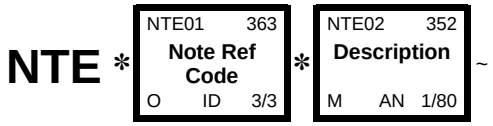
Loop: 2300

Requirement: Optional

Max Use: 20

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NTE01**	**363**	**Note Reference Code** Code identifying the functional area or purpose for which the note applies	**O ID 3/3**

CODE	DEFINITION
ADD	**Additional Information**

REQUIRED	**NTE02**	**352**	**Description** A free-form description to clarify the related data elements and their content	**M**	**AN**	**1/80**

INDUSTRY: ***Billing Note Text***

UB-92 Reference [UB-92 Name]:

84 [Remarks]

EMC v.6.0 Reference:

Record Type 90 Field No. 4, 17

IMPLEMENTATION

HOME HEALTH CARE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required for Home Health claims.**

Example: **CR6*4*941101*RD8*19941101-19941231*941015*N*Y*I*****941101****A~**

STANDARD

CR6 Home Health Care Certification

Level: Detail

Position: 216

Loop: 2300

Requirement: Optional

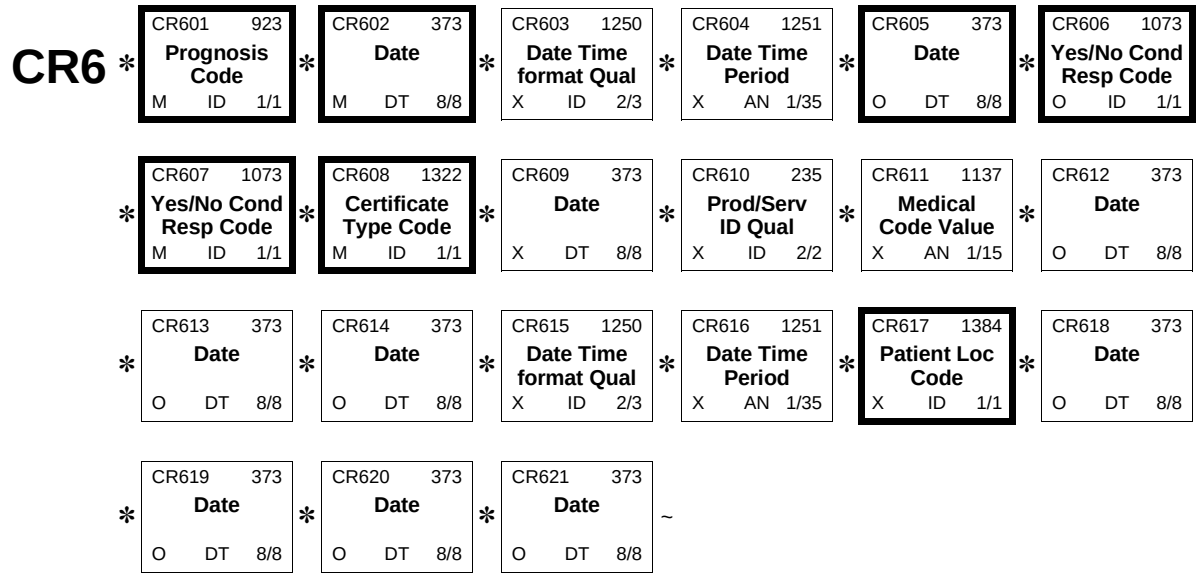
Max Use: 1

Purpose: To supply information related to the certification of a home health care patient

Syntax:

1. **P0304**
   If either CR603 or CR604 is present, then the other is required.
2. **P091011**
   If either CR609, CR610 or CR611 are present, then the others are required.
3. **P151617**
   If either CR615, CR616 or CR617 are present, then the others are required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CR601**	**923**	**Prognosis Code** Code indicating physician's prognosis for the patient *ALIAS:* ***Prognosis Indicator*** **EMC v.6.0 Reference:** **Record Type 71 Field No. 18**	**M ID 1/1**

CODE	DEFINITION
1	**Poor**
2	**Guarded**
3	**Fair**
4	**Good**
5	**Very Good**
6	**Excellent**
7	**Less than 6 Months to Live**
8	**Terminal**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CR602**	**373**	**Date** Date expressed as CCYYMMDD *INDUSTRY:* ***Service From Date*** *ALIAS:* ***SOC Date*** **SEMANTIC:** CR602 is the date covered home health services began. **EMC v.6.0 Reference:** **Record Type 71 Field No. 5 (MMDDYY)**	**M DT 8/8**
SITUATIONAL	**CR603**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format **SYNTAX:** P0304 **Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.**	**X ID 2/3**

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

SITUATIONAL **CR604** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Home Health Certification Period***

ALIAS: ***Certification Period***

SYNTAX: P0304

SEMANTIC: CR604 is the certification period covered by this plan of treatment.

EMC v.6.0 Reference:

Record Type 71 Field No. 6, 7

Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.

REQUIRED **CR605** **373** **Date** **O** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Diagnosis Date***

ALIAS: ***Date of Onset or Exacerbation of Principal Diagnosis***

SEMANTIC: CR605 is the date of onset or exacerbation of the principal diagnosis.

EMC v.6.0 Reference:

Record Type 71 Field No. 8 (MMDDYY)

REQUIRED **CR606** **1073** **Yes/No Condition or Response Code** **O** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Skilled Nursing Facility Indicator***

ALIAS: ***Patient Receiving Care in 1861 (j) (1) Facility Indicator***

SEMANTIC: A “Y” value indicates patient is receiving care in a 1861J1 (skilled nursing) facility. An “N” value indicates patient is not receiving care in a 1861J1 facility. A “U” value indicates it is unknown whether or not the patient is receiving care in a 1861J1 facility.

UB-92 Reference [UB-92 Name]:

EMC v.6.0 Reference:

Record Type 71 Field No. 27

CODE	DEFINITION
N	**No**
U	**Unknown**
Y	**Yes**

REQUIRED **CR607** **1073** **Yes/No Condition or Response Code** **M** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Medicare Coverage Indicator***

ALIAS: ***Medicare Covered Indicator***

SEMANTIC: CR607 indicates if the patient is covered by Medicare. A "Y" value indicates the patient is covered by Medicare; an "N" value indicates patient is not covered by Medicare.

EMC v.6.0 Reference:

Record Type 71 Field No. 24

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

REQUIRED **CR608** **1322** **Certification Type Code** **M** **ID** **1/1**
Code indicating the type of certification

ALIAS: ***Certification Type Indicator***

EMC v.6.0 Reference:

Record Type 71 Field No. 28

Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.

CODE	DEFINITION
I	**Initial**
R	**Renewal**
S	**Revised**

SITUATIONAL **CR609** **373** **Date** **X** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Surgery Date***

ALIAS: ***Date Surgical Procedure Performed***

SYNTAX: P091011

SEMANTIC: CR609 is date that the surgery identified in CR614 was performed.

EMC v.6.0 Reference:

Record Type 71 Field No. 10 (MMDDYY)

This data element is required when a surgical procedure was performed on the patient.

SITUATIONAL **CR610** **235** **Product/Service ID Qualifier** **X** **ID** **2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

SYNTAX: P091011

SEMANTIC: CR610 qualifies CR611.

This data element is required when a surgical procedure was performed on the patient.

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **This code includes Current Procedural Terminology (CPT) and HCPCS coding.**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
ID	**International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SITUATIONAL **CR611** **1137** **Medical Code Value** **X** **AN** **1/15**
Code value for describing a medical condition or procedure

INDUSTRY: ***Surgical Procedure Code***

SYNTAX: P091011

SEMANTIC: CR611 is the surgical procedure most relevant to the care being rendered.

EMC v.6.0 Reference:

Record Type 71 Field No. 9

This data element is required when a surgical procedure was performed on the patient.

SITUATIONAL **CR612** **373** **Date** **O** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Physician Order Date***

ALIAS: ***Verbal SOC Date***

SEMANTIC: CR612 is the date the agency received the verbal orders from the physician for start of care.

EMC v.6.0 Reference:

Record Type 71 Field No. 19 (MMDDYY)

This data element is required when the Provider has the Physician Order Date information on file.

SITUATIONAL **CR613** **373** **Date** **O** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Last Visit Date***

ALIAS: ***Date Physician Last Saw Patient***

SEMANTIC: CR613 is the date that the patient was last seen by the physician.

EMC v.6.0 Reference:

Record Type 71 Field No. 25 (MMDDYY)

This data element is required when the Provider has the Last Visit Date information on file.

SITUATIONAL **CR614** **373** **Date** **O** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Physician Contact Date***

ALIAS: ***Date Last Contacted Physician***

SEMANTIC: CR614 is the date of the home health agency's most recent contact with the physician.

EMC v.6.0 Reference:

Record Type 71 Field No. 26 (MMDDYY)

This data element is required when the Provider has the Physician Contact Date information on file.

SITUATIONAL **CR615** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

SYNTAX: P151617

This data element is required when a hospital admission occurred to the patient.

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

SITUATIONAL **CR616** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Last Admission Period***

ALIAS: ***Admission Date and Discharge Date***

SYNTAX: P151617

SEMANTIC: CR616 is the date range of the most recent inpatient stay.

EMC v.6.0 Reference:

Record Type 71 Field No. 29, 30 (MMDDYY)

This data element is required when a hospital admission occurred to the patient.

REQUIRED **CR617** **1384** **Patient Location Code** **X** **ID** **1/1**
Code identifying the location where patient is receiving medical treatment

INDUSTRY: ***Patient Discharge Facility Type Code***

ALIAS: ***Type of Facility***

SYNTAX: P151617

SEMANTIC: CR617 indicates the type of facility from which the patient was most recently discharged.

EMC v.6.0 Reference:

Record Type 71 Field No. 31

CODE	DEFINITION
A	Acute Care Facility
B	Boarding Home
C	Hospice
D	Intermediate Care Facility
E	Long-term or Extended Care Facility
F	Not Specified
G	Nursing Home
H	Sub-acute Care Facility
L	Other Location
M	Rehabilitation Facility
O	Outpatient Facility
R	Residential Treatment Facility
S	Skilled Nursing Home
T	Rest Home

SITUATIONAL **CR618** **373** **Date** **O** **DT** **8/8**
Date expressed as CCYYMMDD

INDUSTRY: ***Diagnosis Date***

ALIAS: ***Date Secondary Diagnosis - 1***

SEMANTIC: CR618 is the date of onset or exacerbation of the first secondary diagnosis.

EMC v.6.0 Reference:

Record Type 71 Field No. 11

This data element is required when a secondary diagnosis code is present on this claim.

SITUATIONAL	**CR619**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**

INDUSTRY: ***Diagnosis Date***

ALIAS: ***Date Secondary Diagnosis - 2***

SEMANTIC: CR619 is the date of onset or exacerbation of the second secondary diagnosis.

EMC v.6.0 Reference:

Record Type 71 Field No. 12

This data element is required when a second secondary diagnosis code is present on this claim.

SITUATIONAL	**CR620**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**

INDUSTRY: ***Diagnosis Date***

ALIAS: ***Date Secondary Diagnosis - 3***

SEMANTIC: CR620 is the date of onset or exacerbation of the third secondary diagnosis.

EMC v.6.0 Reference:

Record Type 71 Field No. 13

This data element is required when a third secondary diagnosis code is present on this claim.

SITUATIONAL	**CR621**	**373**	**Date** Date expressed as CCYYMMDD	**O**	**DT**	**8/8**

INDUSTRY: ***Diagnosis Date***

ALIAS: ***Date Secondary Diagnosis - 4***

SEMANTIC: CR621 is the date of onset or exacerbation of the fourth secondary diagnosis.

EMC v.6.0 Reference:

Record Type 71 Field No. 14

This data element is required when a fourth secondary diagnosis code is present on this claim.

IMPLEMENTATION

HOME HEALTH FUNCTIONAL LIMITATIONS

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes:

1. **The CRC segment in Loop ID-2300 applies to the entire claim unless it is overridden by a CRC segment at the service line level in Loop ID-2400 with the same value in CRC01.**
2. **This segment is required to convey Home Health Plan of Treatment information when applicable.**

Example: **CRC*75*Y*AL~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 220

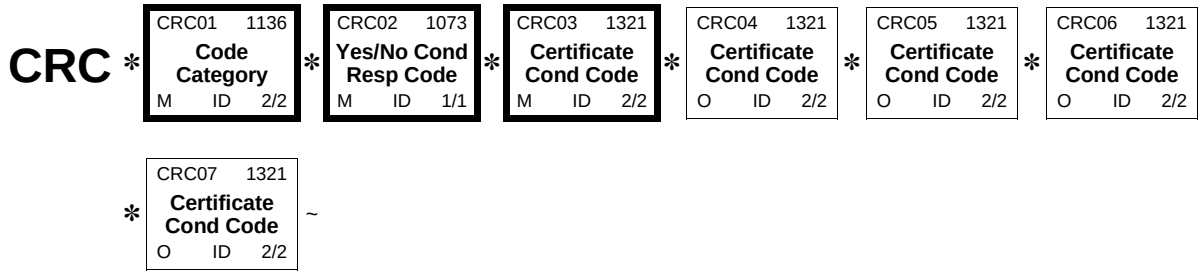
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
75	**Functional Limitations**

REQUIRED **CRC02** **1073** **Yes/No Condition or Response Code** **M** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Certification Condition Indicator***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

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

REQUIRED **CRC03** **1321** **Condition Indicator** **M** **ID** **2/2**
Code indicating a condition

INDUSTRY: ***Functional Limitation Code***

EMC v.6.0 Reference:

Record Type 71 Field No. 15

The codes for CRC03 also can be used for CRC04 through CRC07.

CODE	DEFINITION
AA	**Amputation** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 1**
AL	**Ambulation Limitations** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 7**
BL	**Bowel Limitations, Bladder Limitations, or both (Incontinence)** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 2**
CO	**Contracture** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 3**
DY	**Dyspnea with Minimal Exertion** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code A**
EL	**Endurance Limitations** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 6**
HL	**Hearing Limitations** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 4**
LB	**Legally Blind** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 9**

			OL **Other Limitation** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code B**			
			PA **Paralysis** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 5**			
			SL **Speech Limitations** EMC v.6.0 Reference: **Record Type 71 Field No. 15 Code 8**			
SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Functional Limitation Code*** **See CRC03** **This data element is required when more than one Functional Limitation Code is applicable to the patient.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Functional Limitation Code*** **See CRC03** **This data element is required when more than one Functional Limitation Code is applicable to the patient.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Functional Limitation Code*** **See CRC03** **This data element is required when more than one Functional Limitation Code is applicable to the patient.**	**O**	**ID**	**2/2**
SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Functional Limitation Code*** **See CRC03** **This data element is required when more than one Functional Limitation Code is applicable to the patient.**	**O**	**ID**	**2/2**

IMPLEMENTATION

HOME HEALTH ACTIVITIES PERMITTED

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. This segment is required to convey Home Health Plan of Treatment information when applicable.**

Example: **CRC*76*Y*CB~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 220

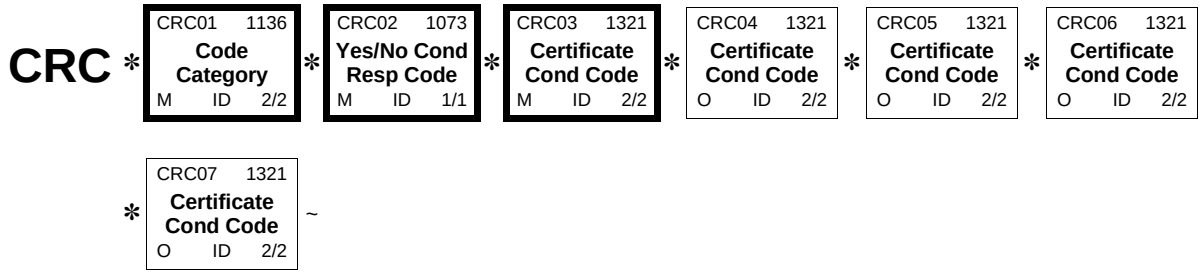
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies *INDUSTRY:* ***Certification Condition Indicator*** **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
76	**Activities Permitted**

REQUIRED **CRC02** **1073** **Yes/No Condition or Response Code** **M** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Functional Limitation Code***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

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

REQUIRED **CRC03** **1321** **Condition Indicator** **M** **ID** **2/2**
Code indicating a condition

INDUSTRY: ***Activities Permitted Code***

EMC v.6.0 Reference:

Record Type 71 Field No. 16

The codes for CRC03 also can be used for CRC04 through CRC07.

CODE	DEFINITION
BR	**Bedrest BRP (Bathroom Privileges)** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 2**
CA	**Cane Required** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 9**
CB	**Complete Bedrest** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 1**
CR	**Crutches Required** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 8**
EP	**Exercises Prescribed** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 5**
IH	**Independent at Home** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 7**
NR	**No Restrictions** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code C** **(This is the same qualifier used in CLP06 of the 835 Health Care Claim Payment.)**
PW	**Partial Weight Bearing** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 6**

			TR **Transfer to Bed, or Chair, or Both** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 4**			
			UT **Up as Tolerated** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code 3**			
			WA **Walker Required** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code B**			
			WR **Wheelchair Required** EMC v.6.0 Reference: **Record Type 71 Field No. 16 Code A**			
SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Activities Permitted Code***	**O**	**ID**	**2/2**
			See CRC03			
			This data element is required when more than one Activities Permitted Code is applicable to the patient.			
SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Activities Permitted Code***	**O**	**ID**	**2/2**
			See CRC03			
			This data element is required when more than one Activities Permitted Code is applicable to the patient.			
SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Activities Permitted Code***	**O**	**ID**	**2/2**
			See CRC03			
			This data element is required when more than one Activities Permitted Code is applicable to the patient.			
SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition *INDUSTRY:* ***Activities Permitted Code***	**O**	**ID**	**2/2**
			See CRC03			
			This data element is required when more than one Activities Permitted Code is applicable to the patient.			

IMPLEMENTATION

HOME HEALTH MENTAL STATUS

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. This segment is required to convey Home Health Plan of Treatment information when applicable.**

Example: **CRC*77*Y*DI~**

STANDARD

CRC Conditions Indicator

Level: Detail

Position: 220

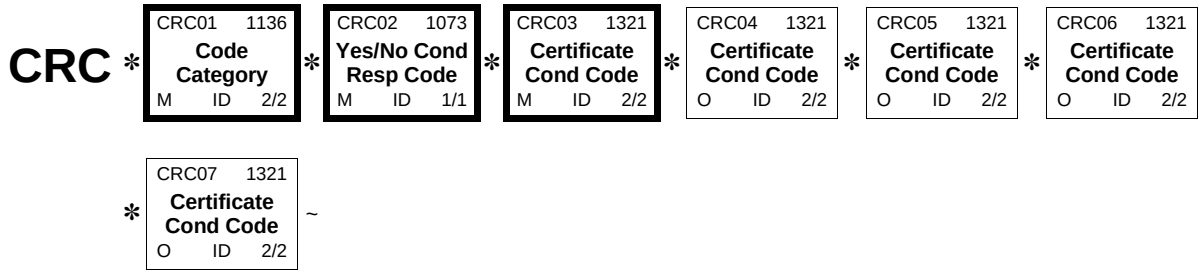
Loop: 2300

Requirement: Optional

Max Use: 100

Purpose: To supply information on conditions

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CRC01**	**1136**	**Code Category** Specifies the situation or category to which the code applies *INDUSTRY:* ***Certification Condition Indicator*** **SEMANTIC:** CRC01 qualifies CRC03 through CRC07.	**M ID 2/2**

CODE	DEFINITION
77	**Mental Status**

REQUIRED **CRC02** **1073** **Yes/No Condition or Response Code** **M** **ID** **1/1**
Code indicating a Yes or No condition or response

INDUSTRY: ***Functional Limitation Code***

SEMANTIC: CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.

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

REQUIRED **CRC03** **1321** **Condition Indicator** **M** **ID** **2/2**
Code indicating a condition

INDUSTRY: ***Mental Status Code***

EMC v.6.0 Reference:

Record Type 71 Field No. 17

The codes for CRC03 also can be used for CRC04 through CRC07.

CODE	DEFINITION
AG	**Agitated** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 7**
CM	**Comatose** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 2**
DI	**Disoriented** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 5**
DP	**Depressed** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 4**
FO	**Forgetful** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 3**
LE	**Lethargic** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 6**
MC	**Other Mental Condition** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 8**
OT	**Oriented** EMC v.6.0 Reference: **Record Type 71 Field No. 17 Code 1**

SITUATIONAL	**CRC04**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**
			INDUSTRY: ***Mental Status Code***			
			See CRC03			
			This data element is required when more than one Mental Status Code is applicable to the patient.			
SITUATIONAL	**CRC05**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**
			INDUSTRY: ***Mental Status Code***			
			See CRC03			
			This data element is required when more than one Mental Status Code is applicable to the patient.			
SITUATIONAL	**CRC06**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**
			INDUSTRY: ***Mental Status Code***			
			See CRC03			
			This data element is required when more than one Mental Status Code is applicable to the patient.			
SITUATIONAL	**CRC07**	**1321**	**Condition Indicator** Code indicating a condition	**O**	**ID**	**2/2**
			INDUSTRY: ***Mental Status Code***			
			See CRC03			
			This data element is required when more than one Mental Status Code is applicable to the patient.			

IMPLEMENTATION

PRINCIPAL, ADMITTING, E-CODE AND PATIENT REASON FOR VISIT DIAGNOSIS INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **The Principal Diagnosis is required on all inpatient and oupatient claims.**
2. **The Admitting Diagnosis is required on all inpatient admission claims and encounters.**
3. **An E-Code diagnosis is required whenever a diagnosis is needed to describe an injury, poisoning or adverse effect.**
4. **The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits.**

Example: **HI*BK:9976~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

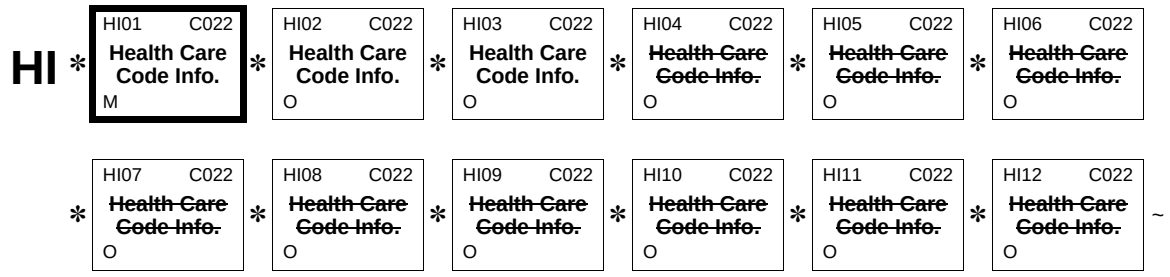
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**

REQUIRED	**HI01 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BK	**Principal Diagnosis** **CODE SOURCE 131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

UB-92 Reference [UB-92 Name]:

67 [Principal Diagnosis Code]

EMC v.6.0 Reference:

Record Type 70 Field No. 4

NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Required for all unscheduled outpatient visits or upon the patient's admission to the hosptial.

REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

ZZ used to indicate the "Patient Reason For Visit."

CODE	DEFINITION
BJ	**Admitting Diagnosis** **CODE SOURCE 131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
ZZ	**Mutually Defined** **ZZ used to indicate the "Patient Reason For Visit." See Code Source 131.**

REQUIRED	**HI02 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

UB-92 Reference [UB-92 Name]:

76 [Admitting Diagnosis/Patient's Reason for Visit]

EMC v.6.0 Reference:

Record Type 70 Field No. 25

NOT USED	**HI02 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	HI02 - 6		380	Quantity	O	R	1/15
NOT USED	HI02 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	HI03 - 1		1270	**Code List Qualifier Code** Code identifying a specific industry code list	M	ID	1/3
			CODE	DEFINITION			
			BN	**United States Department of Health and Human Services, Office of Vital Statistics E-code** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure			
REQUIRED	HI03 - 2		1271	**Industry Code** Code indicating a code from a specific industry code list **UB-92 Reference [UB-92 Name]:** **77 [External Cause of Injury Code (E-code)]** **EMC v.6.0 Reference:** **Record Type 70 Field No. 26**	M	AN	1/30
NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI03 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI03 - 6		380	Quantity	O	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	O	AN	1/30
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION		O		

IMPLEMENTATION

DIAGNOSIS RELATED GROUP (DRG) INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. DRG Information is required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.**

Example: **HI*DR:123~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

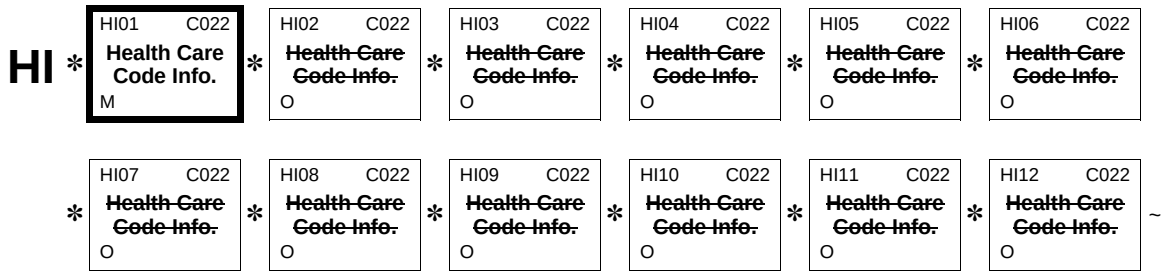
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**
			CODE **DEFINITION** **DR** **Diagnosis Related Group (DRG)** **CODE SOURCE 229:** Diagnosis Related Group Number (DRG)	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list *INDUSTRY:* ***Diagnosis Related Group (DRG) Code***	**M AN 1/30**

NOT USED	HI01 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI01 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI01 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI01 - 6		380	Quantity	O	R	1/15
NOT USED	HI01 - 7		799	Version Identifier	O	AN	1/30
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION		O		
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION		O		

IMPLEMENTATION

OTHER DIAGNOSIS INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required when other condition(s) co-exists with the principal diagnosis, co-exists at the time of admission or develops subsequently during the patient's treatment.**

Example: **HI*BF:V9782~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

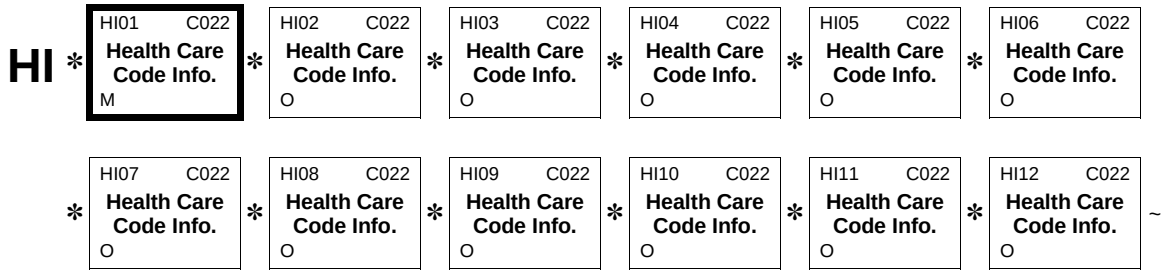
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BF	**Diagnosis** **CODE SOURCE 131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Other Diagnosis

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis** **CODE SOURCE 131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI02 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Other Diagnosis

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	HI02 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI02 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI02 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI02 - 6		380	Quantity	O	R	1/15
NOT USED	HI02 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI03 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BF	Diagnosis

CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	HI03 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI03 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI03 - 6		380	Quantity	O	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI04 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis**

CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI04 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI04 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI05 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis**

CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI05 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]

72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI05 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI06 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BF	**Diagnosis**

CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI06 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI06 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI07 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION			
			BF Diagnosis			
			CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure			
REQUIRED	**HI07 - 2**		**1271 Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: Other Diagnosis			
			UB-92 Reference [UB-92 Name]:			
			68 [Other Diagnoses Codes]			
			69 [Other Diagnoses Codes]			
			70 [Other Diagnoses Codes]			
			71 [Other Diagnoses Codes]			
			72 [Other Diagnoses Codes]			
			73 [Other Diagnoses Codes]			
			74 [Other Diagnoses Codes]			
			75 [Other Diagnoses Codes]			
			EMC v.6.0 Reference:			
			Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12			
NOT USED	**HI07 - 3**		**1250 Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**		**1251 Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**		**782 Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**		**380 Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**		**799 Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE DEFINITION			
			BF Diagnosis			
			CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure			

REQUIRED	**HI08 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI08 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI08 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI09 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis**

CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI09 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI09 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI10 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Other Diagnosis***

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI10 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI11 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis**

CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Other Diagnosis

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]
72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:

Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	**HI11 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI12**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI12 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BF	**Diagnosis**

CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI12 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Other Diagnosis

UB-92 Reference [UB-92 Name]:

68 [Other Diagnoses Codes]
69 [Other Diagnoses Codes]
70 [Other Diagnoses Codes]
71 [Other Diagnoses Codes]

72 [Other Diagnoses Codes]
73 [Other Diagnoses Codes]
74 [Other Diagnoses Codes]
75 [Other Diagnoses Codes]

EMC v.6.0 Reference:
Record Type 70 Field No. 5, 6, 7, 8, 9, 10, 11, 12

NOT USED	HI12 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI12 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI12 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI12 - 6	380	Quantity	O	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	O	AN	1/30

IMPLEMENTATION

PRINCIPAL PROCEDURE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated.**
2. **Required on inpatient claims or encounters when a procedure was performed.**

Example: **HI*BR:92795:D8:19980321~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

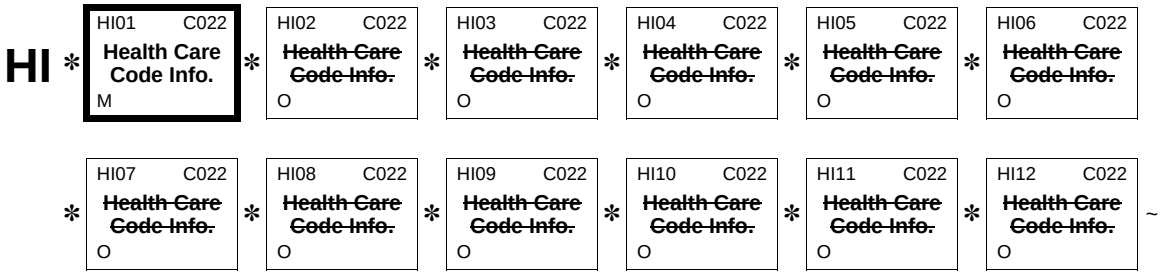
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BP	**Health Care Financing Administration Common Procedural Coding System Principal Procedure**

CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System

				BR	**International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure**			
					CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure			
REQUIRED	**HI01 - 2**			**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
					INDUSTRY: ***Principal Procedure Code***			
					UB-92 Reference [UB-92 Name]:			
					80 [Principal Procedure Code and Date]			
					EMC v.6.0 Reference:			
					Record Type 70 Field No. 13			
SITUATIONAL	**HI01 - 3**			**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
					CODE — DEFINITION			
				D8	**Date Expressed in Format CCYYMMDD** **Use code D8 when the value in composite data element HI01-1 equals "BR".**			
SITUATIONAL	**HI01 - 4**			**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**
					UB-92 Reference [UB-92 Name]:			
					80, "DATE" field [Principal Procedure Code and Date]			
					EMC v.6.0 Reference:			
					Record Type 70 Field No. 14			
					Required when HI01-3 is used.			
NOT USED	**HI01 - 5**			**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**			**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**			**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**HI02**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI03**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI04**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI05**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI06**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI07**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI08**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI09**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI10**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI11**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		
NOT USED	**HI12**		**C022**	**HEALTH CARE CODE INFORMATION**		**O**		

IMPLEMENTATION

OTHER PROCEDURE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:

1. **Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated.**

2. **Required on inpatient claims or encounters when additional procedures must be reported.**

Example: **HI*BQ:92795:D8:19980321~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

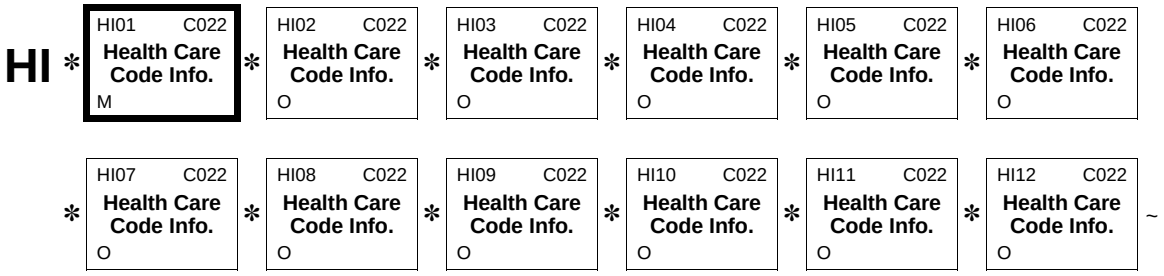
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System** **CODE SOURCE 130:** Health Care Financing Administration Common Procedural Coding System

			BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**				
				CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Procedure Code***				
				UB-92 Reference [UB-92 Name]:				
				81 (A-E) [Other Procedure Codes and Dates]				
				EMC v.6.0 Reference:				
				Record Type 70 Field No. 15, 17, 19, 21, 23				
SITUATIONAL	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
				Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.				
				CODE — DEFINITION				
			D8	**Date Expressed in Format CCYYMMDD**				
SITUATIONAL	**HI01 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**
				INDUSTRY: ***Procedure Date***				
				UB-92 Reference [UB-92 Name]:				
				81 (A-E) [Other Procedure Codes and Dates]				
				EMC v.6.0 Reference:				
				Record Type 70 Field No. 16, 18, 20, 22, 24				
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE — DEFINITION				
			BO	**Health Care Financing Administration Common Procedural Coding System**				
				CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System				
			BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**				
				CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				

REQUIRED **HI02 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI02 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL **HI02 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED **HI02 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI02 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI02 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI03 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI03 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI03 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL **HI03 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED **HI03 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI03 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI03 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI04 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI04 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI04 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL **HI04 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED **HI04 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI04 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI04 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI05** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI05 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI05 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI05 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL **HI05 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED **HI05 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI05 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI05 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI06 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI06 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI06 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD

SITUATIONAL **HI06 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED **HI06 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI06 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI06 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI07 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System** CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure** CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI07 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI07 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

				CODE	DEFINITION			
				D8	**Date Expressed in Format CCYYMMDD**			
SITUATIONAL	**HI07 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**
				INDUSTRY: ***Procedure Date***			
				UB-92 Reference [UB-92 Name]:			
				81 (A-E) [Other Procedure Codes and Dates]			
				EMC v.6.0 Reference:			
				Record Type 70 Field No. 16, 18, 20, 22, 24			
NOT USED	**HI07 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI08**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE	DEFINITION		
				BO	**Health Care Financing Administration Common Procedural Coding System**		
				CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System			
				BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**		
				CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure			
REQUIRED	**HI08 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Procedure Code***			
				UB-92 Reference [UB-92 Name]:			
				81 (A-E) [Other Procedure Codes and Dates]			
				EMC v.6.0 Reference:			
				Record Type 70 Field No. 15, 17, 19, 21, 23			
SITUATIONAL	**HI08 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**
				Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.			
				CODE	DEFINITION		
				D8	**Date Expressed in Format CCYYMMDD**		

SITUATIONAL **HI08 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED **HI08 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI08 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI08 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI09** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI09 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED **HI09 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL **HI09 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL **HI09 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED	**HI09 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION**		**O**		

To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI10 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL	**HI10 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL	**HI10 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED	**HI10 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI11 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BO	**Health Care Financing Administration Common Procedural Coding System**
	CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System
BQ	**International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure**
	CODE SOURCE **131:** International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	**HI11 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

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

SITUATIONAL	**HI11 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**

NOT USED	HI11 - 6		380	Quantity	O	R	1/15
NOT USED	HI11 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI12	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI12 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BO	Health Care Financing Administration Common Procedural Coding System
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

REQUIRED	HI12 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Procedure Code***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 15, 17, 19, 21, 23

SITUATIONAL	HI12 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X	ID	2/3

Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediatley following element is required.

CODE	DEFINITION
D8	Date Expressed in Format CCYYMMDD

SITUATIONAL	HI12 - 4		1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X	AN	1/35

INDUSTRY: ***Procedure Date***

UB-92 Reference [UB-92 Name]:

81 (A-E) [Other Procedure Codes and Dates]

EMC v.6.0 Reference:

Record Type 70 Field No. 16, 18, 20, 22, 24

NOT USED	HI12 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI12 - 6		380	Quantity	O	R	1/15
NOT USED	HI12 - 7		799	Version Identifier	O	AN	1/30

IMPLEMENTATION

OCCURRENCE SPAN INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required when occurrence span information applies to the claim or encounter.**

Example: **HI*BI:70:RD8:19981202-19981212~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

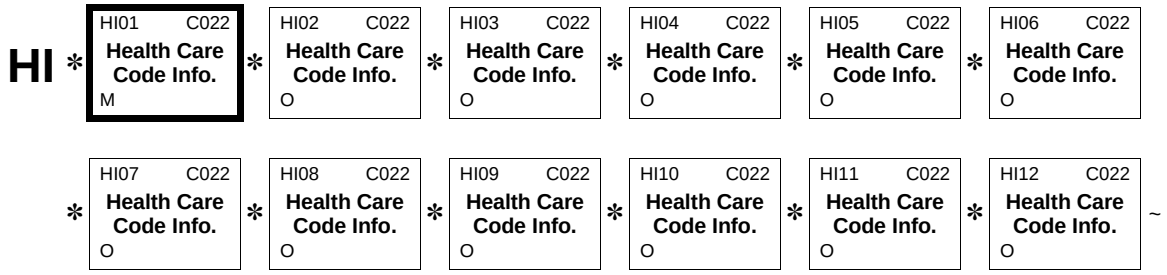
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BI	**Occurrence Span**
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31

REQUIRED **HI01 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **HI01 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED **HI01 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI01 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI01 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI02 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI02 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31

REQUIRED **HI02 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **HI02 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED **HI02 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI02 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI02 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI03 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI03 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED **HI03 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**HI03 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	**HI03 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI04**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI04 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI04 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED	**HI04 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**HI04 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	HI04 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI04 - 6		380	Quantity	O	R	1/15
NOT USED	HI04 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI05	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI05 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BI	Occurrence Span

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	HI05 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED	HI05 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	X	ID	2/3

CODE	DEFINITION
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

REQUIRED	HI05 - 4		1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	X	AN	1/35

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	HI05 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI05 - 6		380	Quantity	O	R	1/15
NOT USED	HI05 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI06	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI06 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI06 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED **HI06 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **HI06 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED **HI06 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI06 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI06 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI07 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI07 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Span Code

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED	**HI07 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**HI07 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	**HI07 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI08**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI08 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI08 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Span Code

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED **HI08 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **HI08 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED **HI08 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI08 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI08 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI09** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI09 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI09 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED **HI09 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **HI09 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	**HI09 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI10**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI10 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED	**HI10 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**HI10 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	**HI10 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL **HI11** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI11 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI11 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Span Code***

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED **HI11 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED **HI11 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED **HI11 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI11 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI11 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI12** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI12 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BI	**Occurrence Span**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI12 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Span Code

UB-92 Reference [UB-92 Name]:

36 (a-b) [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 28, 29, 30, 31, 32, 33

REQUIRED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

CODE	DEFINITION
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD**

REQUIRED	**HI12 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 29, 30, 32, 33

NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

OCCURRENCE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required when occurrence information applies to the claim or encounter.**

Example: **HI*BH:42:D8:19981208~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

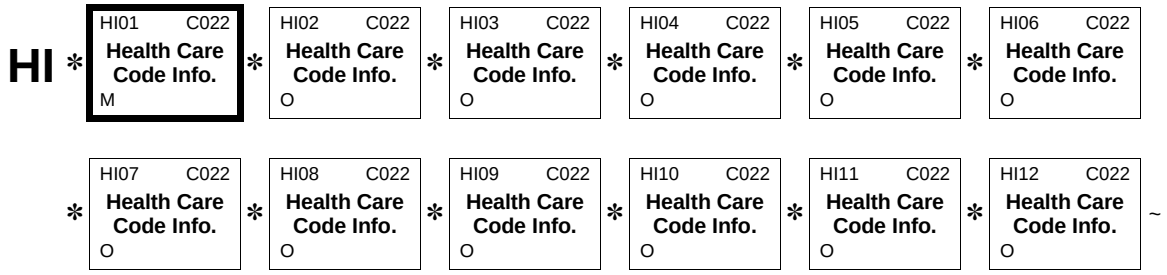
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BH	**Occurrence**
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI01 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED **HI01 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

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

REQUIRED **HI01 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED **HI01 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI01 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI01 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI02 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI02 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]

33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED **HI02 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

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

REQUIRED **HI02 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED **HI02 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI02 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI02 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI03 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI03 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED **HI03 - 3** **1250** **Date Time Period Format Qualifier** **X ID 2/3**
Code indicating the date format, time format, or date and time format

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

REQUIRED **HI03 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED **HI03 - 5** **782** **Monetary Amount** **O R 1/18**

NOT USED **HI03 - 6** **380** **Quantity** **O R 1/15**

NOT USED **HI03 - 7** **799** **Version Identifier** **O AN 1/30**

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI04 - 1** **1270** **Code List Qualifier Code** **M ID 1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI04 - 2** **1271** **Industry Code** **M AN 1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED	**HI04 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

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

REQUIRED	**HI04 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED	**HI04 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI05 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI05 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Code

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED	**HI05 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

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

REQUIRED **HI05 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED **HI05 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI05 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI05 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI06 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI06 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED **HI06 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

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

REQUIRED	**HI06 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED	**HI06 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI07 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI07 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Code

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED	**HI07 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

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

REQUIRED **HI07 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED **HI07 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI07 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI07 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI08** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI08 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI08 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED **HI08 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

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

REQUIRED	**HI08 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED	**HI08 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI08 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI09**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI09 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI09 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Code

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED	**HI09 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

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

REQUIRED	**HI09 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED	**HI09 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI10 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI10 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Code

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED	**HI10 - 3**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

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

REQUIRED	**HI10 - 4**		**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY:* *Occurrence or Occurrence Span Code Associated Date

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED	**HI10 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI11 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Occurrence Code

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED	**HI11 - 3**		**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format	**X**	**ID**	**2/3**

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

REQUIRED **HI11 - 4** **1251** **Date Time Period** **X** **AN** **1/35**
Expression of a date, a time, or range of dates, times or dates and times

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED **HI11 - 5** **782** **Monetary Amount** **O** **R** **1/18**

NOT USED **HI11 - 6** **380** **Quantity** **O** **R** **1/15**

NOT USED **HI11 - 7** **799** **Version Identifier** **O** **AN** **1/30**

SITUATIONAL **HI12** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI12 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
BH	**Occurrence**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED **HI12 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Occurrence Code***

UB-92 Reference [UB-92 Name]:

32 (a-b) [Occurrence Codes and Dates]
33 (a-b) [Occurrence Codes and Dates]
34 (a-b) [Occurrence Codes and Dates]
35 (a-b) [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 8, 10, 12, 14, 16, 18, 20, 22, 24, 26

REQUIRED **HI12 - 3** **1250** **Date Time Period Format Qualifier** **X** **ID** **2/3**
Code indicating the date format, time format, or date and time format

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

REQUIRED	**HI12 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**X**	**AN**	**1/35**

INDUSTRY: ***Occurrence or Occurrence Span Code Associated Date***

UB-92 Reference [UB-92 Name]:

32 (a-b), "DATE" field [Occurrence Codes and Dates]
33 (a-b), "DATE" field [Occurrence Codes and Dates]
34 (a-b), "DATE" field [Occurrence Codes and Dates]
35 (a-b), "DATE" field [Occurrence Codes and Dates]

EMC v.6.0 Reference:

Record Type 40 Field No. 9, 11, 13, 15, 17, 19, 21, 23, 25, 27

NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

VALUE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required when value information applies to the claim or encounter.**

Example: **HI*BE:08:::1740~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

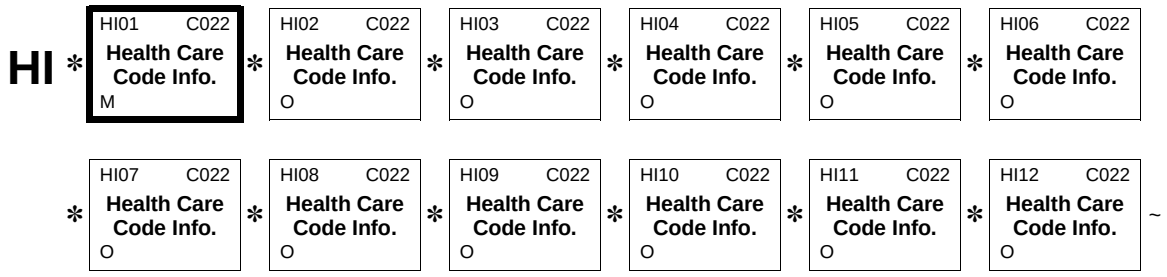
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BE	**Value**
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Value Code***			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts]			
				40 (a-d) [Value Codes and Amounts]			
				41 (a-d) [Value Codes and Amounts]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI01 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				INDUSTRY: ***Value Code Associated Amount***			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE: **BE** — DEFINITION: **Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI02 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Value Code***			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts]			
				40 (a-d) [Value Codes and Amounts]			
				41 (a-d) [Value Codes and Amounts]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI02 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**

REQUIRED	**HI02 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				INDUSTRY: ***Value Code Associated Amount***			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI02 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI03 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE	**DEFINITION**			
			BE	**Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI03 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Value Code***			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts] **40 (a-d) [Value Codes and Amounts]** **41 (a-d) [Value Codes and Amounts]**			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI03 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI03 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				INDUSTRY: ***Value Code Associated Amount***			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI03 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI04**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				

REQUIRED	**HI04 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BE	**Value**
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI04 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Value Code

UB-92 Reference [UB-92 Name]:

39 (a-d) [Value Codes and Amounts]

40 (a-d) [Value Codes and Amounts]

41 (a-d) [Value Codes and Amounts]

EMC v.6.0 Reference:

Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39

NOT USED	**HI04 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI04 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY:* *Value Code Associated Amount

This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).

