

CONSOLIDATED GUIDE

Health Care Claim: Institutional (837)

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ASC X12 Consolidated Guides aid in transaction implementation by combining official material into one user friendly document. Although the consolidated guides have not been explicitly mandated under HIPAA, they incorporate the individual guides that have been named into single documents. In the event that there is a conflict between the Consolidated Guides and the ASC X12 Type 3 Technical Reports or any subsequent errata, the underlying ASC X12 publications are the authoritative source.

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Table of Contents

1 Purpose and Business Information	1
1.1 Implementation Purpose and Scope	1
1.2 Version Information	1
1.3 Implementation Limitations	2
1.3.1 Batch and Real-time Usage	2
1.3.2 Other Usage Limitations	2
1.4 Business Usage	2
1.4.1 Coordination of Benefits	3
1.4.1.1 Coordination of Benefits Data Models — Detail	4
1.4.1.2 Crosswalking COB Data Elements	7
1.4.1.3 Coordination of Benefits Claims from Paper or Proprietary Remittance Advices	17
1.4.1.4 Coordination of Benefits - Service Line Procedure Code Bundling and Unbundling	19
1.4.1.5 Coordination of Benefits - Medicaid Subrogation	26
1.4.2 Property and Casualty	26
1.4.3 Data Overview	26
1.4.3.1 Loop Labeling, Sequence, and Use	27
1.4.3.2 Data Use by Business Use	27
1.4.3.2.1 Table 1 — Transaction Control Information	28
1.4.3.2.2 Table 2 — Detail Information	29
1.4.4 Balancing	34
1.4.4.1 Claim Level	34
1.4.4.2 Service Line	35
1.4.5 Allowed/Approved Amount Calculation	36
1.5 Business Terminology	36
1.6 Transaction Acknowledgments	39
1.6.1 997 Functional Acknowledgment	39
1.6.2 999 Implementation Acknowledgment	39
1.6.3 824 Application Advice	39
1.6.4 277 Health Care Claim Acknowledgment	40
1.7 Related Transactions	40
1.7.1 Health Care Claim Payment/Advice (835)	40
1.8 Trading Partner Agreements	40
1.9 HIPAA Role in Implementation Guides	41
1.10 National Provider Identifier Usage within the HIPAA 837 Transaction	41
1.10.1 Providers who are Not Eligible for Enumeration	41
1.10.2 Implementation Migration Strategy	41
1.10.3 Organization Health Care Provider Subpart Representation	42
1.10.4 Subparts and the 2010 AA - Billing Provider Name Loop	43

1.11	Coding of Drugs in the 837 Claim	43
1.11.1	Single Drug Billing	44
1.11.2	Compound Drug Billing	44
1.12	Additional Instructions and Considerations	44
1.12.1	Individuals with one Legal Name	44
1.12.2	Rejecting Claims Based on the Inclusion of Situational Data	44
1.12.3	Multiple REF Segments with the same Qualifier	45
1.12.4	Provider Tax IDs	45
1.12.5	Claim and Line Redundant Information	45
1.12.6	Inpatient and Outpatient Designation	46
1.12.7	Trading Partner Acknowledgments	46
2	Transaction Set	47
2.1	Presentation Examples	47
2.2	Implementation Usage	52
2.2.1	Industry Usage	52
2.2.1.1	Transaction Compliance Related to Industry Usage	53
2.2.2	Loops	53
2.3	Transaction Set Listing	55
2.3.1	Implementation	55
2.3.2	X12 Standard	61
2.4	837 Segment Detail	66
ST	Transaction Set Header	67
BHT	Beginning of Hierarchical Transaction	68
NM1	Submitter Name	71
PER	Submitter EDI Contact Information	73
NM1	Receiver Name	76
HL	Billing Provider Hierarchical Level	78
PRV	Billing Provider Specialty Information	80
CUR	Foreign Currency Information	81
NM1	Billing Provider Name	84
N3	Billing Provider Address	87
N4	Billing Provider City, State, ZIP Code	88
REF	Billing Provider Tax Identification	90
PER	Billing Provider Contact Information	91
NM1	Pay-to Address Name	94
N3	Pay-to Address - ADDRESS	96
N4	Pay-To Address City, State, ZIP Code	97
NM1	Pay-To Plan Name	99
N3	Pay-to Plan Address	101
N4	Pay-To Plan City, State, ZIP Code	102
REF	Pay-to Plan Secondary Identification	104
REF	Pay-To Plan Tax Identification Number	106
HL	Subscriber Hierarchical Level	107
SBR	Subscriber Information	109
NM1	Subscriber Name	112
N3	Subscriber Address	115
N4	Subscriber City, State, ZIP Code	116

DMG	Subscriber Demographic Information	118
REF	Subscriber Secondary Identification	120
REF	Property and Casualty Claim Number	121
NM1	Payer Name.....	122
N3	Payer Address	124
N4	Payer City, State, ZIP Code	125
REF	Payer Secondary Identification	127
REF	Billing Provider Secondary Identification	129
HL	Patient Hierarchical Level	131
PAT	Patient Information	133
NM1	Patient Name	135
N3	Patient Address	137
N4	Patient City, State, ZIP Code	138
DMG	Patient Demographic Information	140
REF	Property and Casualty Claim Number	142
REF	Property and Casualty Patient Identifier	143
CLM	Claim Information	145
DTP	Discharge Hour.....	151
DTP	Statement Dates	152
DTP	Admission Date/Hour.....	153
DTP	Date - Repricer Received Date.....	154
CL1	Institutional Claim Code.....	155
PWK	Claim Supplemental Information.....	156
CN1	Contract Information	160
AMT	Patient Estimated Amount Due.....	162
REF	Service Authorization Exception Code	163
REF	Referral Number	165
REF	Prior Authorization	166
REF	Payer Claim Control Number.....	168
REF	Repriced Claim Number	169
REF	Adjusted Repriced Claim Number	170
REF	Investigational Device Exemption Number	171
REF	Claim Identifier For Transmission Intermediaries	172
REF	Auto Accident State	174
REF	Medical Record Number	175
REF	Demonstration Project Identifier	176
REF	Peer Review Organization (PRO) Approval Number	177
K3	File Information	178
NTE	Claim Note	180
NTE	Billing Note	182
CRC	EPSDT Referral	183
HI	Principal Diagnosis	186
HI	Admitting Diagnosis	189
HI	Patient's Reason For Visit	191
HI	External Cause of Injury	195
HI	Diagnosis Related Group (DRG) Information	220
HI	Other Diagnosis Information	222
HI	Principal Procedure Information	241
HI	Other Procedure Information	244
HI	Occurrence Span Information.....	260
HI	Occurrence Information	273

HI Value Information	286
HI Condition Information	296
HI Treatment Code Information	306
HCP Claim Pricing/Repricing Information	315
NM1 Attending Provider Name	321
PRV Attending Provider Specialty Information	324
REF Attending Provider Secondary Identification	326
NM1 Operating Physician Name	328
REF Operating Physician Secondary Identification	331
NM1 Other Operating Physician Name	333
REF Other Operating Physician Secondary Identification	336
NM1 Rendering Provider Name	338
REF Rendering Provider Secondary Identification	341
NM1 Service Facility Location Name	343
N3 Service Facility Location Address	346
N4 Service Facility Location City, State, ZIP Code	347
REF Service Facility Location Secondary Identification	349
NM1 Referring Provider Name	351
REF Referring Provider Secondary Identification	354
SBR Other Subscriber Information	356
CAS Claim Level Adjustments	360
AMT Coordination of Benefits (COB) Payer Paid Amount	366
AMT Remaining Patient Liability	367
AMT Coordination of Benefits (COB) Total Non-Covered Amount	368
OI Other Insurance Coverage Information	369
MIA Inpatient Adjudication Information	371
MOA Outpatient Adjudication Information	376
NM1 Other Subscriber Name	379
N3 Other Subscriber Address	382
N4 Other Subscriber City, State, ZIP Code	383
REF Other Subscriber Secondary Identification	385
NM1 Other Payer Name	386
N3 Other Payer Address	388
N4 Other Payer City, State, ZIP Code	389
DTP Claim Check or Remittance Date	391
REF Other Payer Secondary Identifier	392
REF Other Payer Prior Authorization Number	394
REF Other Payer Referral Number	395
REF Other Payer Claim Adjustment Indicator	396
REF Other Payer Claim Control Number	397
NM1 Other Payer Attending Provider	398
REF Other Payer Attending Provider Secondary Identification	400
NM1 Other Payer Operating Physician	402
REF Other Payer Operating Physician Secondary Identification	404
NM1 Other Payer Other Operating Physician	406
REF Other Payer Other Operating Physician Secondary Identification	408

NM1	Other Payer Service Facility Location	410
REF	Other Payer Service Facility Location Secondary Identification	412
NM1	Other Payer Rendering Provider Name	414
REF	Other Payer Rendering Provider Secondary Identification	416
NM1	Other Payer Referring Provider	418
REF	Other Payer Referring Provider Secondary Identification	420
NM1	Other Payer Billing Provider	422
REF	Other Payer Billing Provider Secondary Identification	424
LX	Service Line Number	425
SV2	Institutional Service Line	426
PWK	Line Supplemental Information	431
DTP	Date - Service Date	435
REF	Line Item Control Number	437
REF	Repriced Line Item Reference Number	439
REF	Adjusted Repriced Line Item Reference Number	440
AMT	Service Tax Amount	441
AMT	Facility Tax Amount	442
NTE	Third Party Organization Notes	443
HCP	Line Pricing/Repricing Information	444
LIN	Drug Identification	451
CTP	Drug Quantity	454
REF	Prescription or Compound Drug Association Number	456
NM1	Operating Physician Name	458
REF	Operating Physician Secondary Identification	461
NM1	Other Operating Physician Name	463
REF	Other Operating Physician Secondary Identification	466
NM1	Rendering Provider Name	468
REF	Rendering Provider Secondary Identification	471
NM1	Referring Provider Name	473
REF	Referring Provider Secondary Identification	476
SVD	Line Adjudication Information	478
CAS	Line Adjustment	482
DTP	Line Check or Remittance Date	488
AMT	Remaining Patient Liability	489
SE	Transaction Set Trailer	490

3 Examples 491

3.1 Institutional	491
3.1.1 Business Scenario 1 — 837 Institutional Claim	491
3.1.2 Business Scenario 2 — Two Claims for the Same Provider	496
3.1.3 Business Scenario 3 — PPO Repriced Claim	502
3.1.4 Business Scenario 4 — Out of Network Repriced Claim	509

3.2 Property and Casualty	513
3.2.1 Business Scenario 1 — Automobile Accident.....	514

A External Code Sources

5 Countries, Currencies and Funds	A.1
22 States and Provinces	A.2
51 ZIP Code	A.2
130 Healthcare Common Procedural Coding System	A.3
131 International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)	A.4
132 National Uniform Billing Committee (NUBC) Codes.....	A.4
139 Claim Adjustment Reason Code.....	A.5
229 Diagnosis Related Group Number (DRG)	A.5
230 Point of Origin for Admission or Visit	A.5
231 Priority (Type) of Admission or Visit	A.6
235 Claim Frequency Type Code	A.6
236 Uniform Billing Claim Form Bill Type.....	A.7
239 Patient Status Code	A.7
240 National Drug Code by Format	A.8
245 National Association of Insurance Commissioners (NAIC) Code	A.8
359 Treatment Codes	A.8
411 Remittance Advice Remark Codes	A.9
513 Home Infusion EDI Coalition (HIEC) Product/Service Code List.....	A.9
537 Centers for Medicare and Medicaid Services National Provider Identifier	A.10
540 Centers for Medicare and Medicaid Services PlanID	A.10
576 Workers Compensation Specific Procedure and Supply Codes	A.11
682 Health Care Provider Taxonomy	A.11
716 Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities.....	A.12
843 Advanced Billing Concepts (ABC) Codes	A.13
896 International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS).....	A.13
897 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	A.14
932 Universal Postal Codes	A.14

B Nomenclature

B.1 ASC X12 Nomenclature	B.1
B.1.1 Interchange and Application Control Structures	B.1
B.1.1.1 Interchange Control Structure	B.1
B.1.1.2 Application Control Structure Definitions and Concepts	B.2
B.1.1.3 Business Transaction Structure Definitions and Concepts	B.6
B.1.1.4 Envelopes and Control Structures	B.19
B.1.1.5 Acknowledgments	B.22
B.2 Object Descriptors.....	B.23

C	EDI Control Directory	C.1
C.1	Control Segments	C.1
	ISA Interchange Control Header	C.3
	GS Functional Group Header	C.7
	GE Functional Group Trailer	C.9
	IEA Interchange Control Trailer	C.10

D	Change Summary	D.1
D.1	Global Changes	D.1
D.2	Detailed Transaction Changes	D.2

E	Data Element Glossary	E.1
E.1	Data Element Name Index	E.1

1 Purpose and Business Information

1.1 Implementation Purpose and Scope

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 technical report document for the ANSI ASC X12N 837 Health Care Claims (837) transaction for institutional claims and/or encounters. This document provides a definitive statement of what trading partners must be able to support in this version of the 837. This document 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.

1.2 Version Information

This implementation guide is based on the October 2003 ASC X12 standards, referred to as Version 5, Release 1, Sub-release 0 (005010).

The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010**X223A2**.

The two-character Functional Identifier Code for the transaction set included in this implementation guide:

- **HC Health Care Claim (837)**

The Version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted in the Functional Group Header (GS segment) that begins a functional group of these transaction sets. For more information, see the descriptions of GS01 and GS08 in Appendix C, *EDI Control Directory*.

1.3 Implementation Limitations

1.3.1 Batch and Real-time Usage

There are multiple methods available for sending and receiving business transactions electronically. Two common modes for EDI transactions are batch and real-time.

Batch - In a batch mode the sender does not remain connected while the receiver processes the transactions. Processing is usually completed according to a set schedule. If there is an associated business response transaction (such as a 271 Response to a 270 Request for Eligibility), the receiver creates the response transaction and stores it for future delivery. The sender of the original transmission reconnects at a later time and picks up the response transaction. This implementation guide does not set specific response time parameters for these activities.

Real Time - In real-time mode the sender remains connected while the receiver processes the transactions and returns a response transaction to the sender. This implementation guide does not set specific response time parameters for implementers.

This implementation guide is intended to support use in batch mode. This implementation guide is not intended to support use in real-time mode. A statement that the transaction is not intended to support a specific mode does not preclude its use in that mode between willing trading partners.

1.3.2 Other Usage Limitations

Receiving trading partners may have system limitations which control the size of the transmission they can receive. Some submitters may have the capability and the desire to transmit large 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 higher limits. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA.

1.4 Business Usage

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 billing services 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 (COB) 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, dentists, hospitals, pharmacies, other medical facilities or suppliers, and entities providing medical information to meet regulatory requirements. The payer is 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, TRICARE, etc.) or an entity such as a third party administrator (TPA), reprinter, 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 segment of the health care/insurance industry.

The transaction defined by this implementation guide is intended to originate with the health care provider or the health care provider's designated agent. In some instances, a health care payer may originate an 837 to report a health care encounter to another payer or sponsoring organization. The 837 Transaction 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: Health Care Information Status Notification (277), Health Care Claim Payment/Advice (835) and the Functional Acknowledgment (997). See Section 1.6 - *Transaction Acknowledgments*, and Section 1.7 - *Related Transactions*, for a summary description of these interactions.

1.4.1 Coordination of Benefits

A primary enhancement for this version is upgrading COB functionality to minimize manual intervention and/or the necessity for paper supporting document. Electronic COB is predicated upon using two transactions – the 837 and the 835 Health Care Claim Payment/Advice. See Section 1.4.1.1 - *Coordination of Benefits Data Models -- Detail* for details about the two models for using these transactions to achieve a totally electronic interchange of COB information. Section 3, EDI Transmission Examples for Different Business Uses, contains detailed examples of how these transactions are completed for several business situations. Section 1.4.1.3 - *Coordination of Benefits Claims from Paper or Proprietary Remittance Advices* provides guidance on creating electronic COB claims when the payer's remittance was a paper or proprietary remittance advice.

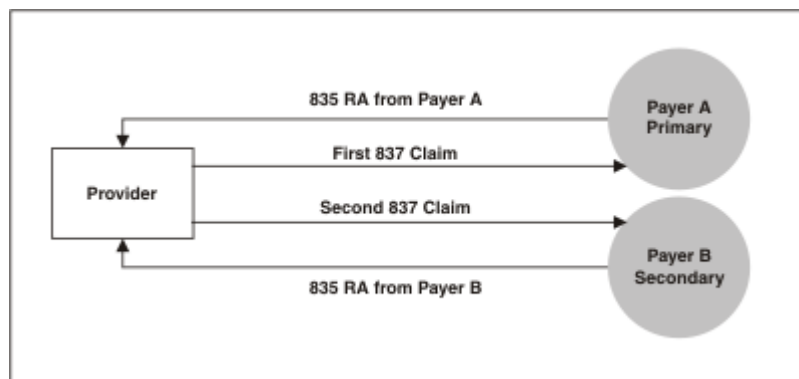
1.4.1.1 Coordination of Benefits Data Models -- Detail

The 837 Transaction handles two different models of benefit coordination. Both models are discussed in this section. Section 3, Examples, contains detailed examples of these models. Each COB related data element contains notes within this implementation guide specifying when it is used. The HIPAA final rules contain additional information on COB.

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

Step 1. In model 1, the provider originates the transaction and sends the claim information to Payer A, the primary payer. See Figure 1.1 - *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 any claim adjustment reason codes that apply to that specific claim. The claim adjustment reason codes detail what was adjusted and why.

Figure 1.1 - Provider-to-Payer-to-Provider COB Model



Step 2. Upon receipt of the 835, the provider sends a second health care claim transaction (837) to Payer B, the secondary payer. The Subscriber loop (Loop ID-2000B) now contains information about the subscriber who holds the policy with Payer B. The Other Subscriber Information loop (Loop ID-2320) now contains information about the subscriber for Payer A. Any total amounts paid at the claim level go in the AMT segment in Loop ID-2320. Any claim level adjustment codes are retrieved from the 835 from Payer A and put in the CAS (Claims Adjustment) segment in Loop ID-2320. 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.

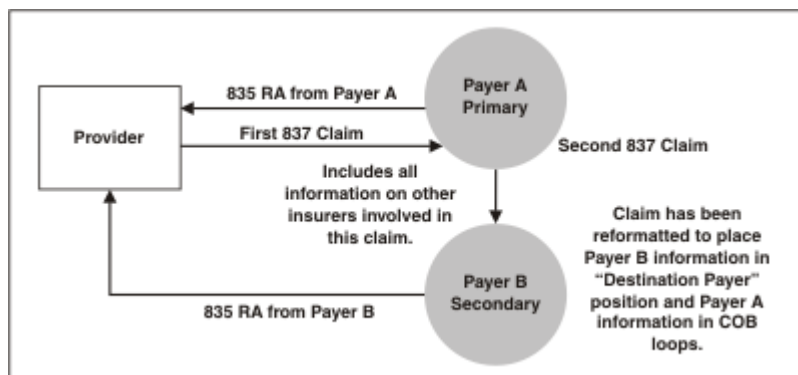
Step 3. If there are additional payers (not shown in Figure 1.1 - *Provider-to-Payer-to-Provider COB Model*), step 2 is repeated with the

Subscriber loop (Loop ID-2000B) having information about the subscriber who holds the policy with Payer C, the tertiary payer. COB information specific to Payer A continues to be included as written in step 2 with an occurrence of Loop ID-2320 and specifying the payer as primary. If necessary, Loop ID-2430 is included for any line level adjudications. COB information specific to Payer B is included by repeating the Loop ID-2320 again and specifying the payer as secondary. If necessary, Loop ID-2430 is included for Payer B 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 1.2 - *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. Subscriber/payer information about secondary coverage is included in Loop ID-2320 or is on file at Payer A as a result of an eligibility file sent by Payer B (as in Medicare crossover arrangements). In this model, the primary payer adjudicates the claim and sends an 835 back to the provider.

Figure 1.2 - Provider-to-Payer-to-Payer COB Model



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 in either Model 1 or Model 2.

