CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1343	**Date: SEPTEMBER 21, 2007**
	Change Request 5452

NOTE: Transmittal 1241, dated May 18, 2007 is rescinded and replaced with this transmittal. The implementation date for FISS and MCS has been changed from October 1, 2007 to April 7, 2008. All other information remains the same.

SUBJECT: Stage 3 NPI Changes for Transaction 835 and Standard Paper Remittance Advice

I. SUMMARY OF CHANGES: This instruction includes Stage 3 NPI Changes for Transaction 835, and Standard Paper Remittance Advice, and Changes in Medicare Claims Processing Manual, Chapter 22 - Remittance Advice.

NEW / REVISED MATERIAL
**EFFECTIVE DATE: ***July 2, 2007
IMPLEMENTATION DATE: April 2, 2007 for Analysis ONLY
July 2, 2007 for IOM update and Implementation for VMS
April 7, 2008 for Implementation for FISS and MCS

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	22/10/Background
R	22/30/Remittance Balancing
R	22/40/40.4/Medicare Standard Electronic PC Print Sofware for Institutional Providers
R	22/50/50.2.1/Part A (A/B Macs/FIs/RHHIs)SPR Format
R	22/50/50.2.2/Part B (A/B Mac/Carrier/DMERC/DME MAC) SPR Format
R	22/50/50.3/Part A (A/B MAC/FI/RHHI) SPR Crosswalk to the 835
R	22/50/50.4/Part B (A/B Mac/Carrier/DMERC/DME MAC) SPR Crosswalk to the 835

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirement

Pub. 100-04	Transmittal: 1343	Date: September 21, 2007	Change Request: 5452

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SUBJECT: Stage 3 NPI Changes for Transaction 835, and Standard Paper Remittance Advice

Effective Date: July 2, 2007

Implementation Date: April 2, 2007 for Analysis ONLY
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I. GENERAL INFORMATION

A. Background: This Change Request (CR) instructs the Shared System Maintainers and A/B Medicare Administrative Contractors (A/B MACs), carriers, Durable Medical Equipment Regional Carriers (DMERCs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs) how to report NPIs on a Health Insurance Portability and Accountability Act (HIPAA) compliant Electronic Remittance Advice (ERA) – X12N transaction 835 version 004010A1, Standard Paper Remittance (SPR) advice, and any output using PC Print or Medicare Remit Easy Print (MREP) on and after NPI effective date. The Taxpayer Identification Number (TIN) will continue to be reported for payees for tax reporting purposes. The Companion Documents and Flat Files for both Parts A and B will be updated to reflect these changes and the updated documents will be posted at:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage.

NPIs received on claims will be cross walked to the Medicare legacy number(s) for processing. Medicare's internal provider files will continue to be based upon records established in relation to the legacy identifiers. The crosswalk may result in:

Scenario I: Single NPI	cross walked to	Single Medicare legacy number
Scenario II: Multiple NPIs	cross walked to	Single Medicare legacy number
Scenario III: Single NPI	cross walked to	Multiple Medicare legacy numbers

NOTE 1: All 3 scenarios may not happen with all types of providers.

Medicare fee-for-service will adjudicate claims based upon a unique NPI/Legacy combination for Scenarios II and III, but the remittance advice –both electronic and paper- and any output using PC Print or Medicare Remit Easy Print (MREP) will have NPI as the provider identification. The TIN will be used as the secondary identifier for the Payee. The NPI regulation permits continued use of TIN for tax purposes if the implementation guide allows it.

NOTE 2: Although the following 3 scenarios refer to reporting of NPIs, current requirements concerning reporting of provider names and addresses will continue to apply.

Scenario I – Single NPI cross walked to single legacy number:

ERA: Under this scenario, report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then report any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs shall also report relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, there will be one remittance advice, and one check/EFT per NPI.
SPR: Insert the appropriate Payee NPI at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
PC Print Software: Show the Payee NPI at the header level. Then add the relevant Rendering Provider NPI at the claim level if different from the Payee NPI.
MREP software: Show the Payee NPI at the header level. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI, and any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI.

Scenario II: Multiple NPIs cross walked to Single Medicare legacy number:

ERA: Under this scenario, report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs also shall add any relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
SPR: Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
PC Print Software: Same as Scenario I.
MREP software: Same as Scenario I .

Scenario III: Single NPI cross walked to Multiple Medicare legacy numbers:

ERA: Under this scenario, report the NPI at the Payee level as the Payee primary ID, and the TIN (EIN/SSN) in the REF segment as Payee Additional ID. Then add any relevant Rendering Provider NPI at the claim level if different from the Payee NPI. A/B MACs, carriers, DME MACs, and DMERCs also shall add relevant Rendering NPI(s) at the service line level if different from the claim level Rendering Provider NPI. Under this scenario, adjudication will be based on the unique combination of NPI/legacy number, and there would be multiple remittance advices, checks and/or EFTs based on that unique combination.
SPR: Insert the appropriate NPI number at the header level. The ERA reporting requirements apply to the corresponding SPR fields. See above for additional notes.
PC Print Software: Same as Scenario I.
MREP software: Same as Scenario I.