NOT USED	**HI04 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI05**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI05 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BE	**Value**
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI05 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY:* *Value Code

UB-92 Reference [UB-92 Name]:

39 (a-d) [Value Codes and Amounts]

40 (a-d) [Value Codes and Amounts]

41 (a-d) [Value Codes and Amounts]

EMC v.6.0 Reference:

Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39

NOT USED	**HI05 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI05 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Value Code Associated Amount***

This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).

NOT USED	**HI05 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	**HI06 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**

CODE	DEFINITION
BE	**Value**
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI06 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**

INDUSTRY: ***Value Code***

UB-92 Reference [UB-92 Name]:

39 (a-d) [Value Codes and Amounts]

40 (a-d) [Value Codes and Amounts]

41 (a-d) [Value Codes and Amounts]

EMC v.6.0 Reference:

Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39

NOT USED	**HI06 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI06 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Value Code Associated Amount***

This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).

NOT USED	**HI06 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI07 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			BE Value			
			CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI07 - 2**		**1271 Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
			INDUSTRY: ***Value Code***			
			UB-92 Reference [UB-92 Name]:			
			39 (a-d) [Value Codes and Amounts] **40 (a-d) [Value Codes and Amounts]** **41 (a-d) [Value Codes and Amounts]**			
			EMC v.6.0 Reference:			
			Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI07 - 3**		**1250 Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**		**1251 Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI07 - 5**		**782 Monetary Amount** Monetary amount	**O**	**R**	**1/18**
			INDUSTRY: ***Value Code Associated Amount***			
			This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI07 - 6**		**380 Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**		**799 Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI08**	**C022**	**HEALTH CARE CODE INFORMATION**	**O**		
			To send health care codes and their associated dates, amounts and quantities			
			Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**		**1270 Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
			CODE / DEFINITION			
			BE Value			
			CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes			

REQUIRED	**HI08 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				***INDUSTRY:* Value Code**			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts]			
				40 (a-d) [Value Codes and Amounts]			
				41 (a-d) [Value Codes and Amounts]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI08 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI08 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI08 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				***INDUSTRY:* Value Code Associated Amount**			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI08 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI08 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI09**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI09 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / **DEFINITION**			
				BE — **Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI09 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				***INDUSTRY:* Value Code**			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts]			
				40 (a-d) [Value Codes and Amounts]			
				41 (a-d) [Value Codes and Amounts]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI09 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**

REQUIRED	**HI09 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				INDUSTRY: ***Value Code Associated Amount***			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI09 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI10 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE: **BE** — DEFINITION: **Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Value Code***			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts] **40 (a-d) [Value Codes and Amounts]** **41 (a-d) [Value Codes and Amounts]**			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI10 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI10 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				INDUSTRY: ***Value Code Associated Amount***			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI10 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
				Used when necessary to report multiple additional co-existing conditions.			

REQUIRED	**HI11 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / DEFINITION			
				BE **Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY:* *Value Code			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts]			
				40 (a-d) [Value Codes and Amounts]			
				41 (a-d) [Value Codes and Amounts]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI11 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI11 - 5**		**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**
				INDUSTRY:* *Value Code Associated Amount			
				This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI11 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI12**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI12 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / DEFINITION			
				BE **Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI12 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY:* *Value Code			
				UB-92 Reference [UB-92 Name]:			
				39 (a-d) [Value Codes and Amounts]			
				40 (a-d) [Value Codes and Amounts]			
				41 (a-d) [Value Codes and Amounts]			

			EMC v.6.0 Reference:			
			Record Type 41 Field No. 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 35, 37, 38, 39			
NOT USED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
REQUIRED	**HI12 - 5**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Value Code Associated Amount***	**O**	**R**	**1/18**
			This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).			
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

CONDITION INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required when condition information applies to the claim or encounter.**

Example: **HI*BG:67~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

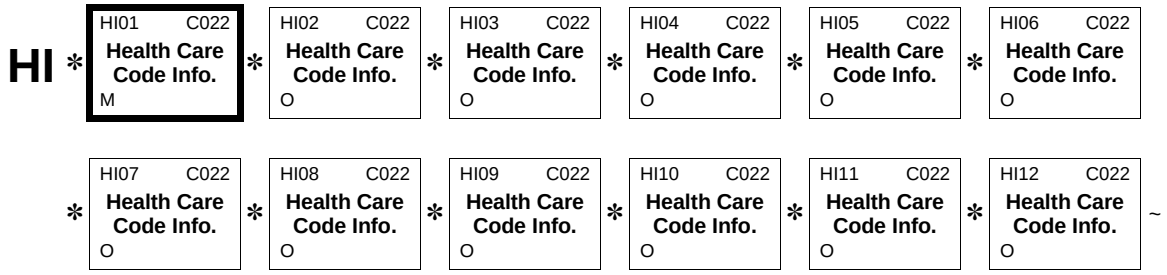
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
BG	**Condition** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Condition Code***			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / **DEFINITION**			
				BG — **Condition**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI02 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Condition Code***			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI02 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

NOT USED	HI02 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI02 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI02 - 6		380	Quantity	O	R	1/15
NOT USED	HI02 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI03 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	HI03 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Condition Code***

UB-92 Reference [UB-92 Name]:

24 [Condition Codes]
25 [Condition Codes]
26 [Condition Codes]
27 [Condition Codes]
28 [Condition Codes]
29 [Condition Codes]
30 [Condition Codes]

EMC v.6.0 Reference:

Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13

NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI03 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI03 - 6		380	Quantity	O	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI04 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI04 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY:* *Condition Code			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI04 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI04 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI04 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI04 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI04 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI05**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI05 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / **DEFINITION**			
				BG — **Condition**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI05 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY:* *Condition Code			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI05 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

NOT USED	HI05 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI05 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI05 - 6		380	Quantity	O	R	1/15
NOT USED	HI05 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI06 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	HI06 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Condition Code***

UB-92 Reference [UB-92 Name]:

24 [Condition Codes]
25 [Condition Codes]
26 [Condition Codes]
27 [Condition Codes]
28 [Condition Codes]
29 [Condition Codes]
30 [Condition Codes]

EMC v.6.0 Reference:

Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13

NOT USED	HI06 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI06 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI06 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI06 - 6		380	Quantity	O	R	1/15
NOT USED	HI06 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI07 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI07 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Condition Code***			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI07 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI07 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI07 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI07 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI07 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI08**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI08 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / **DEFINITION**			
				BG — **Condition**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI08 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Condition Code***			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI08 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

NOT USED	HI08 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI08 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI08 - 6		380	Quantity	O	R	1/15
NOT USED	HI08 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI09 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	HI09 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Condition Code***

UB-92 Reference [UB-92 Name]:

24 [Condition Codes]
25 [Condition Codes]
26 [Condition Codes]
27 [Condition Codes]
28 [Condition Codes]
29 [Condition Codes]
30 [Condition Codes]

EMC v.6.0 Reference:

Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13

NOT USED	HI09 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI09 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI09 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI09 - 6		380	Quantity	O	R	1/15
NOT USED	HI09 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities		O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI10 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Condition Code***			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI10 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI11**	**C022**		**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**O**		
				Used when necessary to report multiple additional co-existing conditions.			
REQUIRED	**HI11 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE / DEFINITION			
				BG **Condition**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Condition Code***			
				UB-92 Reference [UB-92 Name]:			
				24 [Condition Codes]			
				25 [Condition Codes]			
				26 [Condition Codes]			
				27 [Condition Codes]			
				28 [Condition Codes]			
				29 [Condition Codes]			
				30 [Condition Codes]			
				EMC v.6.0 Reference:			
				Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13			
NOT USED	**HI11 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**

NOT USED	HI11 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI11 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI11 - 6		380	Quantity	O	R	1/15
NOT USED	HI11 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI12	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI12 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
BG	Condition

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	HI12 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Condition Code***

UB-92 Reference [UB-92 Name]:

24 [Condition Codes]
25 [Condition Codes]
26 [Condition Codes]
27 [Condition Codes]
28 [Condition Codes]
29 [Condition Codes]
30 [Condition Codes]

EMC v.6.0 Reference:

Record Type 41 Field No. 4, 5, 6, 7, 8, 9, 10, 11, 12, 13

NOT USED	HI12 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI12 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI12 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI12 - 6		380	Quantity	O	R	1/15
NOT USED	HI12 - 7		799	Version Identifier	O	AN	1/30

IMPLEMENTATION

TREATMENT CODE INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **2**

Notes: **1. Required when Home Health Agencies need to report Plan of Treatment information under various payer contracts.**

Example: **HI*TC:A01~**

STANDARD

HI Health Care Information Codes

Level: Detail

Position: 231

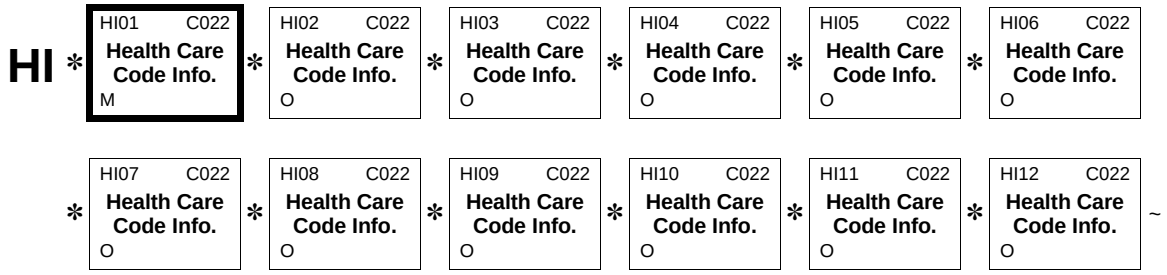
Loop: 2300

Requirement: Optional

Max Use: 25

Purpose: To supply information related to the delivery of health care

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**HI01**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities	**M**
REQUIRED	**HI01 - 1**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M ID 1/3**

CODE	DEFINITION
TC	**Treatment Codes**
	CODE SOURCE 359: Treatment Codes

REQUIRED	**HI01 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			
				EMC v.6.0 Reference:			
				Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42			
NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI02**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI02 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE — DEFINITION			
				TC — Treatment Codes			
				CODE SOURCE **359:** Treatment Codes			
REQUIRED	**HI02 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			
				EMC v.6.0 Reference:			
				Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42			
NOT USED	**HI02 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI02 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI02 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI02 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI02 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI03**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI03 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE — DEFINITION			
				TC — Treatment Codes			
				CODE SOURCE **359:** Treatment Codes			
REQUIRED	**HI03 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			

EMC v.6.0 Reference:

Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI03 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI03 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI03 - 6		380	Quantity	O	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI04	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI04 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
TC	Treatment Codes

CODE SOURCE **359:** Treatment Codes

REQUIRED	HI04 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Treatment Code***

EMC v.6.0 Reference:

Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

NOT USED	HI04 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI04 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI04 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI04 - 6		380	Quantity	O	R	1/15
NOT USED	HI04 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI05	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI05 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
TC	Treatment Codes

CODE SOURCE **359:** Treatment Codes

REQUIRED	**HI05 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			
				EMC v.6.0 Reference:			
				Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42			
NOT USED	**HI05 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI05 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI05 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI05 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI05 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI06**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI06 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE — DEFINITION			
				TC — **Treatment Codes**			
				CODE SOURCE 359: Treatment Codes			
REQUIRED	**HI06 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			
				EMC v.6.0 Reference:			
				Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42			
NOT USED	**HI06 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI06 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI06 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI06 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI06 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI07**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI07 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE — DEFINITION			
				TC — **Treatment Codes**			
				CODE SOURCE 359: Treatment Codes			
REQUIRED	**HI07 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			

EMC v.6.0 Reference:

Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

NOT USED	HI07 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI07 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI07 - 6		380	Quantity	O	R	1/15
NOT USED	HI07 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI08	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI08 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
TC	Treatment Codes

CODE SOURCE **359:** Treatment Codes

REQUIRED	HI08 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

INDUSTRY: ***Treatment Code***

EMC v.6.0 Reference:

Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

NOT USED	HI08 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI08 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI08 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI08 - 6		380	Quantity	O	R	1/15
NOT USED	HI08 - 7		799	Version Identifier	O	AN	1/30
SITUATIONAL	HI09	C022		HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O		

Used when necessary to report multiple additional co-existing conditions.

REQUIRED	HI09 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3

CODE	DEFINITION
TC	Treatment Codes

CODE SOURCE **359:** Treatment Codes

REQUIRED	**HI09 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			
				EMC v.6.0 Reference:			
				Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42			
NOT USED	**HI09 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI09 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI09 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI09 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI09 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI10**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI10 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE **DEFINITION**			
				TC **Treatment Codes**			
				CODE SOURCE 359: Treatment Codes			
REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			
				EMC v.6.0 Reference:			
				Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42			
NOT USED	**HI10 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI10 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI10 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI10 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI10 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
SITUATIONAL	**HI11**	**C022**	**HEALTH CARE CODE INFORMATION** To send health care codes and their associated dates, amounts and quantities		**O**		
			Used when necessary to report multiple additional co-existing conditions.				
REQUIRED	**HI11 - 1**		**1270**	**Code List Qualifier Code** Code identifying a specific industry code list	**M**	**ID**	**1/3**
				CODE **DEFINITION**			
				TC **Treatment Codes**			
				CODE SOURCE 359: Treatment Codes			
REQUIRED	**HI11 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				INDUSTRY: ***Treatment Code***			

EMC v.6.0 Reference:

Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

NOT USED	**HI11 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI11 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI11 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI11 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI11 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

SITUATIONAL **HI12** **C022** **HEALTH CARE CODE INFORMATION** **O**
To send health care codes and their associated dates, amounts and quantities

Used when necessary to report multiple additional co-existing conditions.

REQUIRED **HI12 - 1** **1270** **Code List Qualifier Code** **M** **ID** **1/3**
Code identifying a specific industry code list

CODE	DEFINITION
TC	**Treatment Codes**

CODE SOURCE **359:** Treatment Codes

REQUIRED **HI12 - 2** **1271** **Industry Code** **M** **AN** **1/30**
Code indicating a code from a specific industry code list

INDUSTRY: ***Treatment Code***

EMC v.6.0 Reference:

Record Type 72 Field No. 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

NOT USED	**HI12 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI12 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI12 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI12 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI12 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

CLAIM QUANTITY

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **4**

Notes:

1. **Use the Quantity segment at the claim level Loop ID-2300 to transmit quantities that apply to the entire claim.**
2. **Required on Inpatient claims or encounters when covered, co-insured, life-time reserved or non-covered days are being reported.**

Example: **QTY*LA*20*DA~**

STANDARD

QTY Quantity

Level: Detail

Position: 240

Loop: 2300

Requirement: Optional

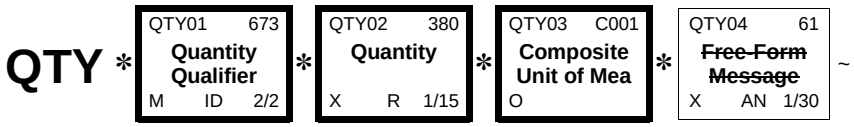
Max Use: 10

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
CA	**Covered - Actual** UB-92 Reference [UB-92 Name]: **7 [Covered Days]** EMC v.6.0 Reference: **Record Type 30 Field No. 20 (Sequence 01-03)**

				CD	**Co-insured - Actual** UB-92 Reference [UB-92 Name]: **9 [Coinsurance Days]** EMC v.6.0 Reference: **Record Type 30 Field No. 22 (Sequence 01-03)**			
				LA	**Life-time Reserve - Actual** UB-92 Reference [UB-92 Name]: **10 [Lifetime Reserve Days]** EMC v.6.0 Reference: **Record Type 30 Field No. 23 (Sequence 01-03)**			
				NA	**Number of Non-covered Days** UB-92 Reference [UB-92 Name]: **8 [Non-Covered Days]** EMC v.6.0 Reference: **Record Type 30 Field No. 21**			
REQUIRED	**QTY02**		**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Claim Days Count*** SYNTAX: R0204, E0204		**X**	**R**	**1/15**
REQUIRED	**QTY03**		**C001**	**COMPOSITE UNIT OF MEASURE** To identify a composite unit of measure		**O**		
REQUIRED	**QTY03**	**- 1**		**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	**M**	**ID**	**2/2**
				CODE	**DEFINITION**			
				DA	**Days**			
NOT USED	**QTY03**	**- 2**		**1018**	**Exponent**	**O**	**R**	**1/15**
NOT USED	**QTY03**	**- 3**		**649**	**Multiplier**	**O**	**R**	**1/10**
NOT USED	**QTY03**	**- 4**		**355**	**Unit or Basis for Measurement Code**	**O**	**ID**	**2/2**
NOT USED	**QTY03**	**- 5**		**1018**	**Exponent**	**O**	**R**	**1/15**
NOT USED	**QTY03**	**- 6**		**649**	**Multiplier**	**O**	**R**	**1/10**
NOT USED	**QTY03**	**- 7**		**355**	**Unit or Basis for Measurement Code**	**O**	**ID**	**2/2**
NOT USED	**QTY03**	**- 8**		**1018**	**Exponent**	**O**	**R**	**1/15**
NOT USED	**QTY03**	**- 9**		**649**	**Multiplier**	**O**	**R**	**1/10**
NOT USED	**QTY03**	**- 10**		**355**	**Unit or Basis for Measurement Code**	**O**	**ID**	**2/2**
NOT USED	**QTY03**	**- 11**		**1018**	**Exponent**	**O**	**R**	**1/15**
NOT USED	**QTY03**	**- 12**		**649**	**Multiplier**	**O**	**R**	**1/10**
NOT USED	**QTY03**	**- 13**		**355**	**Unit or Basis for Measurement Code**	**O**	**ID**	**2/2**
NOT USED	**QTY03**	**- 14**		**1018**	**Exponent**	**O**	**R**	**1/15**
NOT USED	**QTY03**	**- 15**		**649**	**Multiplier**	**O**	**R**	**1/10**
NOT USED	**QTY04**		**61**	**Free-Form Message**		**X**	**AN**	**1/30**

IMPLEMENTATION

CLAIM PRICING/REPRICING INFORMATION

Loop: **2300 — CLAIM INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.**
2. **This segment is used when the sender is required to provide the receiver with pricing or repricing information necessary to process the claim or encounter.**

Example: **HCP*03*100*10*RPO12345~**

STANDARD

HCP Health Care Pricing

Level: Detail

Position: 241

Loop: 2300

Requirement: Optional

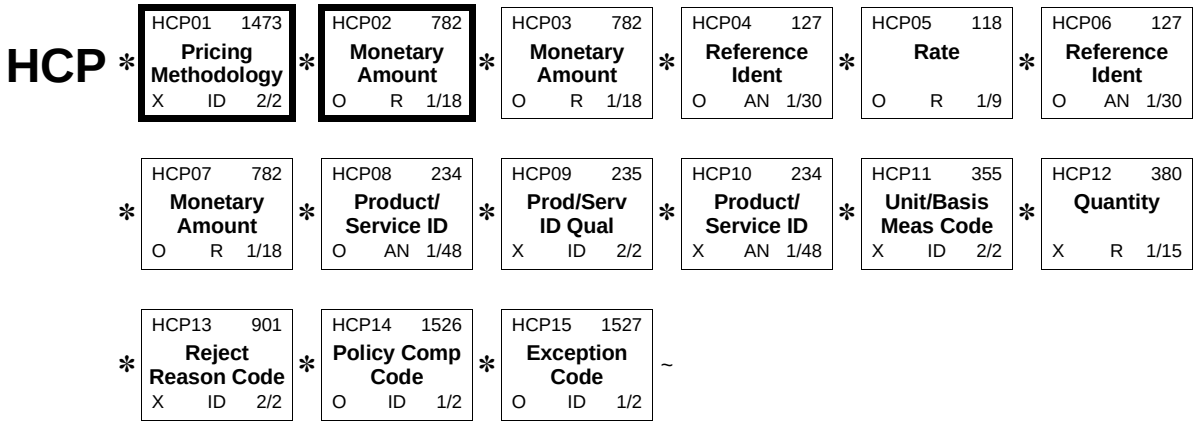
Max Use: 1

Purpose: To specify pricing or repricing information about a health care claim or line item

Syntax:

1. **R0113**
   At least one of HCP01 or HCP13 is required.
2. **P0910**
   If either HCP09 or HCP10 is present, then the other is required.
3. **P1112**
   If either HCP11 or HCP12 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HCP01	1473	**Pricing Methodology** Code specifying pricing methodology at which the claim or line item has been priced or repriced *ALIAS:* ***Pricing Methodology*** SYNTAX: R0113 **Trading partners need to agree on which codes to use in this element. There do not appear to be standard definitions for the code elements.**	X ID 2/2
REQUIRED	HCP02	782	**Monetary Amount** Monetary amount *INDUSTRY:* ***Repriced Allowed Amount*** *ALIAS:* ***Allowed Amount*** SEMANTIC: HCP02 is the allowed amount.	O R 1/18

CODE	DEFINITION
00	Zero Pricing (Not Covered Under Contract)
01	Priced as Billed at 100%
02	Priced at the Standard Fee Schedule
03	Priced at a Contractual Percentage
04	Bundled Pricing
05	Peer Review Pricing
06	Per Diem Pricing
07	Flat Rate Pricing
08	Combination Pricing
09	Maternity Pricing
10	Other Pricing
11	Lower of Cost
12	Ratio of Cost
13	Cost Reimbursed
14	Adjustment Pricing

SITUATIONAL	**HCP03**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Saving Amount***

ALIAS: ***Savings Amount***

SEMANTIC: HCP03 is the savings amount.

This data element is required when it is necessary to report Savings Amount on claims which has been priced or repriced.

SITUATIONAL	**HCP04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repricing Organization Identifier***

ALIAS: ***Repricing Organization ID***

SEMANTIC: HCP04 is the repricing organization identification number.

This data element is required when it is necessary to report Repricing Organization ID on claims which has been priced or repriced.

SITUATIONAL	**HCP05**	**118**	**Rate** Rate expressed in the standard monetary denomination for the currency specified	**O**	**R**	**1/9**

INDUSTRY: ***Repricing Per Diem or Flat Rate Amount***

ALIAS: ***Pricing Rate***

SEMANTIC: HCP05 is the pricing rate associated with per diem or flat rate repricing.

This data element is required when it is necessary to report Pricing Rate on claims which has been priced or repriced.

SITUATIONAL	**HCP06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Repriced Approved DRG Code***

ALIAS: ***Approved DRG Code***

SEMANTIC: HCP06 is the approved DRG code.

COMMENT: HCP06, HCP07, HCP08, HCP10, and HCP12 are fields that will contain different values from the original submitted values.

This data element is required when it is necessary to report Approved DRG Code on claims which has been priced or repriced.

SITUATIONAL	**HCP07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Repriced Approved Amount***

ALIAS: ***Approved DRG Amount***

SEMANTIC: HCP07 is the approved DRG amount.

This data element is required when it is necessary to report Approved DRG Amount on claims which has been priced or repriced.

SITUATIONAL **HCP08** **234** **Product/Service ID** **O** **AN** **1/48**
Identifying number for a product or service

INDUSTRY: ***Repriced Approved Revenue Code***

ALIAS: ***Approved Revenue Code***

SEMANTIC: HCP08 is the approved revenue code.

This data element is required when it is necessary to report Approved Revenue Code on claims which has been priced or repriced.

SITUATIONAL **HCP09** **235** **Product/Service ID Qualifier** **X** **ID** **2/2**
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

INDUSTRY: ***Product or Service ID Qualifier***

SYNTAX: P0910

Required when HCP10 exists.

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **This code includes Current Procedural Terminology (CPT) and HCPCS coding.**

CODE SOURCE **130:** Health Care Financing Administration Common Procedural Coding System

SITUATIONAL **HCP10** **234** **Product/Service ID** **X** **AN** **1/48**
Identifying number for a product or service

INDUSTRY: ***Repriced Approved HCPCS Code***

ALIAS: ***Approved Procedure Code***

SYNTAX: P0910

SEMANTIC: HCP10 is the approved procedure code.

This data element is required when it is necessary to report Approved HCPCS Code on claims which has been priced or repriced.

SITUATIONAL **HCP11** **355** **Unit or Basis for Measurement Code** **X** **ID** **2/2**
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P1112

Required when HCP12 exists.

CODE	DEFINITION
DA	**Days**
UN	**Unit**

SITUATIONAL **HCP12** **380** **Quantity** **X** **R** **1/15**
Numeric value of quantity

INDUSTRY: ***Repriced Approved Service Unit Count***

ALIAS: ***Approved Service Units***

SYNTAX: P1112

SEMANTIC: HCP12 is the approved service units or inpatient days.

This data element is required when it is necessary to report Approved Service Unit Count on claims which has been priced or repriced.

SITUATIONAL **HCP13** **901** **Reject Reason Code** **X** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

ALIAS: ***Rejection Message***

SYNTAX: R0113

SEMANTIC: HCP13 is the rejection message returned from the third party organization.

This data element is required when it is necessary to report Rejection Message on claims which has been priced or repriced.

CODE	DEFINITION
T1	**Cannot Identify Provider as TPO (Third Party Organization) Participant**
T2	**Cannot Identify Payer as TPO (Third Party Organization) Participant**
T3	**Cannot Identify Insured as TPO (Third Party Organization) Participant**
T4	**Payer Name or Identifier Missing**
T5	**Certification Information Missing**
T6	**Claim does not contain enough information for re-pricing**

SITUATIONAL **HCP14** **1526** **Policy Compliance Code** **O** **ID** **1/2**
Code specifying policy compliance

ALIAS: ***Policy Compliance Code***

This data element is required when it is necessary to report Policy Compliance Code on claims which has been priced or repriced.

CODE	DEFINITION
1	**Procedure Followed (Compliance)**
2	**Not Followed - Call Not Made (Non-Compliance Call Not Made)**
3	**Not Medically Necessary (Non-Compliance Non-Medically Necessary)**
4	**Not Followed Other (Non-Compliance Other)**
5	**Emergency Admit to Non-Network Hospital**

SITUATIONAL **HCP15** **1527** **Exception Code** **O** **ID** **1/2**

Code specifying the exception reason for consideration of out-of-network health care services

ALIAS: ***Exception Reason Code***

SEMANTIC: HCP15 is the exception reason generated by a third party organization.

This data element is required when it is necessary to report Exception Reason Code on claims which have been priced or repriced.

CODE	DEFINITION
1	**Non-Network Professional Provider in Network Hospital**
2	**Emergency Care**
3	**Services or Specialist not in Network**
4	**Out-of-Service Area**
5	**State Mandates**
6	**Other**

IMPLEMENTATION

HOME HEALTH CARE PLAN INFORMATION

Loop: **2305 — HOME HEALTH CARE PLAN INFORMATION** **Repeat:** **6**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **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 nomenclature.**

2. **This segment is required to convey Home Health Plan of Treatment information for this claim when applicable.**

Example: **CR7*PT*4*12~**

STANDARD

CR7 Home Health Treatment Plan Certification

Level: Detail

Position: 242

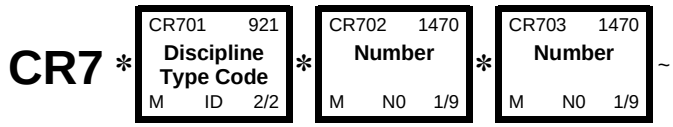
Loop: 2305 **Repeat:** 6

Requirement: Optional

Max Use: 1

Purpose: To supply information related to the home health care plan of treatment and services

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**CR701**	**921**	**Discipline Type Code** Code indicating disciplines ordered by a physician *ALIAS:* ***Disipline Type Code*** **EMC v.6.0 Reference:** **Record Type 72 Field No. 4**	**M ID 2/2**

CODE	DEFINITION
AI	**Home Health Aide**
MS	**Medical Social Worker**
OT	**Occupational Therapy**

			PT **Physical Therapy**			
			SN **Skilled Nursing**			
			ST **Speech Therapy**			
REQUIRED	**CR702**	**1470**	**Number** A generic number *INDUSTRY:* ***Visits Prior to Recertification Date Count*** *ALIAS:* ***Total Visits Prior to Recertification Date*** **SEMANTIC:** CR702 is the total visits on this bill rendered prior to the recertification "to" date. **EMC v.6.0 Reference:** **Record Type 72 Field No. 5**	**M**	**N0**	**1/9**
REQUIRED	**CR703**	**1470**	**Number** A generic number *INDUSTRY:* ***Total Visits Projected This Certification Count*** *ALIAS:* ***Total Visits Projected During Certification Period*** **SEMANTIC:** CR703 is the total visits projected during this certification period. **EMC v.6.0 Reference:** **Record Type 72 Field No. 43**	**M**	**N0**	**1/9**

IMPLEMENTATION

HEALTH CARE SERVICES DELIVERY

Loop: **2305 — HOME HEALTH CARE PLAN INFORMATION**

Usage: **SITUATIONAL**

Repeat: **12**

Notes:

1. **Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment.**

2. **HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit".**
   Between HDS02 and HSD03 verbally insert a "per every."
   HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days."
   Between HSD04 and HSD05 verbally insert a "for."
   HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days."
   The total message reads:
   HSD*VS*1*DA*3*7*21~ = "One visit per every three days for 21 days."

3. **Another similar data string of HSD*VS*2*DA*4*7*20~ = Two visits per every four days for 20 days.**

4. **An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1*****SX*D~ means "1 visit on Wednesday and Thursday morning."**

Example: **HSD*VS*1*DA**7*10~ (This indicates "1 visit every (per) 1 day (daily) for 10 days.")**

Example: **HSD*VS*1*DA~ (This indicates one visit per day.)**

STANDARD

HSD Health Care Services Delivery

Level: Detail

Position: 243

Loop: 2305

Requirement: Optional

Max Use: 12

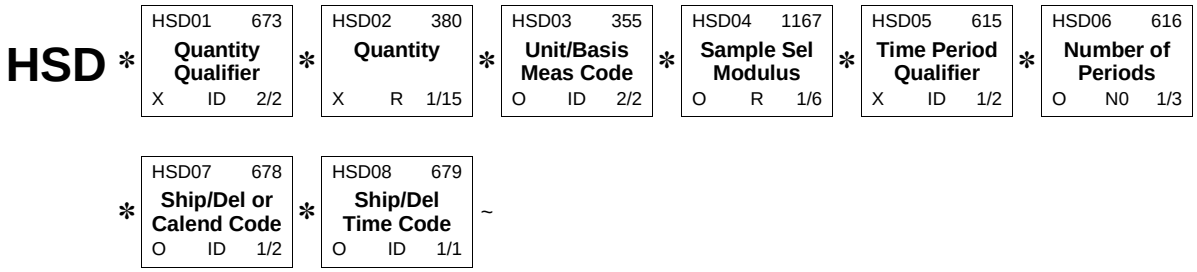
Purpose: To specify the delivery pattern of health care services

Syntax:

1. **P0102**
   If either HSD01 or HSD02 is present, then the other is required.

2. **C0605**
   If HSD06 is present, then HSD05 is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	HSD01	673	**Quantity Qualifier** Code specifying the type of quantity *INDUSTRY:* ***Visits*** *ALIAS:* ***Quantity Qualifier*** SYNTAX: P0102 **Required if the physician's order or prescription for the service contains the data.** CODE / DEFINITION **VS** **Visits**	**X ID 2/2**
SITUATIONAL	HSD02	380	**Quantity** Numeric value of quantity *INDUSTRY:* ***Number of Visits*** *ALIAS:* ***Frequency Number - 1*** SYNTAX: P0102 **EMC v.6.0 Reference:** **Record Type 72 Field No. 6 (position 1)** **Required if the physician's order or prescription for the service contains the data.**	**X R 1/15**
SITUATIONAL	HSD03	355	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken *INDUSTRY:* ***Frequency Period*** *ALIAS:* ***Frequency Period - 1*** **EMC v.6.0 Reference:** **Record Type 72 Field No. 6 (positions 2-3)** **Required if the physician's order or prescription for the service contains the data.** CODE / DEFINITION **DA** **Days**	**O ID 2/2**

			MO	**Months**			
			Q1	**Quarter (Time)**			
			WK	**Week**			
SITUATIONAL	**HSD04**	**1167**	**Sample Selection Modulus** To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes *INDUSTRY:* ***Frequency Count*** **Required if the physician's order or prescription for the service contains the data.**	**O**	**R**	**1/6**	
SITUATIONAL	**HSD05**	**615**	**Time Period Qualifier** Code defining periods *INDUSTRY:* ***Duration of Visits Units*** *ALIAS:* ***Frequency Time Period*** SYNTAX: C0605 **Absence of data indicates PRN orders.** **Required if the physician's order or prescription for the service contains the data.**	**X**	**ID**	**1/2**	
			CODE	**DEFINITION**			
			7	**Day**			
			35	**Week**			
SITUATIONAL	**HSD06**	**616**	**Number of Periods** Total number of periods *INDUSTRY:* ***Duration of Visits, Number of Units*** *ALIAS:* ***Duration - 1*** SYNTAX: C0605 **EMC v.6.0 Reference:** **Record Type 72 Field No. 6 (positions 4-6)** **Required if the physician's order or prescription for the service contains the data.**	**O**	**N0**	**1/3**	
SITUATIONAL	**HSD07**	**678**	**Ship/Delivery or Calendar Pattern Code** Code which specifies the routine shipments, deliveries, or calendar pattern *INDUSTRY:* ***Ship, Delivery or Calendar Pattern Code*** **Required if the physician's order or prescription for the service contains the data.**	**O**	**ID**	**1/2**	
			CODE	**DEFINITION**			
			1	**1st Week of the Month**			
			2	**2nd Week of the Month**			
			3	**3rd Week of the Month**			
			4	**4th Week of the Month**			

5	5th Week of the Month
6	1st & 3rd Weeks of the Month
7	2nd & 4th Weeks of the Month
8	1st Working Day of Period
9	Last Working Day of Period
A	Monday through Friday
B	Monday through Saturday
C	Monday through Sunday
D	Monday
E	Tuesday
F	Wednesday
G	Thursday
H	Friday
J	Saturday
K	Sunday
L	Monday through Thursday
N	As Directed
O	Daily Mon. through Fri.
S	Once Anytime Mon. through Fri.
SA	Sunday, Monday, Thursday, Friday, Saturday
SB	Tuesday through Saturday
SC	Sunday, Wednesday, Thursday, Friday, Saturday
SD	Monday, Wednesday, Thursday, Friday, Saturday
SG	Tuesday through Friday
SL	Monday, Tuesday and Thursday
SP	Monday, Tuesday and Friday
SX	Wednesday and Thursday
SY	Monday, Wednesday and Thursday
SZ	Tuesday, Thursday and Friday
W	Whenever Necessary

SITUATIONAL **HSD08** **679** **Ship/Delivery Pattern Time Code** **O** **ID** **1/1**
Code which specifies the time for routine shipments or deliveries

INDUSTRY: ***Delivery Pattern Time Code***

Required if the physician's order or prescription for the service contains the data.

CODE	DEFINITION
D	**A.M.**
E	**P.M.**
F	**As Directed**

IMPLEMENTATION

ATTENDING PHYSICIAN NAME

Loop: **2310A — ATTENDING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
3. **Required on all inpatient claims or encounters.**
4. **Required to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.**

Example: **NM1*71*1*JONES*JOHN****XX*12345678~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

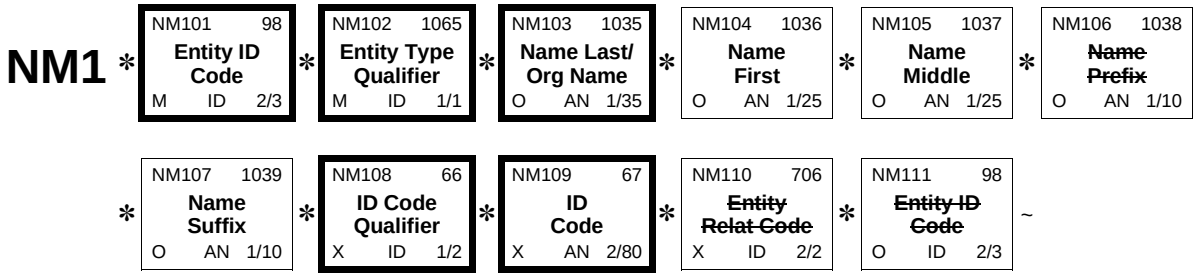
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** CODE: 71 — DEFINITION: Attending Physician	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person 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:* ***Attending Physician Last Name*** **UB-92 Reference [UB-92 Name]:** **82, Line b [Attending Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 9, Positions 91-106 (Also maps to Record Type 71 Field No. 20 if you are creating this attachment)**	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY:* ***Attending Physician First Name*** **UB-92 Reference [UB-92 Name]:** **82, Line b [Attending Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 9, Positions 107-114 (Also maps to EMC v.4.1 Record Type 71 Field No. 21 if you are creating this attachment)** **Required if NM102=1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Attending Physician Middle 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:* ***Attending Physician 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 **EMC v.6.0 Reference:** **Record Type 80 Field No. 4 (The National Registry for Medicare assigns the UPIN to the provider for identification purposes.)**	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Attending Physician Primary Identifier*** SYNTAX: P0809 **UB-92 Reference [UB-92 Name]:** **82, Line a [Attending Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 5**	**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

ATTENDING PHYSICIAN SPECIALTY INFORMATION

Loop: **2310A — ATTENDING PHYSICIAN NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **Use code value AT to report the specialty of the attending physician. Use code value SU when the physician is responsible for the patient's Home Health Plan of Treatment.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*AT*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

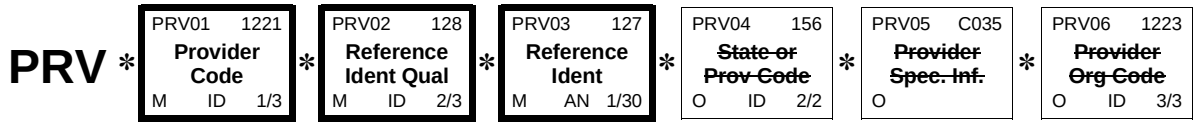
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
AT	**Attending**
SU	**Supervising**

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

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

CODE	DEFINITION
ZZ	**Mutually Defined** **Provider Taxonomy Code**

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

ATTENDING PHYSICIAN SECONDARY IDENTIFICATION

Loop: **2310A — ATTENDING PHYSICIAN NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.**

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

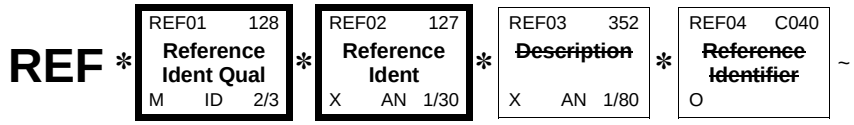
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**		
			EI	**Employer's Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			SY	**Social Security Number** **The social security number may not be used for Medicare.**		
			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:* ***Attending Physician 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

OPERATING PHYSICIAN NAME

Loop: 2310B — OPERATING PHYSICIAN NAME Repeat: 1

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.**
2. **This segment is required when any surgical procedure code is listed on this claim.**
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 nomenclature.**

Example: NM1*72*1*MEYERS*JANE**XX*12345678~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

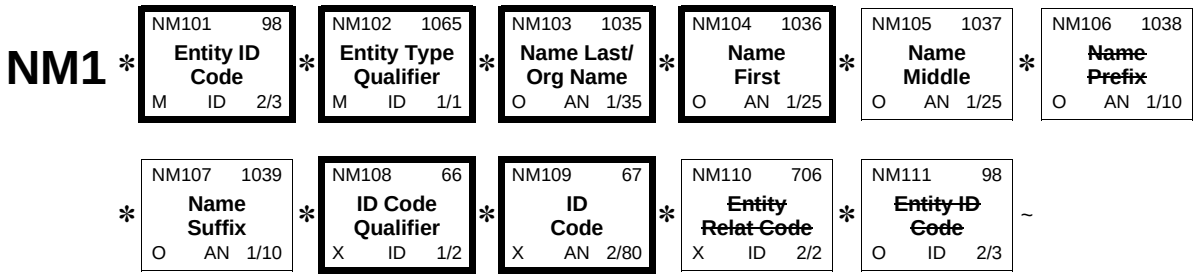
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual **The entity identifier in NM101 applies to all segments in Loop ID-2310.** CODE: **72** DEFINITION: **Operating Physician**	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: **1** DEFINITION: **Person**	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY:* ***Operating Physician Last Name*** **UB-92 Reference [UB-92 Name]:** **83A, Line b [Other Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 10, Positions 116-131.**	O AN 1/35
REQUIRED	NM104	1036	**Name First** Individual first name *INDUSTRY:* ***Operating Physician First Name*** **UB-92 Reference [UB-92 Name]:** **83A, Line b [Other Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 10, Position 132-139**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Operating Physican Middle Name*** **This data element is required when NM102 equals one (1) and the Middle Name or Initial of the person is known by the provider.**	O AN 1/25
NOT USED	NM106	1038	**Name Prefix**	O AN 1/10
SITUATIONAL	NM107	1039	**Name Suffix** Suffix to individual name *INDUSTRY:* ***Operating Physician 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:*** ***Operating Physician Primary Identifier*** **SYNTAX:** P0809 **UB-92 Reference [UB-92 Name]:** **83A, Line a [Other Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 6**	**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

OPERATING PHYSICIAN SPECIALTY INFORMATION

Loop: **2310B — OPERATING PHYSICIAN NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **Required when required by contract between the payer and the provider.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*OP*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

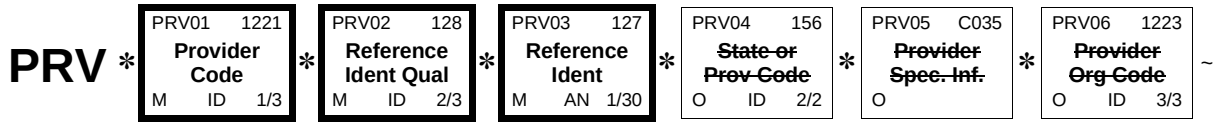
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
OP	**Operating**

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

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

CODE	DEFINITION
ZZ	**Mutually Defined** **Provider Taxonomy Code**

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

OPERATING PHYSICIAN SECONDARY IDENTIFICATION

Loop: **2310B — OPERATING PHYSICIAN NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.**

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

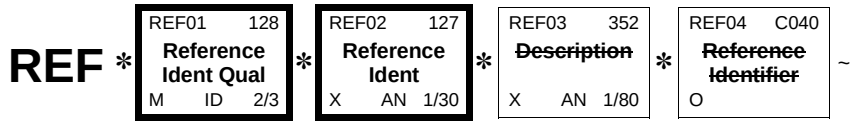
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			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:* ***Operating Physician 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 PROVIDER NAME

Loop: **2310C — OTHER PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.**

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

3. **Required on all outpatient and home health claims/encounters to indicate the person or organization (Home Health Agency) who rendered the care. In the case where a subsitute provider (locum tenans) was used, that person should be entered here. Required when the Other Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider in the 2010AA/AB loops.**

4. **Required on non-outpatient (e.g inpatient, SNF, ICF etc.) claims or encounters to indicate the physician who rendered service for the principal procedure if other than the operating physician reported in Loop 2310B. Not required on non-outpatient claims or encounters if no principal procedure was performed.**

Example: **NM1*73*1*DOE*JOHN*A***34*201749586~**

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:

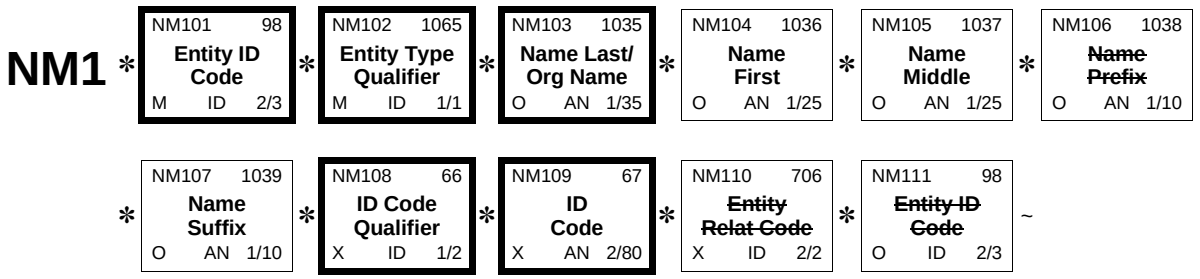
1. Loop 2310 contains information about the rendering, referring, or attending provider.