1.4.1.1.1 Coordination of Benefits -- Claim Level

The destination payer's information is located in Loop ID-2010BB. In addition, any destination payer-specific claim information (for example, referral number) is located in the 2300 loop. All provider identifiers in the 2310 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). Provider identifiers in the 2330 loops are specific to the corresponding non-destination payer.

Loop ID-2320 contains the following:

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

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

1.4.1.1.2 Coordination of Benefits -- Service Line Level

Loop ID-2430 is a situational loop that can occur up to 15 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, the payer must return the original billed procedure code(s) and/or modifiers in the SVC06 and SVC07 data element of 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 any corresponding 835 regardless of whether bundling or unbundling has occurred.

1.4.1.2 Crosswalking COB Data Elements

This section provides additional guidance for automation of the COB process. The purpose of the discussion below is to clarify how multiple payer and related COB data is structured and interrelated to facilitate an automated COB process. These strategies apply to both payer and provider submitted COB claims.

For the purposes of this discussion, there are two types of payers in the 837; (1) the destination payer, the payer receiving the claim and defined in the 2010BB loop, and (2) any 'other' payers, those defined in the 2330B loop(s). The destination payer or the 'other' payers may be the primary, secondary or another position payer in terms of their sequence of paying on the claim. The payment position is not particularly important in discussing how to manage COB data elements in the 837. 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, payer information must change position along with the payer to stay associated with that payer. The same is true of all the 'other' payers, who will each, in turn, become the destination payer as the claim is forwarded to them. It is the purpose of the example detailed below to demonstrate exactly how payer specific information stays associated with the correct payer as the destination payer rotates through the various COB payers.

Business Model:

The destination payer is defined as the payer that is described in the 2010BB loop. All of the information contained in the 2300 and 2310 loops is specific to the destination payer. Information specific to other payers is contained in the 2320, 2330, and 2430 loops. Referral, predetermination, and prior authorization numbers in the 2400 loop; and provider numbers in the 2420 loop are associated with either the destination or a non-destination payer.

837 Institutional Claim

(In this crosswalk, the Subscriber is NOT the Patient, and the Original Claim is NOT a resubmission)

Primary Subscriber is JOHN DOE who has coverage with ABC INS; Secondary Subscriber is JANE DOE who has coverage with XYZ INS GROUP; Patient is daughter SALLY DOE.

COLOR KEY

D -- Destination Payer Loops and Data - Once the primary payer has adjudicated the claim, whoever submits the claim to the secondary payer needs to place the information specific to the secondary payer (columns 4 and 5) into the "destination payer" location (column 1) in the secondary claim.

N -- Other (non-destination) Payer Loops and Data - Once the primary payer has adjudicated the claim, whoever submits the claim to the secondary payer needs to place the information specific to the primary payer (columns 4 and 5) into the other (non-destination) payer location (column 1) in the secondary claim.

M -- Medicare COB - This information is entered by Medicare on the secondary (crossover) claim in Payer-to-Payer COB elements (column 4).

P -- Provider Submitted COB Data – This information is entered by the provider into the secondary claim elements (column 4) prior to forwarding to the next payer.

E -- Prior Payer 835 Data – This information is cross-walked from the 835 Remittance Advice (column 3) to elements in the secondary claim (column 4).

	1 Primary Payer 837 Claim	2 Primary Payer Claim Example	3 835 ERA	4 Crosswalk Secondary 837 Claim From Primary ¹	5 Secondary Payer Claim Example
D	2000B | SBR Subscriber Information	FOR JOHN DOE		2320 | SBR (except SBR02)	FOR JANE DOE
D	2010BA | NM1 | REF Subscriber Name Secondary Identification	JOHN DOE JD03398777 033987777		2330A | NM1 | REF	JANE DOE JA7654321 765432111
D	Not Used ² Subscriber Address	Not Used ²		Not Used	Not Used ²
D	2010BB Payer Information	ABC INS		2330B	XYZ INS GROUP
D	2010BB | REF (G2) Billing Provider Secondary ID	FOR ABC INS 12345678		2330I | REF (2U with G2)	FOR XYZ INS GROUP (G2) XYZ3434343
D	2010BB | REF (LU) Billing Provider Location Code	FOR ABC INS 678		2330I | REF (2U with LU)	FOR XYZ INS GROUP (LU) 455
D	2000C | PAT01 Patient Information	SALLY'S RELATIONSHIP TO JOHN – 19 CHILD		2320 | SBR02	SALLY'S RELATIONSHIP TO JANE – 19 CHILD
D	2010CA | NM1 Patient Name Information	SALLY DOE		2010CA | NM1	SALLY DOE
D	2300 | CLM07 Accept Assignment Indicator	FOR JOHN DOE		2320 | OI05	FOR JANE DOE

	1 Primary Payer 837 Claim	2 Primary Payer Claim Example	3 835 ERA	4 Crosswalk Secondary 837 Claim From Primary ¹	5 Secondary Payer Claim Example
D	2300 | CLM08 Assignment of Benefits Indicator	FOR JOHN DOE		2320 | OI03	FOR JANE DOE
D	2300 | CLM09 Release of Information	FOR JOHN DOE		2320 | OI06	FOR JANE DOE
D	2300 | CLM10 Patient's Signature Source Code	FOR JOHN DOE		2320 | OI04	FOR JANE DOE
M	N/A Medicare (Section 4081) Crossover Indicator	Not Used		2300 | REF01/02	Set by Medicare in Crossover Claims
D	2300 | REF (G1) Prior Authorization	FOR ABC INS (G1) ABC456		2330B | REF (G1)	FOR XYZ INS GROUP (G1) XYZ345200
D	2300 | REF (9F) Referral Number	FOR ABC INS (9F) ABC670000		2330B | REF (9F)	FOR XYZ INS GROUP (9F) XYZ6798777
D	2310A | REF (G2) Attending Provider Secondary ID	FOR ABC INS (G2) ABC670001		2330C | REF (G2)	FOR XYZ INS GROUP (G2) XYZ6798666
D	2310A | REF (LU) Attending Provider Secondary ID	FOR ABC INS (LU) 671		2330C | REF (LU)	FOR XYZ INS GROUP (LU) 986
D	2310B | REF (G2) Operating Physician Secondary ID	FOR ABC INS (G2) ABC670002		2330D | REF (G2)	FOR XYZ INS GROUP (G2) XYZ6798444
D	2310B | REF (LU) Operating Physician Secondary ID	FOR ABC INS (LU) 672		2330D | REF (LU)	FOR XYZ INS GROUP (LU) 984
D	2310C | REF (G2) Other Operating Physician Secondary ID	FOR ABC INS (G2) ABC670004		2330E | REF (G2)	FOR XYZ INS GROUP (G2) XYZ6798222
D	2310C | REF (LU) Other Operating Physician Secondary ID	FOR ABC INS (LU) 674		2330E | REF (LU)	FOR XYZ INS GROUP (LU) 982
D	2310E | REF (G2) Service Facility Location Secondary ID	FOR ABC INS (G2) ABC670005		2330F | REF (G2)	FOR XYZ INS GROUP (G2) XYZ6798111
D	2310E | REF (LU) Service Facility Location Secondary ID	FOR ABC INS (LU) 675		2330F | REF (LU)	FOR XYZ INS GROUP (LU) 981

	1 Primary Payer 837 Claim	2 Primary Payer Claim Example	3 835 ERA	4 Crosswalk Secondary 837 Claim From Primary ¹	5 Secondary Payer Claim Example
N	2320 | SBR (except SBR02) Subscriber Information	FOR JANE DOE		2000B | SBR (except SBR02)	FOR JOHN DOE
N	2320 | SBR02 Subscriber Relationship to Patient	SALLY'S RELATIONSHIP TO JANE – 17 STEPCHILD		2000C | PAT01	SALLY'S RELATIONSHIP TO JOHN – 19 CHILD
E	Claim Adjustment Group Code	Not Used	2100 | CAS	2320 | CAS	FROM ABC INS
E	Payer Paid Amount	Not Used	2100 | CLP04	2320 | AMT01/02 (D)	FROM ABC INS
E	Total Non-Covered Amount	Not Used	2100 | AMT (A8)	2320 | AMT01/02 (A8)	FROM ABC INS
P	Remaining Patient Liability	Not Used		2320 | AMT01 (EAF)	Calculated by Provider
N	2320 | DMG Subscriber Demographic Information	FOR JANE DOE		Not Used	Not Used
N	2320 | OI05 Accept Assignment Indicator	FOR JANE DOE		2300 | CLM07	FOR JOHN DOE
N	2320 | OI03 Assignment of Benefit Indicator	FOR JANE DOE		2300 | CLM08	FOR JOHN DOE
N	2320 | OI06 Release of Information	FOR JANE DOE		2300 | CLM09	FOR JOHN DOE
N	2320 | OI04 Patient's Signature Source Code	FOR JANE DOE		2300 | CLM10	FOR JOHN DOE
E	Medicare Outpatient Adjudication Information	Not Used	2100 | MOA	2320 | MOA	FROM ABC INS
N	2330A | NM1 | REF Subscriber Name Secondary ID	JANE DOE JA7654321 765432111		2010BA | NM1 | REF	JOHN DOE JD03398777 033987777
N	2330A | N3/N4 Subscriber Address	FOR JANE DOE		2010BA | N3/N4	FOR JOHN DOE
N	2330B Payer Information	FOR XYZ INS GROUP		2010BB	FOR JOHN DOE

	1 Primary Payer 837 Claim	2 Primary Payer Claim Example	3 835 ERA	4 Crosswalk Secondary 837 Claim From Primary ¹	5 Secondary Payer Claim Example
N	2330B | PER Payer Contact Information	FOR XYZ INS GROUP		Not Used	FOR ABC INS
E	Claim Adjudication Date	Not Used	Table 1 | BPR16	2330B | DTP (573)	FROM ABC INS
N	Payer Claim Control Secondary Number	Not Used	2100 | CLP07 ³	2330B | REF (F8)	FROM ABC INS XYZCLM0005
N	2330B | REF (G1) Prior Authorization	FOR XYZ INS GROUP XYZ345200		2300 | REF (G1)	FOR ABC INS ABC456
N	2330B | REF (9F) Referral Number	FOR XYZ INS GROUP XYZ6798777		2300 | REF (9F)	FOR ABC INS ABC670000
N	2330C | REF (G2) Attending Provider Secondary ID	FOR XYZ INS GROUP (G2) XYZ6798666		2310A | REF (G2)	FOR ABC INS (G2) ABC670001
N	2330C | REF (LU) Attending Provider Secondary ID	FOR XYZ INS GROUP (LU) 986		2310A | REF (LU)	FOR ABC INS (LU) 671
N	2330D | REF (G2) Operating Physician Secondary ID	FOR XYZ INS GROUP (G2) XYZ6798444		2310B | REF (G2)	FOR ABC INS (G2) ABC670002
N	2330D | REF (LU) Operating Physician Secondary ID	FOR XYZ INS GROUP (LU) 984		2310B | REF (LU)	FOR ABC INS (LU) 672
N	2330E | REF (G2) Other Operating Physician Secondary ID	FOR XYZ INS GROUP (G2) XYZ6798222		2310C | REF (G2)	FOR ABC INS (G2) ABC670004
N	2330E | REF (LU) Other Operating Physician Secondary ID	FOR XYZ INS GROUP (LU) 982		2310C | REF (LU)	FOR ABC INS (LU) 674
N	2330F | REF (G2) Service Facility Location Secondary ID	FOR XYZ INS GROUP (G2) XYZ6798111		2310E | REF (G2)	FOR ABC INS (G2) ABC670005
N	2330F | REF (LU) Service Facility Location Secondary ID	FOR XYZ INS GROUP (LU) 981		2310E | REF (LU)	FOR ABC INS (LU) 675
N	2330I | REF (G2) Billing Provider ID	FOR XYZ INS GROUP (G2) XYZ3434343		2010BB | REF (G2)	FOR ABC INS (G2) 12345678
N	2330I | REF (LU) Billing Provider ID	FOR XYZ INS GROUP (LU) 455		2010BB | REF (LU)	FOR ABC INS (LU) 678

	1 Primary Payer 837 Claim	2 Primary Payer Claim Example	3 835 ERA	4 Crosswalk Secondary 837 Claim From Primary ¹	5 Secondary Payer Claim Example
D	2400 | REF (G1) Prior Authorization Number	FOR ABC INS (G1) ABC222222		2400 | REF (G1/2U)	FOR XYZ INS GROUP (G1) XYZ888888
N	2400 | REF (G1/2U) Prior Authorization Number	FOR XYZ INS GROUP (G1) XYZ888888 (2U) 54698		2400 | REF (G1)	FOR ABC INS (G1) ABC222222 (2U) 12345
D	2400 | REF (9F) Referral Number	FOR ABC INS (9F) ABC111111		2400 | REF (9F/2U)	FOR XYZ INS GROUP (9F) XYZ777777
N	2400 | REF (9F/2U) Referral Number	FOR XYZ INS GROUP (9F) XYZ777777 (2U) 54698		2400 | REF (9F)	FOR ABC INS (9F) ABC111111 (2U) 12345
D	2420A | REF (G2) ⁴ Operating Physician Secondary ID	FOR ABC INS (G2) ABC888888		2420A | REF (G2/2U) ⁴	FOR XYZ INS GROUP (G2) XYZ111111
D	2420A | REF (LU) ⁴ Operating Physician Secondary ID	FOR ABC INS (LU) C333		2420A | REF (LU/2U) ⁴	FOR XYZ INS GROUP (LU) Z666
N	2420A | REF (G2/2U) ⁴ Operating Physician Secondary ID	FOR XYZ INS GROUP (G2) XYZ666666 (2U) 54698		2420A | REF (G2) ⁴	FOR ABC INS (G2) ABC333333 (2U) 12345
N	2420A | REF (LU/2U) ⁴ Operating Physician Secondary ID	FOR XYZ INS GROUP (LU) Z666 (2U) 54698		2420A | REF (LU) ⁴	FOR ABC INS (LU) C333 (2U) 12345
D	2420B | REF (G2) ⁴ Other Operating Physician Secondary ID	FOR ABC INS (G2) ABC444444		2420B | REF (G2/2U) ⁴	FOR XYZ INS GROUP (G2) XYZ555555
D	2420B | REF (LU) ⁴ Other Operating Physician Secondary ID	FOR ABC INS (LU) C444		2420B | REF (LU/2U) ⁴	FOR XYZ INS GROUP (LU) Z555
N	2420B | REF (G2/2U) ⁴ Other Operating Physician Secondary ID	FOR XYZ INS GROUP (G2) XYZ555555 (2U) 54698		2420B | REF (G2) ⁴	FOR ABC INS (G2) ABC444444 (2U) 12345
N	2420B | REF (LU/2U) ⁴ Other Operating Physician Secondary ID	FOR XYZ INS GROUP (LU) Z555 (2U) 54698		2420B | REF (LU) ⁴	FOR ABC INS (LU) C444 (2U) 12345
D	2420C | REF (G2) ⁴ Rendering Provider Secondary ID	FOR ABC INS (G2) ABC555555		2420C | REF (G2/2U) ⁴	FOR XYZ INS GROUP (G2) XYZ444444

	1 Primary Payer 837 Claim	2 Primary Payer Claim Example	3 835 ERA	4 Crosswalk Secondary 837 Claim From Primary ¹	5 Secondary Payer Claim Example
D	2420C | REF (LU) ⁴ Rendering Provider Secondary ID	FOR ABC INS (LU) C555		2420C | REF (LU/2U) ⁴	FOR XYZ INS GROUP (LU) Z444
N	2420C | REF (G2/2U) ⁴ Rendering Provider Secondary ID	FOR XYZ INS GROUP (G2) XYZ444444 (2U) 54698		2420C | REF (G2) ⁴	FOR ABC INS (G2) ABC555555 (2U) 12345
N	2420C | REF (LU/2U) ⁴ Rendering Provider Secondary ID	FOR XYZ INS GROUP (LU) Z444 (2U) 54698		2420C | REF (LU) ⁴	FOR ABC INS (LU) C555 (2U) 12345
D	2420D | REF (G2) ⁴ Referring Provider Secondary ID	FOR ABC INS (G2) ABC888888		2420F | REF (G2/2U) ⁴	FOR XYZ INS GROUP (G2) XYZ111111
D	2420D | REF (LU) ⁴ Referring Provider Secondary ID	FOR ABC INS (LU) C888		2420F | REF (LU/2U) ⁴	FOR XYZ INS GROUP (LU) Z111
N	2420D | REF (G2/2U) ⁴ Referring Provider Secondary ID	FOR XYZ INS GROUP (G2) XYZ111111 (2U) 54698		2420F | REF (G2) ⁴	FOR ABC INS (G2) ABC888888 (2U) 12345
N	2420D | REF (LU/2U) ⁴ Referring Provider Secondary ID	FOR XYZ INS GROUP (LU) Z111 (2U) 54698		2420F | REF (LU) ⁴	FOR ABC INS (LU) C888 (2U) 12345
E	Service Line Paid Amount	Not Used	2200 | SVD	2430 | SVD	FROM ABC INS
E	Claim Adjustment Information	Not Used	2200 | CAS	2430 | CAS	FROM ABC INS
E	Line Adjudication Date	Not Used	Table 1 | BPR16	2430 | DTP (573)	FROM ABC INS
P	Remaining Patient Liability Amount	Not Used		2430 | AMT01 (EAF)	Calculated by Provider

¹ The secondary claim information shows where the original claim information would be mapped to when creating the secondary claim. This information must be in the correct order of the implementation guide and not in the order shown above.

² The Subscriber Address in the 2010BB Loop is only used when the Patient is the Subscriber.

³ 2300REF Original Payer Claim Number

The Original Payer Claim Number is used to submit the Claim Number returned on the 835 whenever a claim is resubmitted to the same payer. When submitting a secondary claim that was resubmitted to the first payer, this number is carried in the 2330B REF. It is important to keep a Payer Original Claim Number in the loop associated with that payer. In the example below, the number returned by the first payer is used in the destination claim loop when resubmitting to that payer. Then when the secondary claim is created, the first payer's Original Claim Number is moved down into the Loop ID-2330B REF for the first payer.

	Original Claim	Remittance Advice	Resubmitted Claim	Secondary Claim
2300 REF (F8)	Not Used	2100 | CLP07	2300 | REF (F8)	Not Used
2330B REF (F8)	Not Used	Not Used	2300 REF (F8)	

⁴ **2420A-F Provider Secondary Identifiers**

The G2 and LU Qualifiers and the Secondary Identifiers in these Loops are for both the Destination Payer and the Non-Destination Payer. The 2U Qualifier is specific to the Non-Destination Payer. When creating the secondary claim, the numbers are swapped as follows:

			Original Claim	Secondary Claim
2010BB	NM108/09	Payer ID	12345	54698
2330B	NM108-09	Payer ID	54698	12345
2420A	REF01	Rendering Provider ID FOR Payer	G2	G2
2420A	REF02		ABC333333	XYZ666666
2420A	REF01	Rendering Provider Location Code	LU	LU
2420A	REF02		C333	Z666
2420A	REF01	Rendering Provider Secondary ID	G2	G2
2420A	REF02	(For Non-destination Payer identified below)	XYZ666666	ABC333333
2420A	REF03	Not Used		
2420A	REF04-1	Other Payer ID (linked to 2330B Payer)	2U	2U
2420A	REF04-2		54698	12345
2420A	REF01	Rendering Provider Location Code	LU	LU
2420A	REF02	(For Non-destination Payer identified below)	Z666	C333
2420A	REF03	Not Used		
2420A	REF04-1	Other Payer ID (linked to 2330B Payer)	2U	2U
2420A	REF04-2		54698	12345

Example

In the following example, the first column is a claim as submitted to the primary payer. The second column is the corresponding claim with the same business data as it would be submitted to the secondary payer. For the COB claim to the secondary payer, this

example shows information related to the primary payer being placed in the other (non-destination) payer locations, and it also shows information related to the secondary payer being placed in the destination payer locations. Segments in red, italicized text are related to the secondary payer.