Surrogate placeholder NPIs should not be sent on the 835. Send legacy numbers at the payee, and claim and line level, if applicable, on the ERA. Claims processed with placeholder NPIs should not drop to SPR if the receiver currently receives ERA.

B. **Policy:** Medicare will report NPIs as provider identification (at payee, and claim and line level, if applicable) on ERAs if NPI is received on the claim. The Taxpayer Identification Number (TIN) - Employer Identification Number (EIN)/Social Security Number (SSN) - will be reported as additional payee identification where applicable. NPI will also be reported on SPRs as provider identification (at payee, and line level, if applicable)) if NPI is available. If NPI is not available, both ERA and SPR will be generated with legacy numbers as provider identifiers (at payee, and claim and line level, if applicable) and will follow the currently used formats. NPI obtained from the crosswalk may be reported on ERAs

when providers are currently receiving ERAs, or SPRs when providers are currently receiving SPRs only in some special cases, e.g., adjustment claims received without NPI before NPI effective date.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5452.1	The billing/pay-to NPI received on the claim shall be reported as the payee primary identifier in Loop 1000B in N104 with the qualifier XX in N103 on the 835.							X	X	X		
5452.2	The TIN (EIN/SSN) shall be reported in Loop 1000B, data field REF 02 with qualifier TJ in data field REF 01 on the 835.							X	X	X		
5452.3	If a claim level rendering provider NPI has been received on the claim that differs from the billing/pay-to NPI, the rendering provider NPI shall be returned on the 835 at the claim level in Loop 2100; data field NM 109 with qualifier XX in data field NM 108 as service provider on the 835.								X	X		
5452.4	A service line rendering provider NPI shall be returned on the 835 at the service level in Loop 2110, data field REF02 with qualifier HPI in REF01, if received on the claim and is different than the payee level or claim level provider NPI.								X	X		
5452.5	The payee NPI shall be reported in Loop 2000, data field TS301.							X				
5452.6	The payee NPI shall be reported in data field PLB01 as the "Provider Identifier" if PLB segment is used.							X	X	X		
5452.7	Paper remittance advice shall report NPI at the header level when the billing/pay-to provider NPI is received on the claim.							X	X	X		
5452.8	If an NPI has been received on the claim to identify the rendering provider, MCS and VMS shall report the NPI at the service level on the SPRs if the rendering provider NPI is different								X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	than the billing/pay to NPI.											
5452.9	The Shared System Maintainers shall make necessary programming changes to continue to create the ERA and the SPR with legacy numbers if a claim either does not contain an NPI or contains a placeholder value.							X	X	X		
5452.10	FISS shall update PC Print software to accommodate changes as instructed in 5452.1, 5452.2, 5452.3, 5452.4, 5452.5, 5452.6, and 5452.9.							X				
5452.11	VMS shall update Medicare Remit Easy Print software to accommodate changes as instructed in 5452.1, 5452.2, 5452.3, 5452.4, 5452.6, and 5452.9.									X		
5452.12	The Shared Systems shall install logic making the effective date for full NPI implementation contractor-controlled.	X	X	X	X	X	X		X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5452.13	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next	X	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION N/A

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	**Recommendations or other supporting information:**

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen, 410-786-5755, sumita.sen@cms.hhs.gov

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

10 - Background

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

A/B Medicare Administrative Contractors (A/B MACs), carriers, Durable Medical Equipment Regional Carriers (DMERCs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), and Regional Home Health Intermediaries (RHHIs) send to providers, physicians, and suppliers, as a companion to claim payments, a notice of payment, referred to as the Remittance Advice (RA). RAs explain the payment and any adjustment(s) made during claim adjudication. For each claim or line item payment, and/or adjustment (including denial), there is an associated remittance advice item. Payments and/or adjustments for multiple claims can be reported on one transmission of the remittance advice. RA notices can be produced and transferred in either paper or electronic format.

A/B MACs, carriers, DMERCs, and DME MACs also send informational RAs to nonparticipating physicians, suppliers, and non-physician practitioners billing non-assigned claims (billing and receiving payments from patients instead of accepting direct Medicare payments), unless the beneficiary or the provider requests that the remittance notice be suppressed. An informational RA is identical to other RAs, but must carry a standard message to notify providers that they do not have appeal rights beyond those afforded when limitation on liability (rules regulating the amount of liability that an entity can accrue because of medical services which are not covered by Medicare – see Chapter 30) applies.

Medicare contractors are allowed to charge for generating and mailing, if applicable, duplicate remittance advice (both electronic and paper) to recoup cost when generated at the request of a provider or any entity working on behalf of the provider.