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 **73 Other Physician**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION **1 Person** **2 Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name INDUSTRY: ***Other Physician Last Name*** **UB-92 Reference [UB-92 Name]:** **83B, Line b [Other Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 11, 12**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name INDUSTRY: ***Other Physician First Name*** **UB-92 Reference [UB-92 Name]:** **83B, Line b [Other Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 11, 12** **Required if NM102=1 (person).**	**O AN 1/25**

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Other Provider Middle Name*** **Required when NM102=1-Person and the Middle Name or Initial of the person is known by the provider.**	**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 Provider Name Suffix*** **Other Provider Generation** **Required if known.**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **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:* ***Other Physician Identifier*** *ALIAS:* ***Other Physician Primary ID*** **SYNTAX:** P0809 **UB-92 Reference [UB-92 Name]:** **83B, Line a [Other Physician ID]** **EMC v.6.0 Reference:** **Record Type 80 Field No. 7** **Record Type 81 Field No. 6**	**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 PROVIDER SPECIALTY INFORMATION

Loop: **2310C — OTHER PROVIDER NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **PRV02 qualifies PRV03.**

Example: **PRV*PE*ZZ*203BA0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

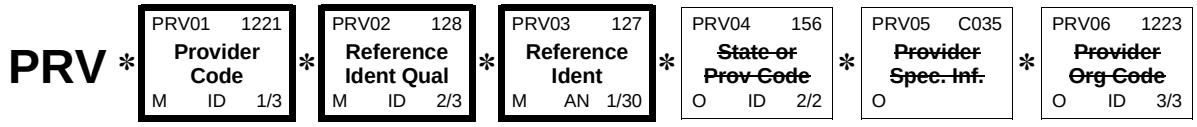
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
OT	**Other Physician** **Non-outpatient claims/encounters must use code value OT - Other in PRV01.**
PE	**Performing** **Outpatient and Home Health Agency claims and enounters must use code value PE - Performing in PRV01.**

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

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

CODE	DEFINITION
ZZ	**Mutually Defined**

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

OTHER PROVIDER SECONDARY IDENTIFICATION

Loop: **2310C — OTHER PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.**

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

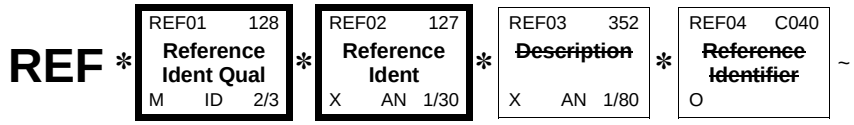
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**		
			EI	**Employer's Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			SY	**Social Security Number** **The social security number may not be used for Medicare.**		
			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:* ***Other 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

REFERRING PROVIDER NAME

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.**
2. **When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral/order, use code DN in the first iteration of this loop to indicate the referral/order received by the rendering provider or Service Facility on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral/order from the primary care provider or whatever provider wrote the initial referral/order for this patient's episode of care being billed/reported in this transaction.**
3. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
4. **Required if claim or encounter involved a referral/order.**

Example: **NM1*DN*1*SMITH*JANE****XX*12345678~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

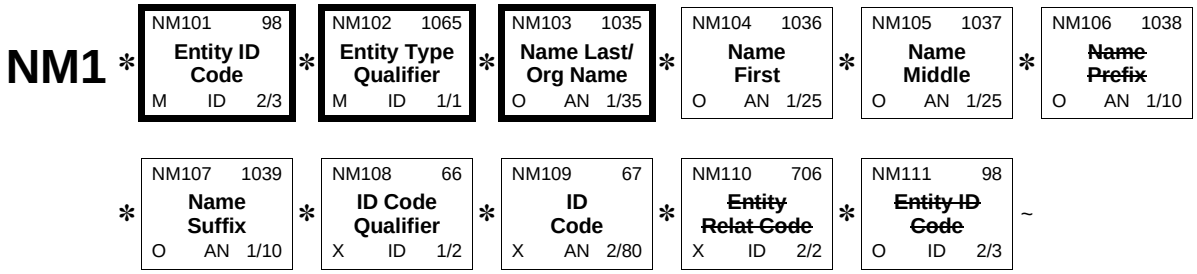
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial *INDUSTRY:* ***Referring Provider Middle 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:* ***Referring Provider Name Suffix*** *ALIAS:* ***Referring Provider Generation*** **Required if known.**	**O**	**AN**	**1/10**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if Employer's Identification/Social Security number or National Provider Identifier is known.** **A code qualifier is recommended for managed care claims.**	**X**	**ID**	**1/2**
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Referring Provider Identifier*** *ALIAS:* ***Referring Provider Primary Identifier*** SYNTAX: P0809 **Required if Employer's Identification/Social Security number, UPIN, or National Provider Identifier is known.** **A number is recommended for managed care claims.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

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

IMPLEMENTATION

REFERRING PROVIDER SPECIALTY INFORMATION

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

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **Required if required under provider-payer contract.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*RF*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

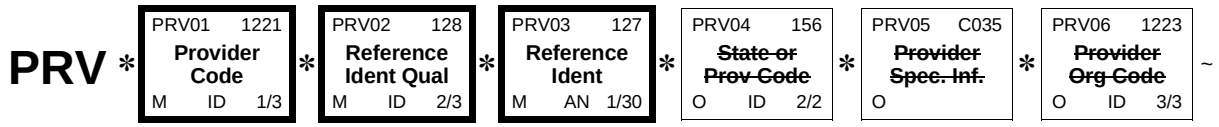
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
RF	**Referring**

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

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

CODE	DEFINITION
ZZ	**Mutually Defined**

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

REFERRING PROVIDER SECONDARY IDENTIFICATION

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

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Required if NM108/09 is not used.**

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

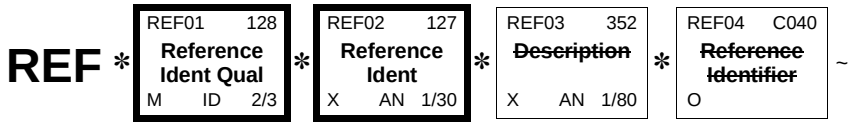
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
B3	**Preferred Provider Organization Number**

			BQ	**Health Maintenance Organization Code Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referring Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

SERVICE FACILITY NAME

Loop: **2310E — SERVICE FACILITY NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
3. **This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.**

Example: **NM1*FA*2*Rehab Facility*****XX*12345678~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 250

Loop: 2310 **Repeat:** 9

Requirement: Optional

Max Use: 1

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

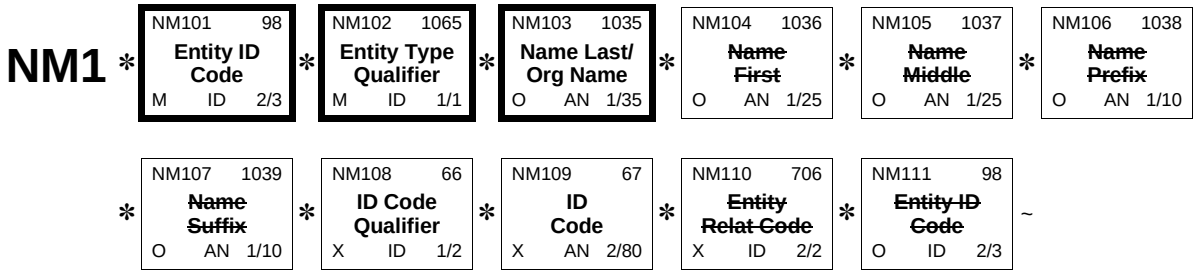
Set Notes:

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M ID 2/3**
			CODE: **FA** — DEFINITION: **Facility**	
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:* ***Laboratory or Facility Name*** *ALIAS:* ***Laboratory/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**
SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.**	**X ID 1/2**
			CODE: **24** — DEFINITION: **Employer's Identification Number**	
			CODE: **34** — DEFINITION: **Social Security Number**	
			CODE: **XX** — DEFINITION: **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***	
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Laboratory or Facility Primary Identifier*** *ALIAS:* ***Laboratory/Facility Primary Identifier*** SYNTAX: P0809 **Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.**	**X AN 2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X ID 2/2**

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

IMPLEMENTATION

SERVICE FACILITY SPECIALTY INFORMATION

Loop: **2310E — SERVICE FACILITY NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01.**
2. **Required if required under provider-payer contract.**
3. **PRV02 qualifies PRV03.**

Example: **PRV*RP*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 255

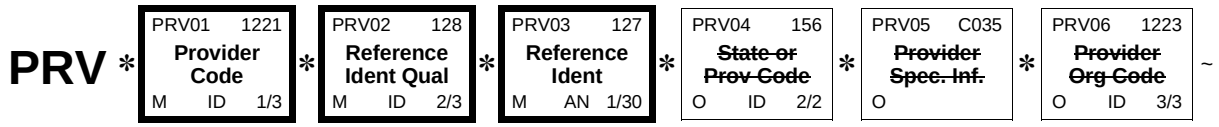
Loop: 2310

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
RP	**Reporting Provider**

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 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

SERVICE FACILITY ADDRESS

Loop: **2310E — SERVICE FACILITY NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N3 Address Information

Level: Detail

Position: 265

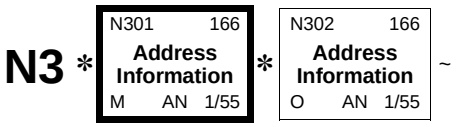
Loop: 2310

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**N301**	**166**	**Address Information** Address information	**M**	**AN**	**1/55**
			INDUSTRY: ***Laboratory or Facility Address Line***			
			ALIAS: ***Laboratory/Facility Address 1***			
SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**
			INDUSTRY: ***Laboratory or Facility Address Line***			
			Required if a second address line exists.			

IMPLEMENTATION

SERVICE FACILITY CITY/STATE/ZIP CODE

Loop: **2310E — SERVICE FACILITY NAME**

Usage: **REQUIRED**

Repeat: **1**

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

STANDARD

N4 Geographic Location

Level: Detail

Position: 270

Loop: 2310

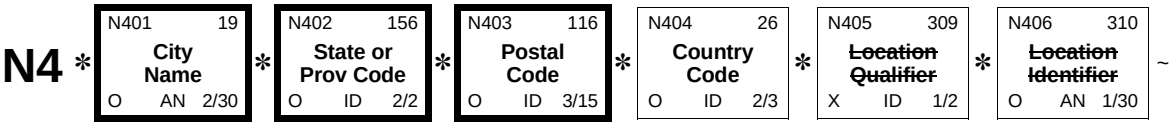
Requirement: Optional

Max Use: 1

Purpose: To specify the geographic place of the named party

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

DIAGRAM



ELEMENT SUMMARY

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

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

IMPLEMENTATION

SERVICE FACILITY SECONDARY IDENTIFICATION

Loop: **2310E — SERVICE FACILITY NAME**

Usage: **SITUATIONAL**

Repeat: **5**

Notes: **1. Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.**

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 271

Loop: 2310

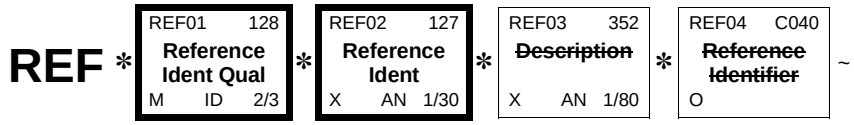
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**			
			1J	**Facility ID Number**			
			EI	**Employer's Identification Number**			
			FH	**Clinic Number**			
			G2	**Provider Commercial Number**			
			G5	**Provider Site Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification 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*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER SUBSCRIBER INFORMATION

Loop: 2320 — OTHER SUBSCRIBER INFORMATION Repeat: 10

Usage: SITUATIONAL

Repeat: 1

Notes:

1. **Required if other payers are known to potentially be involved in paying on this claim.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
3. **All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 Loop again with it's respective 2330 Loops.**

Example: SBR*S*01*GR00786MC****OF~**

STANDARD

SBR Subscriber Information

Level: Detail

Position: 290

Loop: 2320 **Repeat:** 10

Requirement: Optional

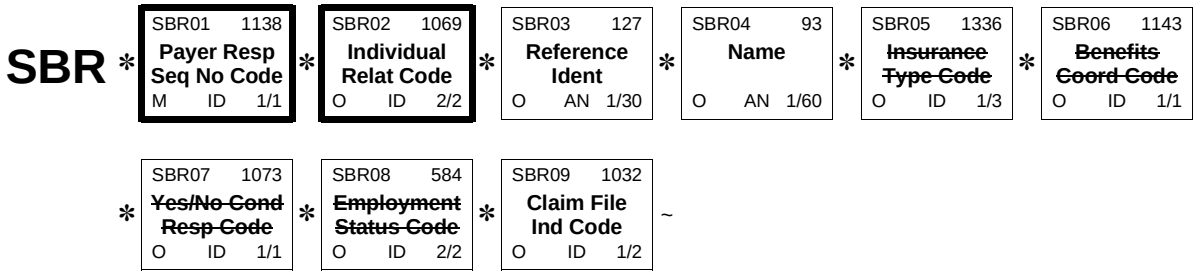
Max Use: 1

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

Set Notes:

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

DIAGRAM



ELEMENT SUMMARY

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

UB-92 Reference [UB-92 Name]:

50 (A-C) [Payer Identification]
51 (A-C) [Provider Number]
52 (A-C) [Release of Information Certification Indicator]
53 (A-C) [Assignment of Benefits Certification Indicator]
54 (A-C) [Prior Payments - Payers and Patient]
55 (A-C) [Estimated Amount Due]
58 (A-C) [Insured's Name]
59 (A-C) [Patient's Relationship to Insured]
60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]
61 (A-C) [Insured Group Name]
62 (A-C) [Insurance Group Number]
63 (A-C) [Treatment Authorization Code]
64 (A-C) [Employment Status Code of the Insured]
65 (A-C) [Employer Name of the Insured]
66 (A-C) [Employer Location of the Insured]

EMC v.6.0 Reference:

Record Type 30 Field No. 2 (Sequence 01-03)
Record Type 31 Field No. 2 (Sequence 01-03)
Record Type 32 Field No. 2 (Sequence 01-03)
Record Type 40 Field No. 5, 6, 7

CODE	DEFINITION
P	Primary
S	Secondary
T	Tertiary Used to indicate "payer of last resort".

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

SEMANTIC: SBR02 specifies the relationship to the person insured.

UB-92 Reference [UB-92 Name]:

59 (A-C) [Patient's Relationship to Insured]

EMC v.6.0 Reference:

Record Type 30 Field No. 18 (Sequence 01-03)

Use this code to specify the patient's relationship to the person insured.

CODE	DEFINITION
01	**Spouse** UB-92 Reference [UB-92 Name]: **59 Code 02 [Spouse]**
04	**Grandfather or Grandmother** UB-92 Reference [UB-92 Name]: **59 Code 19 [Grandparent]**
05	**Grandson or Granddaughter** UB-92 Reference [UB-92 Name]: **59 Code 13 [Grandchild]**
07	**Nephew or Niece** UB-92 Reference [UB-92 Name]: **59 Code 14 [Niece/Nephew]**
10	**Foster Child** UB-92 Reference [UB-92 Name]: **59 Code 06 [Foster Child]**
15	**Ward** UB-92 Reference [UB-92 Name]: **59 Code 07 [Ward of the Court]**
17	**Stepson or Stepdaughter** UB-92 Reference [UB-92 Name]: **59 Code 05 [Step Child]**
18	**Self** UB-92 Reference [UB-92 Name]: **59 Code 01 [Patient Is Insured]**
19	**Child** UB-92 Reference [UB-92 Name]: **59 Code 03 [Natural Child/Insured Financial Responsibility]**
20	**Employee** UB-92 Reference [UB-92 Name]: **59 Code 08 [Employee]**

21	**Unknown** UB-92 Reference [UB-92 Name]: **59 Code 09 [Unknown]**
22	**Handicapped Dependent** UB-92 Reference [UB-92 Name]: **59 Code 10 [Handicapped Dependent]**
23	**Sponsored Dependent** UB-92 Reference [UB-92 Name]: **59 Code 16 [Sponsored Dependent]**
24	**Dependent of a Minor Dependent** UB-92 Reference [UB-92 Name]: **59 Code 17 [Minor Dependent of a Minor Dependent]**
29	**Significant Other**
32	**Mother**
33	**Father**
36	**Emancipated Minor**
39	**Organ Donor** UB-92 Reference [UB-92 Name]: **59 Code 11 [Organ Donor]**
40	**Cadaver Donor** UB-92 Reference [UB-92 Name]: **59 Code 12 [Cadaver Donor]**
41	**Injured Plaintiff** UB-92 Reference [UB-92 Name]: **59 Code 15 [Injured Plaintiff]**
43	**Child Where Insured Has No Financial Responsibility** UB-92 Reference [UB-92 Name]: **59 Code 04 [Natural Child/Insured Does not Have Financial Responsibility]**
53	**Life Partner** UB-92 Reference [UB-92 Name]: **59 Code 20 [Life Partner]**
G8	**Other Relationship**

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

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

SEMANTIC: SBR03 is policy or group number.

UB-92 Reference [UB-92 Name]:

62 (A-C) [Insurance Group Number]

EMC v.6.0 Reference:

Record Type 30 Field No. 10 (Sequence 01-03) Insurance Group No.

Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.

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

INDUSTRY: ***Other Insured Group Name***

SEMANTIC: SBR04 is plan name.

UB-92 Reference [UB-92 Name]:

61 (A-C) [Insured Group Name]

EMC v.6.0 Reference:

Record Type 30 Field No. 11 (Sequence 01-03)

Plan Name (Group Name)

This data element is required when the Provider has the Plan Name (Group Name) within their files.

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**

EMC v.6.0 Reference:

Record Type 30 Field No. 4 (Sequence 01-03. See SBR09 in LOOP 2000B for EMC code translation.)

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

CODE	DEFINITION
09	**Self-pay**
10	**Central Certification**
11	**Other Non-Federal Programs**
12	**Preferred Provider Organization (PPO)**

13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TV	Title V
VA	Veteran Administration Plan Refers to Veterans Affairs Plan.
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined Unknown

IMPLEMENTATION

CLAIM LEVEL ADJUSTMENT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **Submitter should use this CAS segment to report prior payers claim level adjustments that cause the amount paid to differ from the amount originally charged.**
2. **Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment again.**
3. **Codes and associated amount should come from 835 (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 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 web site: http://www.wpc-edi.com. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.**

Example: **CAS*CO*96*555.52~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 295

Loop: 2320

Requirement: Optional

Max Use: 99

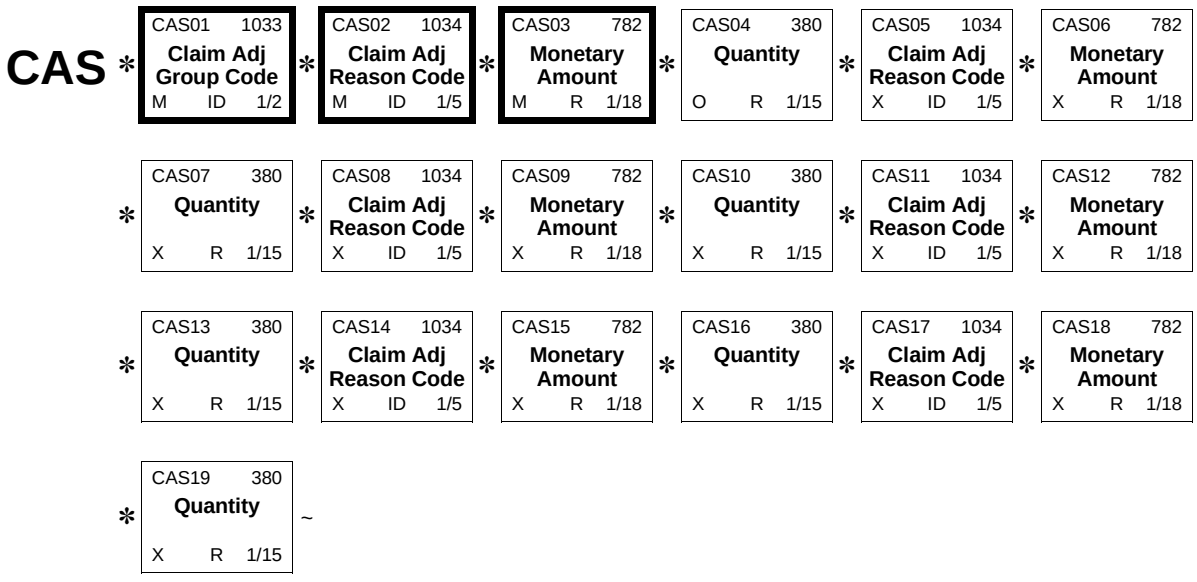
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

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**
			EMC v.6.0 Reference: **Record Type 42 Field No. 5**			
			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*** **CODE SOURCE 139:** Claim Adjustment Reason Code **EMC v.6.0 Reference:** **Record Type 42 Field No. 6**	**M**	**ID**	**1/5**
REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount *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. **EMC v.6.0 Reference:** **Record Type 42 Field No. 7**	**M**	**R**	**1/18**
SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** **SEMANTIC:** CAS04 is the units of service being adjusted. **EMC v.6.0 Reference:** **Record Type 42 Field No. 8** **Use this number for the units of service being adjusted.**	**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***

SYNTAX: L050607, C0605, C0705

CODE SOURCE **139:** Claim Adjustment Reason Code

EMC v.6.0 Reference:

Record Type 42 Field No. 9

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 10

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 11

Used when additional adjustment information applies to claim.

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

EMC v.6.0 Reference:

Record Type 42 Field No. 12

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 13

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 14

Used when additional adjustment information applies to claim.

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

EMC v.6.0 Reference:

Record Type 42 Field No. 15

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 16

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 17

Used when additional adjustment information applies to claim.

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

EMC v.6.0 Reference:

Record Type 42 Field No. 18

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 19

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 20

Used when additional adjustment information applies to claim.

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

EMC v.6.0 Reference:

Record Type 42 Field No. 21

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 22

Used when additional adjustment information applies to claim.

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.

EMC v.6.0 Reference:

Record Type 42 Field No. 23

Used when additional adjustment information applies to claim.

IMPLEMENTATION

PAYER PRIOR PAYMENT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **The amount this payer has paid to the provider towards this bill.**
2. **This segment is required when the present payer has paid an amount to the provider towards this bill.**

Example: **AMT*C4*150~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

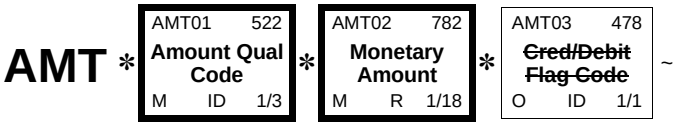
Loop: 2320

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 **C4 — Prior Payment - Actual**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Other Payer Patient Paid Amount*** **UB-92 Reference [UB-92 Name]:** **54 (A-C) [Prior Payments - Payers and Patient]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 25 (Sequence 01-03)**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TOTAL ALLOWED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Total Allowed Amount applicable to this claim when known.**

Example: **AMT*B6*3794.82~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

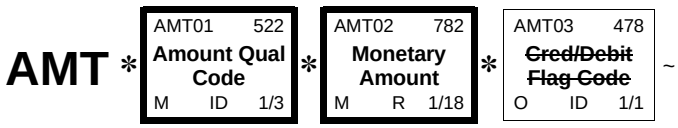
Loop: 2320

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*** **EMC v.6.0 Reference:** **Record Type 92 Field No. 8 (For COB use. Use this amount for the total claim level charges allowed.)**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TOTAL SUBMITTED CHARGES

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Total Submitted Charges applicable to this claim when known.**

Example: **AMT*T3*7490.7~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

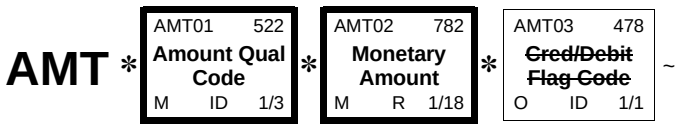
Loop: 2320

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 **T3** — **Total Submitted Charges**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Coordination of Benefits Total Submitted Charge Amount*** **EMC v.6.0 Reference:** **Record Type 92 Field No. 6 (For COB use. Use this amount for the total claim level submitted charges.)**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

DIAGNOSTIC RELATED GROUP (DRG) OUTLIER AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the DRG Outlier Amount applicable to this claim when known.**

Example: **AMT*ZZ*9034.7~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

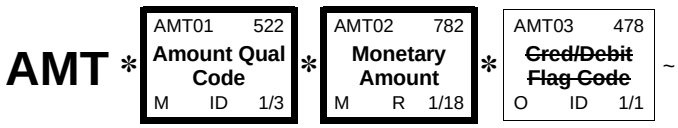
Loop: 2320

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**
			Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	
			CODE — DEFINITION **ZZ — Mutually Defined**	

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim DRG Outlier Amount*** **EMC v.6.0 Reference:** **Record Type 92 Field No. 15 (For COB use [temporary qualifier]. Use this amount for the DRG outlier amount.)**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TOTAL MEDICARE PAID AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Total Medicare Paid Amount applicable to this claim when known.**

Example: **AMT*N1*873.4~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

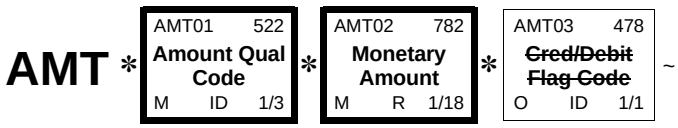
Loop: 2320

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**
			Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	

CODE	DEFINITION
N1	**Net Worth**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Total Medicare Paid Amount***			
			EMC v.6.0 Reference:			
			Record Type 92 Field No. 9 (For COB use [temporary qualifier]. Use this amount for the total Medicare reimbursement.)			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

MEDICARE PAID AMOUNT - 100%

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Medicare Paid Amount - 100% applicable to this claim when known.**

Example: **AMT*KF*73.01~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

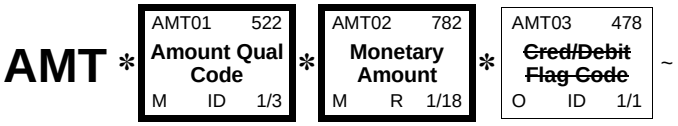
Loop: 2320

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**
			Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	
			CODE / DEFINITION	
			KF — Net Paid Amount	
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M R 1/18**
			INDUSTRY: ***Medicare Paid at 100% Amount***	
			EMC v.6.0 Reference:	
			Record Type 93 Field No. 4 (For COB use [temporary qualifier]. Use this amount for the claim level allowed charges Medicare paid at 100%.)	

NOT USED	AMT03	478	Credit/Debit Flag Code	O	ID	1/1

IMPLEMENTATION

MEDICARE PAID AMOUNT - 80%

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Medicare Paid Amount - 80% applicable to this claim when known.**

Example: **AMT*PG*639.4~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

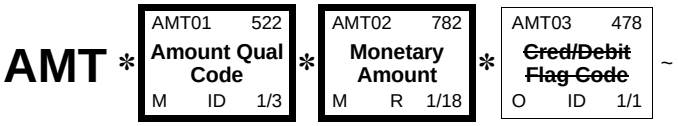
Loop: 2320

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**
			Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	
			CODE / DEFINITION	
			PG Payoff	
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M R 1/18**
			INDUSTRY: ***Medicare Paid at 80% Amount***	
			EMC v.6.0 Reference:	
			Record Type 93 Field No. 5 (For COB use [temporary qualifier]. Use this amount for the claim level allowed charges Medicare paid at 80%.)	

NOT USED	AMT03	478	Credit/Debit Flag Code	O	ID	1/1

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) MEDICARE A TRUST FUND PAID AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Medicare A Trust Fund Paid Amount applicable to this claim when known.**

Example: **AMT*AA*4394.7~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

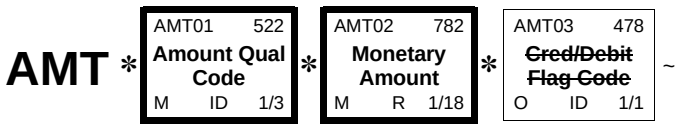
Loop: 2320

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**
			Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	
			CODE **DEFINITION**	
			AA **Allocated**	

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Paid From Part A Medicare Trust Fund Amount***			
			EMC v.6.0 Reference:			
			Record Type 93 Field No. 6 (For COB use [temporary qualifier]. Use this amount for the amount paid from the Medicare A trust fund.)			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) MEDICARE B TRUST FUND PAID AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Medicare B Trust Fund Paid Amount applicable to this claim when known.**

Example: **AMT*B1*150~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

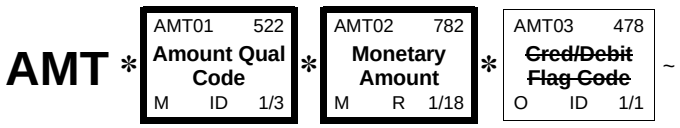
Loop: 2320

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**
			Use this qualifier until a more suitable one is developed. At this time, the qualifier represents what the amount is being used for (see monetary amount description).	

CODE	DEFINITION
B1	**Benefit Amount** **Use this qualifier until a more suitable one is developed. At this time, B1 represents the Paid From Medicare B Trust Fund Amount.**

REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			INDUSTRY: ***Paid From Part B Medicare Trust Fund Amount***			
			EMC v.6.0 Reference:			
			Record Type 93 Field No. 7 (For COB use [temporary qualifier]. Use this amount for the amount paid from the Medicare B trust fund.)			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TOTAL NON-COVERED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Total Non-Covered Amount applicable to this claim when known.**

Example: **AMT*A8*273~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

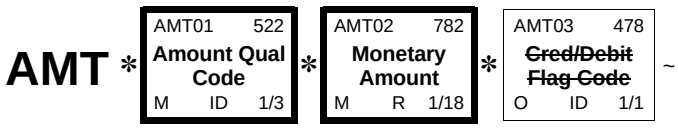
Loop: 2320

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 **A8** — **Noncovered Charges - Actual**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Non-Covered Charge Amount*** **EMC v.6.0 Reference:** **Record Type 92 Field No. 7 (For COB use [temporary qualifier]. Use this amount for the total of non-covered claim level charges.)**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

COORDINATION OF BENEFITS (COB) TOTAL DENIED AMOUNT

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **This segment is for COB use.**
2. **This segment is used to convey the COB Total Denied Amount applicable to this claim when known.**

Example: **AMT*YT*32~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 300

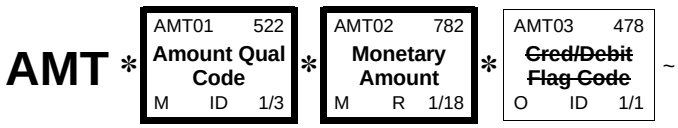
Loop: 2320

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 **YT** **Denied**	**M**	**ID**	**1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Total Denied Charge Amount*** **EMC v.6.0 Reference:** **Record Type 92 Field No. 16 (For COB use. Use this amount for the total claim level denied charges.)**	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

OTHER SUBSCRIBER DEMOGRAPHIC INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when 2330A - Other Subscriber Name NM102 = 1 (Person).**

Example: **DMG✻✻✻F~**

STANDARD

DMG Demographic Information

Level: Detail

Position: 305

Loop: 2320

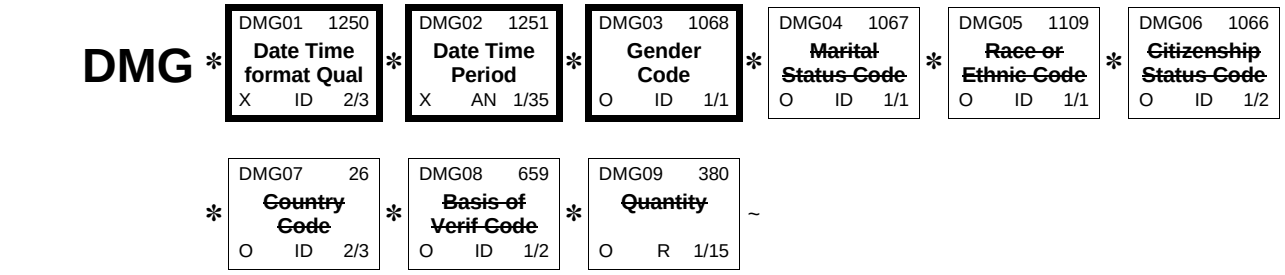
Requirement: Optional

Max Use: 1

Purpose: To supply demographic information

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

DIAGRAM



ELEMENT SUMMARY

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

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

REQUIRED	**DMG02**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times *INDUSTRY:* ***Other Insured Birth Date*** 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*** **EMC v.6.0 Reference:** **Record Type 30 Field No. 15**	**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

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

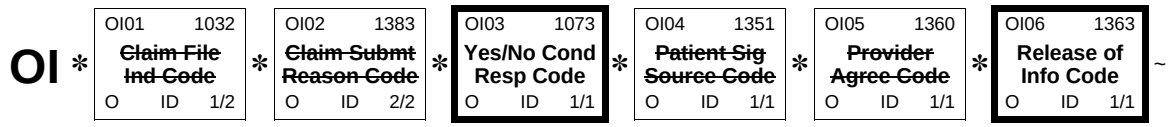
Loop: 2320

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.

EMC v.6.0 Reference:

Record Type 30 Field No. 17

Assignment of Benefits Indicator

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

EMC v.6.0 Reference:

Record Type 30 Field No. 16

CODE	DEFINITION
A	**Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization**
I	**Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes**
M	**The Provider has Limited or Restricted Ability to Release Data Related to a Claim** EMC v.6.0 Reference: **Record Type 30 Field No. 16 Code R**
N	**No, Provider is Not Allowed to Release Data** EMC v.6.0 Reference: **Record Type 30 Field No. 16 Code N**
O	**On file at Payor or at Plan Sponsor**
Y	**Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim** EMC v.6.0 Reference: **Record Type 30 Field No. 16 Code Y**

IMPLEMENTATION

MEDICARE INPATIENT ADJUDICATION INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is used to convey the Medicare Inpatient Adjudication Information if returned in the 835.**

Example: **MIA*1***3568.98*MAO**********21***MA25~**

STANDARD

MIA Medicare Inpatient Adjudication

Level: Detail

Position: 315

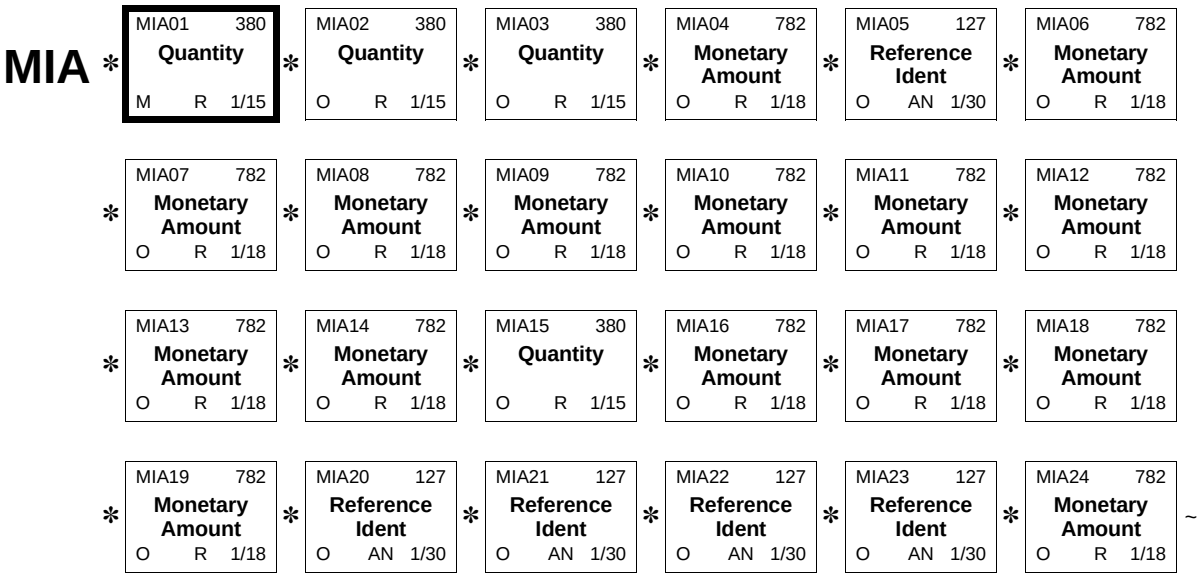
Loop: 2320

Requirement: Optional

Max Use: 1

Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**MIA01**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Covered Days or Visits Count*** **SEMANTIC:** MIA01 is the covered days.	**M**	**R**	**1/15**
SITUATIONAL	**MIA02**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Lifetime Reserve Days Count*** **SEMANTIC:** MIA02 is the lifetime reserve days. **Use this quantity to indicate the lifetime reserve days.**	**O**	**R**	**1/15**
SITUATIONAL	**MIA03**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Lifetime Psychiatric Days Count*** **SEMANTIC:** MIA03 is the lifetime psychiatric days. **EMC v.6.0 Reference:** **Record Type 92 Field No. 18**	**O**	**R**	**1/15**
SITUATIONAL	**MIA04**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim DRG Amount*** **SEMANTIC:** MIA04 is the Diagnosis Related Group (DRG) amount. **EMC v.6.0 Reference:** **Record Type 92 Field No. 14** **Use this amount to indicate the Diagnosis Related Group (DRG) amount.**	**O**	**R**	**1/18**
SITUATIONAL	**MIA05**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Remark Code*** **SEMANTIC:** MIA05 is the Remittance Remark Code. See Code Source 411. **EMC v.6.0 Reference:** **Record Type 42 Field No. 24** **Use this reference identification for the Health Care Financing Administration claim payment remark code.**	**O**	**AN**	**1/30**
SITUATIONAL	**MIA06**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Claim Disproportionate Share Amount*** **SEMANTIC:** MIA06 is the disproportionate share amount. **Use this amount to indicate the disproportionate share amount.**	**O**	**R**	**1/18**

SITUATIONAL	**MIA07**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim MSP Pass-through Amount***

SEMANTIC: MIA07 is the Medicare Secondary Payer (MSP) pass-through amount.

Use this amount to indicate the Medicare Secondary Payer (MSP) pass-through amount.

SITUATIONAL	**MIA08**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim PPS Capital Amount***

SEMANTIC: MIA08 is the total Prospective Payment System (PPS) capital amount.

Use this amount to indicate the Total Prospective Payment System (PPS) capital amount.

SITUATIONAL	**MIA09**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital FSP DRG Amount***

SEMANTIC: MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.

Use this amount to indicate the Prospective Payment System (PPS) capital, federal-specific portion, Diagnosis Related Group (DRG) amount.

SITUATIONAL	**MIA10**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital HSP DRG Amount***

SEMANTIC: MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount.

Use this amount to indicate the Prospective Payment System (PPS) capital, hospital-specific portion, Diagnosis Related Group (DRG) amount.

SITUATIONAL	**MIA11**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital DSH DRG Amount***

SEMANTIC: MIA11 is the Prospective Payment System (PPS) capital, disaproportionate share, hospital Diagnosis Related Group (DRG) amount.

Use this amount to indicate the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.

SITUATIONAL	**MIA12**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Old Capital Amount***

SEMANTIC: MIA12 is the old capital amount.

Use this amount to indicate the old capital amount.

SITUATIONAL	**MIA13**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital IME amount***

SEMANTIC: MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.

Use this amount to indicate the Prospective Payment System (PPS) capital indirect medical education claim amount.

SITUATIONAL	**MIA14**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Operating Hospital Specific DRG Amount***

SEMANTIC: MIA14 is hospital specifc Diagnosis Related Group (DRG) Amount.

Use this amount to indicate the hospital-specific, Diagnosis Related Group (DRG) amount.

SITUATIONAL	**MIA15**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Cost Report Day Count***

SEMANTIC: MIA15 is the cost report days.