HEADER ST*837*0002*005010X223A2~ BHT*0019*00*0123*20050730*1023*CH~	HEADER ST*837*0002*005010X223A2~ BHT*0019*00*0123*20050730*1023*CH~
1000A SUBMITTER NM1*41*2*GET WELL CLINIC*****46*567890~ PER*IC*MARY*TE*6155552222~	1000A SUBMITTER NM1*41*2*GET WELL CLINIC*****46*567890~ PER*IC*MARY*TE*6155552222~
1000B RECEIVER NM1*40*2*MY CLEARINGHOUSE*****46*988888888~	1000B RECEIVER NM1*40*2*MY CLEARINGHOUSE*****46*988888888~
2000A BILLING/PAY-TO PROVIDER HL LOOP HL*1**20*1~	2000A BILLING/PAY-TO PROVIDER HL LOOP HL*1**20*1~
2010AA BILLING PROVIDER NM1*85*2*GET WELL CLINIC*****XX*5876543216~ N3*1234 MAIN ST~ N4*ANYWHERE*TN*37214~ REF*EI*111222333~	2010AA BILLING PROVIDER NM1*85*2*GET WELL CLINIC*****XX*5876543216~ N3*1234 MAIN ST~ N4*ANYWHERE*TN*37214~ REF*EI*111222333~
2000B SUBSCRIBER HL LOOP HL*2*1*22*1~ SBR*P*****BL~	2000B SUBSCRIBER HL LOOP HL*2*1*22*1~ <i>SBR*S*****CI~</i>
2010BA SUBSCRIBER NM1*IL*1*DOE*JOHN***MI*JD03398777~ REF*SY*03398777~	2010BA SUBSCRIBER <i>NM1*IL*1*DOE*JANE***MI*JA7654321~</i> <i>REF*SY*765432111~</i>
2010BB PAYER NM1*PR*2*ABC INS*****PI*12345~ REF*G2*12345678~ REF*LU*678~	2010BB PAYER <i>NM1*PR*2*XYZ INS GROUP*****PI*54698~</i> <i>REF*G2*XYZ3434343~</i> <i>REF*LU*455~</i>
2000C PATIENT HL LOOP HL*3*2*23*0~ PAT*19~	2000C PATIENT HL LOOP HL*3*2*23*0~ <i>PAT*19~</i>
2010CA PATIENT NM1*QC*1*DOE*SALLY~ N3*234 SOUTH ST~ N4*ANYWHERE*TN*37214~ DMG*D8*19930501*F~	2010CA PATIENT NM1*QC*1*DOE*SALLY~ N3*234 SOUTH ST~ N4*ANYWHERE*TN*37214~ DMG*D8*19930501*F~

2300 CLAIM CLM*26407789*115***13:A:1*Y**Y*Y~ REF*G1*ABC456~ REF*9F*ABC670000~ HI*BK:4779*BF:2724*BF:2780*BF:53081~	2300 CLAIM CLM*26407789*115***13:A:1*Y**Y*Y~ REF*G1*XYZ345200~ REF*9F*XYZ6798777~ HI*BK:4779*BF:2724*BF:2780*BF:53081~
2310A ATTENDING PROVIDER NM1*AT*1*KILDARE*RICHARD****XX*9999977777~ REF*G2*ABC670001~ REF*LU*671~	2310A ATTENDING PROVIDER NM1*AT*1*KILDARE*RICHARD****XX*9999977777~ REF*G2*XYZ6798666~ REF*LU*986~
2310D RENDERING PROVIDER NM1*82*1*CASEY*BEN****XX*9999966666~ REF*G2*ABC670002~ REF*LU*672~	2310D RENDERING PROVIDER NM1*82*1*CASEY*BEN****XX*9999966666~ REF*G2*XYZ6798444~ REF*LU*984~
2310E SERVICE FACILITY LOCATION NM1*77*2*ANYWHERE CLINIC****XX*9999955555~ N3*2345 STATE ST~ N4*NASHVILLE*TN*37212~ REF*G2*ABC670004~ REF*LU*674~	2310E SERVICE FACILITY LOCATION NM1*77*2*ANYWHERE CLINIC****XX*9999955555~ N3*2345 STATE ST~ N4*NASHVILLE*TN*37212~ REF*G2*XYZ6798222~ REF*LU*982~
2320 OTHER SUBSCRIBER INFORMATION SBR*S*19*****CI~ DMG*D8*19500501*F~ OI***N*B**Y~	2320 OTHER SUBSCRIBER INFORMATION SBR*P*19*****BL~ AMT*D*65~ DMG*D8*19481013*M~ OI***Y*B**Y~
2330A OTHER SUBSCRIBER NAME NM1*IL*1*DOE*JANE****MI*JA7654321~ N3*234 SOUTH ST~ N4*ANYWHERE*TN*37214~ REF*SY*765432111~	2330A OTHER SUBSCRIBER NAME NM1*IL*1*DOE*JOHN****MI*JD03398777~ N3*234 SOUTH ST~ N4*ANYWHERE*TN*37214~ REF*SY*033987777~
2330B OTHER PAYER NM1*PR*2*XYZ INS GROUP****PI*54698~ REF*G1*XYZ345200~ REF*9F*XYZ6798777~	2330B OTHER PAYER NM1*PR*2*ABC INS****PI*12345~ REF*F8*ABCCLM0005~ REF*G1*ABC456~ REF*9F*ABC670000~
2330C OTHER PAYER ATTENDING PROVIDER NM1*AT*1~ REF*G2*XYZ6798666~ REF*LU*986~	2330C OTHER PAYER ATTENDING PROVIDER NM1*AT*1~ REF*G2*ABC670001~ REF*LU*671~
2330G OTHER PAYER RENDERING PROVIDER NM1*82*1~ REF*G2*XYZ6798444~ REF*LU*984~	2330G OTHER PAYER RENDERING PROVIDER NM1*82*1~ REF*G2*ABC670002~ REF*LU*672~
2330F OTHER PAYER SERVICE FACILITY LOCATION NM1*77*2~ REF*G2*XYZ6798222~ REF*LU*982~	2330F OTHER PAYER SERVICE FACILITY LOCATION NM1*77*2~ REF*G2*ABC670004~ REF*LU*674~

2400 SERVICE LINE LX*1~ SV2*0300*HC:99213*100*UN*1~ DTP*472*D8*20050705~ REF*G1*ABC222222~ REF*G1*XYZ888888**2U:54698~ REF*9F*ABC111111~ REF*9F*XYZ777777**2U:54698~	SERVICE LINE LX*1~ SV2*0300*HC:99213*100*UN*1~ DTP*472*D8*20050705~ REF*G1*XYZ888888~ REF*G1*ABC222222**2U:12345~ REF*9F*XYZ777777~ REF*9F*ABC111111**2U:12345~
2420C RENDERING PROVIDER NM1*82*1*WELBY*MARCUS***XX*1545454541~ REF*G2*ABC333333~ REF*LU*C333~ REF*G2*XYZ666666**2U:54698~ REF*LU*Z666**2U:54698~	2420C RENDERING PROVIDER NM1*82*1*WELBY*MARCUS***XX*1545454541~ REF*G2*XYZ666666~ LU*Z666~ REF*G2*ABC333333**2U:12345~ REF*LU*C333**2U:12345~
2420D REFERRING PROVIDER NM1*DN*1*BROWN*JOE***XX*1323232321~ REF*G2*ABC888888~ REF*LU*C888~ REF*G2*XYZ111111**2U:54698~ REF*LU*Z111**2U:54698~	2420D REFERRING PROVIDER NM1*DN*1*BROWN*JOE***XX*1323232321~ REF*G2*XYZ111111~ REF*LU*Z111~ REF*G2*ABC88888888**2U:12345~ REF*LU*C888**2U:12345~
	2430 LINE ADJUDICATION INFORMATION SVD*12345*50*HC:99213*0300*1~ CAS*PR*1*50~ DTP*573*D8*20050726~ AMT*EAF*50~
2400 SERVICE LINE LX*2~ SV2*0300*HC:90782*15*UN*1~ DTP*472*D8*20050705~	2400 SERVICE LINE LX*2~ SV2*0300*HC:90782*15*UN*1~ DTP*472*D8*20050705~
	2430 LINE ADJUDICATION INFORMATION SVD*12345*15*HC:90782*0300*1~ CAS*PR*92*0~ DTP*573*D8*20050726~
TRANSACTION SET TRAILER SE*78*0002~	TRANSACTION SET TRAILER SE*88*0002~

1.4.1.3 Coordination of Benefits Claims from Paper or Proprietary Remittance Advices

Claim submitters may at times need or choose to create electronic secondary/tertiary coordination of benefit (COB) claims to subsequent payers due to regulatory or business relationships when the prior payer's remittance was a paper or proprietary remittance advice. This situation may occur when the prior payer(s) is not a regular trading partner

of the claim submitter or the prior payer(s) produces electronic remittances but has not converted to the standard transaction.

Provider information systems that have the functionality to generate electronic claim transactions to health plans have the majority of the information necessary to create a COB claim. Ideally, payers have adopted usage of the standard codes sets for paper remittance advices or have provided crosswalks for their paper or non-standard electronic remittances to accommodate creation of COB claims. However, this will not always occur.

When standard codes are not available from a prior payer(s) paper/proprietary remittance advice(s), the COB claim submitter must translate the proprietary adjustment/denial edit messages to standard codes.

Generally, a subsequent COB payer(s) determines payment on a combination of “Group Code” and “Claim Adjustment Reason Code” provided in the CAS segment at either the claim or service line. The primary considerations of Group Code of subsequent COB payers are:

Description	837 Standard Value
Patient Responsibility	PR
Contractual Obligation	CO
Payer Initiated	PI
Other Adjustments	OA

The Claim Adjustment Reason Code is equally important in subsequent payers' determination of payment responsibility. In most instances paper or proprietary monetary adjustments may easily be cross-walked to the standard Claim Adjustment Reason Codes as follows:

Description	837 Standard Value
Patient Responsibility	
Deductible Amount	1
Coinsurance Amount	2

Description	837 Standard Value
Co-payment Amount	3
Blood Deductible	66
Psychiatric Reduction	122
Contractual Obligations	
Charges exceed our fee schedule or maximum allowable amount	42
Charges exceed your contracted / legislated fee arrangement	45
Non-covered charges	96

Payment adjustments by the prior payer(s) that are not readily defined by the above cross-walk values may be reported using default Claim Adjustment Reason Code 192 (Non-standard adjustment code from paper remittance advice) or with other codes the claim submitter determines to be appropriate. Submitters must not use default code 192 when a more specific code is available.

1.4.1.4 Coordination of Benefits - Service Line Procedure Code Bundling and Unbundling

This explanation of bundling and unbundling is applicable to secondary claims that must contain the results of the primary payer's processing. It is not applicable to initial claims sent to the primary payer.

Procedure code bundling or unbundling occurs when a payer's business policy requires that the services reported for payment in a claim be either combined or split apart and 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.

See the latest version of the 835 Remittance Advice transaction 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 includes 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 are reported as originally submitted with the following:

- An SVD segment with zero payment (SVD02),
- A pointer to the new bundled procedure code (SVD06, data element 554 (Assigned Number) is the bundled service line number that refers to the LX assigned number of the service line into which this service line was bundled),
- A CAS segment with a claim adjustment reason code of 97 (payment is included in the allowance for the basic service), and
- An adjustment amount equal to the submitted charge.
- The Adjustment Group in the CAS01 will be either CO (Contractual Obligation) or PI (Payer Initiated), depending upon the provider/payer relationship.

Bundling with COB Example

The following example shows how to report bundled lines on a subsequent COB claim. ABC Hospital 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 ABC Hospital contains this information. Only segments specific to bundling are included in the example.

Original 837

LX*1~ (Loop 2400)

1 = Service line 1

SV2*0300*HC:A*100*UN*1~

0300= UB Revenue Code

HC = HCPCS qualifier

A = HCPCS code

100 = Submitted charge

UN = Units code

1 = Units billed

LX*2~ (Loop 2400)

2 = Service line 2

SV2*0300*HC:B*100*UN*1~**0300**= UB Revenue Code**HC** = HCPCS qualifier**B** = HCPCS code**100** = Submitted charge**UN** = Units code**1** = Units billed

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 PPO's total payment on this claim was \$50.00. The following example includes only segments specific to bundling. The key number to automate tracking of bundled lines is the service line number assigned to each service line in LX01.

COB 837**Claim Level****CAS*PR*1*50~** (Loop ID-2320)**PR** = Patient's Responsibility**1** = Adjustment reason - Deductible amount**50** = Amount of adjustment**AMT*D*50~****D** = Payer amount paid qualifier**50** = Amount paid on this claim by this payer**Service Line Level****LX*1~** (Loop ID-2400)**1** = Service line 1**SV2*0300*HC:A*100*UN*1~** (Loop ID-2400)**0300**= UB Revenue Code**HC** = HCPCS qualifier**A** = HCPCS code**100** = Submitted charge**UN** = Units code**1** = Units billed

SVD*PAYER ID*100*HC:C1~ (Loop ID-2430)**

Payer ID

= ID of the payer who adjudicated this service line

100 = Payer amount approved for payment for the line

HC = HCPCS qualifier

C = HCPCS code for bundled procedure

1 = Service Units

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*0300*HC:B*100*UN*1~

0300= UB Revenue Code

HC = HCPCS qualifier

B = HCPCS code

100 = Submitted charge

UN = Units code

1 = Units billed

SVD*PAYER ID*0*HC:C1*1~ (Loop ID-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 = Service Units

1 = Service line number into which this service line was bundled

CAS*C0*97*100~

C0 = Contractual obligations qualifier

97 = Adjustment reason - Payment is included in the allowance for the basic service/procedure

100 = Amount of adjustment

Bundling with COB -- More Than 2 Payers Example

Bundling with more than two payers in a COB situation where there is both bundling and line level adjustments. The COB related loops would appear as follows:

Claim Level 2320 and 2330 Loops**2320 Loop** (for payer A)

SBR* identifies the other subscriber for payer A identified in 2330B

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

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

2330A Loop

NM1* identifies other subscriber for payer C

2330B Loop

NM1* identifies payer C

Repeat as necessary up to a maximum of ten times. Any one claim can carry up to a total of 11 payers (ten carried in Loop ID-2320, and one carried in Loop ID-2010BB). Once all the claim level payers have been identified, use the 2400 loop once for each original billed service line. Use 2430 loops to show line level adjustment by each payer.

Service Line**2400 Loop****LX*1~**

SV2* original data from provider for line 1

2430 Loop (for payer A)

SVD*A* their data for this line (the procedure code A paid on)

CAS* payer A's data for this line (repeat CAS as necessary)

DTP* payer A's adjudication date for this line

2430 Loop (for payer B)

SVD*B* their data for this line (the procedure code B paid on)

CAS* payer B's data for this line (repeat CAS as necessary)

DTP* payer 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 procedure code C paid on)

CAS* payer C's data for this line (repeat CAS as necessary)

DTP* payer 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 procedure code A paid on)

CAS* payer A's data for this line (repeat CAS as necessary)

DTP* payer A's adjudication date for this line

2430 Loop (for payer B)

SVD*B* their data for this line (the procedure code B paid on)

CAS* payer B's data for this line (repeat CAS as necessary)

DTP* payer 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 procedure code C paid on)

CAS* payer C's data for this line (repeat CAS as necessary)

DTP* payer C's adjudication date for this line

etc.

Unbundling with COB

When unbundling, the original service line detail will be followed by one or more occurrences of the Line Adjudication Information (Loop ID-2430) loop. This loop is repeated once for each unbundled procedure code.

Unbundling Example

The same provider submits a claim for one service line. 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. Only segments specific to unbundling are included in the following example.

LX*1~ (Loop-2400)

1 = Service line 1

SV2*0300*HC:A*200*UN*1~

0300= UB Revenue Code

HC = HCPCS qualifier

A = HCPCS code

200 = Submitted charge

UN = Units code

1 = Units billed

SVD*PAYER ID*60*HC:B*0300*1~ (Loop ID-2430)

Payer ID

= ID of the payer who adjudicated this service line

60 = Payer amount paid

HC = HCPCS qualifier

B = Unbundled HCPCS code

0300= UB Revenue Code

1 = Service Units

CAS*C0*45*35~

C0 = Contractual obligations qualifier

45 = Adjustment reason -- Charges exceed your contracted/legislated fee arrangement

35 = Amount of adjustment

SVD*PAYER ID*60*HC:C*0300*1~

Payer ID

= ID of the payer who adjudicated this service line

60 = Payer amount paid

HC = HCPCS qualifier

C = Unbundled HCPCS code

0300= UB Revenue Code

1 = Service Units

CAS*CO*45*45~**CO** = Contractual obligations qualifier**45** = Adjustment reason -- Charges exceed your contracted/legislated fee arrangement**45** = Amount of adjustment

1.4.1.5 Coordination of Benefits - Medicaid Subrogation

Federal law requires Medicaid agencies to pursue recovery of medical expenditures made on behalf of Medicaid recipients when third party liability is determined to exist. Since Medicaid recipients are required to assign any rights of third party liability to the Medicaid agency, this Implementation Guide provides the ability for willing trading partners to allow direct billing by a Medicaid agency to other health plans. These pay-to-plan claims are identified by the inclusion of Loop ID-2010AC Pay-to Plan Name Loop. Medicaid subrogation claims include the Medicaid agency's own payer claim control number in Loop ID-2300 data element CLM01 rather than the provider's patient control number. The Medicaid paid amount, indicated in Loop ID-2320 data element AMT01, represents the maximum amount of liability the Medicaid agency is requesting to recover by submitting the claim.

The Medicaid agency is identified in Loop ID-2330B (Other Payer Name). Loop ID-2320 and Loop ID-2430 include all required segments to indicate the Medicaid agency's adjudication of the original claim submitted to that agency. Receiving payers are to direct information requests about the claim to the Medicaid agency rather than to the original service provider.

At the time of publication, Medicaid subrogation is not a HIPAA mandated business usage of the ASC X12 837 Health Care Claim, but willing trading partners may use this Implementation Guide for that purpose.

1.4.2 Property and Casualty

To ensure timely processing, specific information needs to be included when submitting bills to Property and Casualty payers (for example, Automobile, Homeowner's, or Workers' Compensation insurers and related entities). Section 3.2 of this Implementation Guide explains these requirements and presents a number of examples.

1.4.3 Data Overview

The data overview introduces the 837 transaction set structure and describes the positioning of business data within the structure. For a review of ASC X12 nomenclature, segments, data elements, hierarchical levels, and looping structure, see Appendix B, *Nomenclature*, and Appendix C, *EDI Control Directory*.

1.4.3.1 Loop Labeling, Sequence, and Use

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 PROVIDER contains information about the billing provider, pay-to address and pay-to plan. The descriptive name -- BILLING PROVIDER -- informs the user of the overall focus of the loop. The Loop ID is a short-hand name, for example 2000A, that gives, at a glance, the position of the loop within the overall transaction. Loop ID-2010AA BILLING PROVIDER NAME, Loop ID-2010AB PAY-TO ADDRESS NAME, and Loop ID-2010AC PAY-TO PLAN NAME are subloops of Loop ID-2000A. When a loop is used more than once, a letter is appended to its 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 Provider Hierarchical Level (HL), Subscriber HL and Patient HL. These loops are labeled 2000A, 2000B and 2000C respectively. As the 2000 level loops define the hierarchical structure, they are required to be used in the order shown in the implementation guide.

The order of multiple subloops that do not involve hierarchical structure and that do have the same numeric position within the transaction is less important. Such subloops do not need to be sent in the same order in which they appear in this implementation guide. For such subloops in this transaction, the numeric portion of the loop ID does not end in 00. For example, Loop ID-2010 has two possibilities within Loop ID-2000B (Loop ID-2010BA Subscriber Name and Loop ID-2010BB Payer Name). Each of these 2010 loops is at the same numeric position in the transaction. Since they do not specify an HL, it is not necessary to use them in any particular order. However, it is not acceptable to send subloop 2330 before loop 2310 because these are not equivalent subloops.