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

Under the HIPAA Administrative Provisions, the Secretary of Health and Human Services has established the standard for claim payment transaction. The adopted is the ANSI ASC X12N 835 version 004010A1, and an Implementation Guide (IG) for this HIPAA compliant version of transaction 835 (Health Care Claim/Payment Advice) is available to use. An IG is a reference document governing the implementation of an electronic format. It contains all information necessary to use the subject format, e.g., instructions and structures. This HIPAA compliant 835 has been established as a national standard for use by all health plans including Medicare A/B MACs, carriers, DMERCs, DME MACs, FIs, and RHHIs. Medicare requires the use of this format exclusively for Electronic Remittance Advices (ERAs). Medicare has also established a policy that the paper formats shall mirror the ERAs as much as possible, and A/B MACs, carriers, DMERCs, DME MACs, FIs and RHHIs shall use the formats established by Medicare. The HIPAA compliant version of the 835 includes some significant changes from earlier versions of the 835 supported by Medicare. See appendix D of the 835 version

004010A1IG for a summary of these changes. The IG is available from Washington Publishing Company (WPC). Their Web site: http://www-wpc-edi.com/HIPAA
In addition, CMS has developed a companion document for contractors and the Shared System Maintainers to explain the business requirements for Medicare following the ANSI X12N IG for Transaction 835, and is available at the Web site:
http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage
Go to "Downloads and click on the file you want.

By October 2002, carriers, DMERCs FIs and, had to be able to issue HIPAA compliant 835 version *004010A1* transactions in production mode to any provider or clearinghouse that requested production data in that version. Here after, all contractors must upgrade to most current versions as directed by CMS temporary instructions. HIPAA requires CMS policy to change such that only the current version of electronic format will be maintained, not the current and the previous version.

Effective October 2006, unless a provider has requested that Medicare revert to issuance of Standard Paper Remittance (SPR), all Electronic Remittance Advice (ERA) receivers would receive their ERAs in the HIPAA compliant format – ANSI ASC X12N 835 version 004010A1. Medicare contractors shall stop generating and sending ERAs in any other format or version effective October 1, 2006.

Medicare will accept claims only if they contain the National Provider Identifiers (NPIs) on and after a date to be determined but before May 23, 2008. NPIs received on the claims would be cross walked to Medicare assigned legacy numbers for adjudication. Depending on how providers requested NPIs and how NPIs were disseminated, the relationship could be: one NPI to one legacy number

or

multiple NPIs to one legacy number

or

one NPI to multiple legacy numbers

The adjudication would be based on each unique combination of NPI/legacy number if there is no one-to-one relationship between the two.

Any ERA or SPR sent on and after NPI becomes effective will have the National Provider Identifier (NPI) as the provider ID instead of any Medicare assigned provider number at the provider, claim and service level if NPI is received on the claim. ERAs will be sent with the legacy numbers at the payee level and additional legacy numbers at the claim/service level, if needed, if NPI is not received on the claim.

30 - Remittance Balancing

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

For Medicare the principles of remittance balancing are the same for both paper and electronic remittance formats. Balancing requires that the total paid is equal to the total submitted charges plus or minus payment adjustments for a single 835 remittance in accordance with the rules of the standard 835 format.

Every HIPAA compliant X12N 835 transaction issued by a Medicare contractor must comply with the ANSI ASC X12N *835 version 004010A1* IG requirements, i.e., these remittances must balance at the service, claim and provider levels. Back end validation must be performed to ensure that these conditions are met.

Although issuance of out-of-balance RAs is not encouraged, providers have indicated that receipt of an out-of-balance RA is preferable to not receiving any RA to explain payment. It is permissible on an exception basis for carriers to issue an 835 that does not balance as long as immediate action is initiated to correct the problem that created the out-of –balance situation. However, these out-of-balance 835s must be rare exceptions, and not the rule. A/B MAC /carrier/ /DMERC/DME MAC shared systems will treat production of an out-of-balance 835 as a priority problem, and will work closely with the A/B MACs/carriers/DMERCs/DME MACs and CMS to fix the problem as soon as possible.

A/B MAC /FI/RHHI shared system must make forced balancing adjustments at the line, claim and/or transaction level as applicable to make each 835 transaction balance. A/B MAC /FI/RHHI shared system must report the amount by which a line or claim is out of balance with adjustment reason code A7 (Presumptive Payment Adjustment) at the line or claim level. The A/B MAC /FI/RHHI shared system must report the amount by which a transaction is out-of-balance with reason code CA (manual claim adjustment) as a provider level adjustment (PLB). PLB Medicare composite reason code CS/CA will be reported in this situation.

A7 and CA may be used only on a temporary exception basis, pending diagnosis of the source of the balancing problem and the A/B MAC /FI/RHHI shared system programming to correct that problem. A/B MAC /FI/RHHI must notify effected providers and clearinghouses of the problem and the expected date of correction whenever A7 or CA is used to force 835s to balance. The shared system would treat production of an out-of-balance 835 as a priority problem, and would work closely with the A/B MAC /FI/RHHI and CMS to fix the problem as soon as possible.

40.4 - Medicare Standard Electronic PC-Print Software for Institutional Providers

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

PC Print software enables institutional providers to print remittance data transmitted by Medicare. A/B MACs /FIs/RHHIs are required to make PC Print software available to providers for downloading at no charge. FIs/RHHIs/A/B MACs may charge up to $25.00 per mailing to recoup cost if the software is sent to provider on a CD/DVD or any other means at provider's request when the software is available for downloading. This software must be able to operate on *2000/Me, and Windows NT* platforms, and include self-explanatory loading and use information for providers. It should not be necessary to furnish providers training for use of PC Print software. *A/B MACs* /FIs/*RHHIs* must supply providers with PC-Print software within three weeks of request. The FI/RHHI/A/B MAC Shared System (FISS) maintainer will supply PC Print software and a user's guide for all *A/B MACs* /FIs/*RHHIs*. The FISS maintainer must assure that the PC Print software is modified as needed to correspond to updates in the ERA and SPR formats.