EMC v.6.0 Reference:

Record Type 92 Field No. 17

SITUATIONAL	**MIA16**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Operating Federal Specific DRG Amount***

SEMANTIC: MIA16 is the federal specific Diagnosis Related Group (DRG) amount.

Use this amount to indicate the federal-specific, Diagnosis Related Group (DRG) amount.

SITUATIONAL	**MIA17**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim PPS Capital Outlier Amount***

SEMANTIC: MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.

Use this amount to indicate the Prospective Payment System (PPS) Capital Outlier amount.

SITUATIONAL	**MIA18**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim Indirect Teaching Amount***

SEMANTIC: MIA18 is the indirect teaching amount.

Use this amount to indicate the indirect teaching amount.

SITUATIONAL	**MIA19**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Nonpayable Professional Component Amount***

SEMANTIC: MIA19 is the professional component amount billed but not payable.

Use this amount to indicate the professional component amount billed but not payable.

SITUATIONAL	**MIA20**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MIA20 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 25

Use this reference identification for the Health Care Financing Administration claim payment remark code.

SITUATIONAL	**MIA21**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MIA21 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 26

Use this reference identification for the Health Care Financing Administration claim payment remark code.

SITUATIONAL	**MIA22**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MIA22 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 27

Use this reference identification for the Health Care Financing Administration claim payment remark code.

SITUATIONAL	**MIA23**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MIA23 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 28

Use this reference identification for the Health Care Financing Administration claim payment remark code.

SITUATIONAL	**MIA24**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***PPS-Capital Exception Amount***

SEMANTIC: MIA24 is the capital exception amount.

Use this amount to indicate the capital exception amount.

IMPLEMENTATION

MEDICARE OUTPATIENT ADJUDICATION INFORMATION

Loop: **2320 — OTHER SUBSCRIBER INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required to convey the Medicare Outpatient Adjudication Information if returned in the Electronic Remittance Advice (835).**

Example: **MOA*12.5**MAO1~**

STANDARD

MOA Medicare Outpatient Adjudication

Level: Detail

Position: 320

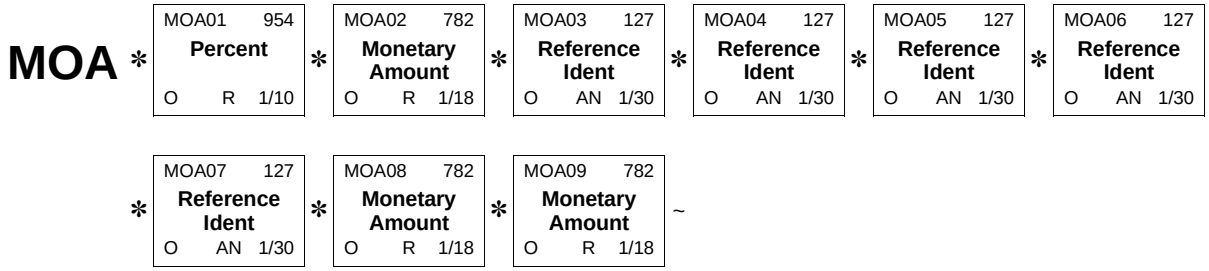
Loop: 2320

Requirement: Optional

Max Use: 1

Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**MOA01**	**954**	**Percent** Percentage expressed as a decimal *INDUSTRY:* ***Reimbursement Rate*** SEMANTIC: MOA01 is the reimbursement rate. **EMC v.6.0 Reference:** **Record Type 92 Field No. 20** **Required if returned on the Electronic Remittance Advice (835).**	**O R 1/10**

SITUATIONAL	**MOA02**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim HCPCS Payable Amount***

SEMANTIC: MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.

Use this amount to indicate the Claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MOA03 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 24

Use this reference identification for the Health Care Financing Administration claim payment remark code.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MOA04 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 25

Use this reference identification for the Health Care Financing Administration claim payment remark code.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA05**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MOA05 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 26

Use this reference identification for the Health Care Financing Administration claim payment remark code.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MOA06 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 27

Use this reference identification for the Health Care Financing Administration claim payment remark code.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA07**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**AN**	**1/30**

INDUSTRY: ***Remark Code***

SEMANTIC: MOA07 is the Remittance Remark Code. See Code Source 411.

EMC v.6.0 Reference:

Record Type 42 Field No. 28

Use this reference identification for the Health Care Financing Administration claim payment remark code.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA08**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Claim ESRD Payment Amount***

SEMANTIC: MOA08 is the End Stage Renal Disease (ESRD) payment amount.

Use this amount to indicate the End Stage Renal Disease (ESRD) payment amount.

Required if returned on the Electronic Remittance Advice (835).

SITUATIONAL	**MOA09**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Nonpayable Professional Component Amount***

SEMANTIC: MOA09 is the professional component amount billed but not payable.

Use this amount to indicate the professional component amount billed but not payable.

Required if returned on the Electronic Remittance Advice (835).

IMPLEMENTATION

OTHER SUBSCRIBER NAME

Loop: **2330A — OTHER SUBSCRIBER NAME Repeat: 1**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **Submitters are required to send information on all known other subscribers in Loop ID 2330.**
2. **The 2330A Loop is required when Loop ID 2320 - Other Subscriber Information is used. Otherwise, this loop is not used.**

Example: **NM1*IL*1*DOE*JOHN*T***34*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

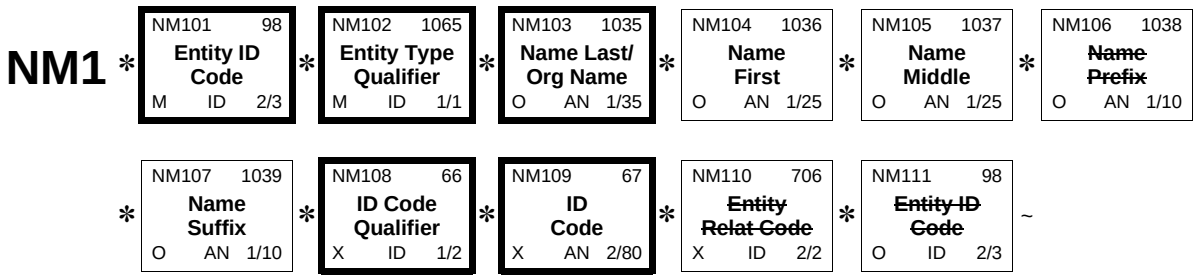
Max Use: 1

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:* ***Subscriber's Last Name*** **UB-92 Reference [UB-92 Name]:** **58 (A-C) [Insured's Name]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 12 (Sequence 01-03)**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name *INDUSTRY:* ***Other Insured First Name*** *ALIAS:* ***Subscriber's First Name*** **UB-92 Reference [UB-92 Name]:** **58 (A-C) [Insured's Name]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 13 (Sequence 01-03)** **This data element is required when NM102 equals one (1).**	**O AN 1/25**

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

INDUSTRY: ***Other Insured Middle Name***

ALIAS: ***Subscriber's Middle Initial***

UB-92 Reference [UB-92 Name]:

58 (A-C) [Insured's Name]

EMC v.6.0 Reference:

Record Type 30 Field No. 14 (Sequence 01-03)

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

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

INDUSTRY: ***Other Insured Name Suffix***

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

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

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 Institutional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Medicaid Recipient ID, Health Insurance Claim Number (HIC), etc.**
ZZ	**Mutually Defined** **The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.**

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Insured Identifier*** *ALIAS:* ***Subscriber Primary ID*** SYNTAX: P0809 **UB-92 Reference [UB-92 Name]:** **60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 7 (Sequence 01-03)**	**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 SUBSCRIBER ADDRESS

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when the Provider has the Other Subscriber Address information on file.**

Example: **N3*4320 WASHINGTON ST SUITE 100~**

STANDARD

N3 Address Information

Level: Detail

Position: 332

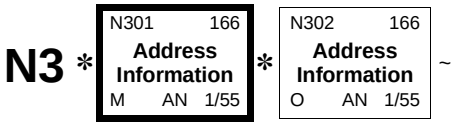
Loop: 2330

Requirement: Optional

Max Use: 2

Purpose: To specify the location of the named party

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**N301**	**166**	**Address Information** Address information *INDUSTRY:* ***Other Insured Address Line*** *ALIAS:* ***Subscriber's Address 1*** **UB-92 Reference [UB-92 Name]:** **84, Line b [Remarks]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 4 (Sequence 01-03)**	**M AN 1/55**

SITUATIONAL	**N302**	**166**	**Address Information** Address information	**O**	**AN**	**1/55**

INDUSTRY: ***Other Insured Address Line***

ALIAS: ***Subscriber Address 2***

EMC v.6.0 Reference:

Record Type 31 Field No. 5 (Sequence 01-03)

Required if a second address line exists.

IMPLEMENTATION

OTHER SUBSCRIBER CITY/STATE/ZIP CODE

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when the associated N3 segment is present.**

Example: **N4*PALISADES*OR*23119~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 340

Loop: 2330

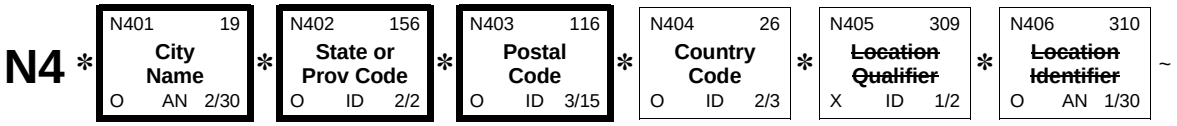
Requirement: Optional

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:* ***Subscriber's City*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **UB-92 Reference [UB-92 Name]:** **84, Line c [Remarks]** **EMC v.6.0 Reference:** **Record Type 31 Field No. 6 (Sequence 01-03)**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**O**	**ID**	**2/2**

INDUSTRY: ***Other Insured 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.

UB-92 Reference [UB-92 Name]:

84, Line c [Remarks]

EMC v.6.0 Reference:

Record Type 31 Field No. 7 (Sequence 01-03)

REQUIRED	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O**	**ID**	**3/15**

INDUSTRY: ***Other Insured Postal Zone or ZIP Code***

ALIAS: ***Subscriber's ZIP Code***

CODE SOURCE 51: ZIP Code

UB-92 Reference [UB-92 Name]:

84, Line d [Remarks]

EMC v.6.0 Reference:

Record Type 31 Field No. 8 (Sequence 01-03)

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**O**	**ID**	**2/3**

ALIAS: ***Subscriber Country Code***

CODE SOURCE 5: Countries, Currencies and Funds

This data element is required when the address is outside of the U.S.

NOT USED	**N405**	**309**	**Location Qualifier**	**X**	**ID**	**1/2**
NOT USED	**N406**	**310**	**Location Identifier**	**O**	**AN**	**1/30**

IMPLEMENTATION

OTHER SUBSCRIBER SECONDARY INFORMATION

Loop: **2330A — OTHER SUBSCRIBER NAME**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. This segment is required when additional identification numbers are required.**

Example: **REF*SY*030385074~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

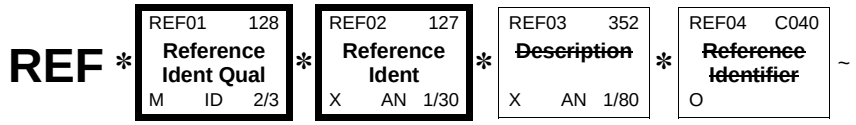
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = MI, this qualifier cannot be used.**
23	**Client Number** **This code is intended to be used only in claims submitted to the Indian Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.**
IG	**Insurance Policy Number**

			SY **Social Security Number** **The social security number may not be used for Medicare.**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Insured Additional Identifier*** SYNTAX: R0203 **UB-92 Reference [UB-92 Name]:** **60 (A-C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 7 (Sequence 01-03)**	**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*****PI*43140~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

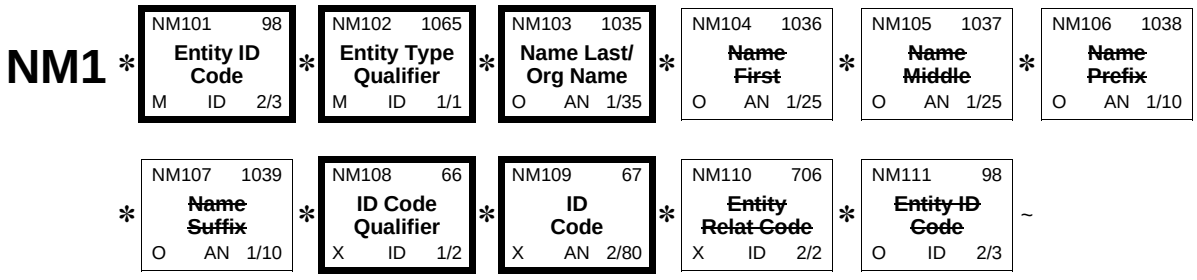
Max Use: 1

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. 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:*** ***Other Payer Last or Organization Name*** ***ALIAS:*** ***Payer Name*** **UB-92 Reference [UB-92 Name]:** **50 (A-C) [Payer Identification]** **EMC v.6.0 Reference:** **Record Type 30 Field No. 8b (Sequence 01-03)** **Record Type 32 Field No. 4 (Sequence 01-03)**	**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 **EMC v.6.0 Reference:** **Record Type 30 Field No. 5, 6 (Sequence 01-03)** 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	**X**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code ***INDUSTRY:*** ***Other Payer Primary Identifier*** ***ALIAS:*** ***Payer Primary ID*** **SYNTAX:** P0809 **This number must be identical to SVD01 (L00p ID - 2430) for COB.**	**X**	**AN**	**2/80**
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

OTHER PAYER ADDRESS

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is only to be used when the Provider needs to identify the address for paper claim printing purposes.**

Example: **N3*4320 WASHINGTON ST SUITE 100~**

STANDARD

N3 Address Information

Level: Detail

Position: 332

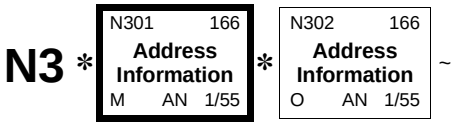
Loop: 2330

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 Payer Address Line*** *ALIAS:* ***Payer's Address 1*** **EMC v.6.0 Reference:** **Record Type 32 Field No. 5 (Sequence 01-03)**	**M**	**AN**	**1/55**
SITUATIONAL	**N302**	**166**	**Address Information** Address information *INDUSTRY:* ***Other Payer Address Line*** *ALIAS:* ***Payer's Address 2*** **EMC v.6.0 Reference:** **Record Type 32 Field No. 6 (Sequence 01-03)** **Required if a second address line exists.**	**O**	**AN**	**1/55**

IMPLEMENTATION

OTHER PAYER CITY/STATE/ZIP CODE

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when the associated N3 segment is present.**

Example: **N4*PALISADES*OR*23119~**

STANDARD

N4 Geographic Location

Level: Detail

Position: 340

Loop: 2330

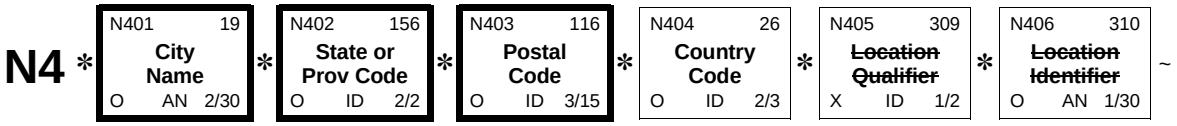
Requirement: Optional

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 Payer City Name*** *ALIAS:* ***Payer City Name*** COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. **EMC v.6.0 Reference:** **Record Type 32 Field No. 7 (Sequence 01-03)**	**O AN 2/30**

REQUIRED	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency *INDUSTRY:* ***Other Payer State Code*** *ALIAS:* ***Payer State Code*** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE **22:** States and Outlying Areas of the U.S. **EMC v.6.0 Reference:** **Record Type 32 Field No. 8 (Sequence 01-03)**	**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 Payer Postal Zone or ZIP Code*** *ALIAS:* ***Payer Postal Code*** CODE SOURCE **51:** ZIP Code **EMC v.6.0 Reference:** **Record Type 32 Field No. 9 (Sequence 01-03)**	**O**	**ID**	**3/15**
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country *ALIAS:* ***Payer Country Code*** CODE SOURCE **5:** Countries, Currencies and Funds **This data element is required when the address is outside 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

CLAIM ADJUDICATION DATE

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when Loop-ID 2430 (Line Adjudication Date) is not used and this payer has adjudicated the claim.**

Example: **DTP*573*D8*19981226~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 350

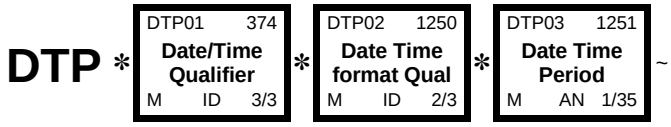
Loop: 2330

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:* ***Adjudication or Payment Date***	**M AN 1/35**

IMPLEMENTATION

OTHER PAYER SECONDARY IDENTIFICATION AND REFERENCE NUMBER

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **2**

Notes:
1. **This segment is required when a secondary number is needed to identify the payer.**
2. **Used when it is necessary to identify the 'other' payer's claim number in a payer-to-payer COB situation (use code F8).**

Example: **REF*FY*465980789~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

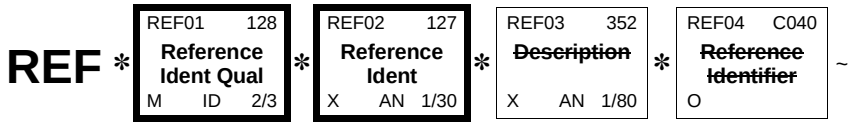
Requirement: Optional

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**

Use code F8 to indicate the payer's claim number assigned to this claim by the payer referenced in this interation of Loop ID - 2330B.

CODE	DEFINITION
2U	**Payer Identification Number**

			F8	**Original Reference Number** UB-92 Reference [UB-92 Name]: **37 (A-C) [Internal Control Number (ICN)/ Document Control Number (DCN)]** EMC v.6.0 Reference: **Record Type 31 Field No. 14 (Sequence 01-03)**			
			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		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER

Loop: **2330B — OTHER PAYER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Used when the payer identified in this loop has given a prior authorization or referral number to this claim. This element is primalrily 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*G1*AB333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

Requirement: Optional

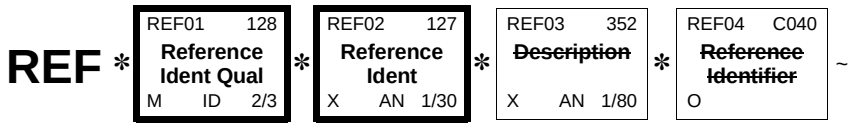
Max Use: 3

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
9F	**Referral Number**
G1	**Prior Authorization Number**

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

IMPLEMENTATION

OTHER PAYER 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 patients 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******EI*128848726~**

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:

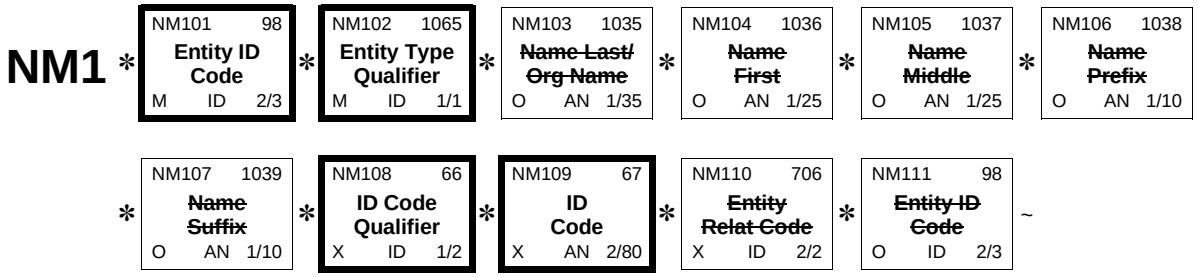
1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

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
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
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: EI — DEFINITION: Employee Identification Number CODE: MI — DEFINITION: Member Identification Number **The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number, therefore, the 837 Institutional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Medicaid Recipient ID, Health Insurance Claim Number (HIC), etc.**	X ID 1/2
REQUIRED	NM109	67	**Identification Code** Code identifying a party or other code INDUSTRY: ***Other Payer Patient Primary Identifier*** ALIAS: ***Patient's Other Payer Primary Identification Number*** SYNTAX: P0809	X AN 2/80
NOT USED	NM110	706	**Entity Relationship Code**	X ID 2/2
NOT USED	NM111	98	**Entity Identifier Code**	O ID 2/3

IMPLEMENTATION

OTHER PAYER PATIENT IDENTIFICATION NUMBER

Loop: **2330C — OTHER PAYER PATIENT INFORMATION**

Usage: **SITUATIONAL**

Repeat: **3**

Notes: **1. Used when a COB payer (listed in 2330B loop) has one or more proprietary patient identification numbers for this claim. The patient (name, DOB, etc) is identified in the 2010BA or 2010CA loop.**

Example: **REF*AZ*B333-Y5~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

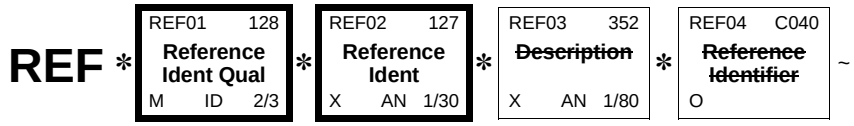
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1W	**Member Identification Number** **If NM108 = MI, this qualifier cannot be used.**
IG	**Insurance Policy Number**
SY	**Social Security Number** **Do not use this code for Medicare.**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Patient Secondary Identifier*** 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 ATTENDING PROVIDER

Loop: **2330D — OTHER PAYER ATTENDING 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*71*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

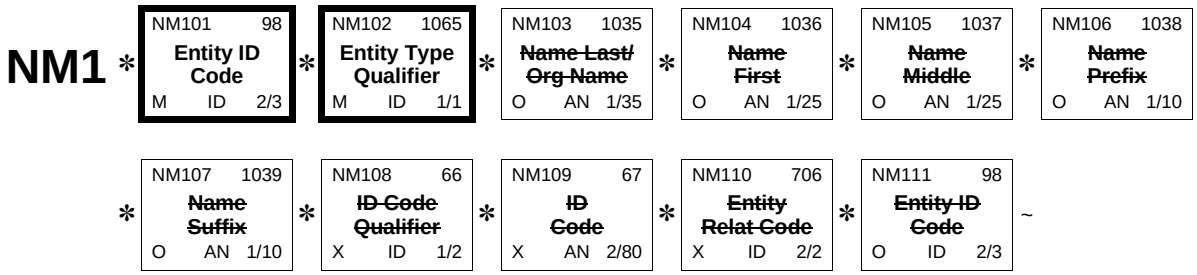
Max Use: 1

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 71 — Attending Physician	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE — DEFINITION 1 — Person 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 ATTENDING PROVIDER IDENTIFICATION

Loop: **2330D — OTHER PAYER ATTENDING PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*N5*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

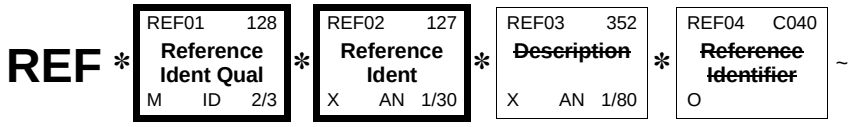
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**
EI	**Employer's Identification Number**

			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
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 Attending 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

OTHER PAYER OPERATING PROVIDER

Loop: **2330E — OTHER PAYER OPERATING 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*72*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

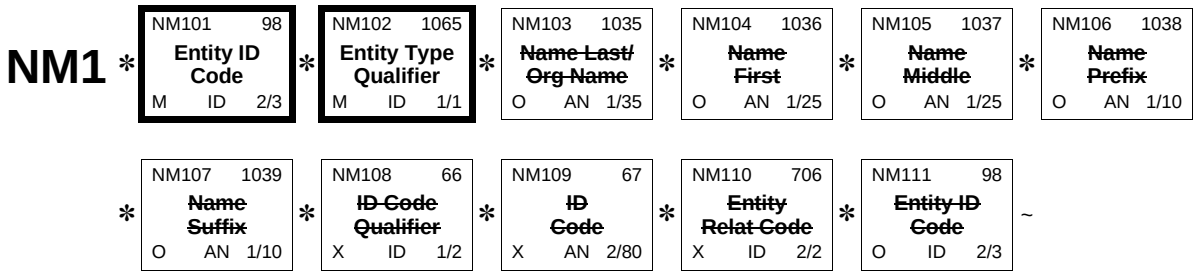
Max Use: 1

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: 72 — DEFINITION: Operating Physician	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M	ID	1/1
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 OPERATING PROVIDER IDENTIFICATION

Loop: **2330E — OTHER PAYER OPERATING PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Example: **REF*N5*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

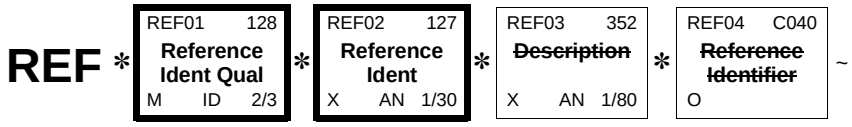
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**
EI	**Employer's Identification Number**
G2	**Provider Commercial Number**

			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
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 Operating 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

OTHER PAYER OTHER PROVIDER

Loop: **2330F — OTHER PAYER OTHER 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*73*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

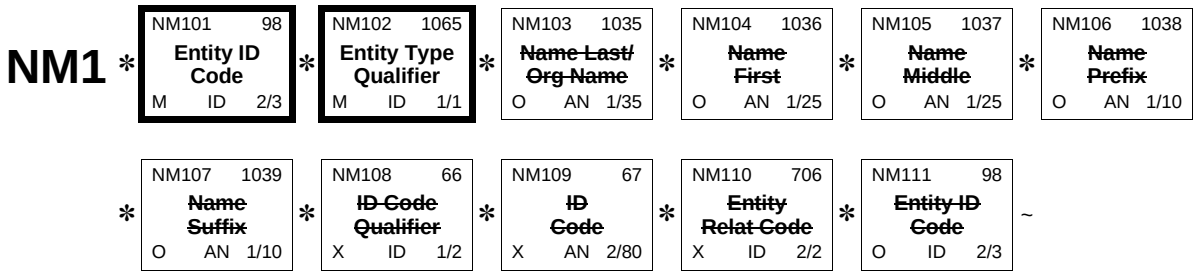
Set Notes:

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: 73 — DEFINITION: Other Physician	M	ID	2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person 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 OTHER PROVIDER IDENTIFICATION

Loop: **2330F — OTHER PAYER OTHER PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*N5*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

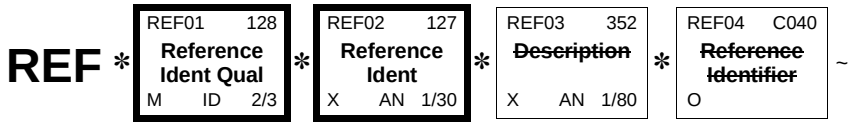
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
1H	**CHAMPUS Identification Number**
EI	**Employer's Identification Number**

			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
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 Other 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

OTHER PAYER REFERRING PROVIDER

Loop: **2330G — OTHER PAYER REFERRING PROVIDER** **Repeat:** **2**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.**
2. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.**

Example: **NM1*DN*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

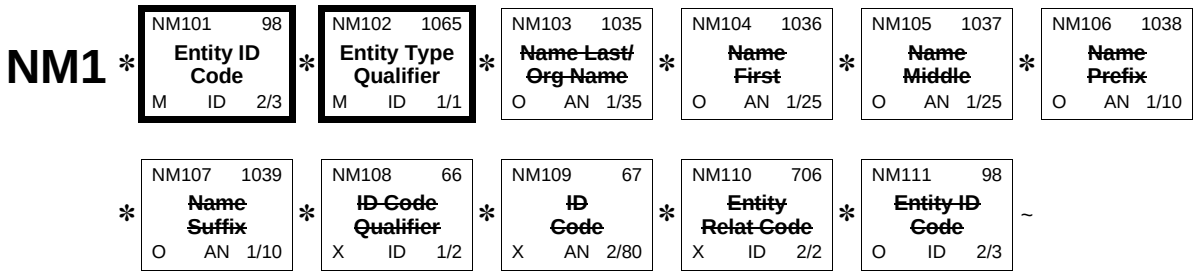
Max Use: 1

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	M	ID	2/3
			CODE / DEFINITION **DN** — **Referring Provider** **Use on first iteration of this loop. Use if loop is used only once.** **P3** — **Primary Care Provider** **Use only if loop is used twice. Use only on second iteration of this loop.**			
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. 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: **2330G — OTHER PAYER REFERRING PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*N5*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

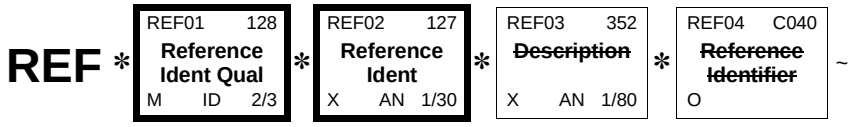
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
B3	**Preferred Provider Organization Number**
BQ	**Health Maintenance Organization Code Number**

			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Referring 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

OTHER PAYER SERVICE FACILITY PROVIDER

Loop: **2330H — OTHER PAYER SERVICE FACILITY 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*FA*1~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 325

Loop: 2330 **Repeat:** 10

Requirement: Optional

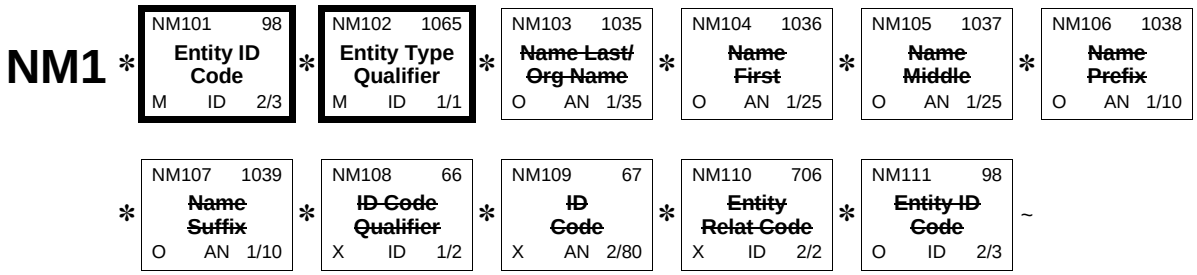
Max Use: 1

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: FA — DEFINITION: Facility	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
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 SERVICE FACILITY PROVIDER IDENTIFICATION

Loop: **2330H — OTHER PAYER SERVICE FACILITY PROVIDER**

Usage: **REQUIRED**

Repeat: **3**

Notes: **1. Non-destination (COB) payers' provider identification number(s).**

Example: **REF*N5*RF446~**

STANDARD

REF Reference Identification

Level: Detail

Position: 355

Loop: 2330

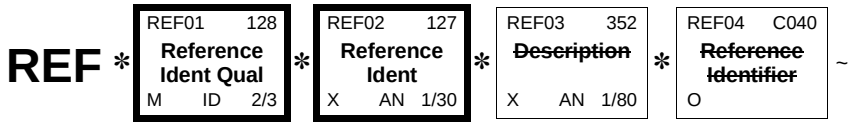
Requirement: Optional

Max Use: 3

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
EI	**Employer's Identification Number**
G2	**Provider Commercial Number**
LU	**Location Number**
N5	**Provider Plan Network Identification Number**

REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Other Payer Service Facility 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

SERVICE LINE NUMBER

Loop: **2400 — SERVICE LINE NUMBER Repeat: 999**

Usage: **REQUIRED**

Repeat: **1**

Notes:

1. **The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.**
2. **The 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.**

Example: **LX*1~**

STANDARD

LX Assigned Number

Level: Detail

Position: 365

Loop: 2400 **Repeat:** >1

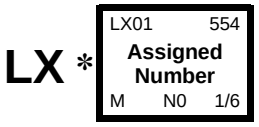
Requirement: Optional

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	**M**	**N0**	**1/6**
			This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.			

IMPLEMENTATION

INSTITUTIONAL SERVICE LINE

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **REQUIRED**

Repeat: **1**

Notes:
1. **This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication.**

Example: **SV2*300*HC:80019*73.42*UN*1~**

Example: **SV2*120**1500*DA*5*300~**

STANDARD

SV2 Institutional Service

Level: Detail

Position: 375

Loop: 2400

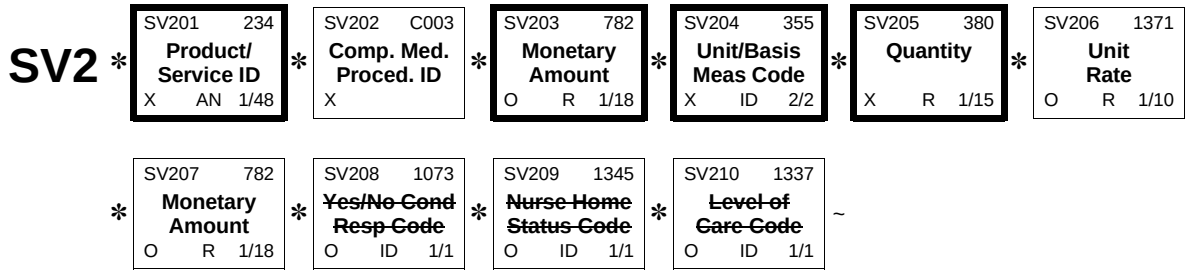
Requirement: Optional

Max Use: 1

Purpose: To specify the claim service detail for a Health Care institution

Syntax:
1. **R0102**
   At least one of SV201 or SV202 is required.
2. **P0405**
   If either SV204 or SV205 is present, then the other is required.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**SV201**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Service Line Revenue Code*** **SYNTAX:** R0102 **SEMANTIC:** SV201 is the revenue code. **UB-92 Reference [UB-92 Name]:** **42 [Revenue Code]** **EMC v.6.0 Reference:** **Record Type 50 Field No. 4, 11, 12, 13** **Record Type 60 Field No. 4, 13, 14** **Record Type 61 Field No. 4, 14, 15** **See Code Source 132: National Uniform Billing Committee (NUBC) Codes.**	**X AN 1/48**
SITUATIONAL	**SV202**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers *ALIAS:* ***Service Line Procedure Code*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** **This data element is required for all Outpatient claims.**	**X**
REQUIRED	**SV202 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE 240: National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE 240: National Drug Code by Format

			N3	**National Drug Code in 5-4-1 Format** CODE SOURCE **240:** National Drug Code by Format			
			N4	**National Drug Code in 5-4-2 Format** CODE SOURCE **240:** National Drug Code by Format			
			ZZ	**Mutually Defined** **Use code ZZ to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from:** **Division of Institutional Care** **Health Care Financing Administration** **S1-03-06** **7500 Security Boulevard** **Baltimore, MD 21244-1850**		
REQUIRED	**SV202 - 2**	**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code*** *ALIAS:* ***HCPCS Procedure Code*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** **EMC v.6.0 Reference:** **Record Type 60 Field No. 5, 13, 14** **Record Type 61 Field No. 5, 14, 15**	**M**	**AN**	**1/48**
SITUATIONAL	**SV202 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***HCPCS Modifier 1*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** **EMC v.6.0 Reference:** **Record Type 60 Field No. 9, 13, 14** **Record Type 61 Field No. 10, 14, 15** **Use this modifier for the first procedure code modifier.** **This data element is required when the Provider needs to convey additional clarification for the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SV202 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners *ALIAS:* ***HCPCS Modifier 2*** **UB-92 Reference [UB-92 Name]:** **44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]** **EMC v.6.0 Reference:** **Record Type 60 Field No. 7, 13, 14**	**O**	**AN**	**2/2**

Record Type 61 Field No. 7, 14, 15

Use this modifier for the second procedure code modifier.

See SV202-3

SITUATIONAL **SV202 - 5** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***HCPCS Modifier 3***

UB-92 Reference [UB-92 Name]:

44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]

See SV202-3

SITUATIONAL **SV202 - 6** **1339** **Procedure Modifier** **O AN 2/2**
This identifies special circumstances related to the performance of the service, as defined by trading partners

ALIAS: ***HCPCS Modifier 4***

UB-92 Reference [UB-92 Name]:

44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]

See SV202-3

NOT USED **SV202 - 7** **352** **Description** **O AN 1/80**

REQUIRED **SV203** **782** **Monetary Amount** **O R 1/18**
Monetary amount

INDUSTRY: ***Line Item Charge Amount***

ALIAS: ***Service Line Charge Amount***

SEMANTIC: SV203 is a submitted charge amount.

UB-92 Reference [UB-92 Name]:

47 [Total Charges (by Revenue Code Category)]

EMC v.6.0 Reference:

Record Type 50 Field No. 7, 11, 12, 13
Record Type 60 Field No. 9, 13, 14
Record Type 61 Field No. 10, 14, 15

Use this amount to indicate the submitted charge amount.

REQUIRED **SV204** **355** **Unit or Basis for Measurement Code** **X ID 2/2**
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

SYNTAX: P0405

CODE	DEFINITION
DA	**Days**
F2	**International Unit** **Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g. blood factors).**
UN	**Unit**

REQUIRED	**SV205**	**380**	**Quantity** Numeric value of quantity	**X**	**R**	**1/15**

INDUSTRY: ***Service Unit Count***

ALIAS: ***Service Line Units***

SYNTAX: P0405

UB-92 Reference [UB-92 Name]:

46 [Units of Service]

EMC v.6.0 Reference:

Record Type 50 Field No. 6, 11, 12, 13
Record Type 60 Field No. 8, 13, 14
Record Type 61 Field No. 8, 14, 15

SITUATIONAL	**SV206**	**1371**	**Unit Rate** The rate per unit of associate revenue for hospital accommodation	**O**	**R**	**1/10**

INDUSTRY: ***Service Line Rate***

ALIAS: ***Service Line Rate Amount***

UB-92 Reference [UB-92 Name]:

44 ("RATES") [HCPCS/Rates/HIPPS Rate Codes]

EMC v.6.0 Reference:

Record Type 50 Field No. 5, 11, 12, 13

This data element is required when the associated revenue code is 100-219.

SITUATIONAL	**SV207**	**782**	**Monetary Amount** Monetary amount	**O**	**R**	**1/18**

INDUSTRY: ***Line Item Denied Charge or Non-Covered Charge Amount***

ALIAS: ***Service Line Non-Covered Charge Amount***

SEMANTIC: SV207 is a noncovered charge amount.

UB-92 Reference [UB-92 Name]:

48 [Non-Covered Charges]

EMC v.6.0 Reference:

Record Type 50 Field No. 8, 11, 12, 13
Record Type 60 Field No. 10, 13, 14
Record Type 61 Field No. 11, 14, 15

Use this amount if needed to report line specific non-covered charge amount.

NOT USED	**SV208**	**1073**	**Yes/No Condition or Response Code**	**O**	**ID**	**1/1**
NOT USED	**SV209**	**1345**	**Nursing Home Residential Status Code**	**O**	**ID**	**1/1**
NOT USED	**SV210**	**1337**	**Level of Care Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

PRESCRIPTION NUMBER

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when a drug has been dispensed with an assigned Rx number.**

2. **In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.**

Example: **SV4*4466777TJ~**

STANDARD

SV4 Drug Service

Level: Detail

Position: 385

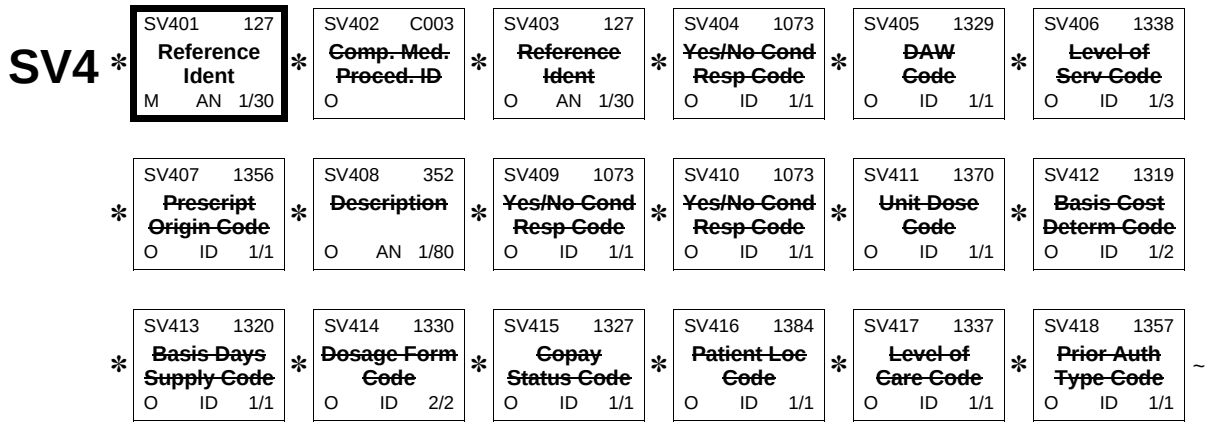
Loop: 2400

Requirement: Optional

Max Use: 1

Purpose: To specify the claim service detail for prescription drugs

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	SV401	127	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Prescription Number*** SEMANTIC: SV401 is a prescription number.	M	AN	1/30
NOT USED	SV402	C003	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER**	O		
NOT USED	SV403	127	**Reference Identification**	O	AN	1/30
NOT USED	SV404	1073	**Yes/No Condition or Response Code**	O	ID	1/1
NOT USED	SV405	1329	**Dispense as Written Code**	O	ID	1/1
NOT USED	SV406	1338	**Level of Service Code**	O	ID	1/3
NOT USED	SV407	1356	**Prescription Origin Code**	O	ID	1/1
NOT USED	SV408	352	**Description**	O	AN	1/80
NOT USED	SV409	1073	**Yes/No Condition or Response Code**	O	ID	1/1
NOT USED	SV410	1073	**Yes/No Condition or Response Code**	O	ID	1/1
NOT USED	SV411	1370	**Unit Dose Code**	O	ID	1/1
NOT USED	SV412	1319	**Basis of Cost Determination Code**	O	ID	1/2
NOT USED	SV413	1320	**Basis of Days Supply Determination Code**	O	ID	1/1
NOT USED	SV414	1330	**Dosage Form Code**	O	ID	2/2
NOT USED	SV415	1327	**Copay Status Code**	O	ID	1/1
NOT USED	SV416	1384	**Patient Location Code**	O	ID	1/1
NOT USED	SV417	1337	**Level of Care Code**	O	ID	1/1
NOT USED	SV418	1357	**Prior Authorization Type Code**	O	ID	1/1

IMPLEMENTATION

LINE SUPPLEMENTAL INFORMATION

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **5**

Notes:

1. **The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope unless reporting Home Infusion (see codes AD & AF in PWK02).**

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

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

Example: **PWK*B2*AA***AC*29438476~**

STANDARD

PWK Paperwork

Level: Detail

Position: 420

Loop: 2400

Requirement: Optional

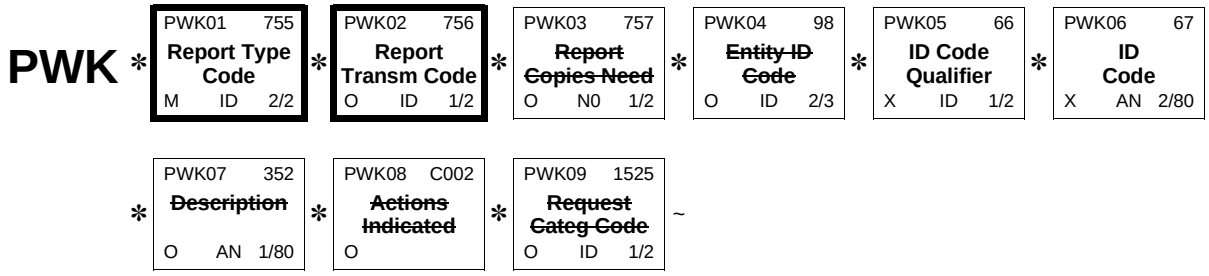
Max Use: 10

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

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

INDUSTRY: ***Attachment Report Type Code***

CODE	DEFINITION
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Referral Form
CT	Certification
DA	Dental Models
DG	Diagnostic Report
DS	Discharge Summary
EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
MT	Models
NN	Nursing Notes
OB	Operative Note
OZ	Support Data for Claim
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report

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

INDUSTRY: ***Attachment Transmission Code***

Codes AB, AD, AF and AG are not in the ASC X12 004-010 Data Dictionary but are included in this guide to provide a standard way to report Home Infusion services until these codes are added to a later version of the 837. A Data Maintenance request for these codes is in the ASC X12 process. It is recommended that entities who have a need to submit or receive Home Infusion Services customize their 004-010 translator map to allow these exception codes.