In a similar manner, if a single loop has multiple iterations (repetitions) of a particular segment, the sequence of those segments within a transaction is not important and is not required to follow the same order in which they appear in this implementation guide. For example, there are many DTP segments in the 2300 loop. It is not required that Initial Treatment Date be sent before Last Seen Date. However, it is required that the DTP segment in the 2300 loop come after the CLM segment because it is carried in a different position within the 2300 loop.

1.4.3.2 Data Use by Business Use

The 837 is divided into two tables. Table 1 contains transaction control information and is described in Section 1.4.3.2.1 - Table 1 -- Transaction Control Information. Table 2 contains the detail information for the transaction's business function and is described in Section 1.4.3.2.2 - Table 2 -- Detail Information.

1.4.3.2.1 Table 1 -- Transaction Control Information

Table 1 is named the Header level (see Figure 1.3 - *Header Level*). Table 1 identifies the start of a transaction, the specific transaction set, the transaction's business purpose, and the submitter/receiver identification numbers.

Figure 1.3 - Header Level

Table 1 - Header				
POS. #	SEG. ID	NAME	USAGE	REPEAT
0050	ST	Transaction Set Header	R	1
0100	BHT	Beginning of Hierarchical Transaction	R	1
...				

1.4.3.2.1.1 Transaction Set Header (ST) Segment

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.

Because the 837 is multi-functional, it is important for the receiver to know which business purpose is served. ST03 contains a reference to the specific implementation guide used to create this 837 transaction. This data element differentiates among the Health Care Claim: Professional (005010X222A1), the Health Care Claim: Institutional (005010X223A2), the Health Care Claim: Dental (005010X224A2), and the Health Care Service: Data Reporting (005010X225A2).

1.4.3.2.1.2 Beginning of Hierarchical Transaction (BHT) Segment

The BHT segment indicates that the transaction uses a hierarchical data structure. The data elements within the BHT are used in the following way:

- BHT01 - The Hierarchical Structure Code designates the type of business data within each hierarchical level. The 0019 value used in the claim BHT01 specifies the order of subsequent hierarchical levels to be:
 - Information source (Billing Provider)
 - Subscriber (can be the patient when the patient is the subscriber or is considered to be the subscriber)
 - Dependent (Patient, when the patient is not considered to be the subscriber)
- BHT02 - The transaction purpose code indicates "original" by using data value 00 or "reissue" by using data value 18.
- BHT03 - originator's reference number; generated by the business application system of the entity building the original transaction.

- BHT04 - date of transaction creation; generated by the business application system of the entity building the original transaction.
- BHT05 - time of transaction creation; generated by the business application system of the entity building the original transaction.
- BHT06 - designates transaction as Subrogation, fee-for-service, or capitated services.

1.4.3.2.2 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 in Loop ID-2000 identifies the participants and the relationship to other participants. The individual or entity information is contained in Loop ID-2010.

1.4.3.2.2.1 Hierarchical Level (HL) Segments

Section B.1.1.4.3 in Appendix B contains a general description of HL structures. The following describes the HL structure within the claim transaction.

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

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

For the Subscriber HL, the Billing Provider HL is the parent. The Patient HL is the child. The Subscriber HL is contained within the Billing Provider HL. The Patient HL is contained within the Subscriber HL.

1.4.3.2.2.2 Subscriber / Patient Hierarchical Level (HL) Segments

The following information illustrates claim 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 patient. In other words, the claim information is placed at the

subscriber hierarchical level when the patient is the subscriber or considered to be the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber and cannot be uniquely identified on their own.

Claim submission when the **patient is the subscriber or is considered to be 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

1.4.3.2.2.3 Hierarchical Level (HL) Structural Example

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 (for example, subscriber #2 spouse)

Claim level information

Line level information, as needed

PATIENT #P2.2 (for example, subscriber #2 first child)

Claim level information

Line level information, as needed

PATIENT #P2.3 (for example, 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

SUBSCRIBER #4 (repeated)

PATIENT #P4.1 (for example, #4 subscriber's first child)

Claim level information

Line level information, as needed

Based on the previous example, the HL structure will be as follows:

HL *120*1~ (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~ (SUBSCRIBER #1)

2 = HL sequence number

1 = parent HL

22 = subscriber

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

HL *3*1*22*1~ (SUBSCRIBER #2)

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~ (PATIENT #P2.1)

4 = HL sequence number

3 = parent HL

23 = dependent

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

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

5 = HL sequence number

3 = parent HL

23 = dependent

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

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

6 = HL sequence number

3 = parent HL

23 = dependent

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

HL*7*1*22*0~ (SUBSCRIBER AND PATIENT #3)

7 = HL sequence number

1 = parent HL

22 = subscriber

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

HL*8*1*22*0~ (SUBSCRIBER AND PATIENT #4)

8 = HL sequence number

1 = parent HL

22 = subscriber

0 = no subordinate HLs

HL*9*1*22*1~ (SUBSCRIBER #4)

9 = HL sequence number

1 = parent HL

22 = subscriber

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

HL*10*9*23*0~ (PATIENT #P4.1)

10 = HL sequence number

9 = parent HL

23 = dependent

0 = no subordinate HLs

If another billing provider is listed in the same ST-SE functional group, it could be listed as follows: **HL*100**20*1~**. The HL sequence number of 100 indicates that there are 99 previous HL segments and it is the billing provider level HL (HL03 = 20).

1.4.3.2.2.4 Hierarchical Level (HL) Structural Summary

The following information summarizes coding and structure of the HL segment:

- HL segments are numbered sequentially within a transaction (ST to SE), beginning with 1. The sequential number is found in HL01, which is the first data element in the HL segment. Sequence number must be numeric.
- The second element, HL02, indicates the sequential number of the parent hierarchical level. The billing provider/information source is the highest hierarchical level and therefore has no parent.
- 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" indicates no subordinate hierarchical levels exist for this HL.

1.4.3.2.2.5 Claim Structure

After the HL structure is defined and the Subscriber and/or Patient information is listed, the specific claim information follows:

- Loop ID-2300 contains claim level information.
- Loop ID-2310 identifies various claim specific providers who may have been involved in the health care services being reported in the transaction.
- Loop ID-2320 identifies claim level adjudication information associated with non-destination, other payer information for the purpose of coordination of benefits.
- Loop ID-2330 identifies the subscriber, payer, and provider identifiers associated with the non-destination, other payer.
- Loop ID-2400 is required for all claims and identifies service line information.
- Loop ID-2410 identifies drug and biologics 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 another payer.

1.4.3.2.2.6 Provider Taxonomy Code Reporting

Provider Taxonomy Codes describe provider type, classification, and area of specialization and are maintained by the National Uniform Claims Committee. For use in an 837 claim, the provider determines the code value from the code set (external Code Source 682) that most accurately describes the type and specialty classification under which the provider performed the services reported on the claim. The payer may not dictate the code value to be reported.

1.4.4 Balancing

In order to ensure internal claim integrity, amounts reported in the 837 **MUST** balance at two different levels -- the claim and the service line.

1.4.4.1 Claim Level

There are two different ways the claim information must balance. They are as follows.

1) Claim Charge Amounts

The total claim charge amount reported in Loop ID-2300 CLM02 must balance to the sum of all service line charge amounts reported in Loop ID-2400 SV203.

2) Claim Payment Amounts

Balancing of claim payment information is done payer by payer. For a given payer, the sum of all line level payment amounts (Loop ID-2430 SVD02) less any claim level adjustment amounts (Loop ID-2320 CAS adjustments) must balance to the claim level payment amount (Loop ID-2320 AMT02).

Expressed as a calculation for given payer: {Loop ID-2320 AMT02 payer payment} = {sum of Loop ID-2430 SVD02 payment amounts} minus {sum of Loop ID-2320 CAS adjustment amounts}.

Line Level Payment Amounts

Line level payment information is reported in Loop ID-2430 SVD02. In order to perform the balancing function, the receiver must know which payer the line payment belongs to. This is accomplished using the identifier reported in Loop ID-2430 SVD01. This identifier must match the identifier of the corresponding payer identifier reported in Loop ID-2330B NM109.

Adjustment Calculations

Adjustments are reported in the CAS segments of Loop ID-2320 (claim level) and Loop ID-2430 (line level). In this context, Adjustment Amounts are the sum of CAS03, CAS06, CAS09, CAS12, CAS15, and CAS18. Adjustment amounts within the CAS segment **DECREASE** the payment amount when the adjustment amount is **POSITIVE**, and **INCREASE** the payment amount when the adjustment amount is **NEGATIVE**.

Claim Level Payment Amount

At the claim level, the payer's total claim payment is reported within the Loop ID-2320 Coordination of Benefits (COB) Payer Paid Amount AMT segment with a D qualifier in AMT01. The associated payer is defined within the Loop ID-2330B child loop.

Example:

Claim Charge - 100.00
Claim Payment - 80.00
Claim Adjustment - 5.00

Line 1 Charge - 80.00
Line 1 Payment - 70.00
Line 1 Adjustment - 10.00

Line 2 Charge - 20.00
Line 2 Payment - 15.00
Line 2 Adjustment - 5.00

Claim Payment = (Line 1 Payment + Line 2 Payment) – Claim Adjustment

80.00 = (70.00 + 15.00) - 5.00

1.4.4.2 Service Line

Line Adjudication Information (Loop ID-2430) is reported when the payer identified in Loop ID-2330B has adjudicated the claim and service line payments and/or adjustments have been applied.

Line level balancing occurs independently for each individual Line Adjudication Information loop. In order to balance, the sum of the line level adjustment amounts and line level payments in each Line Adjudication Information loop must balance to the provider's charge for that line (Loop ID-2400 SV203). The Line Adjudication Information loop can repeat up to 25 times for each line item.

The calculation for each 2430 loop is as follows: {sum of Loop ID-2430 CAS Service Line Adjustments} plus {Loop ID-2430 SVD02 Service Line Paid Amount} = {Loop ID-2400 SV203 Line Item Charge Amount}

Example:

Line 1 Charge - 80.00
Line 1 Payment - 70.00
Line 1 Adjustment - 10.00

Line 2 Charge - 20.00
Line 2 Payment - 15.00
Line 2 Adjustment - 5.00

(Line 1 Adjustments) + (Line 1 Payment) = Line Item 1 Charge

$$10.00 + 70.00 = 80.00$$

$$(\text{Line 2 Adjustments}) + (\text{Line 2 Payment}) = \text{Line Item 2 Charge}$$

$$5.00 + 15.00 = 20.00$$

1.4.5 Allowed/Approved Amount Calculation

During the development cycle of this version, one of the guiding principles was to remove all amount fields that can be calculated with other information already present in the claim. This resulted in the elimination of several AMT segments. Included in these, are the Approved and Allowed Amount segments. The workgroup has found these amounts vary in definition depending upon perspective. Although rare, there are times the provider's determination of what the allowed amount is different from the payers. This occurs for many various reasons. However, there has never been a way to recognize when these differences occur. As a result, the authors offer the following guidance as to how these amounts are calculated.

The Allowed amount as determined by the payer is calculated using the prior payer's payment information coupled with adjustment information in the CAS segments. The prior payer payment + the sum total of all patient responsible adjustment amounts = the Allowed amount. The Patient Responsible adjustments are identified by use of the Category Code PR in CAS01.

The Allowed amount as determined by the provider is calculated using the prior payer's payment information coupled with the Remaining Patient Liability AMT segments. The prior payer payment + the Remaining Patient Liability AMT amount = the Allowed amount.

1.5 Business Terminology

This section defines terms used in this implementation guide that are not included in the Data Dictionary Appendix. See the Data Dictionary Appendix for additional terms and definitions.

Bundling

Bundling occurs when a provider submits two or more reported procedure codes and the payer believes that the actual services performed and reported must be paid under only one (possibly different) procedure code.

Claim

For the purposes of this implementation guide, claim is intended to be an all inclusive term to represent both reimbursable claims and encounter reporting.

Dependent

In the hierarchical loop coding, the dependent code 23 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).

Encounter

Non-reimbursable claim for which the health care encounter information is gathered for reporting. Also thought of as the reporting of a face-to-face encounter between a patient and a provider for which no reimbursement will be made. Often seen in pre-paid capitated financial arrangements in which the provider of services is paid in advance for the patient's health care needs. In some areas called a capitated or zero pay claim.

Inpatient

The determination of what constitutes an Inpatient Claim is defined by the National Uniform Billing Committee code set and documentation. See Section 1.12.6 - *Inpatient and Outpatient Designation* for more information about Inpatient and Outpatient designation.

Outpatient

The determination of what constitutes an Outpatient Claim is defined by the National Uniform Billing Committee code set and documentation. See Section 1.12.6 - *Inpatient and Outpatient Designation* for more information about Inpatient and Outpatient designation.

Pay-To Plan Claims

Pay-to plan claims are payment requests billed by one health plan directly to other health plans. These claims were originally submitted to and paid by the first health plan. An example of a pay-to plan claim is a payment request from a Medicaid agency direct to another health plan that may have liability for the member and services on the claim originally paid by the Medicaid agency.

Patient

The term patient is used in this implementation guide when the Patient loop (Loop ID-2000C) is used. In Loop ID-2000C, the patient is not the same person as the subscriber, and the patient is a person (for example, spouse, children, others) who is covered by the subscriber's insurance plan and does not have a unique member identification number. The person receiving services (in clinical terms, the patient) can

be the same person as the subscriber. In that case, all information about that person is carried in the Subscriber loop (Loop ID-2000B).

See Section 1.4.3.2.2.2 - Subscriber / Patient Hierarchical Level (HL) Segments, and the notes for the SBR and PAT segments for further details. Every effort has been made to ensure that the meaning of the word patient is clear in its specific context.

Provider

A provider is either a person or organizational entity who has either provided or participated in some aspect of the service(s) described in the transaction. Specific types of providers are identified in this implementation guide (for example billing provider, referring provider). Beginning with the 5010 version, the Billing Provider must be a health care or atypical provider (as described in Section 1.10.1 - Providers who are Not Eligible for Enumeration).

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, or who has a unique member identification number. Other synonymous terms include member and/or insured. In some cases the subscriber is the person receiving services. See the definition of patient, and see Section 1.4.3.2.2.2 - Subscriber / Patient Hierarchical Level (HL) Segments, and the notes for the SBR and PAT segments for further details.

Transmission Intermediary

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

Unbundling

Unbundling occurs when a provider is billing multiple procedure codes for a group of procedures that are covered by a single comprehensive code. In other words, the provider submits one reported procedure code and the payer believes that the actual services performed and reported must be paid under two or more separate (possibly different) procedure codes. Unbundling also occurs when the units of service reported on one service line are broken out to two or more service lines for different reimbursement rates.

1.6 Transaction Acknowledgments

There are several acknowledgment implementation transactions available for use. The IG developers have noted acknowledgment requirements in this section. Other recommendations of acknowledgment transactions may be used at the discretion of the trading partners. A statement that the acknowledgment is not required does not preclude its use between willing trading partners.

1.6.1 997 Functional Acknowledgment

The 997 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group.

The Functional Acknowledgment (997) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Functional Acknowledgment (997) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

A 997 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.2 999 Implementation Acknowledgment

The 999 informs the submitter that the functional group arrived at the destination. It may include information about the syntactical quality of the functional group and the implementation guide compliance.

The Implementation Acknowledgment (999) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Implementation Acknowledgment (999) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

A 999 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.3 824 Application Advice

The 824 informs the submitter of the results of the receiving application system's data content edits of transaction sets.

The Application Advice (824) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Application Advice (824) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

An 824 Implementation Guide is being developed for use by the insurance industry and is expected to be available for use with this version of this Implementation Guide.

1.6.4 277 Health Care Claim Acknowledgment

The 277 provides an application level acknowledgment of electronic claims. It may include information about the business validity and acceptability of the claims.

The Health Care Claim Acknowledgment (277) transaction is not required as a response to receipt of a batch transaction compliant with this implementation guide.

The Health Care Claim Acknowledgment (277) transaction is not required as a response to receipt of a real-time transaction compliant with this implementation guide.

1.7 Related Transactions

There are one or more transactions related to the transactions described in this implementation guide.

1.7.1 Health Care Claim Payment/Advice (835)

Information in the Health Care Claim Payment/Advice (835) transaction is generated by the payer's adjudication system. However, in a coordination of benefits (COB) situation where the provider is sending an 837 to a secondary payer, information from the 835 may be included in the secondary 837. As shown in Section 1.4.1.2 - *Crosswalking COB Data Elements*, data from specific segments/elements in the 835 are crosswalked directly into the subsequent 837.

1.8 Trading Partner Agreements

Trading partner agreements are used to establish and document the relationship between trading partners. A trading partner agreement must not override the specifications in this implementation guide if a transmission is reported in GS08 to be a product of this implementation guide.

1.9 HIPAA Role in Implementation Guides

Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191 - known as HIPAA) direct the Secretary of Health and Human Services to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

This implementation guide has been developed for use as an insurance industry implementation guide. At the time of publication it has not been adopted as a HIPAA standard. Should the Secretary adopt this implementation guide as a standard, the Secretary will establish compliance dates for its use by HIPAA covered entities.

1.10 National Provider Identifier Usage within the HIPAA 837 Transaction

Implementation and use of the National Provider Identifier (NPI) has a direct impact on the generation of 837 transaction sets. Previous versions contained placeholder codes and elements in anticipation of the official Rule. With publication of the final rule and industry input on implementation direction, the authors have identified the following areas for clarification and direction for use within the implementation guide.

- Providers who are not eligible for enumeration
- Implementation migration strategy
- Organization health care provider subpart representation
- Subparts and the billing provider

1.10.1 Providers who are Not Eligible for Enumeration

Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi drivers, carpenters, personal care providers, etc. Although, they are not eligible to receive an NPI, these providers perform services that are reimbursed by some health plans. As a result, this implementation guide has been enhanced to accommodate both the NPI (to identify health care providers) and proprietary identifiers (to identify atypical/non-health care providers).

1.10.2 Implementation Migration Strategy

The ANSI ASC X12N Health Care Claims workgroup (TG2WG2) anticipates that during the transition period (i.e., the period from May 23, 2005 until the NPI compliance dates),

the need to use both the NPI and proprietary identifiers to identify health care providers in the same standard claims transaction will be necessary. The implementation guides for the 837 transaction set have been modified to meet this need.

1.10.3 Organization Health Care Provider Subpart Representation

Historically, there has been no standard representation of organization health care providers. How the health care provider entity has been identified has varied by trading partner. The NPI subpart concept provides an organization health care provider the ability to represent itself in a manner consistent to all trading partners. In the health care claim, there are three possible locations for organization health care provider entities to be reported. They are Billing Provider, Rendering Provider, and Service Location.

Billing Provider. In many instances the Billing Provider is an organization; therefore, the Billing Provider NPI reported would belong to an organization health care provider. The Billing Provider may be an individual only when the services were performed by, and will be paid to, an independent, non-incorporated individual. When an organization health care provider has determined that it has subparts requiring enumeration, that organization health care provider will report the NPI of the subpart as the Billing Provider. The subpart reported as the Billing Provider **MUST** always represent the most detailed level of enumeration as determined by the organization health care provider and **MUST** be the same identifier sent to any trading partner.

NOTE

In published versions prior to 5010, the Billing Provider may have been a variety of entities, including billing services and healthcare clearinghouses. Beginning with version 5010, the Billing Provider must be a health care or atypical service provider (as described in the section entitled Providers who are Not Eligible for Enumeration).

Rendering Provider or Service Location. An organization health care provider's NPI used to identify the Rendering Provider or the Service Location must be external to the entity identified as the Billing Provider (for example; reference lab). It is not permissible to report an organization health care provider's NPI as the Rendering Provider or the Service Location if the Rendering Provider or Service Location is a subpart of the Billing Provider.

1.10.4 Subparts and the 2010 AA - Billing Provider Name Loop

Beginning on the NPI compliance date(s): When the Billing Provider is an organization health care provider, the NPI of the organization health care provider or its subpart is reported in NM109. When an organization health care provider has determined a need to enumerate subparts, it is required that a subpart's NPI be reported as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration and MUST be the same identifier sent to any trading partner. For additional explanation, see Section 1.10.3 - Organization Health Care Provider Subpart Representation.