Providers are responsible for any telecommunication costs associated with receipt of the 835, but the software itself can be downloaded at no cost.

The PC Print software enables providers to:

• Receive, over a wire connection, an 835 electronic remittance advice transmission on a personal computer (PC) and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's "A:" drive;

• View and print remittance information on all claims included in the 835;

• View and print remittance information for a single claim;

• View and print a summary of claims billed for each Type of Bill (TOB) processed on this ERA;

• View and print a summary of provider payments.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, e.g., the entire transmission, a single claim, a summary by bill type, or a provider payment summary. If software malfunctions are detected, they are to be corrected through the FISS maintainer. Individual A/B MACs /FIs/RHHIs or data centers may not modify the PC Print software.

50.2.1 - Part A (A/B MACs /FIs/RHHIs/) SPR Format

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

EXAMPLE

MEDICARE PART A P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 004010-A1

NPI PROVIDER NAME PART A PAID DATE: XX/XX/XXXX REMIT#: XXXXX PAGE: 1

PATIENT NAME PATIENT CNTRL NUMBER RC REM DRG# DRG OUT AMT COINSURANCE PAT REFUND CONTRACT ADJ

HIC NUMBER ICN NUMBER RC REM OUTCD CAPCD NEW TECH COVD CHGS ESRD NET ADJ PER DIEM RTE

FROM DT THRU DT NACHG HICHG TOB RC REM PROF COMP MSP PAYMT NCOVD CHGS INTEREST PROC CD AMT

CLM STATUS COST COVDY NCOVDY RC REM DRG AMT DEDUCTIBLES DENIED CHGS PRE PAY ADJ NET REIMB

XXXXXXXXXX X X XXXXXXXXXXXXX XX XXXXX XXX .00 .00 .00 .00

XXXXXXXXXX XXXXXXXXXXXXXX XX X .00 .00 .00 .00

XX/XX/XXXX XX/XX/XXXX XX X XXX XX .00 .00 .00 .00 .00

X X XX XX .00 .00 .00 .00 .00

SUBTOTAL FISCAL YEAR - XXXX .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X X .00 .00 .00 .00 .00

SUBTOTAL PART A .00 .00 .00 .00

14

.00 .00 .00 .00

.00 .00 .00 .00 .00

XX XX .00 .00 .00 .00 .00

15

EXAMPLE

MEDICARE PART B P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 004010-A1

NPI PROVIDER NAME PART B PAID DATE: XX/XX/XXXX REMIT#: XXXXX PAGE: 1

PATIENT NAME PATIENT CNTRL NUMBER RC REM DRG# DRG OUT AMT COINSURANCE PAT REFUND CONTRACT ADJ

HIC NUMBER ICN NUMBER RC REM OUTCD CAPCD NEW TECH COVD CHGS ESRD NET ADJ PER DIEM RTE

FROM DT THRU DT NACHG HICHG TOB RC REM PROF COMP MSP PAYMT NCOVD CHGS INTEREST PROC CD AMT

CLM STATUS COST COVDY NCOVDY RC REM DRG AMT DEDUCTIBLES DENIED CHGS PRE PAY ADJ NET REIMB

XXXXXXXXXXX X X XXXXXXXXXXX XX XXXX 000 .00 .00 .00 .00

XXXXXXXXXX XXXXXXXXXXXXXX XX .00 .00 .00 .00

XX/XX/XXXX XX/XX/XXXX XX X XXX XX .00 .00 .00 .00 .00

1 X XX .00 .00 .00 .00 .00

SUBTOTAL FISCAL YEAR - XXXX .00 .00 .00 .00

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.00 .00 .00 .00 .00

X .00 .00 .00 .00 .00

SUBTOTAL PART B .00 .00 .00 .00

.00 .00 .00 .00

.00 .00 .00 .00 .00

X .00 .00 .00 .00 .00

16

EXAMPLE

MEDICARE PART A P.O. BOX ABC123 LITTLE ROCK AR 72207 TEL# 0000000000 VER# 4010-A1

PROV # PROVIDER NAME PAID DATE: XX/XX/XX REMIT#: XXXXX PAGE: 2

S U M M A R Y

CLAIM DATA: PASS THRU AMOUNTS:

CAPITAL : .00 PROVIDER PAYMENT RECAP :

DAYS : RETURN ON EQUITY : .00

COST : 0 DIRECT MEDICAL EDUCATION : .00 PAYMENTS :