CODE	DEFINITION
AA	**Available on Request at Provider Site** **Paperwork is available at the provider's site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at his or her request.**
AB	**Previously Submitted to Payer**
AD	**Certification Included in this Claim**
AF	**Narrative Segment Included in this Claim**
AG	**No Documentation is Required**
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)	**X**	**ID**	**1/2**

SYNTAX: P0506

COMMENT: PWK05 and PWK06 may be used to identify the addressee by a code number.

Required if PWK02 = "BM", "EL", "EM" or "FX"

CODE	DEFINITION
AC	**Attachment Control Number**

SITUATIONAL	**PWK06**	**67**	**Identification Code** Code identifying a party or other code	**X**	**AN**	**2/80**

INDUSTRY: ***Attachment Control Number***

SYNTAX: P0506

Required if PWK02 = "BM", "EL", "EM" or "FX"

NOT USED	PWK07	352	Description	O	AN	1/80
NOT USED	PWK08	C002	ACTIONS INDICATED	O		
NOT USED	PWK09	1525	Request Category Code	O	ID	1/2

IMPLEMENTATION

SERVICE LINE DATE

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required on outpatient claims when revenue, procedure, HIEC or drug codes are reported in the SV2 segment.**
2. **In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.**
3. **In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).**

Example: **DTP*472*D8*19960819~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

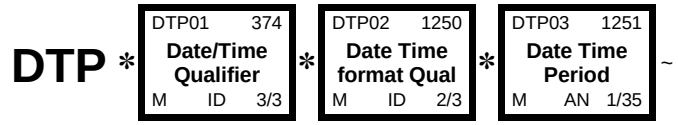
Loop: 2400

Requirement: Optional

Max Use: 15

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

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**DTP01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time	**M ID 3/3**

INDUSTRY: ***Date Time Qualifier***

CODE	DEFINITION
472	**Service** **Use RD8 in DTP02 to indicate begin/end or from/to dates.**

REQUIRED **DTP02** **1250** **Date Time Period Format Qualifier** **M ID 2/3**
Code indicating the date format, time format, or date and time format

SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.

CODE	DEFINITION
D8	**Date Expressed in Format CCYYMMDD**
RD8	**Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD** **Use RD8 if it is necessary to indicate begin/end dates. Date range indicates drug duration for which the supply of drug be will used by the patient. The difference in dates, including both the begin and end dates, are the days supply of the drug.** **Example: 20000101 - 20000107 (1/1/00 to 1/7/00) is used for a 7 day supply where the first day of the drug used by the patient is 1/1/00. In the event a drug is administered on less than a daily basis (e.g., every other day) the date range would include the entire period during which the drug was supplied, including the last day the drug was used.** **Example: 20000101 - 20000108 (1/1/00 to 1/8/00) is used for an 8 days supply where the prescription is written for Q48 (every 48 hours), four doses of the drug are dispensed and the first dose is used on 1/1/00.**

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

INDUSTRY: ***Service Date***

UB-92 Reference [UB-92 Name]:

45 [Service Date]

EMC v.6.0 Reference:

Record Type 60 Field No. 12, 13, 14

Record Type 61 Field No. 9, 14, 15

IMPLEMENTATION

ASSESSMENT DATE

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required when an assessment date is necessary (i.e. Medicare PPS processing).**
2. **Refer to Code Source 132 National Uniform Billing Committee (NUBC) Codes for instructions on the use of this date.**

Example: **DTP*866*19981210~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 455

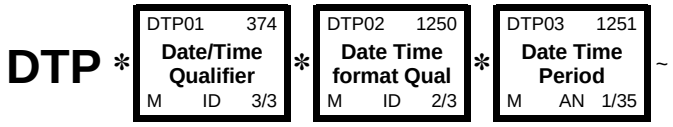
Loop: 2400

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**	
			866 Examination	
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: ***Assessment Date***

UB-92 Reference [UB-92 Name]:

45 [Service Date]

EMC v.6.0 Reference:

Record Type 60 Field No. 13

IMPLEMENTATION

SERVICE TAX AMOUNT

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when a service tax/surcharge applies to the service being reported in SV201.**

Example: **AMT*GT*15~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

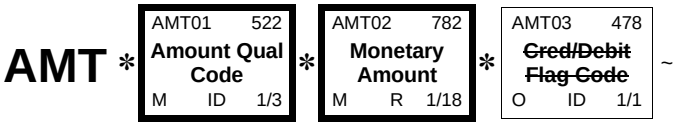
Loop: 2400

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			
			GT **Goods and Services Tax**			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Service Tax Amount***	**M**	**R**	**1/18**
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

FACILITY TAX AMOUNT

Loop: **2400 — SERVICE LINE NUMBER**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Required when a service tax/surcharge applies to the service being reported in SV201.**

Example: **AMT*N8*22~**

STANDARD

AMT Monetary Amount

Level: Detail

Position: 475

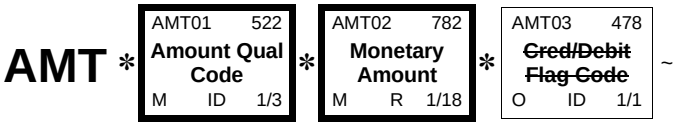
Loop: 2400

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			
			N8 Miscellaneous Taxes			
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M**	**R**	**1/18**
			*INDUSTRY: **Facility Tax Amount***			
NOT USED	**AMT03**	**478**	**Credit/Debit Flag Code**	**O**	**ID**	**1/1**

IMPLEMENTATION

ATTENDING PHYSICIAN NAME

Loop: **2420A — ATTENDING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
2. **Required if the Attending Provider NM1 information is different than that carried in the 2310A (claim) loop.**

Example: **NM1*71*1*JONES*JOHN***SR.*24*123456789~**

STANDARD

NM1 Individual or Organizational Name

Level: Detail

Position: 500

Loop: 2420 **Repeat:** 10

Requirement: Optional

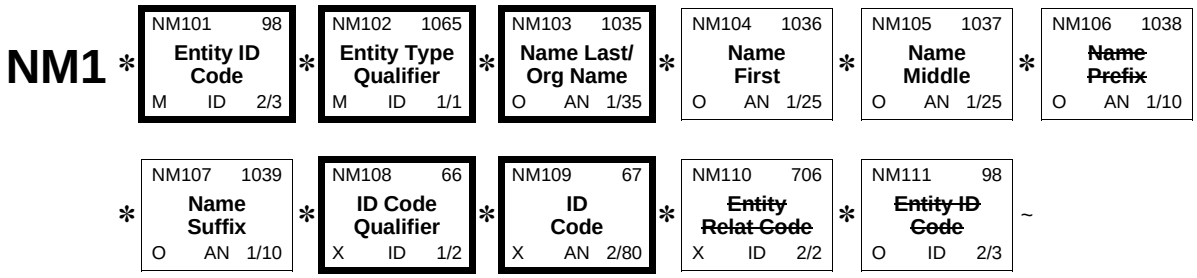
Max Use: 1

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



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 identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** CODE / DEFINITION **71 Attending Physician**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1 Person** **2 Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* *Attending Physician Last Name*** **Attending Provider Last Name**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:* *Attending Physician First Name*** **Required if NM102=1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:* *Attending Physician Middle 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:* *Attending Physician Name Suffix*** ***ALIAS:* *Attending Provider Generation*** **Required if known.**	**O AN 1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 CODE / DEFINITION **24 Employer's Identification Number**	**X ID 1/2**

			34 **Social Security Number** **Social Security Number cannot be used for Medicare claims.**			
			XX **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Attending Physician Primary Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
			Attending Provider Primary Identifier			
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

ATTENDING PHYSICIAN SPECIALTY INFORMATION

Loop: **2420A — ATTENDING PHYSICIAN NAME**

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. PRV02 qualifies PRV03.**

Example: **PRV*AT*ZZ*203BA0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

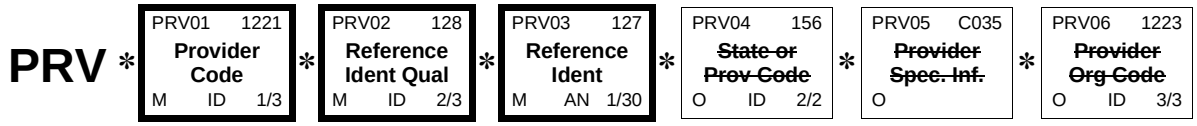
Loop: 2420

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			
			AT — **Attending**			
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.			
			CODE / DEFINITION			
			ZZ — **Mutually Defined** **Provider Taxonomy Code List**			

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

IMPLEMENTATION

ATTENDING PHYSICIAN SECONDARY IDENTIFICATION

Loop: **2420A — ATTENDING PHYSICIAN NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **REF*1D*AC12345H~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

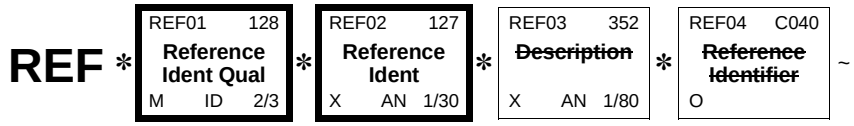
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			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:* ***Attending Physician 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

OPERATING PHYSICIAN NAME

Loop: **2420B — OPERATING PHYSICIAN NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

2. **Required if the Operating Physician NM1 information is different than that carried in the 2310B (claim) loop.**

Example: **NM1*72*1*MEYERS*JANE*I***34*129847263~**

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:

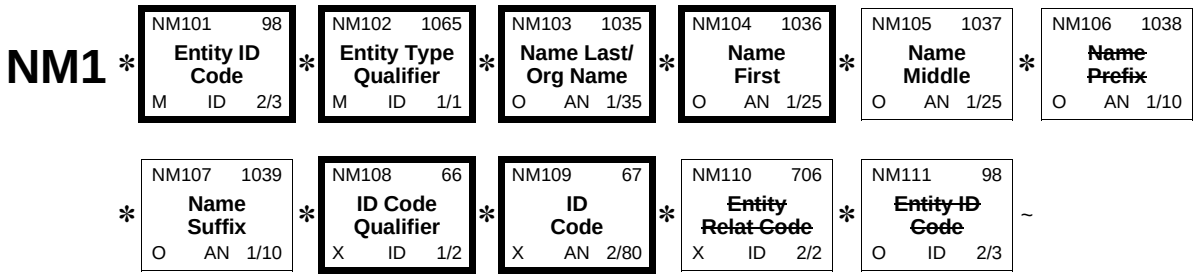
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

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: 72 — DEFINITION: Operating Physician	
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M ID 1/1
			CODE: 1 — DEFINITION: Person	
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Operating Physician Last Name***	O AN 1/35
REQUIRED	NM104	1036	**Name First** Individual first name *INDUSTRY: **Operating Physician First Name***	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Operating Physican Middle Name***	O AN 1/25
			Required when 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 *INDUSTRY: **Operating Physician Name Suffix*** *ALIAS: **Operating Physician Generation***	O AN 1/10
			Required if known.	
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: 24 — DEFINITION: Employer's Identification Number	
			CODE: 34 — DEFINITION: Social Security Number Social Security Number cannot be used for Medicare claims.	
			CODE: XX — DEFINITION: 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:* ***Operating Physician Primary Identifier*** *ALIAS:* ***Operating Physician Primary Identifier.*** 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

OPERATING PHYSICIAN SPECIALTY INFORMATION

Loop: **2420B — OPERATING PHYSICIAN NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when required by contract between the payer and the provider.**
2. **PRV02 qualifies PRV03.**

Example: **PRV*OP*ZZ*363LP0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

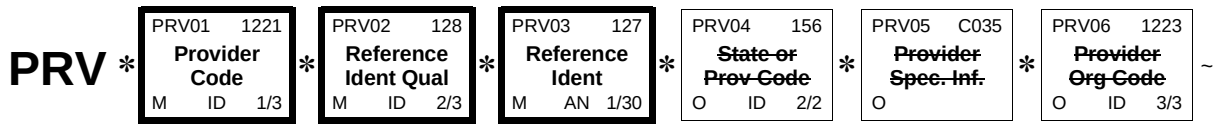
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
OP	**Operating**

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

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

CODE	DEFINITION
ZZ	**Mutually Defined** **Provider Taxonomy Code List**

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

IMPLEMENTATION

OPERATING PHYSICIAN SECONDARY IDENTIFICATION

Loop: **2420B — OPERATING PHYSICIAN NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **REF*1D*AC12345H~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

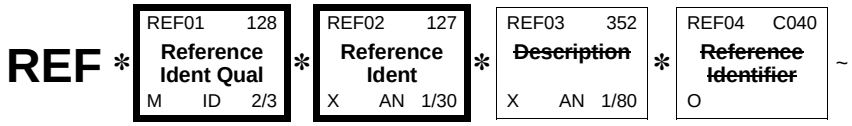
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**

			1H	**CHAMPUS Identification Number**		
			EI	**Employer's Identification Number**		
			G2	**Provider Commercial Number**		
			LU	**Location Number**		
			N5	**Provider Plan Network Identification Number**		
			SY	**Social Security Number** **The social security number may not be used for Medicare.**		
			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:* ***Operating Physician 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 PROVIDER NAME

Loop: **2420C — OTHER PROVIDER NAME Repeat: 1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 nomenclature.**
2. **Required if the Other Provider NM1 information is different than that carried in the 2310C (claim) loop.**
3. **Required on all outpatient and home health claims/encounters to indicate the person or organization (Home Health Agency) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.**
4. **Required on non-outpatient (e.g. Inpatient, SNF, ICF etc) claims or encounters to indicate the physician who rendered the service for the principal procedure if other than the operating physician reported in Loop ID-2420B.**

Example: **NM1*73*1*JONES*JOHN***SR.*24*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

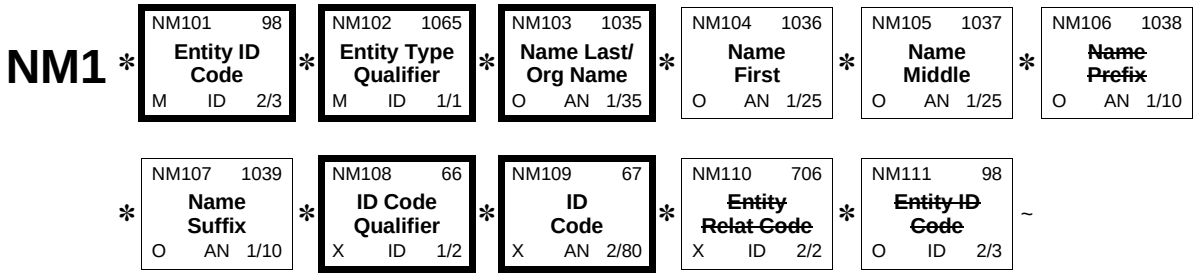
Set Notes:

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



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 identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** CODE / DEFINITION **73 Other Physician**	**M ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1 Person** **2 Non-Person Entity**	**M ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name ***INDUSTRY:* Other Physician Last Name** ***ALIAS:* Other Provider Last Name**	**O AN 1/35**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name ***INDUSTRY:* Other Physician First Name** **Required if NM102=1 (person).**	**O AN 1/25**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial ***INDUSTRY:* Other Provider Middle 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:* ***Other Provider Name Suffix*** *ALIAS:* ***Other Provider Generation*** **Required if known.**	**O**	**AN**	**1/10**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	**X**	**ID**	**1/2**

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

REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Provider Identifier*** *ALIAS:* ***Other Provider Primary Identifier*** 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 PROVIDER SPECIALTY INFORMATION

Loop: **2420C — OTHER PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **PRV*PE*ZZ*203BA0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

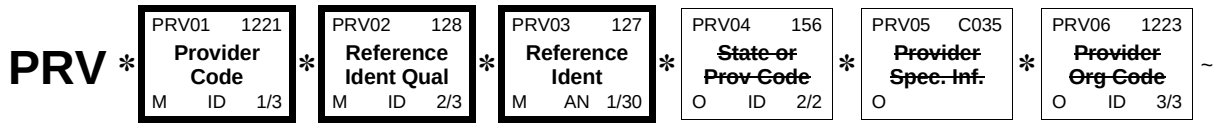
Loop: 2420

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
OT	**Other Physician** **Non-outpatient claims/encounters must use code value OT - Other in PRV01.**
PE	**Performing** **Outpatient and Home Health Agency claims and enounters must use code value PE - Performing in PRV01.**

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

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

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

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

INDUSTRY: ***Provider Taxonomy Code***

Provider Specialty Code

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

OTHER PROVIDER SECONDARY IDENTIFICATION

Loop: **2420C — OTHER PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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 NM109.**

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

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

Requirement: Optional

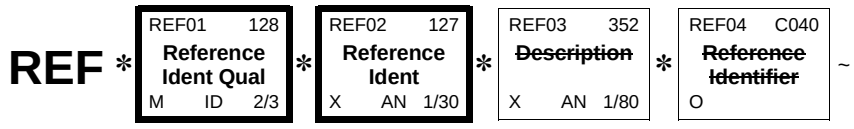
Max Use: 20

Purpose: To specify identifying information

Syntax:

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

DIAGRAM



ELEMENT SUMMARY

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

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

			1D	**Medicaid Provider Number**			
			1G	**Provider UPIN Number**			
			1H	**CHAMPUS Identification Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			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:* ***Other 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

REFERRING PROVIDER NAME

Loop: **2420D — REFERRING PROVIDER NAME** **Repeat:** **1**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

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

2. **Required if the Referring Provider NM1 information is different than that carried in the 2310D (claim) loop.**

Example: **NM1*DN*1*JONES*JOHN***SR.*24*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:

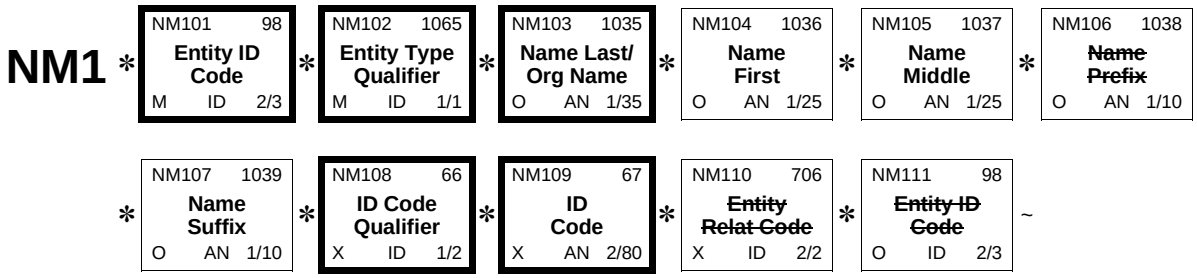
1. Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

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



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 identifier in NM101 applies to all segments in this iteration of Loop ID-2420.** CODE: DN — DEFINITION: Referring Provider	M ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person CODE: 2 — DEFINITION: Non-Person Entity	M ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name *INDUSTRY: **Referring Provider Last Name***	O AN 1/35
SITUATIONAL	NM104	1036	**Name First** Individual first name *INDUSTRY: **Referring Provider First Name*** **Required if NM102=1 (person).**	O AN 1/25
SITUATIONAL	NM105	1037	**Name Middle** Individual middle name or initial *INDUSTRY: **Referring Provider Middle 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: **Referring Provider Name Suffix*** *ALIAS: **Referring Provider Generation*** **Required if known.**	O AN 1/10
REQUIRED	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE: 24 — DEFINITION: Employer's Identification Number	X ID 1/2

			34 **Social Security Number** **Social Security Number cannot be used for Medicare claims.**			
			XX **Health Care Financing Administration National Provider Identifier** ***Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.***			
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code *INDUSTRY:* ***Other Physician Identifier*** SYNTAX: P0809	**X**	**AN**	**2/80**
			Referring Provider Primary Identifier			
NOT USED	**NM110**	**706**	**Entity Relationship Code**	**X**	**ID**	**2/2**
NOT USED	**NM111**	**98**	**Entity Identifier Code**	**O**	**ID**	**2/3**

IMPLEMENTATION

REFERRING PROVIDER SPECIALTY INFORMATION

Loop: **2420D — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

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

Example: **PRV*RF*ZZ*203BA0200N~**

STANDARD

PRV Provider Information

Level: Detail

Position: 505

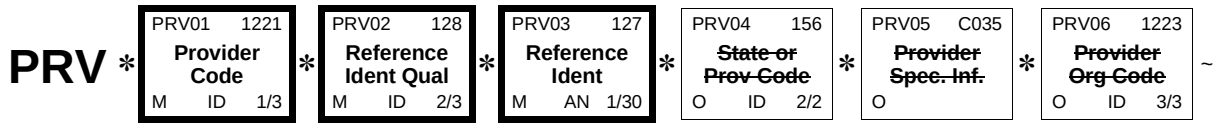
Loop: 2420

Requirement: Optional

Max Use: 1

Purpose: To specify the identifying characteristics of a provider

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
RF	**Referring**

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

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

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

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

IMPLEMENTATION

REFERRING PROVIDER SECONDARY IDENTIFICATION

Loop: **2420D — REFERRING PROVIDER NAME**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used if needed to convey an additional identifier.**

Example: **REF*1G*A12345~**

STANDARD

REF Reference Identification

Level: Detail

Position: 525

Loop: 2420

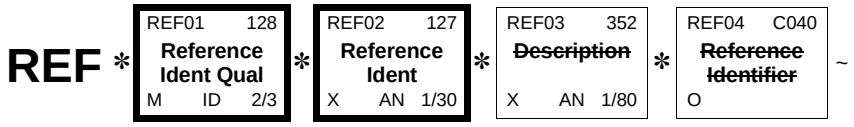
Requirement: Optional

Max Use: 20

Purpose: To specify identifying information

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

DIAGRAM



ELEMENT SUMMARY

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

CODE	DEFINITION
0B	**State License Number**
1A	**Blue Cross Provider Number**
1B	**Blue Shield Provider Number**
1C	**Medicare Provider Number**
1D	**Medicaid Provider Number**
1G	**Provider UPIN Number**
B3	**Preferred Provider Organization Number**

			BQ	**Health Maintenance Organization Code Number**			
			EI	**Employer's Identification Number**			
			G2	**Provider Commercial Number**			
			LU	**Location Number**			
			N5	**Provider Plan Network Identification Number**			
			SY	**Social Security Number** **The social security number may not be used for Medicare.**			
			X5	**State Industrial Accident Provider Number**			
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier *INDUSTRY:* ***Referring Provider Secondary Identifier*** SYNTAX: R0203		**X**	**AN**	**1/30**
NOT USED	**REF03**	**352**	**Description**		**X**	**AN**	**1/80**
NOT USED	**REF04**	**C040**	**REFERENCE IDENTIFIER**		**O**		

IMPLEMENTATION

SERVICE LINE ADJUDICATION INFORMATION

Loop: **2430 — SERVICE LINE ADJUDICATION INFORMATION Repeat: 25**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:

1. **Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.**
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 nomenclature.**
3. **To show unbundled lines: if in the original claim, line 3 is unbundled into lines numbers 8 and 9, then in the secondary claim, LX08 would show 3 in SVD06 and LX09 would also show 3 in SVD06. This indicates that line 3 was unbundled into lines 8 and 9.**
4. **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.**

Example: **SVD*NR002*50.5**0305*1~**

STANDARD

SVD Service Line Adjudication

Level: Detail

Position: 540

Loop: 2430 **Repeat:** >1

Requirement: Optional

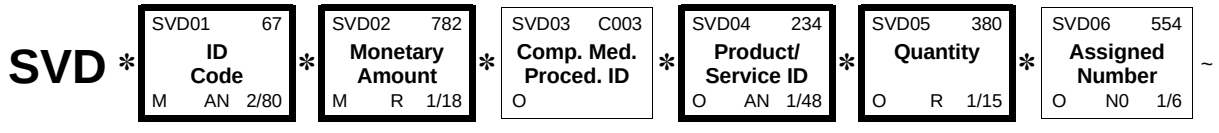
Max Use: 1

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:* ***Payer Identifier*** **SEMANTIC:** SVD01 is the payer identification code. **EMC v.6.0 Reference:** **Record Type 30 Field No. 5, 6 (This must match one of the corresponding loops: 2010BC - Payer Name, or 2330B - Other Payer Name.)**	**M AN 2/80**
REQUIRED	**SVD02**	**782**	**Monetary Amount** Monetary amount *INDUSTRY:* ***Service Line Paid Amount*** *ALIAS:* ***Service Line Amount Paid*** **SEMANTIC:** SVD02 is the amount paid for this service line.	**M R 1/18**
SITUATIONAL	**SVD03**	**C003**	**COMPOSITE MEDICAL PROCEDURE IDENTIFIER** To identify a medical procedure by its standardized codes and applicable modifiers **Required when returned on an 835 payment for this claim or when needed to identify the service line adjudicated.**	**O**
REQUIRED	**SVD03 - 1**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) *INDUSTRY:* ***Product or Service ID Qualifier***	**M ID 2/2**

CODE	DEFINITION
HC	**Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes** **Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.**
	CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System
IV	**Home Infusion EDI Coalition (HIEC) Product/Service Code**
	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List
N1	**National Drug Code in 4-4-2 Format**
	CODE SOURCE 240: National Drug Code by Format
N2	**National Drug Code in 5-3-2 Format**
	CODE SOURCE 240: National Drug Code by Format
N3	**National Drug Code in 5-4-1 Format**
	CODE SOURCE 240: National Drug Code by Format
N4	**National Drug Code in 5-4-2 Format**
	CODE SOURCE 240: National Drug Code by Format

			ZZ	**Mutually Defined** **Use code ZZ to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code.**			
REQUIRED	**SVD03 - 2**		**234**	**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Procedure Code*** **This code list is available from:** **Division of Institutional Care** **Health Care Financing Administration** **S1-03-06** **7500 Security Boulevard** **Baltimore, MD 21244-1850**	**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 **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 4**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 5**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 6**		**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners **Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.**	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 7**		**352**	**Description** A free-form description to clarify the related data elements and their content *INDUSTRY:* ***Procedure Code Description*** **Required if SVC01-7 was returned in the 835 transaction.**	**O**	**AN**	**1/80**
REQUIRED	**SVD04**	**234**		**Product/Service ID** Identifying number for a product or service *INDUSTRY:* ***Service Line Revenue Code*** **SEMANTIC:** SVD04 is the revenue code. **EMC v.6.0 Reference:** **Record Type 52 Field No. 5** **Record Type 62 Field No. 5** **Record Type 63 Field No. 5**	**O**	**AN**	**1/48**

REQUIRED	**SVD05**	**380**	**Quantity** Numeric value of quantity	**O**	**R**	**1/15**

INDUSTRY: ***Adjustment Quantity***

ALIAS: ***Paid Units of Service***

SEMANTIC: SVD05 is the paid units of service.

Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.

SITUATIONAL	**SVD06**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set	**O**	**N0**	**1/6**

INDUSTRY: ***Bundled or Unbundled Line Number***

COMMENT: SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.

Use the LX from this transaction which points to the bundled/unbundled line.

Required if payer bundled/unbundled this service line.

IMPLEMENTATION

SERVICE LINE ADJUSTMENT

Loop: **2430 — SERVICE LINE ADJUDICATION INFORMATION**

Usage: **SITUATIONAL**

Repeat: **99**

Notes:

1. **Inpatient or Outpatient - Service Line Adjustments**
2. **Submitters should use this CAS segment to report line level adjustments from prior payments which cause the amount paid to differ from the amount originally charged.**
3. **The Claim Adjustment Reason codes are located on the Washington Publishing Company web site http://www.wpc-edi.com.**
4. **Required when the prior payment had service line adjustments reported on a remittance.**

Example: **CAS*CO*A1*25~**

STANDARD

CAS Claims Adjustment

Level: Detail

Position: 545

Loop: 2430

Requirement: Optional

Max Use: 99

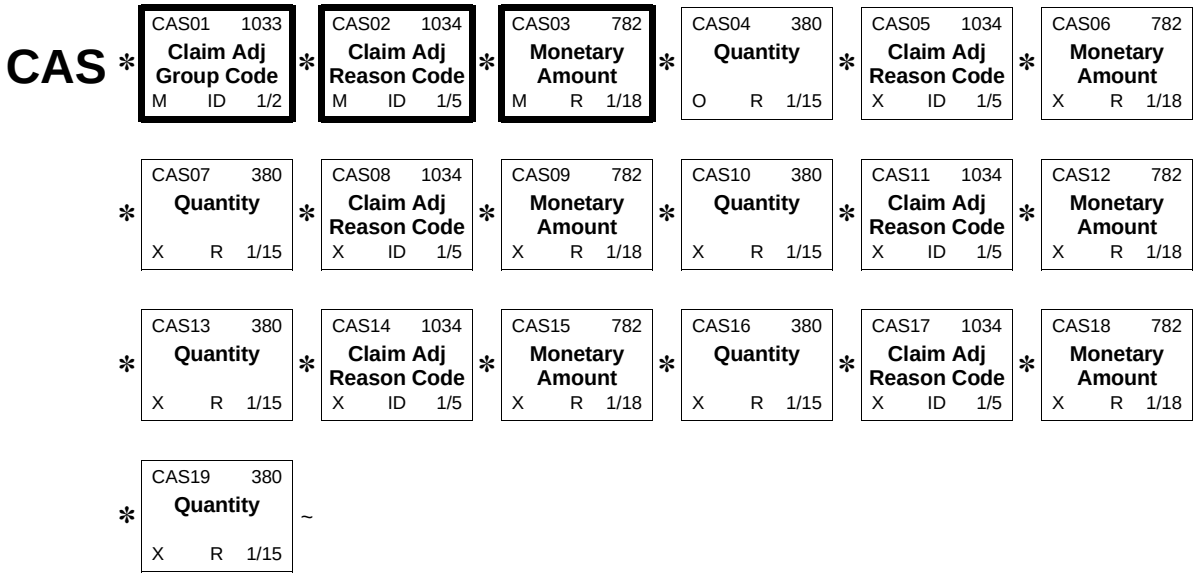
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

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	**M ID 1/2**

EMC v.6.0 Reference:

Record Type 52 Field No. 6

Record Type 63 Field No. 6

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*** **CODE SOURCE 139:** Claim Adjustment Reason Code **EMC v.6.0 Reference:** **Record Type 52 Field No. 7** **Record Type 63 Field No. 7**	**M**	**ID**	**1/5**
REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount *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. **EMC v.6.0 Reference:** **Record Type 52 Field No. 8** **Record Type 63 Field No. 8** **Use this amount for the amount of adjustment.** **Use this amount for the charges applied to the preceding reason code.**	**M**	**R**	**1/18**
SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity *INDUSTRY:* ***Adjustment Quantity*** **SEMANTIC:** CAS04 is the units of service being adjusted. **EMC v.6.0 Reference:** **Record Type 52 Field No. 9** **Record Type 63 Field No. 9** **Use this value for the quantity applied to the preceding reason code.**	**O**	**R**	**1/15**
SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made *INDUSTRY:* ***Adjustment Reason Code*** **SYNTAX:** L050607, C0605, C0705 **CODE SOURCE 139:** Claim Adjustment Reason Code **EMC v.6.0 Reference:** **Record Type 52 Field No. 10** **Record Type 63 Field No. 10** **See CAS02**	**X**	**ID**	**1/5**

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 11

Record Type 63 Field No. 11

Use this amount for the charges applied to the preceding reason code.

See CAS03

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 12

Record Type 63 Field No. 12

Use this value for the quantity applied to the preceding reason code.

See CAS04

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

EMC v.6.0 Reference:

Record Type 52 Field No. 13

Record Type 63 Field No. 13

See CAS02

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 14

Record Type 63 Field No. 14

Use this amount for the charges applied to the preceding reason code.

See CAS03

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 15

Record Type 63 Field No. 15

Use this value for the quantity applied to the preceding reason code.

See CAS04

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

EMC v.6.0 Reference:

Record Type 52 Field No. 16

Record Type 63 Field No. 16

See CAS02

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 17

Record Type 63 Field No. 17

Use this amount for the charges applied to the preceding reason code.

See CAS03

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 18

Record Type 63 Field No. 18

Use this value for the quantity applied to the preceding reason code.

See CAS04

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

EMC v.6.0 Reference:

Record Type 52 Field No. 19

Record Type 63 Field No. 19

See CAS02

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 20

Record Type 63 Field No. 20

Use this amount for the charges applied to the preceding reason code.

See CAS03

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 21

Record Type 63 Field No. 21

Use this value for the quantity applied to the preceding reason code.

See CAS04

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

EMC v.6.0 Reference:

Record Type 52 Field No. 22

Record Type 63 Field No. 22

See CAS02

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 23

Record Type 63 Field No. 23

Use this amount for the charges applied to the preceding reason code.

See CAS03

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.

EMC v.6.0 Reference:

Record Type 52 Field No. 24

Record Type 63 Field No. 24

Use this value for the quantity applied to the preceding reason code.

See CAS04

IMPLEMENTATION

SERVICE ADJUDICATION DATE

Loop: **2430 — SERVICE LINE ADJUDICATION INFORMATION**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. This segment is required when Service line adjudication has been performed.**

Example: **DTP*573*D8*19981226~**

STANDARD

DTP Date or Time or Period

Level: Detail

Position: 550

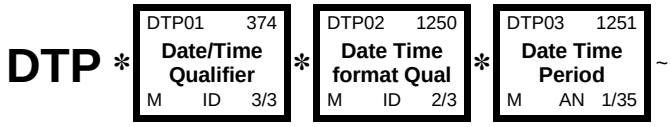
Loop: 2430

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*** 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:* ***Service Adjudication or Payment Date***	**M AN 1/35**

IMPLEMENTATION

TRANSACTION SET TRAILER

Usage: **REQUIRED**

Repeat: **1**

Example: **SE*1230*987654~**

STANDARD

SE Transaction Set Trailer

Level: Detail

Position: 555

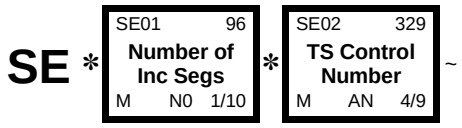
Loop: ____

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 **SE02 must match ST02.**	**M AN 4/9**

4 EDI Transmission Examples for Different Business Uses

4.1 Institutional

4.1.1 Business Scenario 1 — 837 Institutional Claim

Patient is the same person as the Subscriber. The Primary Payer is Medicare and the Secondary payer is State Teachers. The bill is a 141 Type of Bill.

Primay Payer Subscriber: John T Doe
Subscriber Address: 125 City Avenue, Centerville, PA 17111
Sex: M
DOB: 11/11/1926
Medicare Insurance ID#: 030005074A
Payer ID #: 00435

Patient: Same as Primary Subscriber

Destination Payer: Medicare B

Submitter: Jones Hospital
EDI #: 12345

Receiver: Medicare
EDI #: 00120

Billing Provider: Jones Hospital
Medicare Provider #330127
Address: 225 Main Street Barkley Building
Centerville, PA 17111

Attending Physician: John J Jones
UPIN # B99937

Patient Account Number: 756048Q
Date of Admission: 09/11/96
Statement Period Date: 09/11/96 - 09/11/96
Place of Service: Inpatient Hospital
Occurrence Codes and Dates:
A1 11/11/26
A2 11/01/91
B1 11/11/26
B2 01/01/87
Condition Codes:
09
Value Codes:
A2 $15.31
ICD-9 Procedure Codes and Dates:
15.3 09/11/96
Principal Diagnosis Code:
366.9
Secondary Diagnosis Codes:

401.9
794.31
Number of Covered Days: 1

Services:
Institutional Services Rendered:
Revenue Code: 305 HCPCS Procedure Code: 85025 Unit: 1 Price $13.39
Revenue Code: 730 HCPCS Procedure Code: 93005 Unit: 1 Price: $76.54
Total Charges: $89.93

Secondary Payer Subscriber: Jane S Doe (wife)
Subscriber Address: 125 City Avenue, Centerville, PA 17111
Sex: M
DOB: 11/11/1926
State Teachers ID#: 222004433
Payer ID #: 1135

Complete Data String:

```
ST*837*987654~
BHT*0019*00*0123*19960918*0932*CH~
REF*87*004010X096~
NM1*40*2*MEDICARE*****46*00120~
PER*IC*JANE DOE*TE*9005555555~
NM1*41*2*JONES HOSPITAL*****46*12345~
HL*1**20*1~
PRV*BI*ZZ*203BA0200N~
NM1*85*2*JONES HOSPITAL*****XX*330127~
PRV*AT*ZZ*363LP0200N~
N3*225 MAIN STREET BARKLEY BUILDING~
N4*CENTERVILLE*PA*17111~
REF*G2*987654080~
HL*2*1*22*0~
SBR*P*18*******MB~
NM1*IL*1*DOE*JOHN*T***MI*030005074A~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
DMG*D8*19261111*M~
NM1*PR*2*MEDICARE B*****PI*00435~
CLM*756048Q*89.93***14:A:1**Y*Y*Y~
DTP*434*D8*19960911~
CL1*3*1~
HI*BK:366.9~
HI*BF:401.9*BF:794.31~
HI*BQ:15.3:D8:19960911~
HI*BH:A1:D8:19261111*BH:A2:D8:19911101*
BH:B1:D8:19261111*BH:B2:D8:19870101~
HI*BE:A2:::15.31~
HI*BG:09~
```

```
NM1*71*1*JONES*JOHN*J***XX*B99937~
PRV*AT*ZZ*363LP0200N~
SBR*S*01*351630*STATE TEACHERS*GP****CI~
DMG***F~
OI***Y***Y~
NM1*IL*1*DOE*JANE*S***MI*222004433~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
NM1*PR*2*STATE TEACHERS*****PI*1135~
LX*1~
SV2*305*HC:85025*13.39*UN*1~
DTP*472*D8*19960911~
LX*2~
SV2*730*HC:93005*76.54*UN*3~
DTP*472*D8*19960911~
SE*44*987654~
```

4.1.2 Business Scenario 2 — 837 Institutional PPO Repriced Claim

Patient is a different person than the Subscriber. Payer is a commercial health insurance company. The bill has been repriced by a third party PPO vendor.

Subscriber: Lance D. Bozarth
Subscriber Address: 5707 Fern Flower Dr., Columbia, Mo., 65202
Sex: M
DOB: 04/16/68
Employer: Acme, Inc.
Group #: HG00003
Key Insurance Company ID #: 327621135 03
SSN: 327-62-1135

Patient: Maggie B. Bozarth
Address: 5707 Fern Flower Dr., Columbia, Mo., 65202
Sex: F
DOB: 11/25/69
Key Insurance Company ID #: 327621135 03
SSN: 329-52-4430

Destination Payer: Key Insurance Company
Address: 523 Jersey Ave., Columbia, Mo. 65202

Receiver: Key Insurance Company
EDI #: 66783JJT

Billing Provider: General Hospital
Address: 125 Virginia Ave., Bloomington, Il. 61701
Telephone: (309) 454-1222
TIN: 370673111

Attending Provider: Harold Nordstrum
TIN: 572999543

Patient Account Number: 7-225-5589
Case: Mild Hyperemesis
Date of Admission: 12/22/96
Admit Time: 0930
Date of Discharge: 12/24/96
Discharge Time: 1630
Place of Service: Inpatient Hospital

Services:
Institutional Services Rendered: Room and Board (RC 120) 2 days $802.00, Pharmacy (RC 250) $354.49, IV Solutions (RC 258) $949.68, Medical-Surgical Supplies (RC 270) $112.02, Laboratory (RC 300) $375.50 Total Charges: $2593.69

PPO Repricing Vendor/Sender: HealthCare PPO
Pricing Methodology: Per Diem Pricing (06)
Allowed Amount: $2040.00
Savings Amount: $ 553.69
Repricing Orginization ID #: 252665599
Repriced Claim Reference #: 6003E0332701
EDI #: 962TT8R

Complete Data String:

```
ST*837*987655~
BHT*0019*00*0124*19970103*0936*CH~
REF*87*004010X096~
NM1*41*2*HEALTHCARE PPO*****46*TGJ23~
NM1*40*2*KEY INSURANCE COMPANY*****46*962TT8R~
HL*1**20*1~
PRV*BI*ZZ*203BA0200N~
NM1*85*2*GENERAL HOSPITAL*****FI*370673111~
N3*125 VIRGINIA AVE~
N4*BLOOMINGTON*IL*61701~
HL*2*1*22*1~
SBR*P********CI~
NM1*IL*1*BOZARTH*LANCE*D***MI*32762113503~
N3*5707 FERN FLOWER DR~
N4*COLUMBIA*MO*65202~
REF*SY*327621135~
NM1*PR*2*KEY INSURANCE COMPANY*****PI*66783JJT~
HL*3*2*23*0~
PAT*01~
NM1*QC*1*BOZARTH*MAGGIE*B~
N3*5707 FERN FLOWER DR~
N4*COLUMBIA*MO*65202~
DMG*D8*19691125*F~
REF*SY*329524430~
CLM*72255589*2593.69***11:A:1***Y*Y~
```

```
DTP*434*RD8*19961222-19961224~
DTP*435*DT*199612220930~
DTP*096*TM*1630~
QTY*CA*2*DA~
CL1*3*1*01~
REF*9A*6003E0332701~
HI*BK:643.03~
HCP*06*2040*553.69*252665599~
NM1*71*1*NORDSTRUM*HAROLD****XX*572999543~
PRV*AT*ZZ*363LP0200N~
LX*1~
SV2*120**802*DA*2~
LX*2~
SV2*250**354.49*UN*1~
LX*3~
SV2*258**949.68*UN*1~
LX*4~
SV2*270**112.02*UN*1~
LX*5~
SV2*300**375.5*UN*1~
SE*47*987655~
```

4.1.3 Business Scenario 3 — Two Claims for the Same Provider

This example combines two claims for the same provider.

```
ST*837*987654~
BHT*0019*00*0123*19960918*0932CH~
REF*87*004010X096~
NM1*40*2*MEDICARE*****46*00120~
NM1*41*2*JONES HOSPITAL*****46*12345~
HL*1**20*1~
PRV*BI*ZZ*203BA0200N~
NM1*85*2*JONES HOSPITAL*****XX*330127~
N3*225 MAIN STREET BARKLEY BUILDING~
N4*CENTERVILLE*PA*17111~
REF*G2*987654080~
HL*2*1*22*1~
SBR*P*18*******MB~
NM1*IL*1*DOE*JOHN*T***MI*030005074A~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
DMG*D8*19261111*M~
NM1*PR*2*MEDICARE B*****PI*00435~
```

```
CLM*756048Q*89.93***14:A:1**Y*Y*Y~
DTP*434*D8*19960911~
CL1*3*1~
HI*BK:366.9~
HI*BF:401.9*BF:794.31~
HI*BQ:15.3:D8:19960911~
HI*BH:A1:D8:19261111*BH:A2:D8:19911101*BH:B1:D8:192
61111*BH:B2:D8:19870101~
HI*BE:A2:::15.31~
HI*BG:09~
NM1*71*1*JONES*JOHN*J***XX*B99937~
PRV*AT*ZZ*363LP0200N~
SBR*S*01*351630*STATE TEACHERS*GP****CI~
DMG***F~
OI***Y***Y~
NM1*IL*1*DOE*JANE*S***MI*222004433~
N3*125 CITY AVENUE~
N4*CENTERVILLE*PA*17111~
NM1*PR*2*STATE TEACHERS*****PI*1135~
LX*1~
SV2*305*HC:85025*13.39*UN*1~
DTP*472*D8*19960911~
LX*2~
SV2*730*HC:93005*76.54*UN*3~
DTP*472*D8*19960911~
HL*3*1*22*0~
SBR*P*18*******MB~
NM1*IL*1*SMITH*JOE****MI*123405074A~
N3*5 MAIN STREET~
N4*CENTERVILLE*PA*17111~
DMG*D8*19120512*M~
NM1*PR*2*MEDICARE B*****PI*00435~
CLM*756049Q*50***13:A:1**Y*Y*Y~
DTP*434*D8*19960614~
CL1*3*1~
HI*BK:300.00~
NM1*71*1*JONES*JOHN*J***XX*B99937~
PRV*AT*ZZ*363LP0200N~
LX*1~
SV2*300*HC:85087*50*UN*1~
DTP*472*D8*19960911~
SE*58*987654~
```

4.2 Property and Casualty

Healthcare Bill to Property & Casualty Payer

This section outlines the requirements for submission of Healthcare bills to Property & Casualty payers to **ensure prompt processing, meet jurisdictional requirements,** and **avoid potential fines and penalties.**

837 Transaction Set

Bills resulting from accident or occupationally-related injuries and illnesses should be submitted to a Property & Casualty (P&C) payer. Because coverage is triggered by a specific event, certain information is critical for the payment process. Unlike health insurance where each bill is an individual claim, for P&C, a bill is a piece of information that needs to be associated with an event. The ensuing P&C claim includes both the bill information as well as the information on the event that caused the injury or illness. Information concerning the event is necessary to associate a medical bill with the P&C claim. P&C generally is governed by State Insurance Regulations, Departments of Labor, Worker's Compensation Boards, or other jurisdictionally defined entities, which often mandate compliance with jurisdiction-specific procedures.