The Billing Provider may be an individual only when the health care provider performing services is an independent, unincorporated entity. In these cases, the Billing Provider is the individual whose Tax Identification Number (TIN) is used for IRS Form 1099 purposes. That individual's NPI is reported in NM109, and the individual's TIN must be reported in the REF segment of Loop ID-2010AA. The individual's NPI must be reported when the individual provider is eligible for an NPI.

Prior to the NPI compliance date, proprietary identifiers necessary for the receiver to identify the Billing Provider entity are to be reported in the REF segment of Loop ID-2010BB Payer Name. The TIN of the Billing Provider, used for IRS Form 1099 purposes, must be reported in the REF segment of Loop ID-2010AA Billing Provider.

When the Billing Provider is an atypical provider, the Billing Provider should be the legal entity. However, willing trading partners may agree upon varying definitions. Proprietary or legacy identifiers necessary for the trading partner to identify the entity are to be reported in the REF segment of Loop ID-2010BB Payer Name. The TIN, used for IRS Form 1099 purposes, must be reported in the REF segment of Loop ID-2010AA Billing Provider.

1.11 Coding of Drugs in the 837 Claim

This section provides guidance on the coding of drug claims under HIPAA as accomplished in the 2400 and 2410 loops. For home infusion therapy care claims that include the drugs, biologics, and nutrition components of the total home infusion therapy encounters, refer to the 837 Health Care Claim: Institutional implementation guide.

Regarding format, although National Drug Code (NDC) numbers may have different formats, all may be mapped to the 5-4-2 format used in this implementation guide, for

example 12345-6789-01. NDC numbers are to be reported as an 11 character data stream with no separators. In other words, the hyphens are to be suppressed. HCPCS codes are always five characters in length.

1.11.1 Single Drug Billing

An 837 for a single drug will have one 2400 loop with the HCPCS code in SV202-2 and the associated units in SV205. When required by situational rules, the 2410 loop is sent with the NDC number in LIN03 and the associated quantity in CTP04. Loop ID-2410 REF02 contains a prescription number when the drug is provided under prescription.

1.11.2 Compound Drug Billing

An 837 for a multiple ingredient compound will have one 2400 loop for each ingredient with the HCPCS code in SV202-2, the provider's charge for that ingredient in SV203, and the associated units in SV205. When required by situational rules, the 2410 loop is sent with the NDC number in LIN03 with the associated quantity in CTP04. Loop ID-2410 REF02 must have the same prescription number, or the same linkage number if provided without a prescription, for each ingredient of the compound to enable the payer to differentiate and link the ingredients to a single compound.

1.12 Additional Instructions and Considerations

1.12.1 Individuals with one Legal Name

In those situations where an individual has only one legal name, report that name in the last name data element of the NM1 segment, specifically the NM103. The first and middle name data elements for that NM1 segment are then not used. This guideline is true for all loops containing an NM1 segment that may identify an individual.

1.12.2 Rejecting Claims Based on the Inclusion of Situational Data

This implementation guide contains a number of Situational Rules which state the element or segment is required when a payer's adjudication is known to be impacted by that information. These rules must not be construed as allowing the current payer to reject a claim or transaction if the information is submitted but not used by that payer. The

condition in these situational rules is based on a known impact to any potential payer's adjudication.

The purpose is to enable proper adjudication for any potential downstream payers as well as allow affected providers to collect and report information consistently for all trading partners when desired. As a result, the submitter is not restricted from sending the information to other payers in addition to the specific payer that has a known adjudication impact.

1.12.3 Multiple REF Segments with the same Qualifier

A repeat of a REF segment within the same loop is not allowed when the qualifier in the REF01 data element is the same. However, there is one important exception to this rule. Within the 837, there are data elements reported in Loop ID-2400 and the various 2420 loops which are payer specific (for example: Referral Number, Prior Authorization Number, Provider Identifiers...). When these pieces of information are reported, the composite data element in REF04 is used to identify the associated payer. In all cases, the reported data belongs to the destination payer when REF04 is not used. When REF04 is used, the value reported in the first component (REF04-1) equals 2U. This qualifier indicates the value reported in the following component (REF04-2) is a payer identifier. This payer identifier "links" to one of the payer identifiers found in Loop ID-2330B NM109.

1.12.4 Provider Tax IDs

For purposes of this implementation, the Billing Provider is the provider or provider organization to which payment is intended to be made. This payment is included in the provider's 1099 reporting. The Employer Identification Number (EIN) or Social Security Number (SSN) for the billing provider is only reported in the Billing Provider Tax Identification REF segment in Loop ID-2010AA Billing Provider. The EIN and SSN qualifiers are not valid in any provider REF segments other than the 2010AA Billing Provider loop. Other reference qualifiers must be used in the REF segments in those loops to provide identifying information, such as "G2" for Provider's Commercial Number.

1.12.5 Claim and Line Redundant Information

This implementation guide supports the reporting of some information at the claim and the service levels to enable the reporting of individual line specific information. The line level usage notes for these pieces of information state "Required when different than that reported at the claim level. If not required by this implementation guide, do not send." This wording results in the potential for misinterpretation resulting in unintended rigidity. These usage notes, as written with the "do not send" statement, should be applied as

establishing the conditions when a submitter must send, and when a submitter is not required to send, the line level information. This “do not send” statement does not establish situations where a receiver is allowed, or is required, to reject a claim. That would be placing an unnecessary burden on the sender. The appropriate action by a receiver is to “ignore, but don’t reject” this redundant claim/line information. If redundant data segments or elements are reported but are not necessary for the receiver within their application, the receiver ignores the information that is not needed. The presence of the unneeded information must not cause the transaction to be rejected.

These usage notes do not permit a receiver to request or require the redundant line level data. Sending the redundant data is strictly at the submitter’s discretion.

An example of this would be Rendering Provider information that is supported in the 2310 and 2420 loops of the Institutional, Professional, and Dental implementation guides. The same Rendering Provider information might be reported at both the claim and line levels. This situation would not alter the payment of that claim nor complicate the adjudication algorithms. Consequently, rejecting any claims because of the presence of this redundant data would unnecessarily burden the provider community and further complicate the claim process.

Other examples exist in the claim implementation guides where the business cases open up the possibility for redundant data to be reported. For all such situations, the principle is to “ignore, but don’t reject”.

1.12.6 Inpatient and Outpatient Designation

The determination of what constitutes an Inpatient or Outpatient claim is defined in the external code set developed by the National Uniform Billing Committee in its Data Specifications Manual (UB Manual) beginning with UB-04. General guidelines are contained in the Type of Bill section of the UB Manual. Inpatient and Outpatient claims are distinguished by Type of Bill and other factors. Certain bill types are designated for inpatient use while others are designated for outpatient reporting. Exceptions to the general rules are documented with reference to the specific data elements affected.

1.12.7 Trading Partner Acknowledgments

The authors of this implementation guide strongly encourage submitters of this transaction to expect and require standard electronic acknowledgments from receivers. The authors encourage receivers to expect and require submitters to have an operational capability to accept and take action on standard electronic acknowledgments.

2 Transaction Set

NOTE

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

2.1 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 insurance industry-specific implementation. In this implementation guide, **IMPLEMENTATION** specifies the requirements for this implementation. **X12 STANDARD** is included as a reference only.

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

2.3 Transaction Set Listing

There are two sub-sections under this general title. The first sub-section concerns this implementation of a generic X12 transaction set. The second sub-section concerns the generic X12 standard itself.

IMPLEMENTATION

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail.

STANDARD

This section is included as a reference.

2.4 Segment Detail

There are three sub-sections under this general title. This section repeats once for each segment used in this implementation providing segment specific detail and X12 standard detail.

SEGMENT DETAIL

This section is included as a reference.

DIAGRAM

This section is included as a reference. It provides a pictorial view of the standard and shows which elements are used in this implementation.

ELEMENT DETAIL

This section specifies the implementation details of each data element.

These illustrations (Figures 2.1 through 2.5) are examples and are not extracted from the Section 2 detail in this implementation guide. Annotated illustrations, presented below in the same order they appear in this implementation guide, describe the format of the transaction set that follows.

IMPLEMENTATION

Indicates that this section is the implementation and not the standard

8XX Insurance Transaction Set

Table 1 - Header

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
53	0100	ST	Transaction Set Header	R	1	
54	0200	BPR	Financial Information	R	1	
60	0400	TRN	Reassociation Key	R	1	
62	0500	CUR	Non-US Dollars Currency	S	1	
65	0600	REF	Receiver ID	S	1	
66	0600	REF	Version Number	S	1	
68	0700	DTM	Production Date	S	1	
PAYER NAME						1
70	0800	N1	Payer Name	R	1	
72	1000	N3	Payer Address	S	1	
75	1100	N4	Payer City, State, Zip	S	1	
76	1200	REF	Additional Payer Reference Number	S	1	
78	1300	PER	Payer Contact	S	1	
PAYEE NAME						1
79	0800	N1	Payee Name	R	1	
81	1000	N3	Payee Address	S	1	
82	1100	N4	Payee City, State, Zip	S	1	
84	1200	REF	Payee Additional Reference Number	S	>1	

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 2.1. Transaction Set Key — Implementation

STANDARD

Indicates that this section is identical to the ASC X12 standard

See *Appendix B.1, ASC X12 Nomenclature* for a complete description of the standard

8XX Insurance Transaction Set

Functional Group ID: **XX**

This Draft Standard for Trial Use contains the format and establishes the data contents of the Insurance Transaction Set (8XX) within the context of the Electronic Data Interchange (EDI) environment.

Table 1 - Header

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	M	1	
0200	BPR	Beginning Segment	M	1	
0300	NTE	Note/Special Instruction	O	>1	
0400	TRN	Trace	O	1	

Figure 2.2. Transaction Set Key — Standard

SEGMENT DETAIL	
Industry assigned Segment Name	NM1 - PATIENT NAME
X12 Segment Name:	Individual or Organizational Name
X12 Purpose:	To supply the full name of an individual or organizational entity
X12 Syntax:	P0809 If either NM108 or NM109 is present, then the other is required. C1110 If NM111 is present, then NM110 is required. C1203 If NM112 is present, then NM103 is required.
Industry assigned Loop ID and Loop Name	
Industry Segment Repeat	Loop: 2100B — PATIENT NAME Loop Repeat: 1
Segment Repeat:	1
Industry usage	Usage: SITUATIONAL
Situational Rule	Situational Rule: Required when the patient is different from the insured. If not required by this implementation guide, do not send.
Industry Notes	TR3 Notes: 1. Any necessary identification number must be provided in NM109.
Example	TR3 Example: NM1*QC*1*Shepard*Sam*A***34*452114586~

Figure 2.3. Segment Key — Implementation

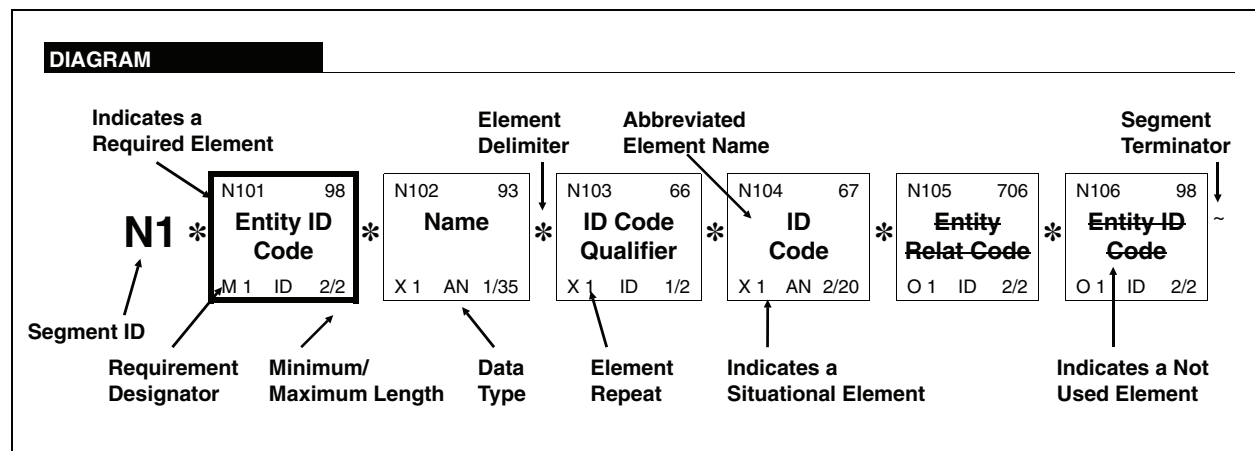


Figure 2.4. Segment Key — Diagram

ELEMENT DETAIL						
USAGE	REF. DES.	DATA ELEMENT	NAME	Element Repeat	ATTRIBUTES	
REQUIRED	SVC01	C003	COMPOSITE MEDICAL PROCEDURE IDENTIFIER To identify a medical procedure by its standardized codes and applicable modifiers Use the Primary Payer's adjudicated Medical Procedure Code.	M 1		
Reference Designator			Composite Number			
REQUIRED	SVC01 - 1	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234) IMPLEMENTATION NAME: Product or Service ID Qualifier The value in SVC01-1 qualifies the values in SVC01-2, SVC01-3, SVC01-4, SVC01-5, and SVC01-6.	M ID	2/2	
Industry Usage: See the following page for complete descriptions			Industry Note			
Selected Code Values			AD	American Dental Association Codes CODE SOURCE 135: American Dental Association		
See Appendix A for external code source reference			HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities		
REQUIRED	SVC01 - 2	234	Product/Service ID Identifying number for a product or service	M AN	1/48	
NOT USED	SVC01 - 3	1339	Procedure Modifier	O AN	2/2	
NOT USED	SVC01 - 4	1339	Procedure Modifier	O AN	2/2	
NOT USED	SVC01 - 5	1339	Procedure Modifier	O AN	2/2	
NOT USED	SVC01 - 6	1339	Procedure Modifier	O AN	2/2	
NOT USED	SVC01 - 7	352	Description	O AN	1/80	
REQUIRED	SVC02	782	Monetary Amount Monetary amount SEMANTIC: SVC02 is the submitted service charge. This value can not be negative.	M 1 R	1/18	
Data Element Number						
NOT USED	SVC03	782	Monetary Amount	O 1 R	1/18	
SITUATIONAL	SVC04	234	Product/Service ID Identifying number for a product or service SEMANTIC: SVC04 is the National Uniform Billing Committee Revenue Code. SITUATIONAL RULE: Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If not required by this implementation guide, do not send. IMPLEMENTATION NAME: National Uniform Billing Committee Revenue Code	O 1 AN	1/48	
X12 Semantic Note						
Situational Rule						
Implementation Name See Appendix E for definition						

Figure 2.5. Segment Key — Element Summary

2.2 Implementation Usage

2.2.1 Industry Usage

Industry Usage describes when loops, segments, and elements are to be sent when complying with this implementation guide. The three choices for Usage are required, not used, and situational. To avoid confusion, these are named differently than the X12 standard Condition Designators (mandatory, optional, and relational).

Required This loop/segment/element must always be sent.

Required segments in Situational loops only occur when the loop is used.

Required elements in Situational segments only occur when the segment is used.

Required component elements in Situational composite elements only occur when the composite element is used.

Not Used This element must never be sent.

Situational Use of this loop/segment/element varies, depending on data content and business context as described in the defining rule. The defining rule is documented in a Situational Rule attached to the item.

There are two forms of Situational Rules.

The first form is “Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender’s discretion, but cannot be required by the receiver.” The data qualified by such a situational rule cannot be required or requested by the receiver, transmission of this data is solely at the sender’s discretion.

The alternative form is “Required when <explicit condition statement>. If not required by this implementation guide, do not send.” The data qualified by such a situational rule cannot be sent except as described in the explicit condition statement.

2.2.1.1**Transaction Compliance Related to Industry Usage**

A transmitted transaction complies with an implementation guide when it satisfies the requirements as defined within the implementation guide. The presence or absence of an item (loop, segment, or element) complies with the industry usage specified by this implementation guide according to the following table.

Industry Usage	Business Condition is	Item is	Transaction Complies with Implementation Guide?
Required	N/A	Sent	Yes
		Not Sent	No
Not Used	N/A	Sent	No
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	Yes
		Not Sent	Yes
Situational (Required when <explicit condition statement>. If not required by this implementation guide, do not send.)	True	Sent	Yes
		Not Sent	No
	Not True	Sent	No
		Not Sent	Yes

This table specifies how an entity is to evaluate a transmitted transaction for compliance with industry usage. It is not intended to require or imply that the receiver must reject non-compliant transactions. The receiver will handle non-compliant transactions based on its business process and any applicable regulations.

2.2.2**Loops**

Loop requirements depend on the context or location of the loop within the transaction. See Appendix B for more information on loops.

- A nested loop can be used only when the associated higher level loop is used.
- The usage of a loop is the same as the usage of its beginning segment.
 - If a loop's beginning segment is Required, the loop is Required and must occur at least once unless it is nested in a loop that is not being used.
 - If a loop's beginning segment is Situational, the loop is Situational.
- Subsequent segments within a loop can be sent only when the beginning segment is used.
- Required segments in Situational loops occur only when the loop is used.

2.3 Transaction Set Listing

2.3.1 Implementation

This section lists the levels, loops, and segments contained in this implementation. It also serves as an index to the segment detail. Refer to section 2.1 Presentation Examples for detailed information on the components of the Implementation section.

IMPLEMENTATION

837 Health Care Claim**Table 1 - Header**

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
67	0050	ST	Transaction Set Header	R	1	
68	0100	BHT	Beginning of Hierarchical Transaction	R	1	
LOOP ID - 1000A SUBMITTER NAME						1
71	0200	NM1	Submitter Name	R	1	
73	0450	PER	Submitter EDI Contact Information	R	2	
LOOP ID - 1000B RECEIVER NAME						1
76	0200	NM1	Receiver Name	R	1	

Table 2 - Billing Provider Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
LOOP ID - 2000A BILLING PROVIDER HIERARCHICAL LEVEL						>1
78	0010	HL	Billing Provider Hierarchical Level	R	1	
80	0030	PRV	Billing Provider Specialty Information	S	1	
81	0100	CUR	Foreign Currency Information	S	1	
LOOP ID - 2010AA BILLING PROVIDER NAME						1
84	0150	NM1	Billing Provider Name	R	1	
87	0250	N3	Billing Provider Address	R	1	
88	0300	N4	Billing Provider City, State, ZIP Code	R	1	
90	0350	REF	Billing Provider Tax Identification	R	1	
91	0400	PER	Billing Provider Contact Information	S	2	
LOOP ID - 2010AB PAY-TO ADDRESS NAME						1
94	0150	NM1	Pay-to Address Name	S	1	
96	0250	N3	Pay-to Address - ADDRESS	R	1	
97	0300	N4	Pay-To Address City, State, ZIP Code	R	1	
LOOP ID - 2010AC PAY-TO PLAN NAME						1
99	0150	NM1	Pay-To Plan Name	S	1	
101	0250	N3	Pay-to Plan Address	R	1	
102	0300	N4	Pay-To Plan City, State, ZIP Code	R	1	
104	0350	REF	Pay-to Plan Secondary Identification	S	1	
106	0350	REF	Pay-To Plan Tax Identification Number	R	1	

Table 2 - Subscriber Detail

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000B SUBSCRIBER HIERARCHICAL LEVEL			>1
107	0010	HL	Subscriber Hierarchical Level	R	1	
109	0050	SBR	Subscriber Information	R	1	
			LOOP ID - 2010BA SUBSCRIBER NAME			1
112	0150	NM1	Subscriber Name	R	1	
115	0250	N3	Subscriber Address	S	1	
116	0300	N4	Subscriber City, State, ZIP Code	S	1	
118	0320	DMG	Subscriber Demographic Information	S	1	
120	0350	REF	Subscriber Secondary Identification	S	1	
121	0350	REF	Property and Casualty Claim Number	S	1	
			LOOP ID - 2010BB PAYER NAME			1
122	0150	NM1	Payer Name	R	1	
124	0250	N3	Payer Address	S	1	
125	0300	N4	Payer City, State, ZIP Code	S	1	
127	0350	REF	Payer Secondary Identification	S	3	
129	0350	REF	Billing Provider Secondary Identification	S	1	

Table 2 - Patient Detail

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 2010BB 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 1.4.3.2.2.1, HL Segment, for details.