COVDY : 2 KIDNEY ACQUISITION : .00 DRG OUT AMT : .00

NCOVDY : 0 BAD DEBT : .00 INTEREST : .00

NON PHYSICIAN ANESTHETISTS: .00 PROC CD AMT : .00

CHARGES : TOTAL PASS THRU : .00 NET REIMB : .00

COVD : .00 TOTAL PASS THRU : .00

NCOVD : .00 PIP PAYMENT : .00 PIP PAYMENTS : .00

DENIED : .00 SETTLEMENT PAYMENTS : .00 SETTLEMENT PYMTS : .00

ACCELERATED PAYMENTS : .00 ACCELERATED PAYMENTS : .00

REFUNDS : .00 REFUNDS : .00

PROF COMP : .00 PENALTY RELEASE : .00 PENALTY RELEASE : .00

MSP PAYMT : .00 TRANS OUTP PYMT : .00 TRANS OUTP PYMT : .00

DEDUCTIBLES : .00 HEMOPHILIA ADD-ON : .00 HEMOPHILIA ADD-ON : .00

COINSURANCE : .00 NEW TECH ADD-ON : .00 NEW TECH ADD-ON : .00

1718

BALANCE FORWARD: .00

PAT REFUND: .00 WITHHOLD FROM PAYMENTS: WITHHOLD: .00

INTEREST: .00 CLAIMS ACCOUNTS RECEIVABLE: .00 ADJUSTMENT TO BALANCE: .00

CONTRACT ADJ: .00 ACCELERATED PAYMENTS: .00 NET PROVIDER PAYMENT: .00

PROC CD AMT: .00 PENALTY: .00 (PAYMENTS MINUS WITHHOLD)
NET REIMB: .00 SETTLEMENTS: .00

TOTAL WITHHOLD: .00 CHECK/EFT NUMBER

50.2.2 - Part B (A/B MAC /Carrier/ /DMERC/DME MAC) SPR Format

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

A/B MAC/carrier/DMERC/DME MAC NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP
(9099) 111-2222

MEDICARE
REMITTANCE ADVICE

PROVIDER NAME
ADDRESS 1
ADDRESS 2
CITY, STATE ZIP

NPI : 1234567890
PAGE #: 1 OF 999
CHECK/EFT #: 12345678901234567890
REMITTANCE # 12345678901234567890 ((NOT A REQUIRED FIELD)

.....
.....
*LINE 1
*
*LINE 2
*
*LINE 3
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*LINE 4
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*LINE 5
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*LINE 6
*
*LINE 7
*
*LINE 8
*
*LINE 9
*
*LINE 10
*
*LINE 11
*
*LINE 12
*
*LINE 13
*
*LINE 14
*
*LINE 15
*
.....

PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS GRP/ RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
RENDERING PROVIDER NPI
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR
1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

A/B MAC/carrier/DMERC/DME MAC NAME YYYY/MM/DD (999) 111-2222 **MEDICARE**
NPI: 1234567890 PROVIDER NAME **REMITTANCE ADVICE**
CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

PERF PROV SERV DATE POS NOS PROC MODS BILLED ALLOWED DEDUCT COINS * RC-AMT PROV PD

NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12
RENDERING PROVIDER NPI (PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12

(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

1234567890 MMDD MMDDYY 12 123 PPPPP aabbccdd 1234567.12 1234567.12 1234567.12 1234567.12 GPRRR 1234567.12 1234567.12

(PPPPP) REM: RRRRR RRRRR RRRRR RRRRR RRRRR

PT RESP 1234567.12 CLAIM TOTAL 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12 1234567.12

ADJ TO TOTALS: PREV PD 1234567.12 INTEREST 1234567.12 LATE FILING CHARGE 1234567.12 NET 1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXXX

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL RC-AMT	PROV PD AMT	PROV ADJ AMT	CHECK AMT
	99999	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12

PROVIDER ADJ DETAILS: PLB	REASON CODE	FCN	HIC	AMOUNT
	1111	12345678901234567	123456789012	1234567.12
	2222	12345678901234567	123456789012	1234567.12
	3333	12345678901234567	123456789012	1234567.12
	4444	12345678901234567	123456789012	1234567.12
	5555	12345678901234567	123456789012	1234567.12

GLOSSARY: GROUP, REASON, MOA, REMARK AND REASON CODES

XX	TTT……..
XXX	TTT……..
MXX	TTT……..
XX	TTT……..

A/B MAC/carrier/DMERC/DME MAC NAME YYYY/MM/DD (999) 111-2222 **MEDICARE**
NPI: 1234567890 PROVIDER NAME **REMITTANCE ADVICE**
CHECK/EFT #:12345678901234567890 PAGE #: 999 OF 999
REMITTANCE # 12345678901234567890 (NOT A REQUIRED FIELD)

SUMMARY OF NON-ASSIGNED CLAIMS

PERF PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC-AMT	PROV PD
NAME LLLLLLLLLLL, FFFFFFFF HIC 123456789012 ACNT 12345678901234567890 ICN 123456789012345 ASG X MOA 11111 22222 33333 44444 55555											
1234567890	MMDD MMDDYY	12	123	PPPPP	aabbccdd	1234567.12	1234567.12	1234567.12	1234567.12	GPRRR 1234567.12	1234567.12
RENDERING PROVIDER NPI				(PPPPP)	REM:	RRRRR	RRRRR	RRRRR	RRRRR	RRRRR	
1234567890	MMDD MMDDYY	12	123	PPPPP	aabbccdd	1234567.12	1234567.12	1234567.12	1234567.12	GPRRR 1234567.12	1234567.12
				(PPPPP)	REM:	RRRRR	RRRRR	RRRRR	RRRRR	RRRRR	
1234567890	MMDD MMDDYY	12	123	PPPPP	aabbccdd	1234567.12	1234567.12	1234567.12	1234567.12	GPRRR 1234567.12	1234567.12
				(PPPPP)	REM:	RRRRR	RRRRR	RRRRR	RRRRR	RRRRR	
PT RESP 1234567.12			CLAIM TOTAL			1234567.12	1234567.12	1234567.12	1234567.12	1234567.12	1234567.12