The Business Need: Provider to P&C Payer Bill Transmission

- Date of Accident/Injury/Onset of Illness (Date of Loss) is a critical piece of information and should always be transmitted in the CLM11 segment of the 2300 Claim loop.
- A unique identification number, referred to in P&C as a "Claim Number," should be transmitted along with the bill information to expedite the adjudication of the bill for payment. This information can be transmitted in the REF segment of the 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 NM1 segment of Subscriber Loop ID-2010BA should be used to transmit the policy number as the Member Identification (MI).
- 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 Subscriber Loop ID-2010BA and the patient's name and Social Security Number in the NM1 segment of Patient 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 SV2 segment in Loop ID-2400 (Service Line Number loop) for clarity.

4.2.1 Business Scenario 1 — Homeowners/Casualty Claim

Claim Type: **Homeowners/Casualty Claim**
Type of Bill:
Primary Payer: **Property & Casualty Insurer**

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company.

Date of Accident: 03/17/97

Subscriber: Graig Norton
Subscriber Address: 72 Fairway Drive, Golfers Haven, FL, 91919
Policy Number: 970925824
Insurance Company: Last Chance Insurance Company
Claim Number: 88-N5223-71

Patient: William Clifton
Patient Address: 1600 Razorback Avenue, Little Rock, AR, 54321
Sex: M
DOB: 10/13/49

Destination Payer/Receiver: Last Chance Insurance Company
Payer Address: 1 Desert Line Road, Reno, NV, 44544
Payer ID: 123456789

Billing Provider/Sender: Duffer's Memorial Hospital
TIN: 444661111
National Provider Identifier: 111DM222
Address: 541 Dogleg Drive, Golfers Haven, FL, 91919

Pay-To-Provider: Duffer's Memorial Hospital

Attending Physician: Theodore Zeuss, MD
National Provider Identifier: 999DS427

Additional Physician: Ray Flood, MD (Radiologist)

Patient Account Number: 686868686
CASE: The patient was a guest in the subscriber's home when the patient fell and injured his low back.
DOS=03/18/97, POS=E/R, TOS=Outpatient

Diagnosis: 922.3 (Principle), 847.2 (Additional)

Services Rendered: Outpatient Emergency Room visit; x-ray of spine; and Attending Physician professional component.
CHARGES: E/R Room = $75.00, x-ray = $150.00, E/R Attending Physician = $225.00. Total charges = $450.00.

Electronic Route: Billing provider (sender) to payer (receiver) via LAN.

Complete Data String:

```
ST*837*987183~
BHT*0019*00*0123*970327*1410*CH~
REF*87*004010X096~
NM1*40*2*CBO*****46*1234~
NM1*41*2*INSURANCE CARRIER*****46*3214~
HL*1**20*1~
PRV*BI*ZZ*203BA0200N~
NM1*85*2*DUFFER'S MEMORIAL HOSPITAL
*****XX*111DM222~
N3*541 DOGLEG DRIVE~
N4*GOLFERS HAVEN*FL*91919~
REF*TJ*444661111~
HL*2*1*22*1~
SBR*P********LI~
NM1*IL*1*NORTON*GRAIG****MI*970925824~
N3*72 FAIRWAY DRIVE~
N4*GOLFERS HAVEN*FL*91919~
NM1*PR*2*LAST CHANCE INSURANCE COMPANY
*****XV*123456789~
HL*3*2*23*0~
PAT*41~
NM1*QC*1*CLIFTON*WILLIAM****34*686868686~
N3*1600 RAZORBACK AVENUE~
N4*LITTLE ROCK*AR*54321~
DMG*D8*19491013*M~
REF*D9*88N522371~
CLM*67129*450***13:A:1***Y*Y~
DTP*434*D8*19970318~
CL1*3*7*1~
HI*BK:922.3*BF:847.2~
NM1*71*1*ZEUSS*THEODORE****XX*999DS427~
PRV*AT*ZZ*363LP0200N~
NM1*73*1*FLOOD*RAY****XX*671RF535~
LX*1~
SV2*450*HC:98765*75*UN*1~
DTP*472*D8*19970318~
LX*2~
SV2*320*HC:72110*150*UN*1~
DTP*472*D8*19970318~
LX*3~
SV2*360*HC:99282*225*UN*1~
DTP*472*D8*19970318~
SE*41*987183~
```

4.2.2 Business Scenario 2 — Worker's Compensation

Claim Type: **Worker's Compensation**
Type of Bill:
Primary Payer: **Property & Casualty Insurer**

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company.

Date of Accident: 02/12/97

Subscriber: Jen & Barry's Ice Cream Shoppe
Subscriber Address: 123 Rocky Road, Cherry, VT, 55555
Policy Number: WC-96-2222-L
Insurance Company: Basket & Roberts Insurance Company
Claim Number: W9-1234-99

Patient: Penny Plump
Patient Address: 265 Double Dip Lane, Sugar Cone, VT, 55544
Sex: F
DOB: 02/11/77

Destination Payer/Receiver: Basket & Roberts Insurance Company
Payer Address: 31 Flavor Street
Payer ID: 345345345

Billing Provider/Sender: Pistachio Community Hospital
TIN: 877196543
National Provider Identifier: 222PC333
Address: 300 Cholesterol Court, Pistachio, VT, 55557

Pay-To-Provider: Pistachio Community Hospital

Attending Physician: Sam Sweettooth, MD

Additional Physician: Ray Gamma, MD (Radiologist)

Patient Account Number: 888-22-8888
CASE: The patient is an employee of subscriber. The patient slammed her thumb in the freezer case.
DOS=02/12/97, POS=E/R, TOS=Outpatient
SERVICES RENDERED: E/R Room visit, x-ray, E/R Attending Physician

Diagnosis: 816.02 (Principle), 354.0 (Additional)

Services Rendered: E/R Room, X-ray, Attending Physician.
CHARGES: E/R Room = $100.00, x-ray = $50.00, E/R Physician = $200.00. Total charges = $350.00

Electronic Route: Billing Service (Clearinghouse/sender), via VAN to Payer (receiver).

Complete Data String:

```
ST*837*987184~
BHT*0019*00*0124*19970331*1020*CH~
REF*87*004010X096~
NM1*41*2*PISTACHIO COMMUNITY HOSPITAL
*****46*877196543~
```

```
PER*IC*JANE DOE*TE*9005555555~
NM1*40*2*CBO*****46*1234~
HL*1**20*1~
PRV*BI*ZZ*203BA0200N~
NM1*85*2*PISTACHIO COMMUNITY HOSPITAL
*****XX*222PC333~
N3*300 CHOLESTEROL COURT~
N4*PISTACHIO*VT*55557~
REF*TJ*877196543~
HL*2*1*22*1~
SBR*P********WC~
NM1*IL*2*JEN & BARRY'S ICE CREAM
SHOPPE*****MI*WC962222L~
N3*123 ROCKY ROAD~
N4*CHERRY*VT*55555~
NM1*PR*2*BASKET & ROBERTS INSURANCE COMPANY
*****XV*345345345~
HL*3*2*23*0~
PAT*20~
NM1*QC*1*PLUMP*PENNY****34*888228888~
N3*265 DOUBLE DIP LANE~
N4*SUGAR CONE*VT*55544~
DMG*D8*19770211*F~
REF*D9*W9123499~
CLM*67188*350***13:A:1***Y*Y~
DTP*434*D8*19970318~
CL1*3*7*1~
HI*BK:816.02~
HI*BF:354.0~
HI*BR:79.04:D8:19970212~
NM1*71*1*SWEETTOOTH*SAM****XX*777ST123~
NM1*73*1*GAMMA*RAY****XX*555XR321~
LX*1~
SV2*450*HC:98765*100*UN*1~
DTP*472*D8*19970212~
LX*2~
SV2*320*HC:73140*50*UN*1~
DTP*472*D8*19970212~
LX*3~
SV2*360*HC:99283*200*UN*1~
DTP*472*D8*19970212~
SE*43*987184~
```

4.2.3 Business Scenario 3 — Automobile Accident

Claim Type: **Automobile Accident**
Type of Bill: **Hospital**
Primary Payer: **Property & Casualty Insurer**

The patient is a different person than the subscriber. The payer is a commercial Property & Casualty Insurance Company.

Date of Accident: 06/17/94

Subscriber: Hal Howling
Subscriber Address: 327 Bronco Drive, Getaway, CA, 99999
Policy Number: B999-777-91G
Insurance Company: Heisman Insurance Company
Claim Number: 32-3232-32

Patient: D.J. Dimpson
Patient Address: 32 Buffalo Run, Rocking Horse, CA, 99666
Sex: M
DOB: 06/01/48

Destination Payer/Receiver: Heisman Insurance Company
Payer Address: 1 Trophy Lane, NYAC, NY, 10032
Payer ID: 999888777

Billing Provider/Sender: Hall of Fame Memorial Hospital
TIN: 737373737
National Provider Identifier: 777TD777
Address: 1Canton Road, Broken Field, CA, 99998

Pay-To-Provider: Hall of Fame Memorial Hospital

Rendering Provider: Vincent Lombardo, MD

Patient Account Number: 000-00-0032
CASE: The patient was a passenger in the subscriber's automobile, and the patient reports that his hand was cut when the car was struck in the rear.

Diagnosis: 884.2, E975.0, E986.0

Services Rendered: Outpatient E/R visit, Laceration Repair, Histology Test
DOS=06/17/94, POS=E/R, TOS=Outpatient
CHARGES: E/R Room = $150.00, Laceration Repair = $75.00, DNA Test = $100.00, E/R Attending Physician = $220.00. Total charges = $545.00.

Electronic Route: Billing provider (sender) to payer (receiver) via VAN.

Complete Data String:

```
ST*837*987185~
BHT*0019*00*0324*19970331*1800*CH~
REF*87*004010X096~
NM1*41*2*INSURANCE CARRIER*****46*3214~
PER*IC*JANE DOE*TE*9005555555~
NM1*40*2*CBO*****46*1234~
HL*1**20*1~
PRV*BI*ZZ*203BA0200N~
```

```
NM1*85*2*HALL OF FAME MEMORIAL HOSPITAL
*****XX*888HF444~
N3*1 CANTON ROAD~
N4*BROKEN FIELD*CA*99998~
REF*TJ*737373737~
HL*2*1*22*1~
SBR*P********AM~
NM1*IL*1*HOWLING*HAL*****MI*B999777791G~
N3*327 BRONCO DRIVE~
N4*GETAWAY*CA*99999~
NM1*PR*2*HEISMAN INSURANCE COMPANY
*****XV*999888777~
HL*3*2*23*0~
PAT*41~
NM1*QC*1*DIMPSON*DJ****34*000000032~
N3*32 BUFFALO RUN~
N4*ROCKING HORSE*CA*99666~
DMG*D8*19480601*M~
REF*D9*32323232~
CLM*6721*545***13:A:1***Y*Y~
DTP*434*D8*19970318~
CL1*3*7*1~
HI*BK:884.2**BN:E986.0~
NM1*71*1*LOMBARDO*VINCENT****XX*777TD777~
LX*1~
SV2*450*HC:98765*150*UN*1~
DTP*472*D8*19940617~
LX*2~
SV2*360*HC:26591*75*UN*1~
DTP*472*D8*19970318~
LX*3~
SV2*312*HC:86225*100*UN*2~
DTP*472*D8*19940318~
LX*4~
SV2*360*HC:99283*220*UN*1~
DTP*472*D8*19940318~
SE*43*987185~
```

A ASC X12 Nomenclature

A.1 Interchange and Application Control Structures

A.1.1 Interchange Control Structure

The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction set.

Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. An analogy would be that the transaction set is like a freight train; the segments are like the train's cars; and each segment can contain several data elements the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12 standard as well as the sequence of segments in the transaction set. In a more conventional computing environment, the segments would be equivalent to records, and the elements equivalent to fields.

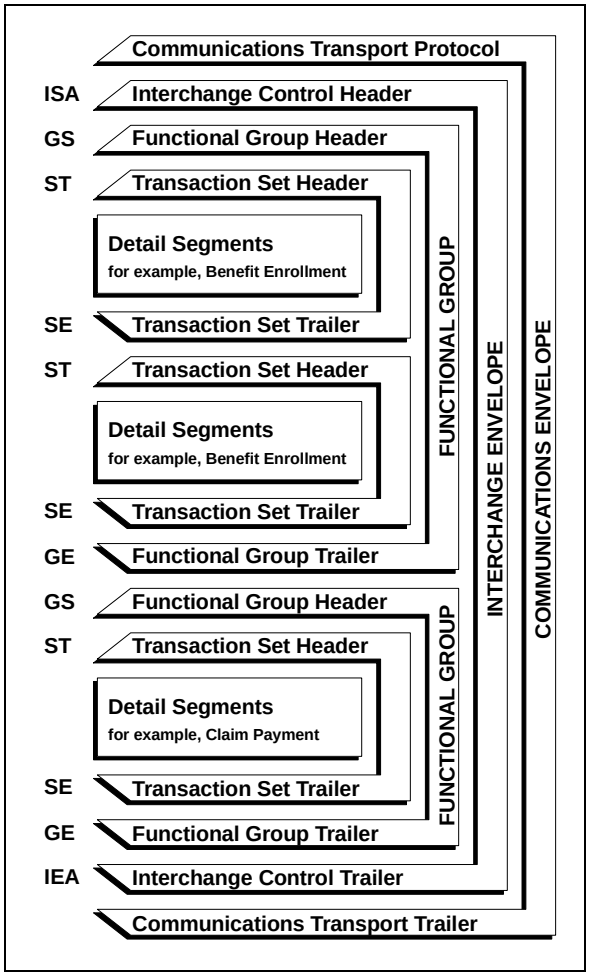


Figure A1. Transmission Control Schematic

Similar transaction sets, called "functional groups," can be sent together within a transmission. Each functional group is prefaced by a group start segment; and a functional group is terminated by a group end segment. One or more functional groups are prefaced by an interchange header and followed by an interchange trailer. Figure A1, Transmission Control Schematic, illustrates this interchange control.

The interchange header and trailer segments envelop one or more functional groups or interchange-related control segments and perform the following functions:

1. Define the data element separators and the data segment terminator.
2. Identify the sender and receiver.
3. Provide control information for the interchange.
4. Allow for authorization and security information.

A.1.2 Application Control Structure Definitions and Concepts

A.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. The data element is the smallest named item in the ASC X12 standard. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. A control segment has the same structure as a data segment; the distinction is in the use. The data segment is used primarily to convey user information, but the control segment is used primarily to convey control information and to group data segments.

A.1.2.2 Basic Character Set

The section that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein may be used as long as a common mapping is available. Because the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard, shown in figure A2, Basic Character Set, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z	**0...9**	**!**	**“**	**&**	**’**	**(**	**)**	*****	**+**
,	**-**	**.**	**/**	**:**	**;**	**?**	**=**	**“ ” (space)**	

Figure A2. Basic Character Set

A.1.2.3 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified in figure A3, Extended Character Set.

a..z	**%**	**~**	**@**	**[**	**]**	**_**	**{**
}	****	**|**	**<**	**>**	**#**	**$**	

Figure A3. Extended Character Set

Note that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears

in other standards such as CCITT S.5. Use of the USA graphics for these codes presents no problem unless data is exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

A.1.2.4 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the matrix A1, Base Control Set, the column IA5 represents CCITT V.3 International Alphabet 5.

A.1.2.5 Base Control Set

The base control set includes those characters that will not have a disruptive effect on most communication protocols. These are represented by:

NOTATION	NAME	EBCDIC	ASCII	IA5
BEL	bell	2F	07	07
HT	horizontal tab	05	09	09
LF	line feed	25	0A	0A
VT	vertical tab	0B	0B	0B
FF	form feed	0C	0C	0C
CR	carriage return	0D	0D	0D
FS	file separator	1C	1C	1C
GS	group separator	1D	1D	1D
RS	record separator	1E	1E	1E
US	unit separator	1F	1F	1F
NL	new line	15		

Matrix A1. Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

A.1.2.6 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in matrix A2, Extended Control Set.

NOTATION	NAME	EBCDIC	ASCII	IA5
SOH	start of header	01	01	01
STX	start of text	02	02	02
ETX	end of text	03	03	03
EOT	end of transmission	37	04	04
ENQ	enquiry	2D	05	05
ACK	acknowledge	2E	06	06
DC1	device control 1	11	11	11
DC2	device control 2	12	12	12
DC3	device control 3	13	13	13
DC4	device control 4	3C	14	14
NAK	negative acknowledge	3D	15	15
SYN	synchronous idle	32	16	16
ETB	end of block	26	17	17

Matrix A2. Extended Control Set

A.1.2.7 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator.

Once specified in the interchange header, the delimiters are not to be used in a data element value elsewhere in the interchange. For consistency, this implementation guide uses the delimiters shown in matrix A3, Delimiters, in all examples of EDI transmissions.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
:	Colon	Subelement Separator
~	Tilde	Segment Terminator

Matrix A3. Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element can result in errors in translation programs. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

A.1.3 Business Transaction Structure Definitions and Concepts

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called “transaction sets.” A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of the following:

- A unique segment ID
- One or more logically related data elements each preceded by a data element separator
- A segment terminator

A.1.3.1 Data Element

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

The data element types shown in matrix A4, Data Element Types, appear in this implementation guide.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

Matrix A4. Data Element Types

A.1.3.1.1 Numeric

A numeric data element is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

This set of guides denotes the number of implied decimal positions. The representation for this data element type is “Nn” where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

EXAMPLE
A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

A.1.3.1.2 Decimal

A decimal data element may contain an explicit decimal point and is used for numeric values that have a varying number of decimal positions. This data element type is represented as “R.”

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

EXAMPLE
A transmitted value of 12.34 represents a decimal value of 12.34.

A.1.3.1.3 Identifier

An identifier data element always contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. An identifier is always left justified. The representation for this data element type is “ID.”

A.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is “AN.”

A.1.3.1.5 Date

A date data element is used to express the standard date in either YYMMDD or CCYYMMDD format in which CC is the first two digits of the calendar year, YY is the last two digits of the calendar year, MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is “DT.” Users of this guide should note that all dates within transactions are 8-character dates (millennium compliant) in the format CCYYMMDD. The only date data element that is in format YYMMDD is the Interchange Date data element in the ISA segment, and also used in the TA1 Interchange Acknowledgment, where the century can be readily interpolated because of the nature of an interchange header.

A.1.3.1.6 Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is “TM.” The length of the data element determines the format of the transmitted time.

EXAMPLE
Transmitted data elements of four characters denote HHMM. Transmitted data elements of six characters denote HHMMSS.

A.1.3.2 Composite Data Structure

The composite data structure is an intermediate unit of information in a segment. Composite data structures are composed of one or more logically related simple data elements, each, except the last, followed by a sub-element separator. The final data element is followed by the next data element separator or the segment terminator. Each simple data element within a composite is called a component.

Each composite data structure has a unique four-character identifier, a name, and a purpose. The identifier serves as a label for the composite. A composite data structure can be further defined through the use of syntax notes, semantic notes, and comments. Each component within the composite is further characterized by a reference designator and a condition designator. The reference designators and the condition designators are described below.

A.1.3.3 Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined through the use of syntax notes, semantic notes, and comments. Each simple data element or composite data structure within the segment is further characterized by a reference designator and a condition designator.

A.1.3.4 Syntax Notes

Syntax notes describe relational conditions among two or more data segment units within the same segment, or among two or more component data elements within the same composite data structure. For a complete description of the relational conditions, See A.1.3.8, Condition Designator.

A.1.3.5 Semantic Notes

Simple data elements or composite data structures may be referenced by a semantic note within a particular segment. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements.

A.1.3.6 Comments

A segment comment provides additional information regarding the intended use of the segment.

A.1.3.7 Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment.

For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member.

This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure.

EXAMPLE

- The first simple element of the CLP segment would be identified as CLP01.
- The first position in the SVC segment is occupied by a composite data structure that contains seven component data elements, the reference designator for the second component data element would be SVC01-02.

A.1.3.8 Condition Designator

This section provides information about X12 standard conditions designators. It is provided so that users will have information about the general standard. Implementation guides may impose other conditions designators. See implementation guide section 3.1 Presentation Examples for detailed information about the implementation guide Industry Usage requirements for compliant implementation.

Data element conditions are of three types: mandatory, optional, and relational. They define the circumstances under which a data element may be required to be present or not present in a particular segment.

DESIGNATOR	DESCRIPTION
M- Mandatory	The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.
O- Optional	The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.
X- Relational	Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition. The definitions for each of the condition codes used within syntax notes are detailed below:

CONDITION CODE	DEFINITION
P- Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
R- Required	At least one of the elements specified in the condition must be present.
E- Exclusion	Not more than one of the elements specified in the condition may be present.
C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.
L- List	

Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Table A5. Condition Designator

A.1.3.9 Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Likewise, when additional information is not necessary within a composite, the composite may be terminated by providing the appropriate data element separator or segment terminator.

A.1.3.10 Control Segments

A control segment has the same structure as a data segment, but it is used for transferring control information rather than application information.

A.1.3.10.1 Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop. Unbounded looping structures do not use loop control segments.

A.1.3.10.2 Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

A.1.3.10.3 Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number

and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

A.1.3.10.4 Relations among Control Segments

The control segment of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.

- **ST** Transaction Set Header, starts a transaction set.
  - **LS** Loop Header, starts a bounded loop of data segments but is not part of the loop.
    - **LS** Loop Header, starts an inner, nested, bounded loop.
    - **LE** Loop Trailer, ends an inner, nested bounded loop.
  - **LE** Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
- **SE** Transaction Set Trailer, ends a transaction set.

GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

A.1.3.11 Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set header segment, one or more data segments in a specified order, and a transaction set trailer segment. See figure A1, Transmission Control Schematic.

A.1.3.11.1 Transaction Set Header and Trailer

A transaction set identifier uniquely identifies a transaction set. This identifier is the first data element of the Transaction Set Header Segment (ST). A user assigned transaction set control number in the header must match the control number in the Trailer Segment (SE) for any given transaction set. The value for the number of included segments in the SE segment is the total number of segments in the transaction set, including the ST and SE segments.

A.1.3.11.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

A.1.3.11.3 Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat

an unlimited number of times. The notation for an unlimited number of repetitions is “>1.”

A.1.3.11.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

A.1.3.11.4.1 Unbounded Loops

To establish the iteration of a loop, the first data segment in the loop must appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions is “>1.”

A specified sequence of segments is in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop. If the loop is optional, the mandatory segment only occurs if the loop occurs.

A.1.3.11.4.2 Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a Loop Start Segment (LS) to appear before the first occurrence and a Loop End Segment (LE) to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

A.1.3.11.5 Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are applied to each data segment: a requirement designator, a position in the transaction set, and a maximum occurrence.

A.1.3.11.6 Data Segment Requirement Designators

A data segment, or loop, has one of the following requirement designators for health care and insurance transaction sets, indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

DESIGNATOR	DESCRIPTION
M- Mandatory	This data segment must be included in the transaction set. (Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)
O- Optional	The presence of this data segment is the option of the sending party.

A.1.3.11.7 Data Segment Position

The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional requirement designators of the segments, this positioning must be maintained.

A.1.3.11.8 Data Segment Occurrence

A data segment may have a maximum occurrence of one, a finite number greater than one, or an unlimited number indicated by ">1."

A.1.3.12 Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets is the total number of transaction sets in the group. See figure A1, Transmission Control Schematic.

A.1.4 Envelopes and Control Structures

A.1.4.1 Interchange Control Structures

Typically, the term "interchange" connotes the ISA/IEA envelope that is transmitted between trading/business partners. Interchange control is achieved through several "control" components. The interchange control number is contained in data element ISA13 of the ISA segment. The identical control number must also occur in data element 02 of the IEA segment. Most commercial translation software products will verify that these two fields are identical. In most translation software products, if these fields are different the interchange will be "suspended" in error.

There are many other features of the ISA segment that are used for control measures. For instance, the ISA segment contains data elements such as authorization information, security information, sender identification, and receiver identification that can be used for control purposes. These data elements are agreed upon by the trading partners prior to transmission and are contained in the written trading partner agreement. The interchange date and time data elements as well as the interchange control number within the ISA segment are used for debugging purposes when there is a problem with the transmission or the interchange.

Data Element ISA12, Interchange Control Version Number, indicates the version of the ISA/IEA envelope. The ISA12 does not indicate the version of the transaction set that is being transmitted but rather the envelope that encapsulates the transaction. An Interchange Acknowledgment can be denoted through data element ISA14. The acknowledgment that would be sent in reply to a "yes" condition in data element ISA14 would be the TA1 segment. Data element ISA15, Test Indicator, is used between trading partners to indicate that the transmission is in a "test" or "production" mode. This becomes significant when the production phase of the project is to commence. Data element ISA16, Subelement Separator, is used by the translator for interpretation of composite data elements.

The ending component of the interchange or ISA/IEA envelope is the IEA segment. Data element IEA01 indicates the number of functional groups that are included within the interchange. In most commercial translation software products, an aggregate count of functional groups is kept while interpreting the interchange. This count is then verified with data element IEA01. If there is a discrep-

ancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See the Appendix B, EDI Control Directory, for a complete detailing of the interchange control header and trailer.

A.1.4.2 Functional Groups

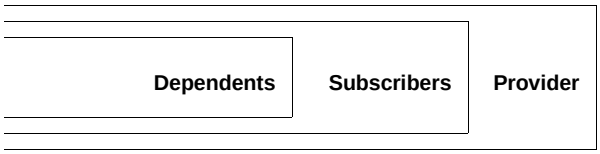
Control structures within the functional group envelope include the functional identifier code in GS01. The Functional Identifier Code is used by the commercial translation software during interpretation of the interchange to determine the different transaction sets that may be included within the functional group. If an inappropriate transaction set is contained within the functional group, most commercial translation software will suspend the functional group within the interchange. The Application Sender's Code in GS02 can be used to identify the sending unit of the transmission. The Application Receiver's Code in GS03 can be used to identify the receiving unit of the transmission. For health care, this unit identification can be used to differentiate between managed care, indemnity, and Medicare. The functional group contains a creation date (GS04) and creation time (GS05) for the functional group. The Group Control Number is contained in GS06. These data elements (GS04, GS05, AND GS06) can be used for debugging purposes during problem resolution. GS08,Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group. Appendix B provides guidance for the value for this data element. The GS08 does not represent the version of the interchange (ISA/IEA) envelope but rather the version/release/sub-release of the transaction sets that are encompassed within the GS/GE envelope.

The Functional Group Control Number in GS06 must be identical to data element 02 of the GE segment. Data element GE01 indicates the number of transaction sets within the functional group. In most commercial translation software products, an aggregate count of the transaction sets is kept while interpreting the functional group. This count is then verified with data element GE01.

See the Appendix B, EDI Control Directory, for a complete detailing of the functional group header and trailer.

A.1.4.3 HL Structures

The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide. The following diagram, from transaction set 837, illustrates a typical hierarchy.



Each provider can bill for one or more subscribers, each subscriber can have one or more dependents and the subscriber and the dependents can make one or more claims. Each guide states what levels are available, the level's requirement, a repeat value, and whether that level has subordinate levels within a transmission.

A.1.5 Acknowledgments

A.1.5.1 Interchange Acknowledgment, TA1

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See A.1.5.2, Functional Acknowledgment, 997, for more details. The TA1 is a single segment and is unique in the sense that this single segment is transmitted without the GS/GE envelope structures. A TA1 can be included in an interchange with other functional groups and transactions.

Encompassed in the TA1 are the interchange control number, interchange date and time, interchange acknowledgment code, and the interchange note code. The interchange control number, interchange date and time are identical to those that were present in the transmitted interchange from the sending trading partner. This provides the capability to associate the TA1 with the transmitted interchange. TA104, Interchange Acknowledgment Code, indicates the status of the interchange control structure. This data element stipulates whether the transmitted interchange was accepted with no errors, accepted with errors, or rejected because of errors. TA105, Interchange Note Code, is a numerical code that indicates the error found while processing the interchange control structure. Values for this data element indicate whether the error occurred at the interchange or functional group envelope.

The TA1 segment provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Due to the uniqueness of the TA1, implementation should be predicated upon the ability for the sending and receiving trading partners commercial translators to accommodate the uniqueness of the TA1. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the TA1, although urged by the authors, is not mandated.

See the Appendix B, EDI Control Directory, for a complete detailing of the TA1 segment.

A.1.5.2 Functional Acknowledgment, 997

The Functional Acknowledgment Transaction Set, 997, has been designed to allow trading partners to establish a comprehensive control function as a part of their business exchange process. This acknowledgment process facilitates control of EDI. There is a one-to-one correspondence between a 997 and a functional group. Segments within the 997 can identify the acceptance or rejection of the functional group, transaction sets or segments. Data elements in error can also be identified. There are many EDI implementations that have incorporated the acknowledgment process in all of their electronic communications. Typically, the 997 is used as a functional acknowledgment to a previously transmitted functional group. Many commercially available translators can automatically generate this transaction set through internal parameter settings. Additionally translators will automatically reconcile received acknowledgments to functional groups that have been sent. The benefit to this process is that the sending trading partner

can determine if the receiving trading partner has received ASC X12 transaction sets through reports that can be generated by the translation software to identify transmissions that have not been acknowledged.

As stated previously the 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

As with any information flow, an acknowledgment process is essential. If an “automatic” acknowledgment process is desired between trading partners then it is recommended that the 997 be used. Unless named as mandatory in the Federal Rules implementing HIPAA, use of the 997, although recommended by the authors, is not mandated.

See Appendix B, EDI Control Directory, for a complete detailing of transaction set 997.

B EDI Control Directory

B.1 Control Segments

- **ISA**
  Interchange Control Header Segment
- **IEA**
  Interchange Control Trailer Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **TA1**
  Interchange Acknowledgment Segment

B.2 Functional Acknowledgment Transaction Set, 997

IMPLEMENTATION

INTERCHANGE CONTROL HEADER

Notes: **1. The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by "." for clarity.**

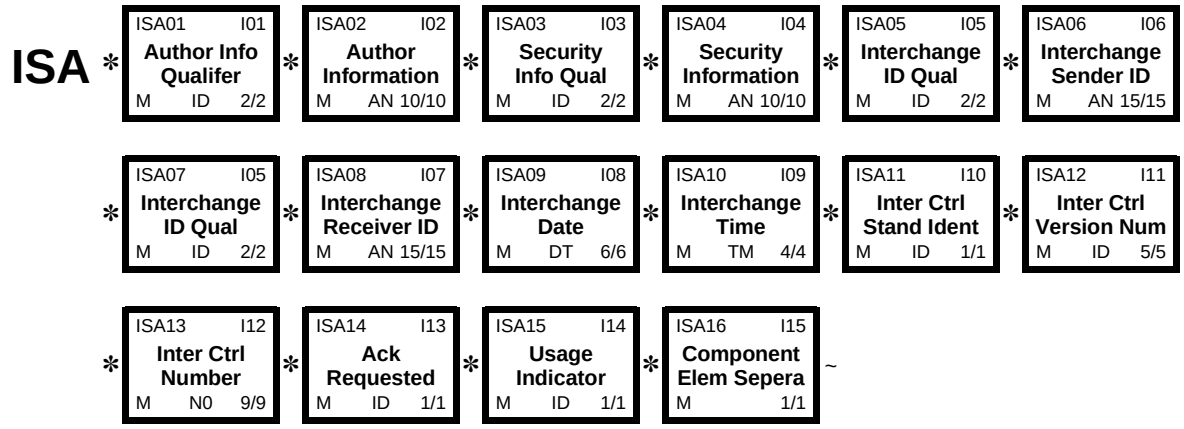
Example: **ISA* 00* .....* 01* SECRET....* ZZ* SUBMITTERS.ID..* ZZ* RECEIVERS.ID...* 930602* 1253* U* 00401* 000000905* 1* T* :~**

STANDARD

ISA Interchange Control Header

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ISA01**	**I01**	**Authorization Information Qualifier** Code to identify the type of information in the Authorization Information	**M ID 2/2**
			CODE / **DEFINITION** **00** — **No Authorization Information Present (No Meaningful Information in I02)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.** **03** — **Additional Data Identification**	
REQUIRED	**ISA02**	**I02**	**Authorization Information** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	**M AN 10/10**

REQUIRED **ISA03** **I03** **Security Information Qualifier** **M ID 2/2**
Code to identify the type of information in the Security Information

CODE	DEFINITION
00	**No Security Information Present (No Meaningful Information in I04)** **ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.**
01	**Password**

REQUIRED **ISA04** **I04** **Security Information** **M AN 10/10**
This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

REQUIRED **ISA05** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Sender in ISA06.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry Identification Number
27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**
28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**
29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**
30	**U.S. Federal Tax Identification Number**
33	**National Association of Insurance Commissioners Company Code (NAIC)**
ZZ	**Mutually Defined**

REQUIRED **ISA06** **I06** **Interchange Sender ID** **M AN 15/15**
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

REQUIRED **ISA07** **I05** **Interchange ID Qualifier** **M ID 2/2**
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**

			14	**Duns Plus Suffix**		
			20	**Health Industry Number (HIN)**		
				CODE SOURCE **121:** Health Industry Identification Number		
			27	**Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			28	**Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			29	**Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)**		
			30	**U.S. Federal Tax Identification Number**		
			33	**National Association of Insurance Commissioners Company Code (NAIC)**		
			ZZ	**Mutually Defined**		
REQUIRED	**ISA08**	**I07**	**Interchange Receiver ID**	**M**	**AN**	**15/15**
			Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them			
REQUIRED	**ISA09**	**I08**	**Interchange Date**	**M**	**DT**	**6/6**
			Date of the interchange			
			The date format is YYMMDD.			
REQUIRED	**ISA10**	**I09**	**Interchange Time**	**M**	**TM**	**4/4**
			Time of the interchange			
			The time format is HHMM.			
REQUIRED	**ISA11**	**I10**	**Interchange Control Standards Identifier**	**M**	**ID**	**1/1**
			Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer			
			CODE / DEFINITION			
			U — **U.S. EDI Community of ASC X12, TDCC, and UCS**			
REQUIRED	**ISA12**	**I11**	**Interchange Control Version Number**	**M**	**ID**	**5/5**
			This version number covers the interchange control segments			
			CODE / DEFINITION			
			00401 — **Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997**			
REQUIRED	**ISA13**	**I12**	**Interchange Control Number**	**M**	**N0**	**9/9**
			A control number assigned by the interchange sender			
			The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.			

REQUIRED **ISA14** **I13** **Acknowledgment Requested** **M** **ID** **1/1**
Code sent by the sender to request an interchange acknowledgment (TA1)

See Section A.1.5.1 for interchange acknowledgment information.

CODE	DEFINITION
0	**No Acknowledgment Requested**
1	**Interchange Acknowledgment Requested**

REQUIRED **ISA15** **I14** **Usage Indicator** **M** **ID** **1/1**
Code to indicate whether data enclosed by this interchange envelope is test, production or information

CODE	DEFINITION
P	**Production Data**
T	**Test Data**

REQUIRED **ISA16** **I15** **Component Element Separator** **M** **1/1**
Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

IMPLEMENTATION

INTERCHANGE CONTROL TRAILER

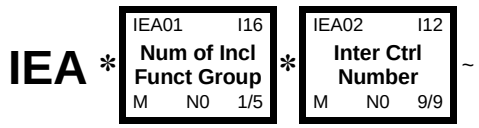
Example: IEA*1*000000905~

STANDARD

IEA Interchange Control Trailer

Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**IEA01**	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**N0**	**1/5**
REQUIRED	**IEA02**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**N0**	**9/9**

IMPLEMENTATION

FUNCTIONAL GROUP HEADER

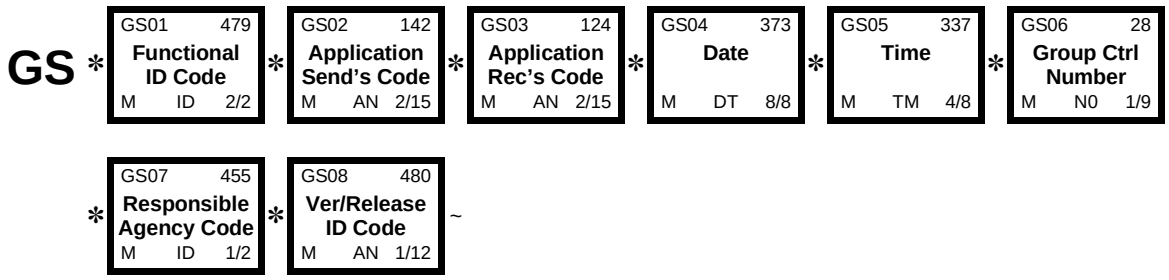
Example: GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X096~

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
004010X096	**Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.**

IMPLEMENTATION

FUNCTIONAL GROUP TRAILER

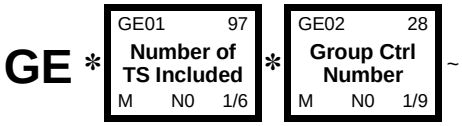
Example: **GE*1*1~**

STANDARD

GE Functional Group Trailer

Purpose: To indicate the end of a functional group and to provide control information

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**GE01**	**97**	**Number of Transaction Sets Included** Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	**M**	**N0**	**1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M**	**N0**	**1/9**

IMPLEMENTATION

INTERCHANGE ACKNOWLEDGMENT

Notes:

1. **All fields must contain data.**
2. **This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly, the TA1 reflects a valid interchange, regardless of the validity of the contents of the data included inside the header/trailer envelope.**
3. **See Section A.1.5.1 for interchange acknowledgment information.**
4. **Use of TA1 is subject to trading partner agreement and is neither mandated or prohibited in this Appendix.**

Example: **TA1*000000905*940101*0100*A*000~**

STANDARD

TA1 Interchange Acknowledgment

Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider

DIAGRAM

ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**TA101**	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M N0 9/9**
			This number uniquely identifies the interchange data to the sender. It is assigned by the sender. Together with the sender ID it uniquely identifies the interchange data to the receiver. It is suggested that the sender, receiver, and all third parties be able to maintain an audit trail of interchanges using this number.	
			In the TA1, this should be the interchange control number of the original interchange that this TA1 is acknowledging.	
REQUIRED	**TA102**	**I08**	**Interchange Date** Date of the interchange	**M DT 6/6**
			This is the date of the original interchange being acknowledged. (YYMMDD)	
REQUIRED	**TA103**	**I09**	**Interchange Time** Time of the interchange	**M TM 4/4**
			This is the time of the original interchange being acknowledged. (HHMM)	

REQUIRED **TA104** **I17** **Interchange Acknowledgment Code** **M ID 1/1**

This indicates the status of the receipt of the interchange control structure

CODE	DEFINITION
A	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors.
E	The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data.
R	The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.

REQUIRED **TA105** **I18** **Interchange Note Code** **M ID 3/3**

This numeric code indicates the error found processing the interchange control structure

CODE	DEFINITION
000	No error
001	The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002	This Standard as Noted in the Control Standards Identifier is Not Supported.
003	This Version of the Controls is Not Supported
004	The Segment Terminator is Invalid
005	Invalid Interchange ID Qualifier for Sender
006	Invalid Interchange Sender ID
007	Invalid Interchange ID Qualifier for Receiver
008	Invalid Interchange Receiver ID
009	Unknown Interchange Receiver ID
010	Invalid Authorization Information Qualifier Value
011	Invalid Authorization Information Value
012	Invalid Security Information Qualifier Value
013	Invalid Security Information Value
014	Invalid Interchange Date Value
015	Invalid Interchange Time Value
016	Invalid Interchange Standards Identifier Value
017	Invalid Interchange Version ID Value
018	Invalid Interchange Control Number Value

019	Invalid Acknowledgment Requested Value
020	Invalid Test Indicator Value
021	Invalid Number of Included Groups Value
022	Invalid Control Structure
023	Improper (Premature) End-of-File (Transmission)
024	Invalid Interchange Content (e.g., Invalid GS Segment)
025	Duplicate Interchange Control Number
026	Invalid Data Element Separator
027	Invalid Component Element Separator
028	Invalid Delivery Date in Deferred Delivery Request
029	Invalid Delivery Time in Deferred Delivery Request
030	Invalid Delivery Time Code in Deferred Delivery Request
031	Invalid Grade of Service Code

STANDARD

997 Functional Acknowledgment

Functional Group ID: FA

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
010	ST	Transaction Set Header	M	1	
020	AK1	Functional Group Response Header	M	1	
		LOOP ID - AK2			999999
030	AK2	Transaction Set Response Header	O	1	
		LOOP ID - AK2/AK3			999999
040	AK3	Data Segment Note	O	1	
050	AK4	Data Element Note	O	99	
060	AK5	Transaction Set Response Trailer	M	1	
070	AK9	Functional Group Response Trailer	M	1	
080	SE	Transaction Set Trailer	M	1	

NOTES:

1/010 These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.