PAGE #	POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
			LOOP ID - 2000C PATIENT HIERARCHICAL LEVEL			>1
131	0010	HL	Patient Hierarchical Level	S	1	
133	0070	PAT	Patient Information	R	1	
			LOOP ID - 2010CA PATIENT NAME			1
135	0150	NM1	Patient Name	R	1	
137	0250	N3	Patient Address	R	1	
138	0300	N4	Patient City, State, ZIP Code	R	1	
140	0320	DMG	Patient Demographic Information	R	1	
142	0350	REF	Property and Casualty Claim Number	S	1	
143	0350	REF	Property and Casualty Patient Identifier	S	1	
			LOOP ID - 2300 CLAIM INFORMATION			100
145	1300	CLM	Claim Information	R	1	
151	1350	DTP	Discharge Hour	S	1	
152	1350	DTP	Statement Dates	R	1	
153	1350	DTP	Admission Date/Hour	S	1	
154	1350	DTP	Date - Repricer Received Date	S	1	
155	1400	CL1	Institutional Claim Code	R	1	
156	1550	PWK	Claim Supplemental Information	S	10	
160	1600	CN1	Contract Information	S	1	
162	1750	AMT	Patient Estimated Amount Due	S	1	

005010X223 & 005010X223A1/A2 • 837

163	1800	REF	Service Authorization Exception Code	S	1
165	1800	REF	Referral Number	S	1
166	1800	REF	Prior Authorization	S	1
168	1800	REF	Payer Claim Control Number	S	1
169	1800	REF	Repriced Claim Number	S	1
170	1800	REF	Adjusted Repriced Claim Number	S	1
171	1800	REF	Investigational Device Exemption Number	S	5
172	1800	REF	Claim Identifier For Transmission Intermediaries	S	1
174	1800	REF	Auto Accident State	S	1
175	1800	REF	Medical Record Number	S	1
176	1800	REF	Demonstration Project Identifier	S	1
177	1800	REF	Peer Review Organization (PRO) Approval Number	S	1
178	1850	K3	File Information	S	10
180	1900	NTE	Claim Note	S	10
182	1900	NTE	Billing Note	S	1
183	2200	CRC	EPSDT Referral	S	1
186	2310	HI	Principal Diagnosis	R	1
189	2310	HI	Admitting Diagnosis	S	1
191	2310	HI	Patient's Reason For Visit	S	1
195	2310	HI	External Cause of Injury	S	1
220	2310	HI	Diagnosis Related Group (DRG) Information	S	1
222	2310	HI	Other Diagnosis Information	S	2
241	2310	HI	Principal Procedure Information	S	1
244	2310	HI	Other Procedure Information	S	2
260	2310	HI	Occurrence Span Information	S	2
273	2310	HI	Occurrence Information	S	2
286	2310	HI	Value Information	S	2
296	2310	HI	Condition Information	S	2
306	2310	HI	Treatment Code Information	S	2
315	2410	HCP	Claim Pricing/Repricing Information	S	1
LOOP ID - 2310A ATTENDING PROVIDER NAME					1
321	2500	NM1	Attending Provider Name	S	1
324	2550	PRV	Attending Provider Specialty Information	S	1
326	2710	REF	Attending Provider Secondary Identification	S	4
LOOP ID - 2310B OPERATING PHYSICIAN NAME					1
328	2500	NM1	Operating Physician Name	S	1
331	2710	REF	Operating Physician Secondary Identification	S	4
LOOP ID - 2310C OTHER OPERATING PHYSICIAN NAME					1
333	2500	NM1	Other Operating Physician Name	S	1
336	2710	REF	Other Operating Physician Secondary Identification	S	4
LOOP ID - 2310D RENDERING PROVIDER NAME					1
338	2500	NM1	Rendering Provider Name	S	1
341	2710	REF	Rendering Provider Secondary Identification	S	4
LOOP ID - 2310E SERVICE FACILITY LOCATION NAME					1
343	2500	NM1	Service Facility Location Name	S	1
346	2650	N3	Service Facility Location Address	R	1
347	2700	N4	Service Facility Location City, State, ZIP Code	R	1
349	2710	REF	Service Facility Location Secondary Identification	S	3
LOOP ID - 2310F REFERRING PROVIDER NAME					1
351	2500	NM1	Referring Provider Name	S	1
354	2710	REF	Referring Provider Secondary Identification	S	3
LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION					10
356	2900	SBR	Other Subscriber Information	S	1

360	2950	CAS	Claim Level Adjustments	S	5
366	3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1
367	3000	AMT	Remaining Patient Liability	S	1
368	3000	AMT	Coordination of Benefits (COB) Total Non-Covered Amount	S	1
369	3100	OI	Other Insurance Coverage Information	R	1
371	3150	MIA	Inpatient Adjudication Information	S	1
376	3200	MOA	Outpatient Adjudication Information	S	1
LOOP ID - 2330A OTHER SUBSCRIBER NAME					1
379	3250	NM1	Other Subscriber Name	R	1
382	3320	N3	Other Subscriber Address	S	1
383	3400	N4	Other Subscriber City, State, ZIP Code	S	1
385	3550	REF	Other Subscriber Secondary Identification	S	2
LOOP ID - 2330B OTHER PAYER NAME					1
386	3250	NM1	Other Payer Name	R	1
388	3320	N3	Other Payer Address	S	1
389	3400	N4	Other Payer City, State, ZIP Code	S	1
391	3500	DTP	Claim Check or Remittance Date	S	1
392	3550	REF	Other Payer Secondary Identifier	S	2
394	3550	REF	Other Payer Prior Authorization Number	S	1
395	3550	REF	Other Payer Referral Number	S	1
396	3550	REF	Other Payer Claim Adjustment Indicator	S	1
397	3550	REF	Other Payer Claim Control Number	S	1
LOOP ID - 2330C OTHER PAYER ATTENDING PROVIDER					1
398	3250	NM1	Other Payer Attending Provider	S	1
400	3550	REF	Other Payer Attending Provider Secondary Identification	R	4
LOOP ID - 2330D OTHER PAYER OPERATING PHYSICIAN					1
402	3250	NM1	Other Payer Operating Physician	S	1
404	3550	REF	Other Payer Operating Physician Secondary Identification	R	4
LOOP ID - 2330E OTHER PAYER OTHER OPERATING PHYSICIAN					1
406	3250	NM1	Other Payer Other Operating Physician	S	1
408	3550	REF	Other Payer Other Operating Physician Secondary Identification	R	4
LOOP ID - 2330F OTHER PAYER SERVICE FACILITY LOCATION					1
410	3250	NM1	Other Payer Service Facility Location	S	1
412	3550	REF	Other Payer Service Facility Location Secondary Identification	R	3
LOOP ID - 2330G OTHER PAYER RENDERING PROVIDER NAME					1
414	3250	NM1	Other Payer Rendering Provider Name	S	1
416	3550	REF	Other Payer Rendering Provider Secondary Identification	R	4
LOOP ID - 2330H OTHER PAYER REFERRING PROVIDER					1
418	3250	NM1	Other Payer Referring Provider	S	1
420	3550	REF	Other Payer Referring Provider Secondary Identification	R	3
LOOP ID - 2330I OTHER PAYER BILLING PROVIDER					1
422	3250	NM1	Other Payer Billing Provider	S	1
424	3550	REF	Other Payer Billing Provider Secondary Identification	R	2
LOOP ID - 2400 SERVICE LINE NUMBER					999
425	3650	LX	Service Line Number	R	1
426	3750	SV2	Institutional Service Line	R	1

431	4200	PWK	Line Supplemental Information	S	10
435	4550	DTP	Date - Service Date	S	1
437	4700	REF	Line Item Control Number	S	1
439	4700	REF	Repriced Line Item Reference Number	S	1
440	4700	REF	Adjusted Repriced Line Item Reference Number	S	1
441	4750	AMT	Service Tax Amount	S	1
442	4750	AMT	Facility Tax Amount	S	1
443	4850	NTE	Third Party Organization Notes	S	1
444	4920	HCP	Line Pricing/Repricing Information	S	1
LOOP ID - 2410 DRUG IDENTIFICATION					1
451	4930	LIN	Drug Identification	S	1
454	4940	CTP	Drug Quantity	R	1
456	4950	REF	Prescription or Compound Drug Association Number	S	1
LOOP ID - 2420A OPERATING PHYSICIAN NAME					1
458	5000	NM1	Operating Physician Name	S	1
461	5250	REF	Operating Physician Secondary Identification	S	20
LOOP ID - 2420B OTHER OPERATING PHYSICIAN NAME					1
463	5000	NM1	Other Operating Physician Name	S	1
466	5250	REF	Other Operating Physician Secondary Identification	S	20
LOOP ID - 2420C RENDERING PROVIDER NAME					1
468	5000	NM1	Rendering Provider Name	S	1
471	5250	REF	Rendering Provider Secondary Identification	S	20
LOOP ID - 2420D REFERRING PROVIDER NAME					1
473	5000	NM1	Referring Provider Name	S	1
476	5250	REF	Referring Provider Secondary Identification	S	20
LOOP ID - 2430 LINE ADJUDICATION INFORMATION					15
478	5400	SVD	Line Adjudication Information	S	1
482	5450	CAS	Line Adjustment	S	5
488	5500	DTP	Line Check or Remittance Date	R	1
489	5505	AMT	Remaining Patient Liability	S	1
490	5550	SE	Transaction Set Trailer	R	1

2.3.2 X12 Standard

This section is included as a reference. The implementation guide reference clarifies actual usage. Refer to section 2.1 Presentation Examples for detailed information on the components of the X12 Standard section.

STANDARD

837 Health Care Claim

Functional Group ID: **HC**

This X12 Transaction Set 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
0050	ST	Transaction Set Header	M	1	
0100	BHT	Beginning of Hierarchical Transaction	M	1	
0150	REF	Reference Information	O	3	
LOOP ID - 1000					10
0200	NM1	Individual or Organizational Name	O	1	
0250	N2	Additional Name Information	O	2	
0300	N3	Party Location	O	2	
0350	N4	Geographic Location	O	1	
0400	REF	Reference Information	O	2	
0450	PER	Administrative Communications Contact	O	2	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
LOOP ID - 2000					>1
0010	HL	Hierarchical Level	M	1	
0030	PRV	Provider Information	O	1	
0050	SBR	Subscriber Information	O	1	
0070	PAT	Patient Information	O	1	
0090	DTP	Date or Time or Period	O	5	
0100	CUR	Currency	O	1	
LOOP ID - 2010					10
0150	NM1	Individual or Organizational Name	O	1	
0200	N2	Additional Name Information	O	2	

0250	N3	Party Location	O	2
0300	N4	Geographic Location	O	1
0320	DMG	Demographic Information	O	1
0350	REF	Reference Information	O	20
0400	PER	Administrative Communications Contact	O	2
LOOP ID - 2300				100
1300	CLM	Health Claim	O	1
1350	DTP	Date or Time or Period	O	150
1400	CL1	Claim Codes	O	1
1450	DN1	Orthodontic Information	O	1
1500	DN2	Tooth Summary	O	35
1550	PWK	Paperwork	O	10
1600	CN1	Contract Information	O	1
1650	DSB	Disability Information	O	1
1700	UR	Peer Review Organization or Utilization Review	O	1
1750	AMT	Monetary Amount Information	O	40
1800	REF	Reference Information	O	30
1850	K3	File Information	O	10
1900	NTE	Note/Special Instruction	O	20
1950	CR1	Ambulance Certification	O	1
2000	CR2	Chiropractic Certification	O	1
2050	CR3	Durable Medical Equipment Certification	O	1
2100	CR4	Enteral or Parenteral Therapy Certification	O	3
2150	CR5	Oxygen Therapy Certification	O	1
2160	CR6	Home Health Care Certification	O	1
2190	CR8	Pacemaker Certification	O	9
2200	CRC	Conditions Indicator	O	100
2310	HI	Health Care Information Codes	O	25
2400	QTY	Quantity Information	O	10
2410	HCP	Health Care Pricing	O	1
LOOP ID - 2305				6
2420	CR7	Home Health Treatment Plan Certification	O	1
2430	HSD	Health Care Services Delivery	O	12
LOOP ID - 2310				9
2500	NM1	Individual or Organizational Name	O	1
2550	PRV	Provider Information	O	1
2600	N2	Additional Name Information	O	2
2650	N3	Party Location	O	2
2700	N4	Geographic Location	O	1
2710	REF	Reference Information	O	20
2750	PER	Administrative Communications Contact	O	2
LOOP ID - 2320				10
2900	SBR	Subscriber Information	O	1
2950	CAS	Claims Adjustment	O	99
3000	AMT	Monetary Amount Information	O	15
3050	DMG	Demographic Information	O	1
3100	OI	Other Health Insurance Information	O	1
3150	MIA	Medicare Inpatient Adjudication	O	1
3200	MOA	Medicare Outpatient Adjudication	O	1
LOOP ID - 2330				10
3250	NM1	Individual or Organizational Name	O	1
3300	N2	Additional Name Information	O	2
3320	N3	Party Location	O	2
3400	N4	Geographic Location	O	1
3450	PER	Administrative Communications Contact	O	2

3500	DTP	Date or Time or Period	O	9	
3550	REF	Reference Information	O	>1	
LOOP ID - 2400					>1
3650	LX	Transaction Set Line Number	O	1	
3700	SV1	Professional Service	O	1	
3750	SV2	Institutional Service	O	1	
3800	SV3	Dental Service	O	1	
3820	TOO	Tooth Identification	O	32	
3850	SV4	Drug Service	O	1	
4000	SV5	Durable Medical Equipment Service	O	1	
4050	SV6	Anesthesia Service	O	1	
4100	SV7	Drug Adjudication	O	1	
4150	HI	Health Care Information Codes	O	25	
4200	PWK	Paperwork	O	10	
4250	CR1	Ambulance Certification	O	1	
4300	CR2	Chiropractic Certification	O	5	
4350	CR3	Durable Medical Equipment Certification	O	1	
4400	CR4	Enteral or Parenteral Therapy Certification	O	3	
4450	CR5	Oxygen Therapy Certification	O	1	
4500	CRC	Conditions Indicator	O	3	
4550	DTP	Date or Time or Period	O	15	
4600	QTY	Quantity Information	O	5	
4620	MEA	Measurements	O	20	
4650	CN1	Contract Information	O	1	
4700	REF	Reference Information	O	30	
4750	AMT	Monetary Amount Information	O	15	
4800	K3	File Information	O	10	
4850	NTE	Note/Special Instruction	O	10	
4880	PS1	Purchase Service	O	1	
4900	IMM	Immunization Status	O	>1	
4910	HSD	Health Care Services Delivery	O	1	
4920	HCP	Health Care Pricing	O	1	
LOOP ID - 2410					>1
4930	LIN	Item Identification	O	1	
4940	CTP	Pricing Information	O	1	
4950	REF	Reference Information	O	1	
LOOP ID - 2420					10
5000	NM1	Individual or Organizational Name	O	1	
5050	PRV	Provider Information	O	1	
5100	N2	Additional Name Information	O	2	
5140	N3	Party Location	O	2	
5200	N4	Geographic Location	O	1	
5250	REF	Reference Information	O	20	
5300	PER	Administrative Communications Contact	O	2	
LOOP ID - 2430					>1
5400	SVD	Service Line Adjudication	O	1	
5450	CAS	Claims Adjustment	O	99	
5500	DTP	Date or Time or Period	O	9	
5505	AMT	Monetary Amount Information	O	20	
LOOP ID - 2440					>1
5510	LQ	Industry Code Identification	O	1	
5520	FRM	Supporting Documentation	M	99	
5550	SE	Transaction Set Trailer	M	1	

NOTES:

- 1/0200** 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.
- 2/0150** 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.
- 2/1950** 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.
- 2/2500** Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/2900** 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.
- 2/3250** Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.
- 2/3650** Loop 2400 contains Service Line information.
- 2/4250** 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.
- 2/4930** Loop 2410 contains compound drug components, quantities and prices.
- 2/5000** 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.
- 2/5400** SVD01 identifies the payer which adjudicated the corresponding service line and must match DE 67 in the NM109 position 325 for the payer.
- 2/5510** Loop 2440 provides certificate of medical necessity information for the procedure identified in SV101 in position 2/3700.
- 2/5520** FRM segment provides question numbers and responses for the questions on the medical necessity information form identified in LQ position 551.

2.4 837 - Segment Detail

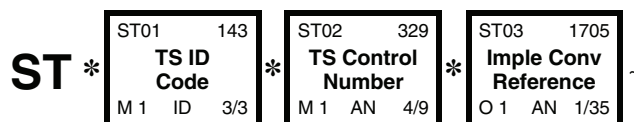
This section specifies the segments, data elements, and codes for this implementation. Refer to section 2.1 Presentation Examples for detailed information on the components of the Segment Detail section.

SEGMENT DETAIL

ST - TRANSACTION SET HEADER

X12 Segment Name: Transaction Set Header**X12 Purpose:** To indicate the start of a transaction set and to assign a control number**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** ST*837*987654*005010X223A2~

DIAGRAM



ELEMENT DETAIL

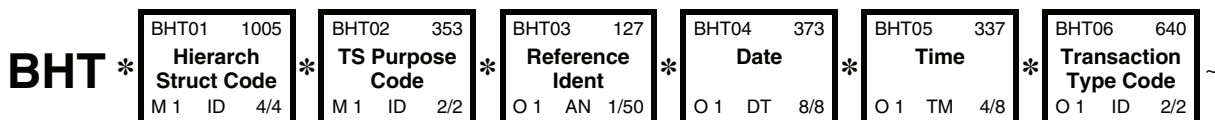
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ST01	143	Transaction Set Identifier Code Code uniquely identifying a Transaction Set	M 1 ID 3/3
SEMANTIC: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).				
			CODE	DEFINITION
			837	Health Care Claim
REQUIRED	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	M 1 AN 4/9
The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.				
REQUIRED	ST03	1705	Implementation Convention Reference Reference assigned to identify Implementation Convention	O 1 AN 1/35
SEMANTIC: The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.				
IMPLEMENTATION NAME: Version, Release, or Industry Identifier				
This element must be populated with the guide identifier named in Section 1.2.				
This field contains the same value as GS08. Some translator products strip off the ISA and GS segments prior to application (ST-SE) processing. Providing the information from the GS08 at this level will ensure that the appropriate application mapping is used at translation time.				

SEGMENT DETAIL

BHT - BEGINNING OF HIERARCHICAL TRANSACTION

X12 Segment Name: Beginning of Hierarchical Transaction**X12 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**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. The second example denotes the case where the entire transaction set contains ENCOUNTERS.**TR3 Example:** BHT*0019*00*0123*20040618*0932*CH~**TR3 Example:** BHT*0019*00*44445*20040213*0345*RP~

DIAGRAM



ELEMENT DETAIL

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 1 ID 4/4						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0019</td><td>Information Source, Subscriber, Dependent</td></tr></table>	CODE	DEFINITION	0019	Information Source, Subscriber, Dependent			
CODE	DEFINITION									
0019	Information Source, Subscriber, Dependent									
REQUIRED	BHT02	353	Transaction Set Purpose Code Code identifying purpose of transaction set	M 1 ID 2/2						
			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.							
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>00</td><td>Original Original transmissions are transmissions which have never been sent to the receiver.</td></tr><tr><td>18</td><td>Reissue If a transmission was disrupted and the receiver requests a retransmission, the sender uses “Reissue” to indicate the transmission has been previously sent.</td></tr></table>	CODE	DEFINITION	00	Original Original transmissions are transmissions which have never been sent to the receiver.	18	Reissue If a transmission was disrupted and the receiver requests a retransmission, the sender uses “Reissue” to indicate the transmission has been previously sent.	
CODE	DEFINITION									
00	Original Original transmissions are transmissions which have never been sent to the receiver.									
18	Reissue If a transmission was disrupted and the receiver requests a retransmission, the sender uses “Reissue” to indicate the transmission has been previously sent.									