CLAIM INFORATION FORWARDED TO: XXXXXXXXXXXXXXXXXXXXXX

50.3 - Part A (A/B MAC /FI/RHHI/) SPR Crosswalk to the 835

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

This crosswalk provides a systematic presentation of SPR data fields and the corresponding fields in an 835 version 004010A1. It also includes some computed fields for provider use that are not present in an ERA. The comment column in the crosswalk provides clarification and instruction in some special cases.

Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
SPR Page Headers			
FI name/ address/city/state/zip/ phone number	as written	Alpha Numeric (AN) 132 characters	Name=1-080.A-N102 Other data elements are Fiscal Intermediary (FI) generated.
NPI	as written	AN 13	1-080.B-N104
Provider name	as written	AN 25	1-080.B-N102
Literal Value: Part A	as written	AN 06	Literal value not included on 835, Medicare Part would be indicated by the type of bill

Paid date	as written	N MM/DD/CCYY	1-020-BPR16
Remittance advice	REMIT	Numeric (N) 9(l 0)	FI generated
Literal Value: Page	as written	AN 06	FI generated
SPR Pages 1 and 2			
Patient Last Name	PATIENT NAME	AN 18	2-030.A-NM103
Patient First Name		AN 01	2-030.A-NM104
Patient Mid. Initial		AN 01	2-030.A-NM105
Health insurance claim number	HIC#	AN 19	2-030.A-NM109
Statement covers period - start	FROM DT	N MMDDCCYY	2-050.A-DTM02

23Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location

Statement covers period - end	THRU DT	N MMDDCCYY	
Claim status code	CLM STATUS	AN02	2-010-CLP02
Patient control #	PATIENT CNTRL #	AN 20	2-010-CLP01
Internal control #	ICN	AN 23	2-010-CLP07
Patient name change	NACHG	AN 02	2-030.A-NM101 if ‘74’
HIC change	HICHG	AN 01	2-030.A-NM108 if ‘C’
Type of bill	TO	AN 03	2-010-CLP08
Cost report days	COST	N S9(3)	2-033-MIA15
Covered days/visits	COVDY	N S9(3)	2-064-QTY02 when ‘CA’ in prior data element
Noncovered days	NCOVDY	N S9(3)	2-064-QTY02 when ‘NA’ in prior data element
Reason code (4 occurrences)	RC	AN 05	2-020-CAS02, 05,08 and 11
Remark code (4 occurrences)	REM	AN 05	Inpatient: 2-033-MIA -05, 20, 21, 22, Outpatient: 2-035- MOA03, 04, 05, 06
DRG #	as written	N 9(3)	2-010-CLP1 1
Outlier code	OUTCD	AN 02	2-062-AMT01 if ‘ZZ’

24Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Capital code	CAPCD	AN 01	2-033-MIA08
Professional component	PROF COMP	N S9(7).99	Total of amounts in 2-020 or 2-090, CAS03, 06, 09, 12, 15 or 18 when ‘89’ in prior data element
DRG operating and capital amount	DRG AMT	N S9(7).99	2-033-MIA04
DRG outlier amount	DRG OUT AMT	N S9(7).99	2-062-AMT02 when ‘ZZ’ in prior data element
MSP primary amount	MSP PAYMT	N S9(7).99	2-062-AMT02 when ‘NJ’ in prior data element
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of 2-020 or 2-090, CAS03, 06, 09, 12, 15 or 18 when ‘66’ in prior data element
Coinsurance amount	COINSURANCE	N S9(7).99	Total of 2-020 or 2-090 CAS03, 06, 09, 12, 15 or 18 when ‘2’ in prior data element
Covered charges	COVD CHGS	N S9(7).99	2-060-AMT02 when ‘AU’ in prior data element
Noncovered charges	NCOVD CHGS	N S9(7).99	2-010-CLP03 minus 2-060-AMT02 when ‘AU’ in prior data element
Denied charges	DENIED CHGS	N S9(7).99	Total of 2-020 or 2-090-CAS03, 06, 09, 12, 15 or 18

25Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
Patient refund	PAT REFUND	N S9(7).99	2-020 or 2-amount 090-CAS 03, 06, 09, 12, 15 or 18 when ‘100’ in prior data element
Claim ESRD	ESRD NET ADJ	N S9(7).99	2-020 or 2-reduction 090-CAS 03, 06, 09, 12, 15 or 18 when ‘118’ in prior data element
Interest	INTEREST	N S9(6).99	2-060-AMT02 when in prior data element
Contractual	CONTRACT ADJ	N S9(7).99	Total of 2-020 adjustment or 2-090 CAS03, 06, 09, 12, 15 and 17 when ‘CO’ in CASOI
Per Diem rate	PER DIEM RTE	N S9(7).99	2-062-AMT02 when ‘DY’ in prior data element