1/010 The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

1/010 There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

1/020 AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

1/030 AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

1/040 The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

IMPLEMENTATION

TRANSACTION SET HEADER

Usage: **REQUIRED**

Repeat: **1**

Notes: **1. Use of the 997 transaction is subject to trading partner agreement or accepted usage and is neither mandated nor prohibited in this Appendix.**

Example: **ST*997*1234~**

STANDARD

ST Transaction Set Header

Level: Header

Position: 010

Loop: ____

Requirement: Mandatory

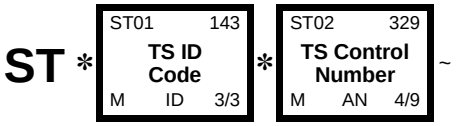
Max Use: 1

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

Set Notes:

1. These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.
2. The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.
3. There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). **CODE** **DEFINITION** **997** **Functional Acknowledgment**	**M ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Numbers in ST02 and SE02 must be identical. The number is assigned by the originator and must be unique within a functional group (GS-GE). The number also aids in error resolution research. For example, start with the number 0001 and increment from there.** **Use the corresponding value in SE02 for this transaction set.**	**M AN 4/9**

IMPLEMENTATION

FUNCTIONAL GROUP RESPONSE HEADER

Usage: **REQUIRED**

Repeat: **1**

Example: **AK1*HC*1~**

STANDARD

AK1 Functional Group Response Header

Level: Header

Position: 020

Loop: ____

Requirement: Mandatory

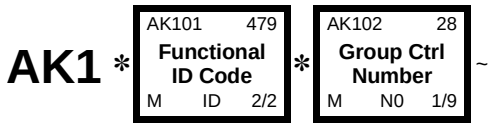
Max Use: 1

Purpose: To start acknowledgment of a functional group

Set Notes:

1. AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	**AK101**	**479**	**Functional Identifier Code** Code identifying a group of application related transaction sets **SEMANTIC:** AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.	**M**	**ID**	**2/2**
			CODE / **DEFINITION** **HC** **Health Care Claim (837)**			
REQUIRED	**AK102**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.	**M**	**N0**	**1/9**

IMPLEMENTATION

TRANSACTION SET RESPONSE HEADER

Loop: **AK2 — TRANSACTION SET RESPONSE HEADER** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes:
1. **Required when communicating information about a transaction set within the functional group identified in AK1.**

Example: **AK2*837*000000905~**

STANDARD

AK2 Transaction Set Response Header

Level: Header

Position: 030

Loop: AK2 **Repeat:** 999999

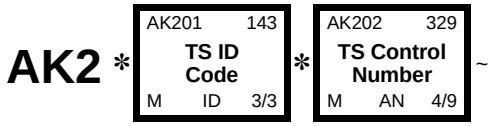
Requirement: Optional

Max Use: 1

Purpose: To start acknowledgment of a single transaction set

Set Notes:
1. AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK201**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged. **CODE** / **DEFINITION** **837** **Health Care Claim**	**M ID 3/3**
REQUIRED	**AK202**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **SEMANTIC:** AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.	**M AN 4/9**

IMPLEMENTATION

DATA SEGMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE** **Repeat:** **999999**

Usage: **SITUATIONAL**

Repeat: **1**

Notes: **1. Used when there are errors to report in a transaction.**

Example: **AK3*NM1*37*2010BB*7~**

STANDARD

AK3 Data Segment Note

Level: Header

Position: 040

Loop: AK2/AK3 **Repeat:** 999999

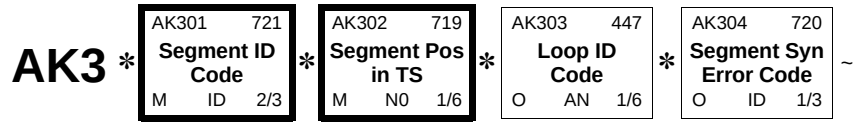
Requirement: Optional

Max Use: 1

Purpose: To report errors in a data segment and identify the location of the data segment

Set Notes: **1.** The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK301**	**721**	**Segment ID Code** Code defining the segment ID of the data segment in error (See Appendix A - Number 77) **CODE SOURCE 77:** X12 Directories **This is the two or three characters which occur at the beginning of a segment.**	**M ID 2/3**
REQUIRED	**AK302**	**719**	**Segment Position in Transaction Set** The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1 **This is a data count, not a segment position in the standard description.**	**M N0 1/6**

SITUATIONAL **AK303** **447** **Loop Identifier Code** **O AN 1/6**
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE

Use this code to identify a loop within the transaction set that is bounded by the related LS and LE segments (corresponding LS and LE segments must have the same value for loop identifier). (Note: The loop ID number given on the transaction set diagram is recommended as the value for this data element in the segments LS and LE.)

SITUATIONAL **AK304** **720** **Segment Syntax Error Code** **O ID 1/3**
Code indicating error found based on the syntax editing of a segment

This code is required if an error exists.

CODE	DEFINITION
1	Unrecognized segment ID
2	Unexpected segment
3	Mandatory segment missing
4	Loop Occurs Over Maximum Times
5	Segment Exceeds Maximum Use
6	Segment Not in Defined Transaction Set
7	Segment Not in Proper Sequence
8	Segment Has Data Element Errors

IMPLEMENTATION

DATA ELEMENT NOTE

Loop: **AK2/AK3 — DATA SEGMENT NOTE**

Usage: **SITUATIONAL**

Repeat: **99**

Notes: **1. Used when there are errors to report in a data element or composite data structure.**

Example: **AK4*1*98*7~**

STANDARD

AK4 Data Element Note

Level: Header

Position: 050

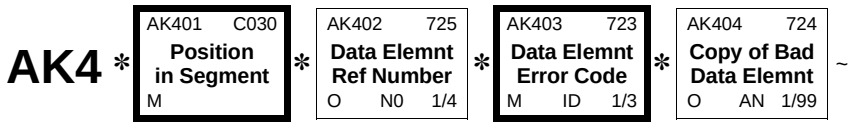
Loop: AK2/AK3

Requirement: Optional

Max Use: 99

Purpose: To report errors in a data element or composite data structure and identify the location of the data element

DIAGRAM



ELEMENT SUMMARY

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**AK401**	**C030**	**POSITION IN SEGMENT** Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M**
REQUIRED	**AK401 - 1**	**722**	**Element Position in Segment** This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	**M N0 1/2**
SITUATIONAL	**AK401 - 2**	**1528**	**Component Data Element Position in Composite** To identify the component data element position within the composite that is in error **Used when an error occurs in a composite data element and the composite data element position can be determined.**	**O N0 1/2**

SITUATIONAL **AK402** **725** **Data Element Reference Number** **O** **N0** **1/4**
Reference number used to locate the data element in the Data Element Dictionary

ADVISORY: Under most circumstances, this element is expected to be sent.

CODE SOURCE 77: X12 Directories

The Data Element Reference Number for this data element is 725. For example, all reference numbers are found with the segment descriptions in this implementation 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

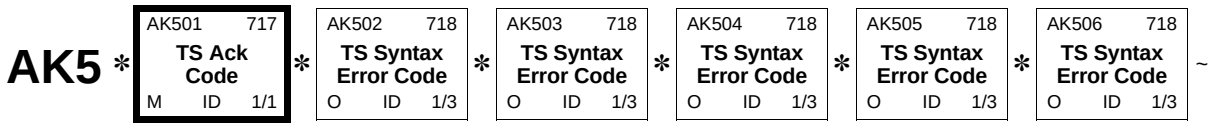
Loop: AK2

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

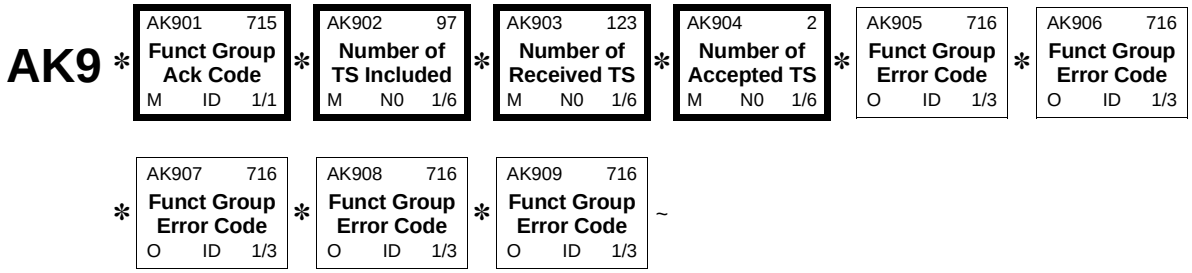
Loop: ____

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

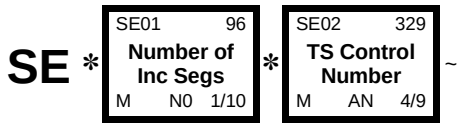
Loop: ____

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.

130 Health Care Financing Administration Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Health Care Finance Administration Common Procedural Coding System

AVAILABLE FROM

www.hcfa.gov/medicare/hcpcs.htm
Health Care Financing Administration
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27

7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

HCPCS is Health Care Finance Administration's (HFCA) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ID, 235/DX, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/SD, 1270/TD, 1270/DD, 128/ICD

SOURCE

International Classification of Diseases, 9th Revision, Clincal Modification (ICD-9-CM)

AVAILABLE FROM

U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/RB, 235/NU, 1270/BE, 1270/BG, 1270/BH, 1270/BI

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

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.

229 Diagnosis Related Group Number (DRG)

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/DR, 1354

SOURCE

Federal Register and Health Insurance Manual 15 (HIM 15)

AVAILABLE FROM

Superintendant of Documents
U.S. Government Printing Office
Washington, DC 20402

ABSTRACT

A patient classification scheme that clusters patients into categories on the basis of patient's illness, diseases, and medical problems.

230 Admission Source Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1314

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining who recommended admission to a medical facility.

231 Admission Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1315

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the priority of the admission to a medical facility.

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 Hospitial Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes explaining the frequency of the bill submission.

236 Uniform Billing Claim Form Bill Type

SIMPLE DATA ELEMENT/CODE REFERENCES

1332/A

SOURCE

National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes describing the type of medical facility.

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.

239 Patient Status Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1352

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT

A variety of codes indicating patient status as of the statement covers through date.

240 National Drug Code by Format

SIMPLE DATA ELEMENT/CODE REFERENCES

235/N1, 235/N2, 235/N3, 235/N4, 1270/NDC, 235/N5, 235/N6

SOURCE

Drug Establishment Registration and Listing Instruction Booklet

AVAILABLE FROM

Federal Drug Listing Branch HFN-315
5600 Fishers Lane
Rockville, MD 20857

ABSTRACT

Publication includes manufacturing and labeling information as well as drug packaging sizes.

245 National Association of Insurance Commissioners (NAIC) Code

SIMPLE DATA ELEMENT/CODE REFERENCES

128/NF

SOURCE

National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM

National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT

Codes that uniquely identify each insurance company.

359 Treatment Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/TD, 1270/TC

SOURCE

Health Care Financing Administration Treatment Codes

AVAILABLE FROM

Health Care Financing Administration Office of Financial Management
Program Integrity Group
C3-02-16
7500 Security Blvd.
Baltimore, MD 21244-1850

ABSTRACT

Codes used to describe the treatments provided in a home health setting.

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

Home Infusion EDI Coalition — affiliated with National Home Infusion Association
205 Daingerfield Road
Alexandria, Virginia 22314
Telephone: 703-549-3740
FAX: 703-683-1484

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

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

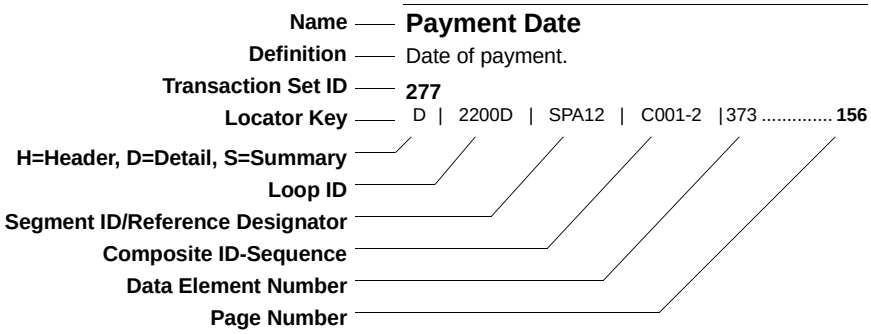
The Health care Financing Administration is developing the PlanID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

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.



Activities Permitted Code

Code describing the activities permitted by the physician or for which physician's orders are present.

D | 2300 | CRC03 | - | 1321 ..... **222**
D | 2300 | CRC04 | - | 1321 ..... **223**
D | 2300 | CRC05 | - | 1321 ..... **223**
D | 2300 | CRC06 | - | 1321 ..... **223**
D | 2300 | CRC07 | - | 1321 ..... **223**

Adjudication or Payment Date

Date of payment or denial determination by previous payer.

D | 2330B | DTP03 | - | 1251 ..... **415**

Adjusted Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify an adjusted claim.

D | 2300 | REF02 | - | 127 ..... **185**

Adjustment Amount

Adjustment amount for the associated reason code.

D | 2320 | CAS03 | - | 782 ..... **367**
D | 2320 | CAS06 | - | 782 ..... **368**
D | 2320 | CAS09 | - | 782 ..... **368**
D | 2320 | CAS12 | - | 782 ..... **369**
D | 2320 | CAS15 | - | 782 ..... **370**
D | 2320 | CAS18 | - | 782 ..... **370**
D | 2430 | CAS03 | - | 782 ..... **496**
D | 2430 | CAS06 | - | 782 ..... **497**
D | 2430 | CAS09 | - | 782 ..... **498**
D | 2430 | CAS12 | - | 782 ..... **499**
D | 2430 | CAS15 | - | 782 ..... **500**
D | 2430 | CAS18 | - | 782 ..... **501**

Adjustment Quantity

Numeric quantity associated with the related reason code for coordination of benefits.

D | 2320 | CAS04 | - | 380 ..... **367**
D | 2320 | CAS07 | - | 380 ..... **368**
D | 2320 | CAS10 | - | 380 ..... **369**
D | 2320 | CAS13 | - | 380 ..... **369**
D | 2320 | CAS16 | - | 380 ..... **370**
D | 2320 | CAS19 | - | 380 ..... **370**
D | 2430 | SVD05 | - | 380 ..... **493**
D | 2430 | CAS04 | - | 380 ..... **496**
D | 2430 | CAS07 | - | 380 ..... **497**
D | 2430 | CAS10 | - | 380 ..... **498**
D | 2430 | CAS13 | - | 380 ..... **499**
D | 2430 | CAS16 | - | 380 ..... **500**
D | 2430 | CAS19 | - | 380 ..... **501**

Adjustment Reason Code

Code that indicates the reason for the adjustment.

D | 2320 | CAS02 | - | 1034 ..... **367**
D | 2320 | CAS05 | - | 1034 ..... **368**
D | 2320 | CAS08 | - | 1034 ..... **368**
D | 2320 | CAS11 | - | 1034 ..... **369**
D | 2320 | CAS14 | - | 1034 ..... **369**
D | 2320 | CAS17 | - | 1034 ..... **370**
D | 2430 | CAS02 | - | 1034 ..... **496**
D | 2430 | CAS05 | - | 1034 ..... **496**
D | 2430 | CAS08 | - | 1034 ..... **497**
D | 2430 | CAS11 | - | 1034 ..... **498**
D | 2430 | CAS14 | - | 1034 ..... **499**
D | 2430 | CAS17 | - | 1034 ..... **500**

Admission Date and Hour

The date and time of the admission to the facility.

D | 2300 | DTP03 | - | 1251 ..... **170**

Admission Source Code

Code indicating the source of this admission.

D | 2300 | CL102 | - | 1314 ..... **172**

Admission Type Code

Code indicating the priority of this admission.

D	2300	CL101	-	1315	.....	**171**

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	.....	**372**

Amount Qualifier Code

Code to qualify amount.

D	2300	AMT01	-	522	.....	**178**
D	2300	AMT01	-	522	.....	**180**
D	2300	AMT01	-	522	.....	**182**
D	2300	AMT01	-	522	.....	**184**
D	2320	AMT01	-	522	.....	**371**
D	2320	AMT01	-	522	.....	**372**
D	2320	AMT01	-	522	.....	**373**
D	2320	AMT01	-	522	.....	**374**
D	2320	AMT01	-	522	.....	**376**
D	2320	AMT01	-	522	.....	**378**
D	2320	AMT01	-	522	.....	**380**
D	2320	AMT01	-	522	.....	**382**
D	2320	AMT01	-	522	.....	**384**
D	2320	AMT01	-	522	.....	**386**
D	2320	AMT01	-	522	.....	**387**
D	2400	AMT01	-	522	.....	**460**
D	2400	AMT01	-	522	.....	**461**

Assessment Date

Date on which patient assessment or other required assessment was performed.

D	2400	DTP03	-	1251	.....	**459**

Assigned Number

Number assigned for differentiation within a transaction set.

D	2400	LX01	-	554	.....	**444**

Attachment Control Number

Identification number of attachment related to the claim.

D	2300	PWK06	-	67	.....	**175**
D	2400	PWK06	-	67	.....	**454**

Attachment Description

Free-form text describing attachments related to the claim.

D	2300	PWK07	-	352	.....	**175**

Attachment Report Type Code

Code to specify the type of attachment that is related to the claim.

D	2300	PWK01	-	755	.....	**174**
D	2400	PWK01	-	755	.....	**453**

Attachment Transmission Code

Code defining timing, transmission method or format by which an attachment report is to be sent or has been sent.

D	2300	PWK02	-	756	.....	**174**
D	2400	PWK02	-	756	.....	**454**

Attending Physician First Name

First name of the physician responsible for care of the patient.

D	2310A	NM104	-	1036	.....	**322**
D	2420A	NM104	-	1036	.....	**463**

Attending Physician Last Name

Last name of the physician responsible for care of the patient.

D	2310A	NM103	-	1035	.....	**322**
D	2420A	NM103	-	1035	.....	**463**

Attending Physician Middle Name

Middle name of the physician responsible for care of the patient.

D	2310A	NM105	-	1037	.....	**322**
D	2420A	NM105	-	1037	.....	**463**

Attending Physician Name Suffix

Suffix to the name of the physician responsible for the care of the patient.

D	2310A	NM107	-	1039	.....	**323**
D	2420A	NM107	-	1039	.....	**463**

Attending Physician Primary Identifier

Primary identification number of the physician responsible for care of the patient.

D	2310A	NM109	-	67	.....	**323**
D	2420A	NM109	-	67	.....	**464**

Attending Physician Secondary Identifier

Secondary identification number of the physician responsible for the care of the patient.

D	2310A	REF02	-	127	.....	**327**
D	2420A	REF02	-	127	.....	**468**

Auto Accident State or Province Code

State or Province where auto accident occurred.

D	2300	CLM11	C024-4	156	.....	**162**

Benefits Assignment Certification Indicator

A code showing whether the provider has a signed form authorizing the third party payer to pay the provider.

D	2300	CLM08	-	1073	.....	**160**

Billing Note Text

Free-form text providing additional information about the bill or claim being submitted.

Billing Provider Additional Identifier

Identifies another or additional distinguishing code number associated with the billing provider.

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 Contact Name

Person at billing organization to contact regarding the billing transaction.

Billing Provider Credit Card Identifier

Identification number for credit card processing for 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 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.

Certification Condition Indicator

Code indicating whether or not the condition codes apply to the patient or another entity.

Certification Type Code

Code indicating the type of certification

Claim Adjustment Group Code

Code identifying the general category of payment adjustment.

Claim DRG Amount

Total of Prospective Payment System operating and capital amounts for this claim.

Claim DRG Outlier Amount

Total Prospective Payment System Outlier and Capital Outlier amounts for this claim.

Claim Days Count

The number of categorized days associated with the claim, such as lifetime reserve days, covered days.

Claim Disproportionate Share Amount

Sum of operating capital disproportionate share amounts for this claim.

Claim ESRD Payment Amount

End Stage Renal Disease (ESRD) payment amount for the claim.

Claim Filing Indicator Code

Code identifying type of claim or expected adjudication process.

D	2000B	SBR09	-	1032	.....	**104**
D	2320	SBR09	-	1032	.....	**363**

Claim Frequency Code

Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.

D	2300	CLM05	C023-3	1325	.....	**159**

Claim HCPCS Payable Amount

Sum of payable line item amounts for HCPCs codes billed on this claim.

D	2320	MOA02	-	782	.....	**398**

Claim Indirect Teaching Amount

Total of operating and capital indirect teaching amounts for this claim.

D	2320	MIA18	-	782	.....	**395**

Claim MSP Pass-through Amount

Interim cost pass-though amount used to determine Medicare Secondary Payer liability.

D	2320	MIA07	-	782	.....	**394**

Claim Note Text

Narrative text providing additional information related to the claim.

D	2300	NTE02	-	352	.....	**207**

Claim Original Reference Number

Number assigned by a processor to identify a claim.

D	2300	REF02	-	127	.....	**192**

Claim PPS Capital Amount

Total Prospective Payment System (PPS) capital amount payable for this claim as output by PPS PRICER.

D	2320	MIA08	-	782	.....	**394**

Claim PPS Capital Outlier Amount

Total Prospective Payment System capital day or cost outlier payable for this claim, excluding operating outlier amount.

D	2320	MIA17	-	782	.....	**395**

Claim Total Denied Charge Amount

Total amount of charges that were denied for this claim.

D	2320	AMT02	-	782	.....	**387**

Claim or Encounter Identifier

Code indicating whether the transaction is a claim or reporting encounter information.

H		BHT06	-	640	.....	**59**

Code Category

Specifies the situation or category to which the code applies.

D	2300	CRC01	-	1136	.....	**218**

Code List Qualifier Code

Code identifying a specific industry code list.

D	2300	HI01	C022-1	1270	.....	**228**
D	2300	HI02	C022-1	1270	.....	**228**
D	2300	HI03	C022-1	1270	.....	**229**
D	2300	HI01	C022-1	1270	.....	**230**
D	2300	HI01	C022-1	1270	.....	**232**
D	2300	HI02	C022-1	1270	.....	**233**
D	2300	HI03	C022-1	1270	.....	**234**
D	2300	HI04	C022-1	1270	.....	**235**
D	2300	HI05	C022-1	1270	.....	**235**
D	2300	HI06	C022-1	1270	.....	**236**
D	2300	HI07	C022-1	1270	.....	**237**
D	2300	HI08	C022-1	1270	.....	**237**
D	2300	HI09	C022-1	1270	.....	**238**
D	2300	HI10	C022-1	1270	.....	**239**
D	2300	HI11	C022-1	1270	.....	**240**
D	2300	HI12	C022-1	1270	.....	**240**
D	2300	HI01	C022-1	1270	.....	**242**
D	2300	HI01	C022-1	1270	.....	**244**
D	2300	HI02	C022-1	1270	.....	**245**
D	2300	HI03	C022-1	1270	.....	**246**
D	2300	HI04	C022-1	1270	.....	**247**
D	2300	HI05	C022-1	1270	.....	**248**
D	2300	HI06	C022-1	1270	.....	**249**
D	2300	HI07	C022-1	1270	.....	**250**
D	2300	HI08	C022-1	1270	.....	**251**
D	2300	HI09	C022-1	1270	.....	**252**
D	2300	HI10	C022-1	1270	.....	**252**
D	2300	HI11	C022-1	1270	.....	**253**
D	2300	HI12	C022-1	1270	.....	**254**
D	2300	HI01	C022-1	1270	.....	**256**
D	2300	HI02	C022-1	1270	.....	**257**
D	2300	HI03	C022-1	1270	.....	**258**
D	2300	HI04	C022-1	1270	.....	**259**
D	2300	HI05	C022-1	1270	.....	**260**
D	2300	HI06	C022-1	1270	.....	**261**
D	2300	HI07	C022-1	1270	.....	**261**
D	2300	HI08	C022-1	1270	.....	**262**
D	2300	HI09	C022-1	1270	.....	**263**
D	2300	HI10	C022-1	1270	.....	**264**
D	2300	HI11	C022-1	1270	.....	**265**
D	2300	HI12	C022-1	1270	.....	**265**
D	2300	HI01	C022-1	1270	.....	**267**
D	2300	HI02	C022-1	1270	.....	**268**
D	2300	HI03	C022-1	1270	.....	**269**
D	2300	HI04	C022-1	1270	.....	**270**
D	2300	HI05	C022-1	1270	.....	**271**
D	2300	HI06	C022-1	1270	.....	**272**
D	2300	HI07	C022-1	1270	.....	**273**
D	2300	HI08	C022-1	1270	.....	**274**
D	2300	HI09	C022-1	1270	.....	**275**
D	2300	HI10	C022-1	1270	.....	**276**
D	2300	HI11	C022-1	1270	.....	**277**
D	2300	HI12	C022-1	1270	.....	**278**
D	2300	HI01	C022-1	1270	.....	**280**
D	2300	HI02	C022-1	1270	.....	**281**
D	2300	HI03	C022-1	1270	.....	**282**
D	2300	HI04	C022-1	1270	.....	**283**
D	2300	HI05	C022-1	1270	.....	**283**
D	2300	HI06	C022-1	1270	.....	**284**

D	2300	HI07	C022-1	1270	**285**
D	2300	HI08	C022-1	1270	**285**
D	2300	HI09	C022-1	1270	**286**
D	2300	HI10	C022-1	1270	**287**
D	2300	HI11	C022-1	1270	**288**
D	2300	HI12	C022-1	1270	**288**
D	2300	HI01	C022-1	1270	**290**
D	2300	HI02	C022-1	1270	**291**
D	2300	HI03	C022-1	1270	**292**
D	2300	HI04	C022-1	1270	**292**
D	2300	HI05	C022-1	1270	**293**
D	2300	HI06	C022-1	1270	**294**
D	2300	HI07	C022-1	1270	**294**
D	2300	HI08	C022-1	1270	**295**
D	2300	HI09	C022-1	1270	**296**
D	2300	HI10	C022-1	1270	**296**
D	2300	HI11	C022-1	1270	**297**
D	2300	HI12	C022-1	1270	**298**
D	2300	HI01	C022-1	1270	**299**
D	2300	HI02	C022-1	1270	**300**
D	2300	HI03	C022-1	1270	**300**
D	2300	HI04	C022-1	1270	**301**
D	2300	HI05	C022-1	1270	**301**
D	2300	HI06	C022-1	1270	**302**
D	2300	HI07	C022-1	1270	**302**
D	2300	HI08	C022-1	1270	**303**
D	2300	HI09	C022-1	1270	**303**
D	2300	HI10	C022-1	1270	**304**
D	2300	HI11	C022-1	1270	**304**
D	2300	HI12	C022-1	1270	**305**

Communication Number

Complete communications number including country or area code when applicable

H	1000A	PER04	-	364	**65**
H	1000A	PER06	-	364	**66**
H	1000A	PER08	-	364	**66**
D	2010AA	PER04	-	364	**88**
D	2010AA	PER06	-	364	**89**
D	2010AA	PER08	-	364	**89**

Communication Number Qualifier

Code identifying the type of communication number

H	1000A	PER03	-	365	**65**
H	1000A	PER05	-	365	**65**
H	1000A	PER07	-	365	**66**
D	2010AA	PER03	-	365	**88**
D	2010AA	PER05	-	365	**89**
D	2010AA	PER07	-	365	**89**

Condition Code

Code(s) used to identify condition(s) relating to this bill or relating to the patient.

D	2300	HI01	C022-2	1271	**291**
D	2300	HI02	C022-2	1271	**291**
D	2300	HI03	C022-2	1271	**292**
D	2300	HI04	C022-2	1271	**293**
D	2300	HI05	C022-2	1271	**293**
D	2300	HI06	C022-2	1271	**294**
D	2300	HI07	C022-2	1271	**295**
D	2300	HI08	C022-2	1271	**295**
D	2300	HI09	C022-2	1271	**296**
D	2300	HI10	C022-2	1271	**297**
D	2300	HI11	C022-2	1271	**297**
D	2300	HI12	C022-2	1271	**298**

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

H	1000A	PER01	-	366	**65**
D	2010AA	PER01	-	366	**88**

Contract Amount

Fixed monetary amount pertaining to the contract

D	2300	CN102	-	782	**177**

Contract Code

Code identifying the specific contract, established by the payer.

D	2300	CN104	-	127	**177**

Contract Percentage

Percent of charges payable under the contract

D	2300	CN103	-	332	**177**

Contract Type Code

Code identifying a contract type

D	2300	CN101	-	1166	**176**

Contract Version Identifier

Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.

D	2300	CN106	-	799	**177**

Coordination of Benefits Total Submitted Charge Amount

The total coordination of benefit charges submitted applicable to the claim.

D	2320	AMT02	-	782	**373**

Cost Report Day Count

The number of days that may be claimed as Medicare patient days on a cost report.

D	2320	MIA15	-	380	**395**

Country Code

Code indicating the geographic location.

D	2010AA	N404	-	26	**81**
D	2010AB	N404	-	26	**96**
D	2010BA	N404	-	26	**114**
D	2010BC	N404	-	26	**131**
D	2010BD	N404	-	26	**138**
D	2010CA	N404	-	26	**150**
D	2300	CLM11	C024-5	26	**163**
D	2310E	N404	-	26	**356**
D	2330A	N404	-	26	**407**
D	2330B	N404	-	26	**414**

Covered Days or Visits Count

Number of days or visits covered by the primary payer or days/visits that would have been covered had Medicare been primary.

D | 2320 | MIA01 | - | 380 ..... **393**

Credit or Debit Card Authorization Number

Credit/Debit card authorization number used to authorize use of card for payment for billed charges.

D | 2010BB | REF02 | - | 127 ..... **125**

Credit or Debit Card Holder First Name

First name of the person or entity who has a credit card that could be used as payment for the billed charges.

D | 2010BB | NM104 | - | 1036 ..... **122**

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 | 2010BB | NM103 | - | 1035 ..... **122**

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 | 2010BB | NM105 | - | 1037 ..... **122**

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 | 2010BB | NM107 | - | 1039 ..... **122**

Credit or Debit Card Maximum Amount

Dollar limit for a credit or debit card

D | 2300 | AMT02 | - | 782 ..... **184**

Credit or Debit Card Number

Credit/Debit card number that may be used to pay for billed charges.

D | 2010BB | NM109 | - | 67 ..... **123**

Currency Code

Code for country in whose currency the charges are specified.

D | 2000A | CUR02 | - | 100 ..... **74**

Date Time Period

Expression of a date, a time, or a range of dates, times, or dates and times.

D | 2300 | HI01 | C022-4 | 1251 ..... **243**

Date Time Period Format Qualifier

Code indicating the date format, time format, or date and time format

D | 2010BA | DMG01 | - | 1250 ..... **115**
D | 2010CA | DMG01 | - | 1250 ..... **151**
D | 2300 | DTP02 | - | 1250 ..... **165**
D | 2300 | DTP02 | - | 1250 ..... **167**
D | 2300 | DTP02 | - | 1250 ..... **169**
D | 2300 | CR603 | - | 1250 ..... **211**
D | 2300 | CR615 | - | 1250 ..... **215**
D | 2300 | HI01 | C022-3 | 1250 ..... **243**
D | 2300 | HI01 | C022-3 | 1250 ..... **245**
D | 2300 | HI02 | C022-3 | 1250 ..... **246**
D | 2300 | HI03 | C022-3 | 1250 ..... **247**
D | 2300 | HI04 | C022-3 | 1250 ..... **248**
D | 2300 | HI05 | C022-3 | 1250 ..... **248**
D | 2300 | HI06 | C022-3 | 1250 ..... **249**
D | 2300 | HI07 | C022-3 | 1250 ..... **250**
D | 2300 | HI08 | C022-3 | 1250 ..... **251**
D | 2300 | HI09 | C022-3 | 1250 ..... **252**
D | 2300 | HI10 | C022-3 | 1250 ..... **253**
D | 2300 | HI11 | C022-3 | 1250 ..... **254**
D | 2300 | HI12 | C022-3 | 1250 ..... **255**
D | 2300 | HI01 | C022-3 | 1250 ..... **257**
D | 2300 | HI02 | C022-3 | 1250 ..... **258**
D | 2300 | HI03 | C022-3 | 1250 ..... **258**
D | 2300 | HI04 | C022-3 | 1250 ..... **259**
D | 2300 | HI05 | C022-3 | 1250 ..... **260**
D | 2300 | HI06 | C022-3 | 1250 ..... **261**
D | 2300 | HI07 | C022-3 | 1250 ..... **262**
D | 2300 | HI08 | C022-3 | 1250 ..... **263**
D | 2300 | HI09 | C022-3 | 1250 ..... **263**
D | 2300 | HI10 | C022-3 | 1250 ..... **264**
D | 2300 | HI11 | C022-3 | 1250 ..... **265**
D | 2300 | HI12 | C022-3 | 1250 ..... **266**
D | 2300 | HI01 | C022-3 | 1250 ..... **268**
D | 2300 | HI02 | C022-3 | 1250 ..... **269**
D | 2300 | HI03 | C022-3 | 1250 ..... **270**
D | 2300 | HI04 | C022-3 | 1250 ..... **271**
D | 2300 | HI05 | C022-3 | 1250 ..... **271**
D | 2300 | HI06 | C022-3 | 1250 ..... **272**
D | 2300 | HI07 | C022-3 | 1250 ..... **273**
D | 2300 | HI08 | C022-3 | 1250 ..... **274**
D | 2300 | HI09 | C022-3 | 1250 ..... **275**
D | 2300 | HI10 | C022-3 | 1250 ..... **276**
D | 2300 | HI11 | C022-3 | 1250 ..... **277**
D | 2300 | HI12 | C022-3 | 1250 ..... **278**
D | 2320 | DMG01 | - | 1250 ..... **388**
D | 2330B | DTP02 | - | 1250 ..... **415**
D | 2400 | DTP02 | - | 1250 ..... **457**
D | 2400 | DTP02 | - | 1250 ..... **458**
D | 2430 | DTP02 | - | 1250 ..... **502**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

D | 2300 | DTP01 | - | 374 ..... **165**
D | 2300 | DTP01 | - | 374 ..... **167**
D | 2300 | DTP01 | - | 374 ..... **169**
D | 2330B | DTP01 | - | 374 ..... **415**
D | 2400 | DTP01 | - | 374 ..... **456**
D | 2400 | DTP01 | - | 374 ..... **458**
D | 2430 | DTP01 | - | 374 ..... **502**

Delay Reason Code

Code indicating the reason why a request was delayed.

D	2300	CLM20	-	1514	.....	**164**

Delivery Pattern Time Code

Code which specifies the time delivery pattern of the services..

D	2305	HSD08	-	679	.....	**320**

Demonstration Project Identifier

Identification number for a Medicare demonstration project.

D	2300	REF02	-	127	.....	**202**

Diagnosis Date

Date the diagnosis was established or recorded.

D	2300	CR605	-	373	.....	**212**
D	2300	CR618	-	373	.....	**216**
D	2300	CR619	-	373	.....	**217**
D	2300	CR620	-	373	.....	**217**
D	2300	CR621	-	373	.....	**217**

Diagnosis Related Group (DRG) Code

Diagnosis related group for this claim.

D	2300	HI01	C022-2	1271	.....	**230**

Discharge Hour

Hour that the patient was discharged from inpatient care.

D	2300	DTP03	-	1251	.....	**166**

Discipline Type Code

Code indicating discipline(s) ordered by the physician.

D	2305	CR701	-	921	.....	**314**

Document Control Identifier

Internal control number assigned by a payer to facilitate retrieval or association of a claim.

D	2300	REF02	-	127	.....	**189**

Duration of Visits Units

The unit (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the one visit every three days occurs over a duration of days.

D	2305	HSD05	-	615	.....	**318**

Duration of Visits, Number of Units

The number of units (month, week, etc.) over which home health visits occur. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit every three days occurs over a duration of 21 days.

D	2305	HSD06	-	616	.....	**318**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual

H	1000A	NM101	-	98	.....	**62**
H	1000B	NM101	-	98	.....	**68**
D	2000A	CUR01	-	98	.....	**74**
D	2010AA	NM101	-	98	.....	**77**
D	2010AB	NM101	-	98	.....	**92**
D	2010BA	NM101	-	98	.....	**109**
D	2010BB	NM101	-	98	.....	**122**
D	2010BC	NM101	-	98	.....	**127**
D	2010BD	NM101	-	98	.....	**135**
D	2010CA	NM101	-	98	.....	**145**
D	2310A	NM101	-	98	.....	**322**
D	2310B	NM101	-	98	.....	**329**
D	2310C	NM101	-	98	.....	**336**
D	2310D	NM101	-	98	.....	**343**
D	2310E	NM101	-	98	.....	**350**
D	2330A	NM101	-	98	.....	**401**
D	2330B	NM101	-	98	.....	**410**
D	2330C	NM101	-	98	.....	**421**
D	2330D	NM101	-	98	.....	**425**
D	2330D	NM101	-	98	.....	**425**
D	2330E	NM101	-	98	.....	**429**
D	2330F	NM101	-	98	.....	**433**
D	2330G	NM101	-	98	.....	**437**
D	2330H	NM101	-	98	.....	**441**
D	2420A	NM101	-	98	.....	**463**
D	2420B	NM101	-	98	.....	**470**
D	2420C	NM101	-	98	.....	**477**
D	2420D	NM101	-	98	.....	**484**

Entity Type Qualifier

Code qualifying the type of entity

H	1000A	NM102	-	1065	.....	**62**
H	1000B	NM102	-	1065	.....	**68**
D	2010AA	NM102	-	1065	.....	**77**
D	2010AB	NM102	-	1065	.....	**92**
D	2010BA	NM102	-	1065	.....	**109**
D	2010BB	NM102	-	1065	.....	**122**
D	2010BC	NM102	-	1065	.....	**127**
D	2010BD	NM102	-	1065	.....	**135**
D	2010CA	NM102	-	1065	.....	**146**
D	2310A	NM102	-	1065	.....	**322**
D	2310B	NM102	-	1065	.....	**329**
D	2310C	NM102	-	1065	.....	**336**
D	2310D	NM102	-	1065	.....	**343**
D	2310E	NM102	-	1065	.....	**350**
D	2330A	NM102	-	1065	.....	**401**
D	2330B	NM102	-	1065	.....	**411**
D	2330C	NM102	-	1065	.....	**421**
D	2330D	NM102	-	1065	.....	**425**
D	2330D	NM102	-	1065	.....	**425**
D	2330E	NM102	-	1065	.....	**429**
D	2330F	NM102	-	1065	.....	**433**
D	2330G	NM102	-	1065	.....	**437**
D	2330H	NM102	-	1065	.....	**441**
D	2420A	NM102	-	1065	.....	**463**
D	2420B	NM102	-	1065	.....	**470**
D	2420C	NM102	-	1065	.....	**477**

D | 2420D | NM102 | - | 1065 ..... **484**

Estimated Claim Due Amount

The amount estimated by the provider to be due from the payer.

D | 2300 | AMT02 | - | 782 ..... **179**

Exception Code

Exception code generated by the Third Party Organization.

D | 2300 | HCP15 | - | 1527 ..... **313**

Explanation of Benefits Indicator

Indicator of whether a paper explanation of benefits (EOB) is requested.

D | 2300 | CLM18 | - | 1073 ..... **163**

Facility Code Qualifier

Code identifying the type of facility referenced.

D | 2300 | CLM05 | C023-2 | 1332 ..... **159**

Facility Tax Amount

The amount of facility tax or surcharge applicable to the reported service.

D | 2400 | AMT02 | - | 782 ..... **461**

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 ..... **159**

Fixed Format Information

Data in fixed format agreed upon by sender and receiver

D | 2300 | K301 | - | 449 ..... **204**

Frequency Count

The count of the frequency units of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating that the one visit occurs at three day intervals.

D | 2305 | HSD04 | - | 1167..... **318**

Frequency Period

The units specifying the frequency of home health visits (e.g., days, months, etc.) Example: One visit every three days for 21 days. This element qualifies that the data is communicating that the the one visit occurs at a frequency of days.

D | 2305 | HSD03 | - | 355 ..... **317**

Functional Limitation Code

Code describing the patient's functional limitations as assessed by the physician.

D | 2300 | CRC03 | - | 1321 ..... **219**
D | 2300 | CRC04 | - | 1321 ..... **220**
D | 2300 | CRC05 | - | 1321 ..... **220**
D | 2300 | CRC06 | - | 1321 ..... **220**
D | 2300 | CRC07 | - | 1321 ..... **220**
D | 2300 | CRC02 | - | 1073 ..... **222**
D | 2300 | CRC02 | - | 1073 ..... **225**

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 ..... **100**
D | 2000C | HL04 | - | 736 ..... **140**

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 ..... **100**
D | 2000C | HL01 | - | 628 ..... **140**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

D | 2000A | HL03 | - | 735 ..... **70**
D | 2000B | HL03 | - | 735 ..... **100**
D | 2000C | HL03 | - | 735 ..... **140**

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 ..... **100**
D | 2000C | HL02 | - | 734 ..... **140**

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 ..... **57**

Home Health Certification Period

Certification period for home health care covered by this plan of treatment.

D | 2300 | CR604 | - | 1251 ..... **212**

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67)

H | 1000A | NM108 | - | 66 ..... **62**
D | 2010AA | NM108 | - | 66 ..... **77**
D | 2010AB | NM108 | - | 66 ..... **92**
D | 2010BA | NM108 | - | 66 .....**110**

D	2010BB	NM108		-	66	**123**
D	2010BC	NM108		-	66	**127**
D	2010CA	NM108		-	66	**147**
D	2300	PWK05		-	66	**175**
D	2310A	NM108		-	66	**323**
D	2310B	NM108		-	66	**330**
D	2310C	NM108		-	66	**337**
D	2310D	NM108		-	66	**344**
D	2310E	NM108		-	66	**350**
D	2330A	NM108		-	66	**402**
D	2330B	NM108		-	66	**411**
D	2330C	NM108		-	66	**421**
D	2400	PWK05		-	66	**454**
D	2420A	NM108		-	66	**463**
D	2420B	NM108		-	66	**470**
D	2420C	NM108		-	66	**478**
D	2420D	NM108		-	66	**484**

Individual Relationship Code

Code indicating the relationship between two individuals or entities

D	2000B	SBR02		-	1069	**103**
D	2000C	PAT01		-	1069	**142**
D	2320	SBR02		-	1069	**361**

Industry Code

Code indicating a code from a specific industry code list.

D	2300	HI01	C022-2		1271	**228**
D	2300	HI02	C022-2		1271	**228**
D	2300	HI03	C022-2		1271	**229**

Information Receiver Identification Number

The identification number of the individual or organization who expects to receive information in response to a query.

H	1000B	NM108		-	66	**68**

Insured Group Name

Name of the group or plan through which the insurance is provided to the insured.

D	2000B	SBR04		-	93	**103**

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	**103**
D	2320	SBR03		-	127	**363**

Investigational Device Exemption Identifier

Number or reference identifying exemption assigned to an ivestigational device referenced in the claim.

D	2300	REF02		-	127	**193**

Laboratory or Facility Address Line

Address line of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D	2310E	N301		-	166	**354**
D	2310E	N302		-	166	**354**

Laboratory or Facility City Name

City of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D	2310E	N401		-	19	**355**

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	2310E	NM103		-	1035	**350**

Laboratory or Facility Postal Zone or ZIP Code

Postal ZIP or zonal code of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D	2310E	N403		-	116	**356**

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	2310E	NM109		-	67	**350**

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	2310E	REF02		-	127	**358**

Laboratory or Facility State or Province Code

State or province of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.

D	2310E	N402		-	156	**355**

Last Admission Period

Admission date of the most recent inpatient stay.

D	2300	CR616		-	1251	**215**

Last Visit Date

Date the patient was last seen by the physician.

D	2300	CR613		-	373	**215**

Lifetime Psychiatric Days Count

Number of lifetime psychiatric days used for this claim.