REQUIRED	BHT03	127	Reference Identification	O 1 AN 1/50

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

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

IMPLEMENTATION NAME: **Originator Application Transaction Identifier**

The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number.

This field is limited to 30 characters.

REQUIRED	BHT04	373	Date	O 1 DT 8/8

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

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

IMPLEMENTATION NAME: **Transaction Set Creation Date**

This is the date that the original submitter created the claim file from their business application system.

REQUIRED	BHT05	337	Time	O 1 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)

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

IMPLEMENTATION NAME: **Transaction Set Creation Time**

This is the time that the original submitter created the claim file from their business application system.

REQUIRED	BHT06	640	Transaction Type Code	O 1 ID 2/2

Code specifying the type of transaction

IMPLEMENTATION NAME: **Claim Identifier**

CODE	DEFINITION
31	Subrogation Demand The subrogation demand code is only for use by state Medicaid agencies performing post payment recovery claiming with willing trading partners. <i>NOTE:</i> At the time of this writing, Subrogation Demand is not a HIPAA mandated use of the 837 transaction.
CH	Chargeable Use CH when the transaction contains only fee for service claims or claims with at least one chargeable line item. If it is not clear whether a transaction contains claims or capitated encounters, or if the transaction contains a mix of claims and capitated encounters, use CH.

RP

Reporting

Use RP when the entire ST-SE envelope contains only capitated encounters.

Use RP when the transaction is being sent to an entity (usually not a payer or a normal provider payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.

SEGMENT DETAIL

NM1 - SUBMITTER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 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.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

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

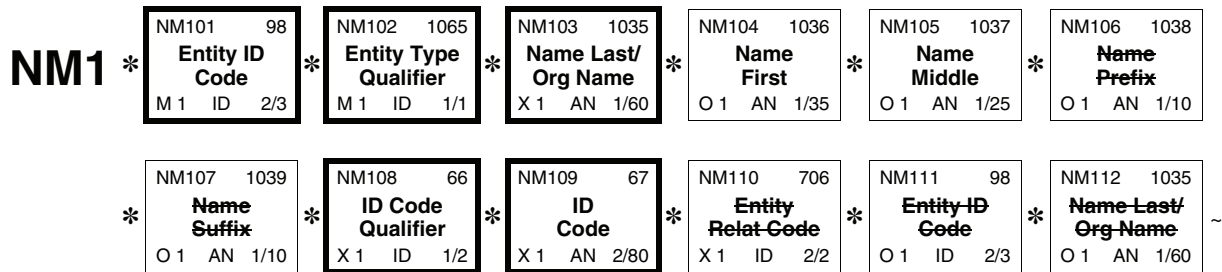
Segment Repeat: 1

Usage: REQUIRED

TR3 Notes: 1. The submitter is the entity responsible for the creation and formatting of this transaction.

TR3 Example: NM1*41*2*ABC SUBMITTER*****46*999999999~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			41	Submitter

REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. <table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	1	Person	2	Non-Person Entity	M 1	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 SYNTAX: C1203 IMPLEMENTATION NAME: Submitter Last or Organization Name	X 1	AN	1/60						
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Submitter First Name	O 1	AN	1/35						
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Submitter Middle Name or Initial	O 1	AN	1/25						
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10						
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10						
REQUIRED	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 <table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>46</td><td>Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement</td></tr></table>	CODE	DEFINITION	46	Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement	X 1	ID	1/2		
CODE	DEFINITION											
46	Electronic Transmitter Identification Number (ETIN) Established by trading partner agreement											
REQUIRED	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: Submitter Identifier	X 1	AN	2/80						
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2						
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3						
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60						

SEGMENT DETAIL

PER - SUBMITTER EDI CONTACT INFORMATION

X12 Segment Name: Administrative Communications Contact

X12 Purpose: To identify a person or office to whom administrative communications should be directed

- X12 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.

Loop: 1000A — SUBMITTER NAME

Segment Repeat: 2

Usage: REQUIRED

TR3 Notes:

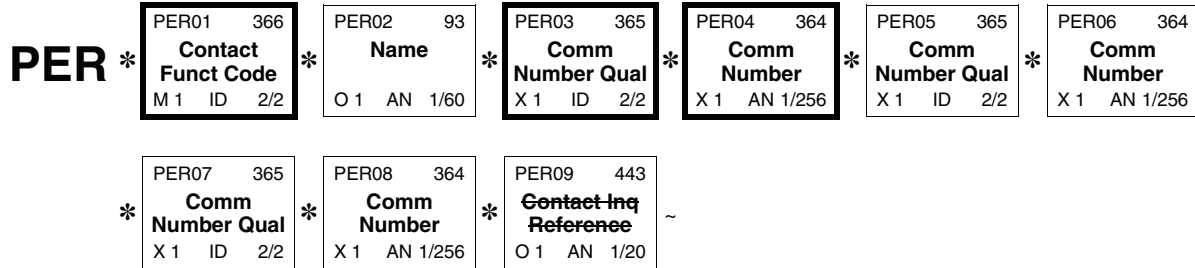
1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number must always include the area code and phone number using the format AAABBBCCCC where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number. Therefore, the following telephone number (555) 555-1234 would be represented as 5555551234. Do not submit long distance access numbers, such as “1”, in the telephone number. Telephone extensions, when applicable, must be submitted in the next element immediately following the telephone number. When submitting telephone extensions, only submit the numeric extension. Do not include data that indicates an extension, such as “ext” or “x-”.

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

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

TR3 Example: PER*IC*JOHN SMITH*TE*5555551234*EX*123~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PER01	366	Contact Function Code	M 1 ID 2/2 Code identifying the major duty or responsibility of the person or group named
			CODE	DEFINITION
			IC	Information Contact
SITUATIONAL	PER02	93	Name	O 1 AN 1/60 Free-form name
			SITUATIONAL RULE: <i>Required when the contact name is different than the name contained in the Submitter Name (NM1) segment of this loop AND it is the first iteration of the Submitter EDI Contact Information (PER) segment. If not required by this implementation guide, do not send.</i>	
			IMPLEMENTATION NAME: Submitter Contact Name	
REQUIRED	PER03	365	Communication Number Qualifier	X 1 ID 2/2 Code identifying the type of communication number
			SYNTAX: P0304	
			CODE	DEFINITION
			EM	Electronic Mail
			FX	Facsimile
			TE	Telephone
REQUIRED	PER04	364	Communication Number	X 1 AN 1/256 Complete communications number including country or area code when applicable
			SYNTAX: P0304	
SITUATIONAL	PER05	365	Communication Number Qualifier	X 1 ID 2/2 Code identifying the type of communication number
			SYNTAX: P0506	
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>	
			CODE	DEFINITION
			EM	Electronic Mail

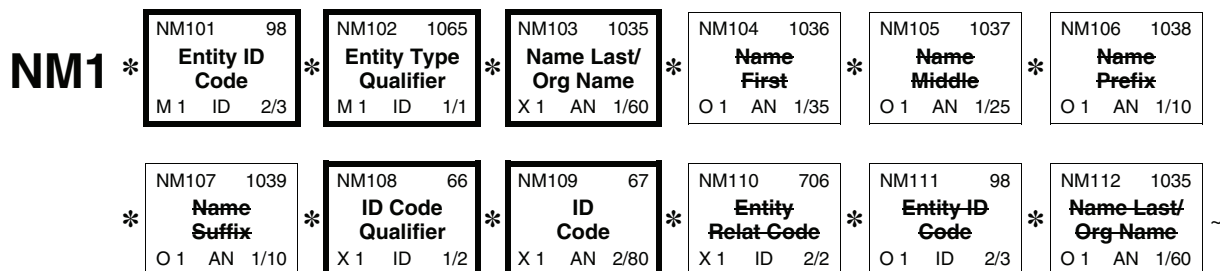
			EX	Telephone Extension			
			FX	Facsimile			
			TE	Telephone			
SITUATIONAL	PER06	364	Communication Number	X 1 AN	1/256		
			Complete communications number including country or area code when applicable				
			SYNTAX: P0506				
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>				
SITUATIONAL	PER07	365	Communication Number Qualifier	X 1 ID	2/2		
			Code identifying the type of communication number				
			SYNTAX: P0708				
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>				
			CODE	DEFINITION			
			EM	Electronic Mail			
			EX	Telephone Extension			
			FX	Facsimile			
			TE	Telephone			
SITUATIONAL	PER08	364	Communication Number	X 1 AN	1/256		
			Complete communications number including country or area code when applicable				
			SYNTAX: P0708				
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>				
NOT USED	PER09	443	Contact Inquiry Reference	O 1 AN	1/20		

SEGMENT DETAIL

NM1 - RECEIVER NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 1000B — RECEIVER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** NM1*40*2*XYZ RECEIVER*****46*111222333~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
		40	Receiver	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1
			CODE	DEFINITION
		2	Non-Person Entity	

REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60				
IMPLEMENTATION NAME: Receiver Name										
NOT USED	NM104	1036	Name First	O 1	AN	1/35				
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25				
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
NOT USED	NM107	1039	Name Suffix	O 1	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 1	ID	1/2				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>46</td><td>Electronic Transmitter Identification Number (ETIN)</td></tr></table>							CODE	DEFINITION	46	Electronic Transmitter Identification Number (ETIN)
CODE	DEFINITION									
46	Electronic Transmitter Identification Number (ETIN)									
REQUIRED	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809	X 1	AN	2/80				
IMPLEMENTATION NAME: Receiver Primary Identifier										
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

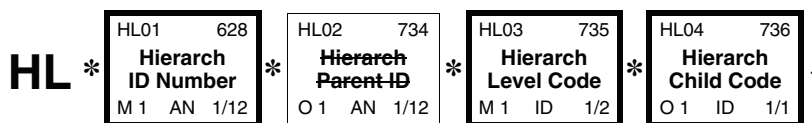
HL - BILLING PROVIDER HIERARCHICAL LEVEL

X12 Segment Name: Hierarchical Level**X12 Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments**X12 Comments:** 1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.

2. The HL segment defines a top-down/left-right ordered structure.

Loop: 2000A — BILLING PROVIDER HIERARCHICAL LEVEL **Loop Repeat:** >1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** HL*1**20*1~

DIAGRAM



ELEMENT DETAIL

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. The first HL01 within each ST-SE envelope 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 1 AN 1/12
NOT USED	HL02	734	Hierarchical Parent ID Number	O 1 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 1 ID 1/2
		CODE	DEFINITION	
		20	Information Source	

REQUIRED	HL04	736	Hierarchical Child Code	O 1 ID 1/1

Code indicating if there are hierarchical child data segments subordinate to the level being described

COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

CODE	DEFINITION
1	Additional Subordinate HL Data Segment in This Hierarchical Structure.

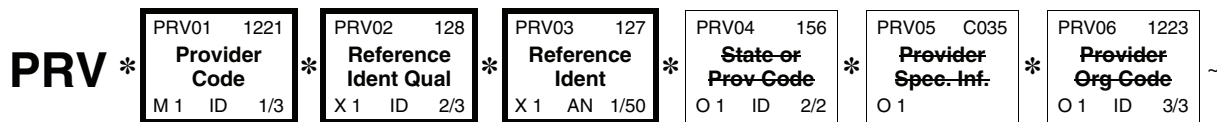
SEGMENT DETAIL

**PRV - BILLING PROVIDER SPECIALTY
INFORMATION****X12 Segment Name:** Provider Information**X12 Purpose:** To specify the identifying characteristics of a provider**X12 Syntax:** 1. P0203

If either PRV02 or PRV03 is present, then the other is required.

Loop: 2000A — BILLING PROVIDER HIERARCHICAL LEVEL**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the payer's adjudication is known to be impacted by the provider taxonomy code. If not required by this implementation guide, do not send.**TR3 Example:** PRV*BI*PXC*282NR1301X~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	Provider Code Code identifying the type of provider	M 1 ID 1/3
			CODE	DEFINITION
			BI	Billing
REQUIRED	PRV02	128	Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203	X 1 ID 2/3
			CODE	DEFINITION
			PXC	Health Care Provider Taxonomy Code CODE SOURCE 682: Health Care Provider Taxonomy
REQUIRED	PRV03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: P0203 IMPLEMENTATION NAME: Provider Taxonomy Code	X 1 AN 1/50
NOT USED	PRV04	156	State or Province Code	O 1 ID 2/2
NOT USED	PRV05	C035	PROVIDER SPECIALTY INFORMATION	O 1
NOT USED	PRV06	1223	Provider Organization Code	O 1 ID 3/3

SEGMENT DETAIL

CUR - FOREIGN CURRENCY INFORMATION**X12 Segment Name:** Currency**X12 Purpose:** To specify the currency (dollars, pounds, francs, etc.) used in a transaction**X12 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**

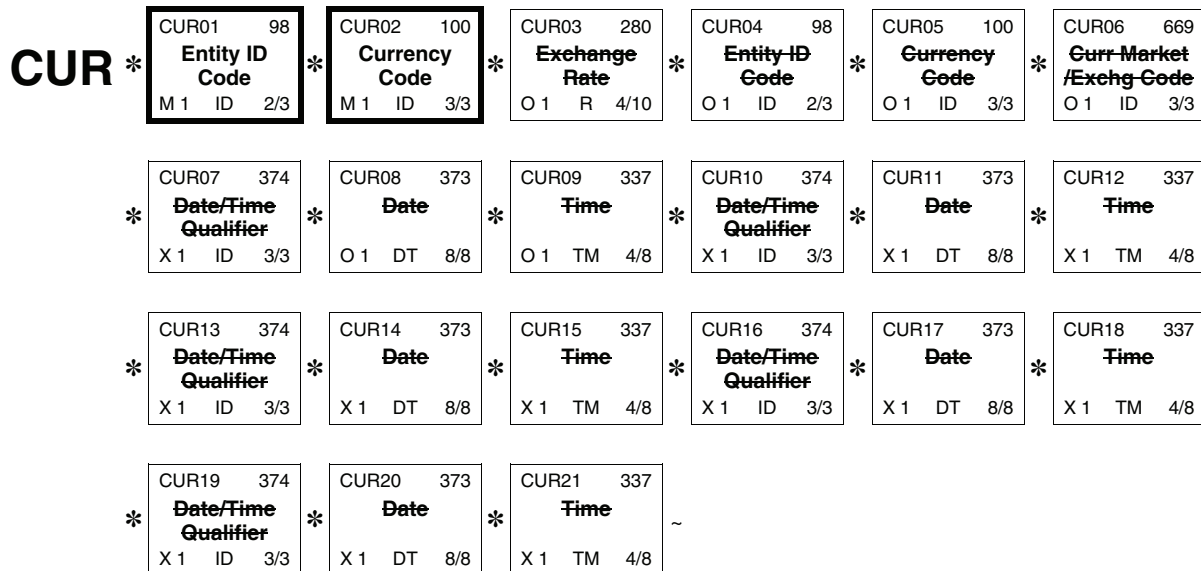
If CUR21 is present, then CUR19 is required.

X12 Comments: 1. See Figures Appendix for examples detailing the use of the CUR segment.**Loop:** 2000A — BILLING PROVIDER HIERARCHICAL LEVEL**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the amounts represented in this transaction are currencies other than the United States dollar. If not required by this implementation guide, do not send.

TR3 Notes: 1. It is **REQUIRED** that all amounts reported within the transaction are of the currency named in this segment. If this segment is not used, then it is required that all amounts in this transaction be expressed in US dollars.

TR3 Example: CUR*85*CAD~

DIAGRAM



ELEMENT DETAIL

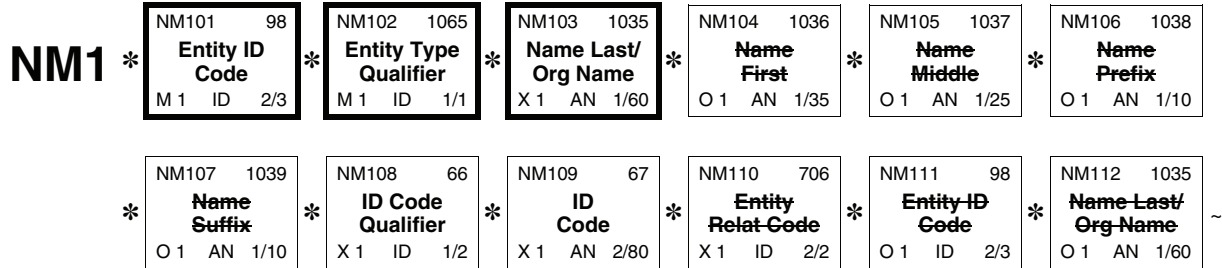
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	CUR01	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M 1 ID 2/3
			CODE	DEFINITION
		85	Billing Provider	
REQUIRED	CUR02	100	Currency Code Code (Standard ISO) for country in whose currency the charges are specified CODE SOURCE 5: Countries, Currencies and Funds The submitter must use the Currency Code, not the Country Code, for this element. For example the Currency Code CAD = Canadian dollars would be valid, while CA = Canada would be invalid.	M 1 ID 3/3
NOT USED	CUR03	280	Exchange Rate	O 1 R 4/10
NOT USED	CUR04	98	Entity Identifier Code	O 1 ID 2/3
NOT USED	CUR05	100	Currency Code	O 1 ID 3/3
NOT USED	CUR06	669	Currency Market/Exchange Code	O 1 ID 3/3
NOT USED	CUR07	374	Date/Time Qualifier	X 1 ID 3/3
NOT USED	CUR08	373	Date	O 1 DT 8/8

NOT USED	CUR09	337	Time	O 1	TM	4/8
NOT USED	CUR10	374	Date/Time Qualifier	X 1	ID	3/3
NOT USED	CUR11	373	Date	X 1	DT	8/8
NOT USED	CUR12	337	Time	X 1	TM	4/8
NOT USED	CUR13	374	Date/Time Qualifier	X 1	ID	3/3
NOT USED	CUR14	373	Date	X 1	DT	8/8
NOT USED	CUR15	337	Time	X 1	TM	4/8
NOT USED	CUR16	374	Date/Time Qualifier	X 1	ID	3/3
NOT USED	CUR17	373	Date	X 1	DT	8/8
NOT USED	CUR18	337	Time	X 1	TM	4/8
NOT USED	CUR19	374	Date/Time Qualifier	X 1	ID	3/3
NOT USED	CUR20	373	Date	X 1	DT	8/8
NOT USED	CUR21	337	Time	X 1	TM	4/8

SEGMENT DETAIL

NM1 - BILLING PROVIDER NAME**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2010AA — BILLING PROVIDER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. **Beginning on the NPI compliance date: When the Billing Provider is an organization health care provider, the organization health care provider's NPI or its subpart's NPI is reported in NM109. When a health care provider organization has determined that it needs to enumerate its subparts, it will report the NPI of a subpart as the Billing Provider. The subpart reported as the Billing Provider MUST always represent the most detailed level of enumeration as determined by the organization health care provider and MUST be the same identifier sent to any trading partner. For additional explanation, see section 1.10.3 Organization Health Care Provider Subpart Presentation.**2. **Prior to the NPI compliance date, proprietary identifiers necessary for the receiver to identify the Billing Provider entity are to be reported in the REF segment of Loop ID-2010BB.**3. **The Taxpayer Identifying Number (TIN) of the Billing Provider to be used for 1099 purposes must be reported in the REF segment of this loop.**4. **When the individual or the organization is not a health care provider and, thus, not eligible to receive an NPI (For example, personal care services, carpenters, etc), the Billing Provider should be the legal entity. However, willing trading partners may agree upon varying definitions. Proprietary identifiers necessary for the receiver to identify the entity are to be reported in the Loop ID-2010BB REF, Billing Provider Secondary Identification segment. The TIN to be used for 1099 purposes must be reported in the REF (Tax Identification Number) segment of this loop.****TR3 Example:** NM1*85*2*ABC HOSPITAL*****XX*1234567890~

DIAGRAM



ELEMENT DETAIL

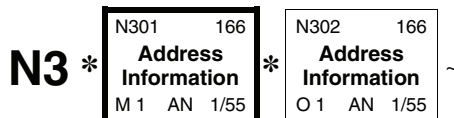
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M 1 ID 2/3
			CODE	DEFINITION
		85	Billing Provider	
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1
			CODE	DEFINITION
		2	Non-Person Entity	
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1 AN 1/60
			IMPLEMENTATION NAME: Billing Provider Organizational Name	
NOT USED	NM104	1036	Name First	O 1 AN 1/35
NOT USED	NM105	1037	Name Middle	O 1 AN 1/25
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10
NOT USED	NM107	1039	Name Suffix	O 1 AN 1/10

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Billing Provider Identifier	X 1	AN	2/80				
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

N3 - BILLING PROVIDER ADDRESS**X12 Segment Name:** Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2010AA — BILLING PROVIDER NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. The Billing Provider Address must be a street address. Post Office Box or Lock Box addresses are to be sent in the Pay-To Address Loop (Loop ID-2010AB), if necessary.**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Billing Provider Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Billing Provider Address Line				

SEGMENT DETAIL

N4 - BILLING PROVIDER CITY, STATE, ZIP CODE**X12 Segment Name:** Geographic Location**X12 Purpose:** To specify the geographic place of the named party**X12 Syntax:** 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

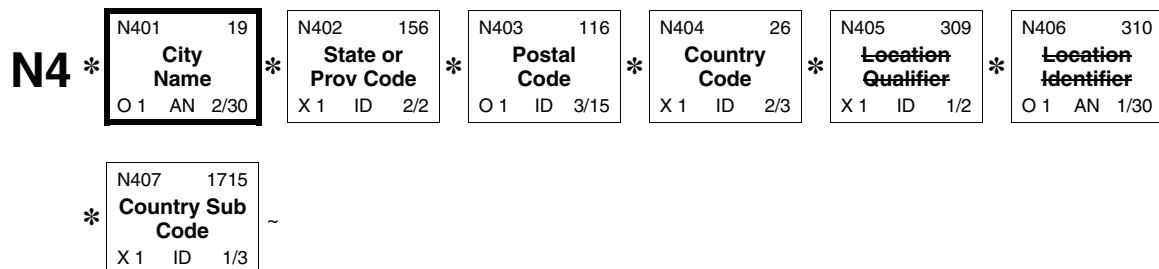
If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2010AA — BILLING PROVIDER NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30
COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.				
IMPLEMENTATION NAME: Billing Provider City Name				

SITUATIONAL	N402	156	State or Province Code X 1 ID 2/2 Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Billing Provider State or Province Code CODE SOURCE 22: States and Provinces
SITUATIONAL	N403	116	Postal Code O 1 ID 3/15 Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Billing Provider Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes When reporting the ZIP code for U.S. addresses, the full nine digit ZIP code must be provided.
SITUATIONAL	N404	26	Country Code X 1 ID 2/3 Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.
NOT USED	N405	309	Location Qualifier X 1 ID 1/2
NOT USED	N406	310	Location Identifier O 1 AN 1/30
SITUATIONAL	N407	1715	Country Subdivision Code X 1 ID 1/3 Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.