Procedure code amount	PROC CD AMT	N S9(7).99	2-035-MOA02
Net reimbursement	NET REIMB	N S9(7).99	2-010-CLP04
SPR Page 3			
SPR Claim Data			
Cost report days	DAYS COST	N S9(3)	Total of claim level SPR Cost
Covered days/visits	DAYS COVDY	N S9(4)	Total of claim level SPR COVDY
Noncovered days	DAYS NCOVDY	N S9(4)	Total of claim level SPR NCOVDY
Covered charges	CHARGES COVD	N S9(7).99	Total of claim level SPR COVD CHGS
Noncovered charges	CHARGES	N S9(7).99	Total of claim level SPR NCOVD

26Full Description (In Order Of Appearance)	SPR ID	SPR Field Size Characteristics	835 Location
NCOVD		CHGS	
Denied charges	CHARGES DENIED	N S9(7).99	Total of claim level SPR DENIED CHGS
Professional component	PROF COMP	N S9(7).99	Total of claim level SPR PROF COMP
MSP primary	MSP PAYMT	N S9(7).99	Total of claim amount level SPR MSP PAYMT
Cash deductible/ blood deductibles	DEDUCTIBLES	N S9(7).99	Total of claim level SPR DEDUCTIBLES
Coinsurance amount	COINSURANCE	N S9(7).99	Total of claim level SPR COINSURANCE
Patient refund	PAT REFUND	N S9(7).99	Total of claim amount level SPR PAT REFUND
Interest	INTEREST	N S9(7).99	Total of claim level SPR INTEREST
Contractual adjustment	CONTRACT ADJ	N S9(7).99	Total of claim level SPR CONTRACT ADJ.
Procedure code payable amount	PROC CD AMT	N S9(7).99	Total of claim level SPR PROC CD AMT
Claim payment amount	NET REIMB	N S9(7).99	Total of claim level SPR NET REIMB

SPR Summary Data

27Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location

Pass Thru Amounts

Capital pass thru	CAPITAL	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘CP’ in prior data element
Return on equity	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RE’ in prior data element
Direct medical education	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘DM’ in prior data element
Kidney acquisition	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘KA’ in prior data element
Bad debt		3-010-PLB04, 06, 08 or 10 when ‘BD’ in prior data element	
Nonphysician anesthetists	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘CR’ in prior data element
Hemophilia add on	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘ZZ’ in prior data element
Total pass through	as written	N S9(7).99	Total of the above pass through amounts.

Non-Pass Through Amounts

PIP payment	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘PP’ in prior data element
Settlement amounts	SETTLEMENT PAYMENTS	3-010-PLB04, 06, 08 or 10 when ‘FP’ in prior data element	
Accelerated payments	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘AP’ in prior data element
Refunds	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RF’ in prior data element

28Full Description (In Order Of Appearance) SPR ID SPR Field Size Characteristics 835 Location

Penalty release	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘RS’ in prior data element
Transitional outpatient payment	TRANS OP PYMT	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘IR’ in prior data element
Withhold from Payment			
Claims accounts	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘AA’ in prior data element
Accelerated payments	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘AW’ in prior data element
Penalty	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘PW’ in prior data element
Settlement	as written	N S9(7).99	3-010-PLB04, 06, 08 or 10 when ‘OR’ in prior data element
Total withholding	TOTAL WTHLD	N S9(7).99	Total of the above withholding amounts
Provider Payment Recap			
Payments and withhold previously listed			
Net provider payment	as written	N S9(7).99	1-020-BPR02
Check/EFT number	as written	N S9(7).99	1-040-TRN02

See 835 implementation guides for data element definitions, completion and use.

50.4 - Part B (A/B MAC /Carrier/ / DMERC/DME MAC) SPR Crosswalk to the 835

(Rev. 1343; Issued: 09-21-07; Effective: 07-02-07; Implementation: 07-02-07)

Part B 835 version 004010 field descriptions may be viewed at

http://www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp#TopOfPage
Go to "Downloads", and click on the file you want.

Remittance Field	835V4010 Field	LOOP ID	NSF V 2.01 Field #	COMMENT
CARRIER NAME	N102	1000A	100-07	
CARRIER ADDRESS 1	N301	1000A		
CARRIER ADDRESS 2	N302	1000A		
CARRIER CITY	N401	1000A		
CARRIER STATE	N402	1000A		
CARRIER ZIP	N403	1000A		
PROVIDER NAME	N102	1000B	200-06	
PROVIDER ADDRESS 1	N301	1000B		
PROVIDER ADDRESS 2	N302	1000B		
PROVIDER CITY	N401	1000B		
PROVIDER STATE	N402	1000B		
PROVIDER ZIP	N403	1000B		
PROVIDER NPI	*N104 when XX IN N103*	1000B	200-07	
DATE (CHECK/EFT ISSUE DATE)	BPR16		200-09	
CHECK/EFT TRACE #	TRN02		200-08	
REMITTANCE #				This is not a required field
BENEFICIARY LAST NAME (PATIENT LAST NAME)	NM103	2100	400-13	
BENEFICIARY FIRST NAME (PATIENT FIRST NAME)	NM104	2100	400-14	
HIC (INSURED IDENTIFICATION #)	NM109	2100	400-07	
ACNT (PATIENT CONTROL #)	CLP01	2100	400-03	Use a single 0 if not received on 837 (CLM01)
ICN (PAYOR CLAIM CONTROL #)	CLP07	2100	400-22	
ASG(ASSIGNMENT)	LX01	2000	500-24	
MOA CODES (CLAIM REMARK CODES)	MOA	2100	400-23 THRU 400-27	
RENDERING PROVIDER NPI	REF02 when HPI IN REF01	2110	450-37	*If different from the Payee NPI at the Payee level*
SERVICE DATE (FROM)	DTM02 when 150 in DTM01	2110	450-07	
SERVICE DATE (THROUGH)	DTM02 when 151 in DTM01	2110	450-08	
POS (PLACE OF SERVICE)	REF02 when LU IN REF01	2110	450-11	
NUM (UNITS OF SERVICE)	SVC05	2110	450-17	
PROC (PROCEDURE CODE - PAID)	SVC01-2	2110	450-13	