D | 2320 | MIA03 | - | 380 ..... **393**

Lifetime Reserve Days Count

Number of lifetime reserve days used for this claim.

D | 2320 | MIA02 | - | 380 ..... **393**

Line Item Charge Amount

Charges related to this service.

D | 2400 | SV203 | - | 782 ..... **448**

Line Item Denied Charge or Non-Covered Charge Amount

Line item charges denied or not covered.

D | 2400 | SV207 | - | 782 ..... **449**

Medical Record Number

A unique number assigned to patient by the provider to assist in retrieval of medical records.

D | 2300 | REF02 | - | 127 ..... **201**

Medicare Assignment Code

An indication, used by Medicare or other government programs, that the provider accepted assignment.

D | 2300 | CLM07 | - | 1359 ..... **160**

Medicare Coverage Indicator

A code indicating the Medicare coverage exists.

D | 2300 | CR607 | - | 1073 ..... **213**

Medicare Paid at 100% Amount

Amount of charges reported to be paid by Medicare at 100% of allowed amount.

D | 2320 | AMT02 | - | 782 ..... **378**

Medicare Paid at 80% Amount

Amount of charges reported to be paid by Medicare at 80% of allowed amount.

D | 2320 | AMT02 | - | 782 ..... **380**

Mental Status Code

Codes describing the patient's mental condition.

D | 2300 | CRC03 | - | 1321 ..... **225**
D | 2300 | CRC04 | - | 1321 ..... **226**
D | 2300 | CRC05 | - | 1321 ..... **226**
D | 2300 | CRC06 | - | 1321 ..... **226**
D | 2300 | CRC07 | - | 1321 ..... **226**

Non-Covered Charge Amount

Charges pertaining to the related revenue center code that the primary payer will not cover.

D | 2320 | AMT02 | - | 782 ..... **386**

Nonpayable Professional Component Amount

Professional fees billed but not payable by payer.

D | 2320 | MIA19 | - | 782 ..... **395**
D | 2320 | MOA09 | - | 782 ..... **399**

Note Reference Code

Code identifying the functional area or purpose for which the note applies.

D | 2300 | NTE01 | - | 363 ..... **206**
D | 2300 | NTE01 | - | 363 ..... **208**

Number of Visits

The number of home health visits. Example: One visit every three days for 21 days. This element indicates that the data is communicating the number of visits, i.e., one.

D | 2305 | HSD02 | - | 380 ..... **317**

Occurrence Code

A code defining a significant event relating to this bill that may affect payer processing.

D | 2300 | HI01 | C022-2 | 1271 ..... **268**
D | 2300 | HI02 | C022-2 | 1271 ..... **268**
D | 2300 | HI03 | C022-2 | 1271 ..... **269**
D | 2300 | HI04 | C022-2 | 1271 ..... **270**
D | 2300 | HI05 | C022-2 | 1271 ..... **271**
D | 2300 | HI06 | C022-2 | 1271 ..... **272**
D | 2300 | HI07 | C022-2 | 1271 ..... **273**
D | 2300 | HI08 | C022-2 | 1271 ..... **274**
D | 2300 | HI09 | C022-2 | 1271 ..... **275**
D | 2300 | HI10 | C022-2 | 1271 ..... **276**
D | 2300 | HI11 | C022-2 | 1271 ..... **277**
D | 2300 | HI12 | C022-2 | 1271 ..... **278**

Occurrence Span Code

A code that identifies an event that relates to payment of the claim. This event occurs over a span of days.

D | 2300 | HI01 | C022-2 | 1271 ..... **257**
D | 2300 | HI02 | C022-2 | 1271 ..... **257**
D | 2300 | HI03 | C022-2 | 1271 ..... **258**
D | 2300 | HI04 | C022-2 | 1271 ..... **259**
D | 2300 | HI05 | C022-2 | 1271 ..... **260**
D | 2300 | HI06 | C022-2 | 1271 ..... **261**
D | 2300 | HI07 | C022-2 | 1271 ..... **262**
D | 2300 | HI08 | C022-2 | 1271 ..... **262**
D | 2300 | HI09 | C022-2 | 1271 ..... **263**
D | 2300 | HI10 | C022-2 | 1271 ..... **264**
D | 2300 | HI11 | C022-2 | 1271 ..... **265**
D | 2300 | HI12 | C022-2 | 1271 ..... **266**

Occurrence or Occurrence Span Code Associated Date

Date associated with indicated code value.

D | 2300 | HI01 | C022-4 | 1251 ..... **257**
D | 2300 | HI02 | C022-4 | 1251 ..... **258**
D | 2300 | HI03 | C022-4 | 1251 ..... **259**
D | 2300 | HI04 | C022-4 | 1251 ..... **259**
D | 2300 | HI05 | C022-4 | 1251 ..... **260**
D | 2300 | HI06 | C022-4 | 1251 ..... **261**
D | 2300 | HI07 | C022-4 | 1251 ..... **262**
D | 2300 | HI08 | C022-4 | 1251 ..... **263**
D | 2300 | HI09 | C022-4 | 1251 ..... **263**

D	2300	HI10	C022-4	1251	**264**
D	2300	HI11	C022-4	1251	**265**
D	2300	HI12	C022-4	1251	**266**
D	2300	HI01	C022-4	1251	**268**
D	2300	HI02	C022-4	1251	**269**
D	2300	HI03	C022-4	1251	**270**
D	2300	HI04	C022-4	1251	**271**
D	2300	HI05	C022-4	1251	**272**
D	2300	HI06	C022-4	1251	**273**
D	2300	HI07	C022-4	1251	**274**
D	2300	HI08	C022-4	1251	**275**
D	2300	HI09	C022-4	1251	**276**
D	2300	HI10	C022-4	1251	**277**
D	2300	HI11	C022-4	1251	**278**
D	2300	HI12	C022-4	1251	**279**

Old Capital Amount

The amount for old capital for this claim.

D	2320	MIA12	-	782	**394**

Operating Physican Middle Name

Middle name of the physician performing the principal procedure.

D	2310B	NM105	-	1037	**329**
D	2420B	NM105	-	1037	**470**

Operating Physician First Name

First name of the physician performing the principle procedure.

D	2310B	NM104	-	1036	**329**
D	2420B	NM104	-	1036	**470**

Operating Physician Last Name

Last name of the physician performing the principle procedure.

D	2310B	NM103	-	1035	**329**
D	2420B	NM103	-	1035	**470**

Operating Physician Name Suffix

Suffix to the name of the physician performing the principal procedure.

D	2310B	NM107	-	1039	**329**
D	2420B	NM107	-	1039	**470**

Operating Physician Primary Identifier

Primary identifier of the physician performing the principle procedure.

D	2310B	NM109	-	67	**330**
D	2420B	NM109	-	67	**471**

Operating Physician Secondary Identifier

Additional identifier for the physician performing the principal procedure.

D	2310B	REF02	-	127	**334**
D	2420B	REF02	-	127	**475**

Originator Application Transaction Identifier

An identification number that identifies a transaction within the originator's applications system.

H		BHT03	-	127	**58**

Other Diagnosis

Other diagnosis for this claim.

D	2300	HI01	C022-2	1271	**233**
D	2300	HI02	C022-2	1271	**233**
D	2300	HI03	C022-2	1271	**234**
D	2300	HI04	C022-2	1271	**235**
D	2300	HI05	C022-2	1271	**235**
D	2300	HI06	C022-2	1271	**236**
D	2300	HI07	C022-2	1271	**237**
D	2300	HI08	C022-2	1271	**238**
D	2300	HI09	C022-2	1271	**238**
D	2300	HI10	C022-2	1271	**239**
D	2300	HI11	C022-2	1271	**240**
D	2300	HI12	C022-2	1271	**240**

Other Insured Additional Identifier

Number providing additional identification of the other insured.

D	2330A	REF02	-	127	**409**

Other Insured Address Line

Address line of the additional insured individual's mailing address.

D	2330A	N301	-	166	**404**
D	2330A	N302	-	166	**405**

Other Insured Birth Date

The birth date of the additional insured individual.

D	2320	DMG02	-	1251	**389**

Other Insured City Name

The city name of the additional insured individual.

D	2330A	N401	-	19	**406**

Other Insured First Name

The first name of the additional insured individual.

D	2330A	NM104	-	1036	**401**

Other Insured Gender Code

A code to specify the sex of the additional insured individual.

D	2320	DMG03	-	1068	**389**

Other Insured Group Name

Name of the group or plan through which the insurance is provided to the other insured.

D	2320	SBR04	-	93	**363**

Other Insured Identifier

An identification number, assigned by the third party payer, to identify the additional insured individual.

D | 2330A | NM109 | - | 67 ..... **403**

Other Insured Last Name

The last name of the additional insured individual.

D | 2330A | NM103 | - | 1035 ..... **401**

Other Insured Middle Name

The middle name of the additional insured individual.

D | 2330A | NM105 | - | 1037 ..... **402**

Other Insured Name Suffix

The suffix to the name of the additional insured individual.

D | 2330A | NM107 | - | 1039 ..... **402**

Other Insured Postal Zone or ZIP Code

The Postal ZIP code of the additional insured individual's mailing address.

D | 2330A | N403 | - | 116..... **407**

Other Insured State Code

The state code of the additional insured individual's mailing address.

D | 2330A | N402 | - | 156 ..... **407**

Other Payer Address Line

Address line of the other payer's mailing address.

D | 2330B | N301 | - | 166 ..... **412**
D | 2330B | N302 | - | 166 ..... **412**

Other Payer Attending Provider Identifier

The non-destination (COB) payer's attending provider identification.

D | 2330D | REF02 | - | 127 ..... **427**

Other Payer City Name

The city name of the other payer's mailing address.

D | 2330B | N401 | - | 19 ..... **413**

Other Payer Last or Organization Name

The name of the other payer organization.

D | 2330B | NM103 | - | 1035 .....**411**

Other Payer Operating Provider Identifier

The non-destination (COB) payer's operating provider identification.

D | 2330E | REF02 | - | 127 ..... **431**

Other Payer Other Provider Identifier

The non-destination (COB) payer's other provider identification.

D | 2330F | REF02 | - | 127 ..... **435**

Other Payer Patient Paid Amount

Amount reported by other payer as paid by the patient

D | 2320 | AMT02 | - | 782 ..... **371**

Other Payer Patient Primary Identifier

The non-destination (COB) payer's patient's primary identification number.

D | 2330C | NM109 | - | 67 ..... **421**

Other Payer Patient Secondary Identifier

The non-destination (COB) payer's patient's secondary identification number(s).

D | 2330C | REF02 | - | 127 ..... **423**

Other Payer Postal Zone or ZIP Code

The ZIP code of the other payer's mailing address.

D | 2330B | N403 | - | 116..... **414**

Other Payer Primary Identifier

An identification number for the other payer.

D | 2330B | NM109 | - | 67 .....**411**

Other Payer Prior Authorization or Referral Number

The non-destination (COB) payer's prior authorization or referral number.

D | 2330B | REF02 | - | 127 ..... **419**

Other Payer Referring Provider Identifier

The non-destination (COB) payer's referring provider identifier.

D | 2330G | REF02 | - | 127 ..... **439**

Other Payer Secondary Identifier

Additional identifier for the other payer organization

D | 2330B | REF02 | - | 127 ..... **417**

Other Payer Service Facility Provider Identifier

The non-destination (COB) payer's service faciltity provider identifier.

D | 2330H | REF02 | - | 127 ..... **443**

Other Payer State Code

The state or province code of the other payer's mailing address.

D | 2330B | N402 | - | 156 ..... **414**

Other Physician First Name

The First Name of the other licensed physician.

D | 2310C | NM104 | - | 1036 ..... **336**
D | 2420C | NM104 | - | 1036 ..... **477**

Other Physician Identifier

The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.

D | 2310C | NM109 | - | 67 ..... **337**
D | 2420D | NM109 | - | 67 ..... **485**

Other Physician Last Name

The Last Name of the other licensed physician.

D | 2310C | NM103 | - | 1035 ..... **336**
D | 2420C | NM103 | - | 1035 ..... **477**

Other Provider Identifier

The number of the other licensed provider.

D | 2420C | NM109 | - | 67 ..... **478**

Other Provider Middle Name

The middle name of the other licensed provider.

D | 2310C | NM105 | - | 1037 ..... **337**
D | 2420C | NM105 | - | 1037 ..... **477**

Other Provider Name Suffix

Suffix to the name of the other licensed provider.

D | 2310C | NM107 | - | 1039 ..... **337**
D | 2420C | NM107 | - | 1039 ..... **478**

Other Provider Secondary Identifier

Additional identification number of the other provider as defined by the payer organization.

D | 2310C | REF02 | - | 127 ..... **341**
D | 2420C | REF02 | - | 127 ..... **482**

PPS-Capital DSH DRG Amount

PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.

D | 2320 | MIA11 | - | 782 ..... **394**

PPS-Capital Exception Amount

A per discharge payment exception paid to the hospital. It is a flat-rate add-on to the PPS payment.

D | 2320 | MIA24 | - | 782 ..... **396**

PPS-Capital FSP DRG Amount

PPS-capital federal portion for this claim as output by PPS-PRICER.

D | 2320 | MIA09 | - | 782 ..... **394**

PPS-Capital HSP DRG Amount

Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.

D | 2320 | MIA10 | - | 782 ..... **394**

PPS-Capital IME amount

PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.

D | 2320 | MIA13 | - | 782 ..... **395**

PPS-Operating Federal Specific DRG Amount

Sum of federal operating portion of the DRG amount this claim as output by PPS-PRICER.

D | 2320 | MIA16 | - | 782 ..... **395**

PPS-Operating Hospital Specific DRG Amount

Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.

D | 2320 | MIA14 | - | 782 ..... **395**

Paid From Part A Medicare Trust Fund Amount

Dollar amount paid for claim from the Part A Medicare Trust fund.

D | 2320 | AMT02 | - | 782 ..... **383**

Paid From Part B Medicare Trust Fund Amount

Dollar amount paid for claim from the Part B Medicare Trust fund.

D | 2320 | AMT02 | - | 782 ..... **385**

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 ..... **158**

Patient Address Line

Address line of the street mailing address of the patient.

D | 2010CA | N301 | - | 166 ..... **148**
D | 2010CA | N302 | - | 166 ..... **148**

Patient Amount Paid

The amount the provider has received from the patient (or insured) toward payment of this claim.

D | 2300 | AMT02 | - | 782 ..... **183**

Patient Birth Date

Date of birth of the patient.

D | 2010CA | DMG02 | - | 1251 ..... **152**

Patient City Name

The city name of the patient.

D | 2010CA | N401 | - | 19 ..... **149**

Patient Discharge Facility Type Code

The type of facility from which the patient was most recently discharged.

D | 2300 | CR617 | - | 1384 ..... **216**

Patient First Name

The first name of the individual to whom the services were provided.

D | 2010CA | NM104 | - | 1036 ..... **146**

Patient Gender Code

A code indicating the sex of the patient.

D | 2010CA | DMG03 | - | 1068 ..... **152**

Patient Last Name

The last name of the individual to whom the services were provided.

D | 2010CA | NM103 | - | 1035 ..... **146**

Patient Middle Name

The middle name of the individual to whom the services were provided.

D | 2010CA | NM105 | - | 1037 ..... **146**

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

D | 2010CA | NM107 | - | 1039 ..... **146**

Patient Postal Zone or ZIP Code

The ZIP Code of the patient.

D | 2010CA | N403 | - | 116..... **150**

Patient Primary Identifier

Identifier assigned by the payer to identify the patient

D | 2010CA | NM109 | - | 67 ..... **147**

Patient Responsibility Amount

The amount determined to be the patient's responsibility for payment..

D | 2300 | AMT02 | - | 782 ..... **181**

Patient Secondary Identifier

Additional identifier assigned to the patient by the payer.

D | 2010CA | REF02 | - | 127 ..... **154**

Patient State Code

The State Postal Code of the patient.

D | 2010CA | N402 | - | 156 ..... **150**

Patient Status Code

A code indicating the patient's status at the date of admission, outpatient service, or start of care.

D | 2300 | CL103 | - | 1352 ..... **172**

Patient Weight

Weight of the patient at time of treatment or transport.

D | 2000B | PAT08 | - | 81 ..... **107**
D | 2000C | PAT08 | - | 81 ..... **144**

Pay-to Provider Additional Identifier

Additional identifer for pay-to provider.

D | 2010AB | REF02 | - | 127 ..... **98**

Pay-to Provider Address Line

Address line of the provider to receive payment

D | 2010AB | N301 | - | 166 ..... **94**
D | 2010AB | N302 | - | 166 ..... **94**

Pay-to Provider City Name

City name of the provider to receive payment.

D | 2010AB | N401 | - | 19 ..... **95**

Pay-to Provider Identifier

Identification number for the provider or organization that will receive payment.

D | 2010AB | NM109 | - | 67 ..... **93**

Pay-to Provider Last or Organizational Name

Last or organizational name of the provider to receive payment.

D | 2010AB | NM103 | - | 1035 ..... **92**

D	2300	HI08	C022-2	1271	**251**
D	2300	HI09	C022-2	1271	**252**
D	2300	HI10	C022-2	1271	**253**
D	2300	HI11	C022-2	1271	**254**
D	2300	HI12	C022-2	1271	**254**
D	2400	SV202	C003-2	234	**447**
D	2430	SVD03	C003-2	234	**492**

Procedure Code Description

Description clarifying the Product/Service Procedure Code and related data elements.

D	2430	SVD03	C003-7	352	**492**

Procedure Date

Date when the health care procedure was performed.

D	2300	HI01	C022-4	1251	**245**
D	2300	HI02	C022-4	1251	**246**
D	2300	HI03	C022-4	1251	**247**
D	2300	HI04	C022-4	1251	**248**
D	2300	HI05	C022-4	1251	**249**
D	2300	HI06	C022-4	1251	**249**
D	2300	HI07	C022-4	1251	**250**
D	2300	HI08	C022-4	1251	**251**
D	2300	HI09	C022-4	1251	**252**
D	2300	HI10	C022-4	1251	**253**
D	2300	HI11	C022-4	1251	**254**
D	2300	HI12	C022-4	1251	**255**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

D	2400	SV202	C003-3	1339	**447**
D	2400	SV202	C003-4	1339	**447**
D	2400	SV202	C003-5	1339	**448**
D	2400	SV202	C003-6	1339	**448**
D	2430	SVD03	C003-3	1339	**492**
D	2430	SVD03	C003-4	1339	**492**
D	2430	SVD03	C003-5	1339	**492**
D	2430	SVD03	C003-6	1339	**492**

Product or Service ID Qualifier

Code identifying the type/source of the descriptive number used in Product/Service ID (234).

D	2300	CR610	-	235	**214**
D	2300	HCP09	-	235	**311**
D	2400	SV202	C003-1	235	**446**
D	2430	SVD03	C003-1	235	**491**

Prognosis Code

Code indicating physician's prognosis for the patient.

D	2300	CR601	-	923	**211**

Property Casualty Claim Number

Identification number for property casualty claim associated with the services identified on the bill.

D	2010BA	REF02	-	127	**120**
D	2010CA	REF02	-	127	**156**

Provider Code

Code identifying the type of provider.

D	2000A	PRV01	-	1221	**71**
D	2310A	PRV01	-	1221	**324**
D	2310B	PRV01	-	1221	**331**
D	2310C	PRV01	-	1221	**338**
D	2310D	PRV01	-	1221	**345**
D	2310E	PRV01	-	1221	**352**
D	2420A	PRV01	-	1221	**465**
D	2420B	PRV01	-	1221	**472**
D	2420C	PRV01	-	1221	**479**
D	2420D	PRV01	-	1221	**486**

Provider Taxonomy Code

Code designating the provider type, classification, and specialization.

D	2000A	PRV03	-	127	**72**
D	2310A	PRV03	-	127	**325**
D	2310B	PRV03	-	127	**332**
D	2310C	PRV03	-	127	**339**
D	2310D	PRV03	-	127	**346**
D	2310E	PRV03	-	127	**353**
D	2420A	PRV03	-	127	**466**
D	2420B	PRV03	-	127	**473**
D	2420C	PRV03	-	127	**480**
D	2420D	PRV03	-	127	**487**

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	**160**

Quantity Qualifier

Code specifying the type of quantity

D	2300	QTY01	-	673	**306**

Receiver Name

Name of organization receiving the transaction.

H	1000B	NM103	-	1035	**68**

Receiver Primary Identifier

Primary identification number for the receiver of the transaction.

H	1000B	NM109	-	67	**68**

Reference Identification Qualifier

Code qualifying the reference identification

H		REF01	-	128	**60**
D	2000A	PRV02	-	128	**72**
D	2010AA	REF01	-	128	**83**
D	2010AA	REF01	-	128	**85**
D	2010AB	REF01	-	128	**97**
D	2010BA	REF01	-	128	**117**
D	2010BA	REF01	-	128	**120**
D	2010BB	REF01	-	128	**124**
D	2010BC	REF01	-	128	**132**
D	2010CA	REF01	-	128	**153**
D	2010CA	REF01	-	128	**155**

D	2300	REF01	-	128	.....	**185**
D	2300	REF01	-	128	.....	**186**
D	2300	REF01	-	128	.....	**187**
D	2300	REF01	-	128	.....	**189**
D	2300	REF01	-	128	.....	**191**
D	2300	REF01	-	128	.....	**193**
D	2300	REF01	-	128	.....	**195**
D	2300	REF01	-	128	.....	**197**
D	2300	REF01	-	128	.....	**198**
D	2300	REF01	-	128	.....	**200**
D	2300	REF01	-	128	.....	**202**
D	2310A	PRV02	-	128	.....	**325**
D	2310A	REF01	-	128	.....	**326**
D	2310B	PRV02	-	128	.....	**332**
D	2310B	REF01	-	128	.....	**333**
D	2310C	PRV02	-	128	.....	**339**
D	2310C	REF01	-	128	.....	**340**
D	2310D	PRV02	-	128	.....	**346**
D	2310D	REF01	-	128	.....	**347**
D	2310E	PRV02	-	128	.....	**353**
D	2310E	REF01	-	128	.....	**357**
D	2330A	REF01	-	128	.....	**408**
D	2330B	REF01	-	128	.....	**416**
D	2330B	REF01	-	128	.....	**418**
D	2330C	REF01	-	128	.....	**422**
D	2330D	REF01	-	128	.....	**426**
D	2330D	REF01	-	128	.....	**426**
D	2330E	REF01	-	128	.....	**430**
D	2330F	REF01	-	128	.....	**434**
D	2330G	REF01	-	128	.....	**438**
D	2330H	REF01	-	128	.....	**442**
D	2420A	PRV02	-	128	.....	**465**
D	2420A	REF01	-	128	.....	**467**
D	2420B	PRV02	-	128	.....	**473**
D	2420B	REF01	-	128	.....	**474**
D	2420C	PRV02	-	128	.....	**480**
D	2420C	REF01	-	128	.....	**481**
D	2420D	PRV02	-	128	.....	**487**
D	2420D	REF01	-	128	.....	**488**

Referring Provider First Name

The first name of provider who referred the patient to the provider of service on this claim.

D	2310D	NM104	-	1036	.....	**343**
D	2420D	NM104	-	1036	.....	**484**

Referring Provider Identifier

The identification number for the referring physician.

D	2310D	NM109	-	67	.....	**344**

Referring Provider Last Name

The Last Name of Provider who referred the patient to the provider of service on this claim.

D	2310D	NM103	-	1035	.....	**343**
D	2420D	NM103	-	1035	.....	**484**

Referring Provider Middle Name

Middle name of the provider who is referring patient for care.

D	2310D	NM105	-	1037	.....	**344**
D	2420D	NM105	-	1037	.....	**484**

Referring Provider Name Suffix

Suffix to the name of the provider referring the patient for care.

D	2310D	NM107	-	1039	.....	**344**
D	2420D	NM107	-	1039	.....	**484**

Referring Provider Secondary Identifier

Additional identification number for the provider referring the patient for service.

D	2310D	REF02	-	127	.....	**348**
D	2420D	REF02	-	127	.....	**489**

Reimbursement Rate

Rate used when payment is based upon a percentage of applicable charges.

D	2320	MOA01	-	954	.....	**397**

Reject Reason Code

Code assigned by issuer to identify reason for rejection

D	2300	HCP13	-	901	.....	**312**

Related Causes Code

Code identifying an accompanying cause of an illness, injury, or an accident.

D	2300	CLM11	C024-1	1362	.....	**161**
D	2300	CLM11	C024-2	1362	.....	**162**
D	2300	CLM11	C024-3	1362	.....	**162**

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	.....	**161**
D	2320	OI06	-	1363	.....	**391**

Remark Code

Code indicating a code from a specific industry code list, such as the Health Care Claim Status Code list.

D	2320	MIA05	-	127	.....	**393**
D	2320	MIA20	-	127	.....	**396**
D	2320	MIA21	-	127	.....	**396**
D	2320	MIA22	-	127	.....	**396**
D	2320	MIA23	-	127	.....	**396**
D	2320	MOA03	-	127	.....	**398**
D	2320	MOA04	-	127	.....	**398**
D	2320	MOA05	-	127	.....	**398**
D	2320	MOA06	-	127	.....	**399**
D	2320	MOA07	-	127	.....	**399**

Repriced Allowed Amount

The maximum amount determined by the repricer as being allowable under the provisions of the contract prior to the determination of the actual payment.

D	2300	HCP02	-	782	.....	**309**

Repriced Approved Amount

The amount allowed by the repricer for the claim or service line net of adjustments.

D | 2300 | HCP07 | - | 782 ..... **310**

Repriced Approved DRG Code

The Diagnosis Related Group approved by the repricer for payment for this claim

D | 2300 | HCP06 | - | 127 ..... **310**

Repriced Approved HCPCS Code

The HCPCS code that describes the services as approved by the repricer.

D | 2300 | HCP10 | - | 234 .....**311**

Repriced Approved Revenue Code

UB92 revenue code approved by the repricer for payment on the claim.

D | 2300 | HCP08 | - | 234 .....**311**

Repriced Approved Service Unit Count

Number of service units approved by pricing or repricing entity.

D | 2300 | HCP12 | - | 380 ..... **312**

Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify the claim.

D | 2300 | REF02 | - | 127 ..... **186**

Repriced Saving Amount

The amount of savings related to Third Party Organization claims.

D | 2300 | HCP03 | - | 782 ..... **310**

Repricing Organization Identifier

Reference or identification number of the repricing organization.

D | 2300 | HCP04 | - | 127 ..... **310**

Repricing Per Diem or Flat Rate Amount

Amount used to determine the flat rate or per diem price by the repricing organization.

D | 2300 | HCP05 | - | 118..... **310**

Responsible Party Address Line

Address line of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | N301 | - | 166 ..... **136**
D | 2010BD | N302 | - | 166 ..... **136**

Responsible Party City Name

City name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | N401 | - | 19 ..... **137**

Responsible Party First Name

First name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | NM104 | - | 1036 ..... **135**

Responsible Party Last or Organization Name

Last name or organization name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | NM103 | - | 1035 ..... **135**

Responsible Party Middle Name

Middle name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | NM105 | - | 1037 ..... **135**

Responsible Party Postal Zone or ZIP Code

Postal ZIP code of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | N403 | - | 116..... **137**

Responsible Party State Code

State or province of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations.

D | 2010BD | N402 | - | 156 ..... **137**

Responsible Party Suffix Name

Suffix for name of the person or entity responsible for payment of balance of bill after applicable processing by other parties, insurers, or organizations..

D | 2010BD | NM107 | - | 1039 ..... **135**

Service Adjudication or Payment Date

Date of payment or denial determination by a payer who has adjudicated this service line.

D | 2430 | DTP03 | - | 1251 ..... **502**

Service Authorization Exception Code

Code identifying the service authorization exception.

D | 2300 | REF02 | - | 127 ..... **196**

Service Date

Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.

D | 2400 | DTP03 | - | 1251 ..... **457**

Service From Date

The date the service referenced in the claim or service line was initiated.

D | 2300 | CR602 | - | 373 .....**211**

Service Line Paid Amount

Amount paid by the indicated payer for a service line

D | 2430 | SVD02 | - | 782 ..... **491**

Service Line Rate

Payment rate that applies to the service line.

D | 2400 | SV206 | - | 1371 ..... **449**

Service Line Revenue Code

UB92 Revenue Code pertaining to the service line.

D | 2400 | SV201 | - | 234 ..... **446**
D | 2430 | SVD04 | - | 234 ..... **492**

Service Tax Amount

The amount of service tax or surcharge applicable to the reported service.

D | 2400 | AMT02 | - | 782 ..... **460**

Service Unit Count

The quantity of units, times, days, visits, services, or treatments for the service described by the HCPCS codes, revenue code or procedure code.

D | 2400 | SV205 | - | 380 ..... **449**

Ship, Delivery or Calendar Pattern Code

The time delivery pattern for the services.

D | 2305 | HSD07 | - | 678 ..... **318**

Skilled Nursing Facility Indicator

Code indicating whether or not a patient is receiving care in a 1861J1 (skilled nursing) facility

D | 2300 | CR606 | - | 1073 ..... **212**

Special Program Indicator

A code indicating the Special Program under which the services rendered to the patient were performed.

D | 2300 | CLM12 | - | 1366 ..... **163**

Statement From or To Date

The date of the start or end of the period covered on the claim.

D | 2300 | DTP03 | - | 1251 ..... **168**

Submitter Contact Name

Name of the person at the submitter organization to whom inquiries about the transaction should be directed.

H | 1000A | PER02 | - | 93 ..... **65**

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 ..... **62**

Submitter Identifier

Code or number identifying the entity submitting the claim.

H | 1000A | NM109 | - | 67 ..... **63**

Submitter Last or Organization Name

The last name or the organizational name of the entity submitting the transaction

H | 1000A | NM103 | - | 1035 ..... **62**

Submitter Middle Name

The middle name of the person submitting the transaction

H | 1000A | NM105 | - | 1037 ..... **62**

Subscriber Address Line

Address line of the current mailing address of the insured individual or subscriber to the coverage.

D | 2010BA | N301 | - | 166 .....**112**
D | 2010BA | N302 | - | 166 .....**112**

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG02 | - | 1251 .....**116**

Subscriber City Name

The City Name of the insured individual or subscriber to the coverage

D | 2010BA | N401 | - | 19 ..... **113**

Subscriber First Name

The first name of the insured individual or subscriber to the coverage

D | 2010BA | NM104 | - | 1036 ..... **109**

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG03 | - | 1068 ..... **116**

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage

D | 2010BA | NM103 | - | 1035 ..... **109**

Subscriber Middle Name

The middle name of the subscriber to the indicated coverage or policy.

D | 2010BA | NM105 | - | 1037 ..... **109**

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

D | 2010BA | NM107 | - | 1039 ..... **110**

Subscriber Postal Zone or ZIP Code

The ZIP Code of the insured individual or subscriber to the coverage

D | 2010BA | N403 | - | 116..... **114**

Subscriber Primary Identifier

Primary identification number of the subscriber to the coverage.

D | 2010BA | NM109 | - | 67 ..... **110**

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage

D | 2010BA | N402 | - | 156 ..... **114**

Subscriber Supplemental Identifier

Identifies another or additional distinguishing code number associated with the subscriber.

D | 2010BA | REF02 | - | 127 ..... **118**

Surgery Date

Requested, anticipated, or actual date of surgery.

D | 2300 | CR609 | - | 373 ..... **213**

Surgical Procedure Code

Code describing the surgical procedure most relevant to the care being rendered.

D | 2300 | CR611 | - | 1137..... **214**

Terms Discount Percentage

Discount percentage available to the payer for payment within a specific time period.

D | 2300 | CN105 | - | 338 ..... **177**

Total Claim Charge Amount

The sum of all charges included within this claim.

D | 2300 | CLM02 | - | 782 ..... **159**

Total Medicare Paid Amount

Amount reported by the payer as paid by Medicare

D | 2320 | AMT02 | - | 782 ..... **377**

Total Visits Projected This Certification Count

Total covered visits to be rendered by each discipline during the period covered by the plan of treatment, including PRN visits.

D | 2305 | CR703 | - | 1470 ..... **315**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

D | | SE01 | - | 96 ..... **503**

Transaction Set Control Number

The unique identification number within a transaction set.

H | | ST02 | - | 329 ..... **56**
D | | SE02 | - | 329 ..... **503**

Transaction Set Creation Date

Identifies the date the submitter created the transaction

H | | BHT04 | - | 373 ..... **58**

Transaction Set Creation Time

Time file is created for transmission.

H | | BHT05 | - | 337 ..... **58**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H | | ST01 | - | 143 ..... **56**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

H | | BHT02 | - | 353 ..... **58**

Transmission Type Code

Code identifying the type of transaction or transmission included in the transaction set.

H		REF02	-	127	**60**

Treatment Code

Codes describing the treatment ordered by the physician.

D	2300	HI01	C022-2	1271		**300**
D	2300	HI02	C022-2	1271		**300**
D	2300	HI03	C022-2	1271		**300**
D	2300	HI04	C022-2	1271		**301**
D	2300	HI05	C022-2	1271		**302**
D	2300	HI06	C022-2	1271		**302**
D	2300	HI07	C022-2	1271		**302**
D	2300	HI08	C022-2	1271		**303**
D	2300	HI09	C022-2	1271		**304**
D	2300	HI10	C022-2	1271		**304**
D	2300	HI11	C022-2	1271		**304**
D	2300	HI12	C022-2	1271		**305**

Unit or Basis for Measurement Code

Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.

D	2000B	PAT07	-	355		**107**
D	2000C	PAT07	-	355		**144**
D	2300	QTY03	C001-1	355		**307**
D	2300	HCP11	-	355		**311**
D	2400	SV204	-	355		**448**

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	**188**

Value Code

A code that identifies data of a monetary nature that is necessary for processing this claim as required by the payer organization.

D	2300	HI01	C022-2	1271		**281**
D	2300	HI02	C022-2	1271		**281**
D	2300	HI03	C022-2	1271		**282**
D	2300	HI04	C022-2	1271		**283**
D	2300	HI05	C022-2	1271		**283**
D	2300	HI06	C022-2	1271		**284**
D	2300	HI07	C022-2	1271		**285**
D	2300	HI08	C022-2	1271		**286**
D	2300	HI09	C022-2	1271		**286**
D	2300	HI10	C022-2	1271		**287**
D	2300	HI11	C022-2	1271		**288**
D	2300	HI12	C022-2	1271		**288**

Value Code Associated Amount

Amount associated with indicated code value

D	2300	HI01	C022-5	782		**281**
D	2300	HI02	C022-5	782		**282**
D	2300	HI03	C022-5	782		**282**
D	2300	HI04	C022-5	782		**283**
D	2300	HI05	C022-5	782		**284**
D	2300	HI06	C022-5	782		**284**
D	2300	HI07	C022-5	782		**285**
D	2300	HI08	C022-5	782		**286**
D	2300	HI09	C022-5	782		**287**
D	2300	HI10	C022-5	782		**287**
D	2300	HI11	C022-5	782		**288**
D	2300	HI12	C022-5	782		**289**

Visits

The unit for home health visitations. Example: One visit every three days for 21 days. This element qualifies that the data is communicating visits.

D	2305	HSD01	-	673	**317**

Visits Prior to Recertification Date Count

Number of visits for care prior to the date of the recertification of services.

D	2305	CR702	-	1470	**315**

F UB-92 Mapping

This is the first part of this two part appendix:

F.1 UB-92 Form Locator [UB-92 Name]

Loop ID | Reference Designator | Composite ID-Composite Sequence | Data Element Number/Code Value

F.2 EMC v.6.0 Mapping

This is the second part of this two part appendix:

Loop ID | Reference Designator | Composite ID-Composite Sequence | Data Element Number/Code Value

G Credit/Debit Card Use

G.1 Credit/Debit Card Scenario 837 Transaction Set

A business scenario using credit/debit cards as an alternate payment vehicle for the patient portion of post-adjudicated claims is defined in this appendix. This scenario does not apply to all health care business environments using the 837. Implementers of this option must ensure that no current federal or state privacy regulations are violated. The use of this payment option is currently prohibited in conjunction with federal health plans such as Medicaid, Champus, VA, etc. This capability, which can be used to improve the provider's accounts receivable situation, is applicable only when trading partners agree to the opportunities and constraints defined in the following business scenario. The scenario has been included as an appendix to this 837 implementation guide after several years of work, as well as presentations and review with the appropriate ANSI X12N committees, including the 837 work group, the 835 work group, and work group 11 (business modeling).

The Business Need: Patient to Provider Payment Options

Providers today can offer patients a variety of service payment options when the patient's portion of the cost is known either before or at the time of service. Examples of payment options include cash, check, and billing (i.e., being billed). Another option, which is the topic of this appendix, is to use a patient's credit or debit card when the amount of the co-payment or service charge is known. Providers typically have a credit card terminal that is connected through a dial-up phone line to their credit card processing network.

The business need of increasing cash flow and providing payment options to a patient reflects a new use of a patient's credit/debit card as an option for payment of the patient/subscriber portion of a claim when that amount is not known at the time of service. This new payment option is being requested to:

- improve patient payment flexibility
- potentially reduce provider billing costs
- provide faster access to monies due from patients, and improve accounts receivable management

Before using this flexible payment option, the provider, value-added network, and/or an intermediary have to form a partnership where credit/debit card transactions are accepted as part of the reimbursement process. These agreements must comply with all current federal and state privacy regulations.

The patient/subscriber also must choose to use his or her credit/debit card for a future yet-to-be-determined amount. The patient/subscriber would provide his or her consent up to a maximum amount allowing the provider/ value-added network to bill the credit card after the claim has been adjudicated. This patient consent form also authorizes the transmission of credit/debit card information over a health care EDI network. The consent form must identify how the transaction will be used, and who will receive the information . It authorizes the service providers to use the account number in this transaction as described. The concept of pre-

authorized payment is currently in use in other industries, and customer acceptance of this type of payment vehicle has increased.

To implement this payment alternative, the patient's/subscriber's credit or debit card information would be carried in the 837, along with selected provider information. This information involves approximately 200 characters of data for each instance of credit or debit card use.

The provider's claims submission system would be enhanced to incorporate the required credit/debit card information into the 837 transaction. The 837 would then be transmitted to the Automated Clearing House/ processor/payer for claim adjudication. After the claim is adjudicated and coordination of benefits issues are resolved, the payer pays his or her portion of the claim and returns its explanation in an 835.

At this point, the value-added network could determine the amount to be applied to the patient's credit or debit card, and initiate a credit or debit card transaction to complete the claim payment. The amount charged to the patient's credit or debit card would then be reported to the provider in a separate transaction.

- Figure G1, Scenario: Patient Uses a Credit/Debit Card, depicts an example of how credit/debit card information could be transmitted using the standard 837 methodology.

Business Process Flow for Credit/Debit Card Payment Alternative for Post-adjudicated Claims

A. The provider/Automated Clearing House agrees to accept credit or debit cards.

B. The subscriber signs a consent form to pre-authorize charges up to a maximum amount and authorizes the use of their account number in this network.

C. The patient incurs the charges.

D. The provider submits an 837, including some claims containing credit or debit card information.

E. The Automated Clearing House notes the credit or debit card option and information, and passes the claim to the payer.

F. The payer adjudicates the claim and determines the coordination of benefits (COB). If no COB is involved, the payer returns the adjudicated claim to the Automated Clearing House or provider with the 835.

G. The Automated Clearing House creates the credit or debit card transaction(s), as appropriate, to close out the claim payment.

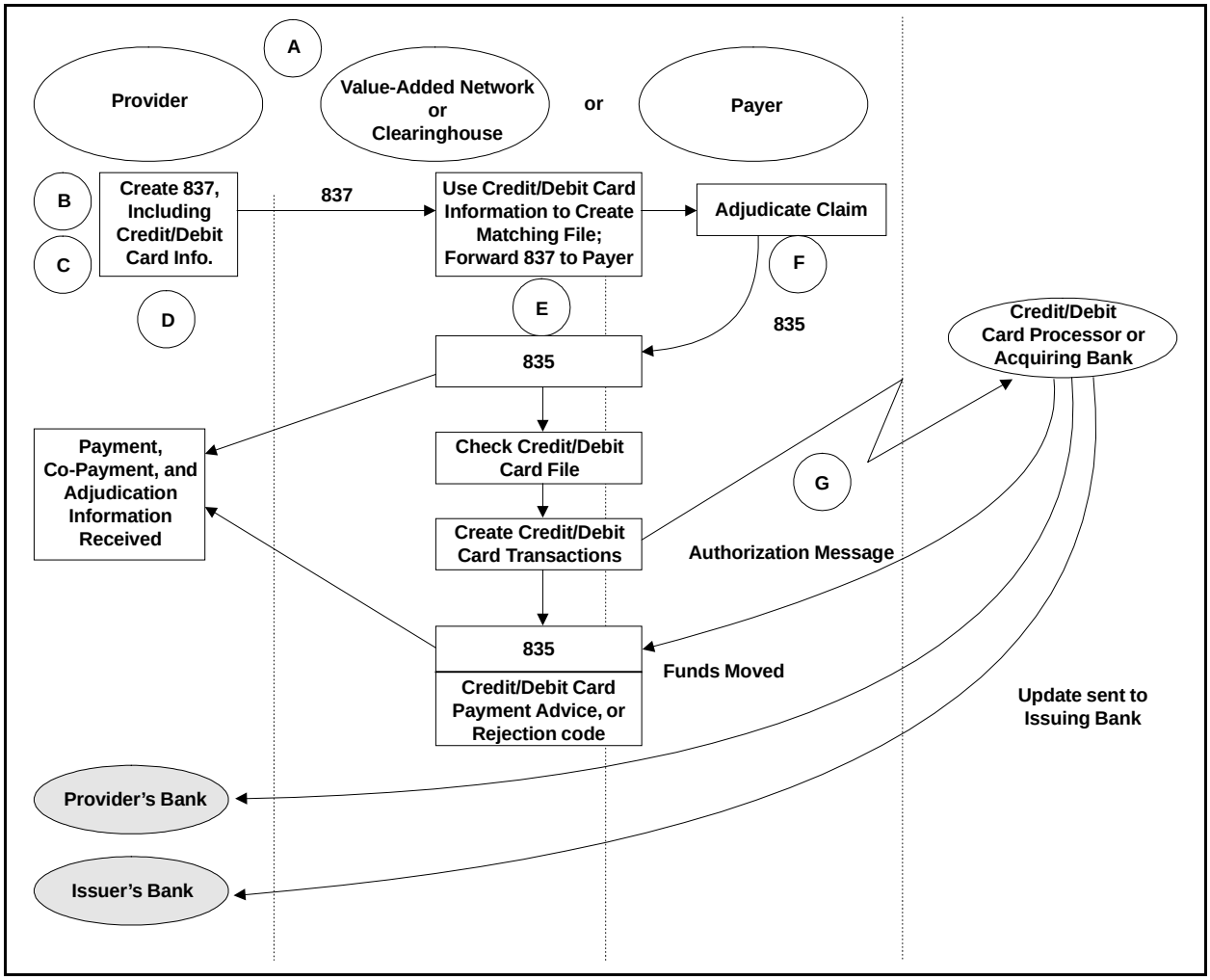


Figure G1. Scenario: Patient Uses a Credit/Debit Card **(Patient payment amount unknown)**

Credit/Debit Card Information

This is a map of only the additional information necessary to carry credit/debit card information. Loop ID-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	2010A	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	2010BB	055	NM101	98	AO	Account of
2	2010BB	055	NM108	66	MI	Charge Card Account Number
2	2010BB	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

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.