MODS (MODIFIERS)	SVC01-3 THRU SVC01-6	2110	450-14 THRU 450-16	aabbccdd in the sample
SUBMITTED PROCEDURE CODE	SVC06-2	2110	451-09	(ppppp) in the sample format
BILLED (SUBMITTED LINE CHARGE)	SVC02	2110	450-18	
ALLOWED (ALLOWED/CONTRACT AMT)	AMT02 when B6 in AMT01	2110	450-21	
DEDUCT (DEDUCTIBLE AMT)	CAS03, 06, 09,12,15, 18 when 1 in CAS 02, 05, 08, 11, 14 or 17	2110	450-22	
COINS (COINSURANCE AMT)	CAS03, 06, 09,12,15, 18 when 2 in CAS 02, 05, 08, 11, 14 or 17	2110	450-23	
PROV PD (CALCULATED PMT TO PROVIDER)	SVC03	2110	450-28	
RC (GROUP AND REASON CODES)	CAS01+ CAS02/05/08/11/14/17	2110	450-38 THRU 450-44	
RC-AMT (REASON CODE AMTS)	CAS03, 06, 09,12,15, 18 when no 1 or 2 in CAS 02, 05, 08, 11, 14 or 17	2110	451-10 THRU 451-14	
REM (LINE REMARK CODES)	LQ02	2110	451-16 THRU 451-20	
PT RESP (PATIENT RESPONSIBILITY)	CLP05	2100	500-23	
BILLED (SUBMITTED CLAIM LEVEL CHARGES)	CLP03	2100	500-05	
ALLOWED (ALLOWED/CONTRACT AMT-CLAIM LEVEL)		2100	500-08	
DEDUCT (DEDUCTIBLE AMT-CLAIM LEVEL))		2100	500-09	
COINS (COINSURANCE AMT-CLAIM LEVEL)		2100	500-10	
TOTAL RC AMOUNT		-	-	Computed. Excludes Interest, Late Filing Charges, Deductible, Coinsurance and Prev. Pd.
PROV PD (CALCULATED PMT TO PROVIDER - CLAIM LEVEL)	CLP04	2100	500-15	
NET (ACTUAL PMT TO PROVIDER FOR CLAIM)		2100	500-19	This is a computed field including Interest, Late Filing Charge and Prev. Pd.
PREVIOUSLY PAID			500-17 THRU 500-18	
INT (INTEREST PAID)	AMT02 when I in AMT01	2100	500-11	
LATE FILING CHARGE	AMT02 WHEN KH IN AMT01	2110	451-07	
INSURER TO WHOM CLAIM IS FORWARDED	NM103 when TT in NM101& 2 in NM102	2100	500-25	CRSSOVER CARRIER NAME
# OF CLAIMS			800-06	
TOAL BILLED AMT(BT SUBMITTED CHARGES)			800-08	
TOTAL ALLOWED AMT			800-11	
TOTAL DEDUCT AMT			800-12	
TOTAL COINS AMT			800-13	

TOTAL RC AMOUNT		-	-	Sum of all RC adjustments. Excludes interest, late filing charge, deductible, coinsurance, and prev. pd.
PROV PD AMT			800-18	
PROVIDER ADJ AMT			COMPUTED	
CHECK AMT	BPR02		800-22	
PROVIDER LEVEL ADJUSTMENT REASON CODE	50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1		700-06	This and the next three lines explain the provider level adjustments.
FCN OR ADJ REASON (FINANCIAL CONROL #/PROV ADJ REASON)	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2. POSITION 3-19		700-08	
HIC	PLB03-2, PLB05-2, PLB07-2, PLB09-2, PLB11-2, PLB13-2 POSITION 20-30		700-04	
PROVIDER LEVEL ADJUSTMENT AMOUNT	PLB04, PLB06, PLB 08, PLB10, PLB12, PLB14 WHEN 50 OR AP OR B2 OR CS OR FB OR IR OR J1 OR L6 OR LE OR SL OR WO IN PLB03-1, PLB05-1, PLB07-1, PLB09-1, PLB11-1, PLB13-1		700-07	Includes Interest, Late Filing Charge, Previously Paid and other adjustments as applicable