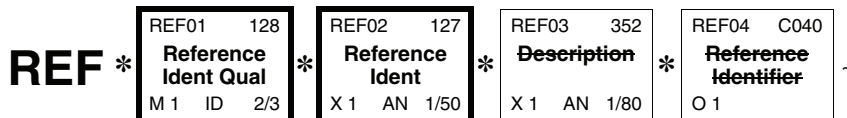
SEGMENT DETAIL

REF - BILLING PROVIDER TAX
IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010AA — BILLING PROVIDER NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. This is the tax identification number (TIN) of the entity to be paid for the submitted services.**TR3 Example:** REF*EI*123456789~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			EI	Employer's Identification Number The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Billing Provider Tax Identification Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

**PER - BILLING PROVIDER CONTACT
INFORMATION****X12 Segment Name:** Administrative Communications Contact**X12 Purpose:** To identify a person or office to whom administrative communications should be directed**X12 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**

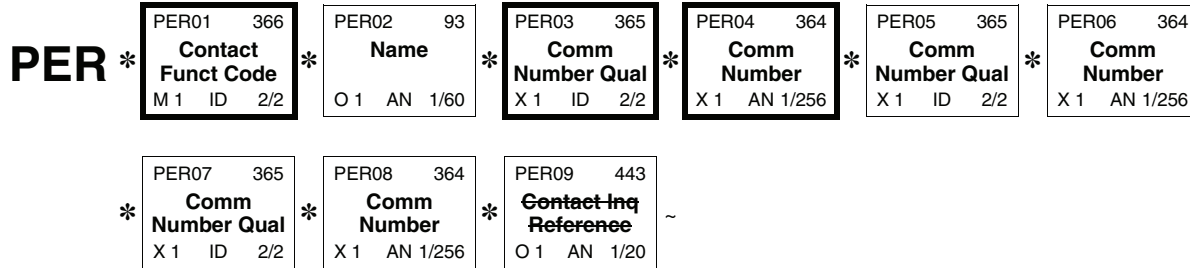
If either PER07 or PER08 is present, then the other is required.

Loop: 2010AA — BILLING PROVIDER NAME**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when this information is different than that contained in the Loop ID-1000A - Submitter PER segment. If not required by this implementation guide, do not send.**TR3 Notes:** 1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number must 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. Therefore, the following telephone number (555) 555-1234 would be represented as 5555551234. Do not submit long distance access numbers, such as “1”, in the telephone number. Telephone extensions, when applicable, must be submitted in the next element immediately following the telephone number. When submitting telephone extensions, only submit the numeric extension. Do not include data that indicates an extension, such as “ext” or “x-”.

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

TR3 Example: PER*IC*JOHN SMITH*TE*5555551234*EX*123~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/2										
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>IC</td><td>Information Contact</td></tr></table>	CODE	DEFINITION	IC	Information Contact									
CODE	DEFINITION															
IC	Information Contact															
SITUATIONAL	PER02	93	Name Free-form name	O 1	AN	1/60										
			SITUATIONAL RULE: <i>Required in the first iteration of the Billing Provider Contact Information segment. If not required by this implementation guide, do not send.</i>													
			IMPLEMENTATION NAME: Billing Provider Contact Name													
REQUIRED	PER03	365	Communication Number Qualifier Code identifying the type of communication number SYNTAX: P0304	X 1	ID	2/2										
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>EM</td><td>Electronic Mail</td></tr><tr><td>FX</td><td>Facsimile</td></tr><tr><td>TE</td><td>Telephone</td></tr></table>	CODE	DEFINITION	EM	Electronic Mail	FX	Facsimile	TE	Telephone					
CODE	DEFINITION															
EM	Electronic Mail															
FX	Facsimile															
TE	Telephone															
REQUIRED	PER04	364	Communication Number Complete communications number including country or area code when applicable SYNTAX: P0304	X 1	AN	1/256										
SITUATIONAL	PER05	365	Communication Number Qualifier Code identifying the type of communication number SYNTAX: P0506	X 1	ID	2/2										
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>													
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>EM</td><td>Electronic Mail</td></tr><tr><td>EX</td><td>Telephone Extension</td></tr><tr><td>FX</td><td>Facsimile</td></tr><tr><td>TE</td><td>Telephone</td></tr></table>	CODE	DEFINITION	EM	Electronic Mail	EX	Telephone Extension	FX	Facsimile	TE	Telephone			
CODE	DEFINITION															
EM	Electronic Mail															
EX	Telephone Extension															
FX	Facsimile															
TE	Telephone															

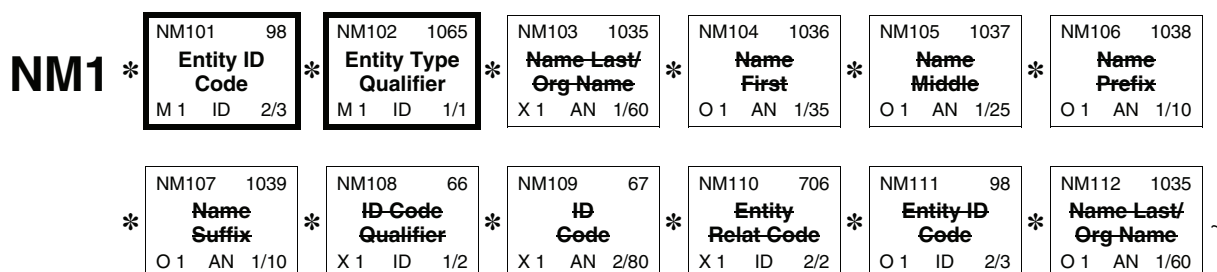
SITUATIONAL	PER06	364	Communication Number Complete communications number including country or area code when applicable SYNTAX: P0506 SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>	X 1	AN	1/256										
SITUATIONAL	PER07	365	Communication Number Qualifier Code identifying the type of communication number SYNTAX: P0708 SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>	X 1	ID	2/2										
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>EM</td><td>Electronic Mail</td></tr><tr><td>EX</td><td>Telephone Extension</td></tr><tr><td>FX</td><td>Facsimile</td></tr><tr><td>TE</td><td>Telephone</td></tr></table>	CODE	DEFINITION	EM	Electronic Mail	EX	Telephone Extension	FX	Facsimile	TE	Telephone			
CODE	DEFINITION															
EM	Electronic Mail															
EX	Telephone Extension															
FX	Facsimile															
TE	Telephone															
SITUATIONAL	PER08	364	Communication Number Complete communications number including country or area code when applicable SYNTAX: P0708 SITUATIONAL RULE: <i>Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.</i>	X 1	AN	1/256										
NOT USED	PER09	443	Contact Inquiry Reference	O 1	AN	1/20										

SEGMENT DETAIL

NM1 - PAY-TO ADDRESS NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2010AB — PAY-TO ADDRESS NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the address for payment is different than that of the Billing Provider. If not required by this implementation guide, do not send.**TR3 Notes:** 1. The purpose of Loop ID-2010AB has changed from previous versions. Loop ID-2010AB only contains address information when different from the Billing Provider Address. There are no applicable identifiers for Pay-To Address information.**TR3 Example:** NM1*87*2~

DIAGRAM



ELEMENT DETAIL

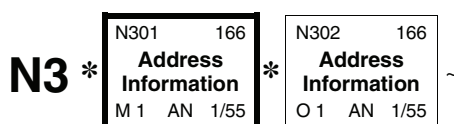
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
			CODE	DEFINITION
			87	Pay-to Provider

REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	2	Non-Person Entity			
CODE	DEFINITION									
2	Non-Person Entity									
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60				
NOT USED	NM104	1036	Name First	O 1	AN	1/35				
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25				
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10				
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2				
NOT USED	NM109	67	Identification Code	X 1	AN	2/80				
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

N3 - PAY-TO ADDRESS - ADDRESS**X12 Segment Name:** Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2010AB — PAY-TO ADDRESS NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Pay-To Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Pay-To Address Line				

SEGMENT DETAIL

N4 - PAY-TO ADDRESS CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

- X12 Syntax:**
- E0207**
Only one of N402 or N407 may be present.
 - C0605**
If N406 is present, then N405 is required.
 - C0704**
If N407 is present, then N404 is required.

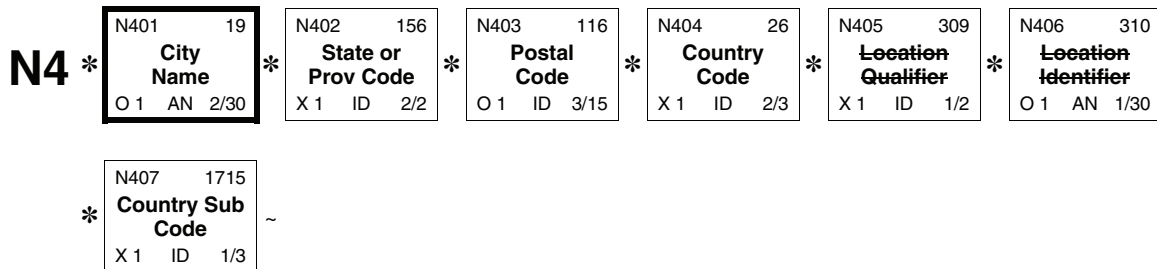
Loop: 2010AB — PAY-TO ADDRESS NAME

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30
COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.				
IMPLEMENTATION NAME: Pay-to Address City Name				

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Pay-to Address State Code CODE SOURCE 22: States and Provinces	X 1	ID	2/2
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Pay-to Address Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	O 1	ID	3/15
SITUATIONAL	N404	26	Country Code Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.	X 1	ID	2/3
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	O 1	AN	1/30
SITUATIONAL	N407	1715	Country Subdivision Code Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.	X 1	ID	1/3

SEGMENT DETAIL

NM1 - PAY-TO PLAN NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.

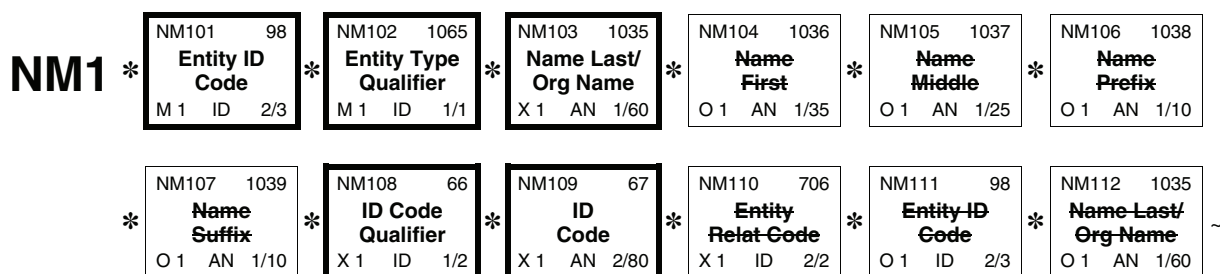
X12 Syntax: 1. **P0809**
If either NM108 or NM109 is present, then the other is required.

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

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2010AC — PAY-TO PLAN NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when willing trading partners agree to use this implementation for their subrogation payment requests.**TR3 Notes:** 1. This loop may only be used when BHT06 = 31.**TR3 Example:** NM1*PE*2*ANY STATE MEDICAID*****PI*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code	M 1 ID 2/3
Code identifying an organizational entity, a physical location, property or an individual				
		CODE	DEFINITION	
		PE	Payee	
			PE is used to indicate the subrogated payee.	

REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1		
			<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>	CODE	DEFINITION			
CODE	DEFINITION							
			2	Non-Person Entity				
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60		
			IMPLEMENTATION NAME: Pay-To Plan Organizational Name					
NOT USED	NM104	1036	Name First	O 1	AN	1/35		
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25		
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10		
NOT USED	NM107	1039	Name Suffix	O 1	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 1	ID	1/2		
			On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent.					
			Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent.					
			If a phase-in period is designated, PI must be sent unless: 1. Both the sender and receiver agree to use the National Plan ID, 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the National Plan ID.					
			If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.					
			<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>	CODE	DEFINITION			
CODE	DEFINITION							
			PI	Payor Identification				
			XV	Centers for Medicare and Medicaid Services PlanID CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID				
REQUIRED	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809	X 1	AN	2/80		
			IMPLEMENTATION NAME: Pay-To Plan Primary Identifier					
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2		
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3		
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60		

SEGMENT DETAIL

N3 - PAY-TO PLAN ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

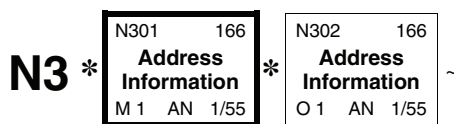
Loop: 2010AC — PAY-TO PLAN NAME

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Pay-To Plan Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Pay-To Plan Address Line				

SEGMENT DETAIL

N4 - PAY-TO PLAN CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location**X12 Purpose:** To specify the geographic place of the named party**X12 Syntax:** 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

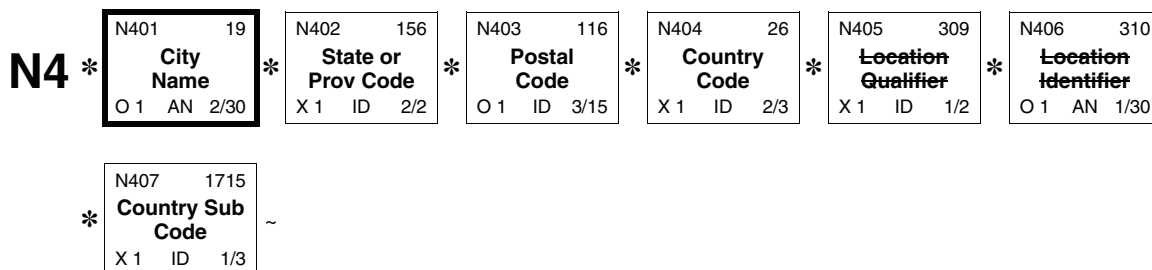
If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2010AC — PAY-TO PLAN NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. IMPLEMENTATION NAME: Pay-To Plan City Name	O 1 AN 2/30
SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Pay-To Plan State or Province Code CODE SOURCE 22: States and Provinces	X 1 ID 2/2

SITUATIONAL	N403	116	Postal Code O 1 ID 3/15 Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Pay-To Plan Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes
SITUATIONAL	N404	26	Country Code X 1 ID 2/3 Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.
NOT USED	N405	309	Location Qualifier X 1 ID 1/2
NOT USED	N406	310	Location Identifier O 1 AN 1/30
SITUATIONAL	N407	1715	Country Subdivision Code X 1 ID 1/3 Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.

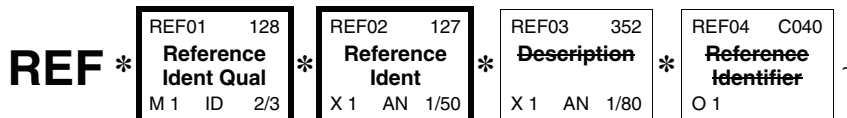
SEGMENT DETAIL

REF - PAY-TO PLAN SECONDARY
IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010AC — PAY-TO PLAN NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.**TR3 Example:** REF*2U*98765~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			2U	Payer Identification Number This code is only allowed when the National Plan Identifier is reported in NM109 of this loop.
			FY	Claim Office Number
			NF	National Association of Insurance Commissioners (NAIC) Code CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Pay-to Plan Secondary Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

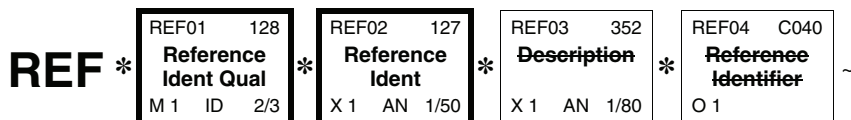
SEGMENT DETAIL

REF - PAY-TO PLAN TAX IDENTIFICATION
NUMBER**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010AC — PAY-TO PLAN NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** REF*EI*123456789~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			EI Employer's Identification Number The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.	
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Pay-To Plan Tax Identification Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

HL - SUBSCRIBER HIERARCHICAL LEVEL**X12 Segment Name:** Hierarchical Level**X12 Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments**X12 Comments:** 1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.

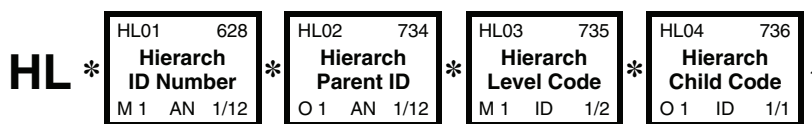
2. The HL segment defines a top-down/left-right ordered structure.

Loop: 2000B — SUBSCRIBER HIERARCHICAL LEVEL **Loop Repeat:** >1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. If a patient can be uniquely identified to the destination payer in Loop ID-2010BB by a unique Member Identification Number, then the patient is the subscriber or is considered to be the subscriber and is identified at this level, and the patient HL in Loop ID-2000C is not used.

2. If the patient is not the subscriber and cannot be identified to the destination payer by a unique Member Identification Number or it is not known to the sender if the Member Identification number is unique, both this HL and the patient HL in Loop ID- 2000C are required.

TR3 Example: HL*2*1*22*1~

DIAGRAM



ELEMENT DETAIL

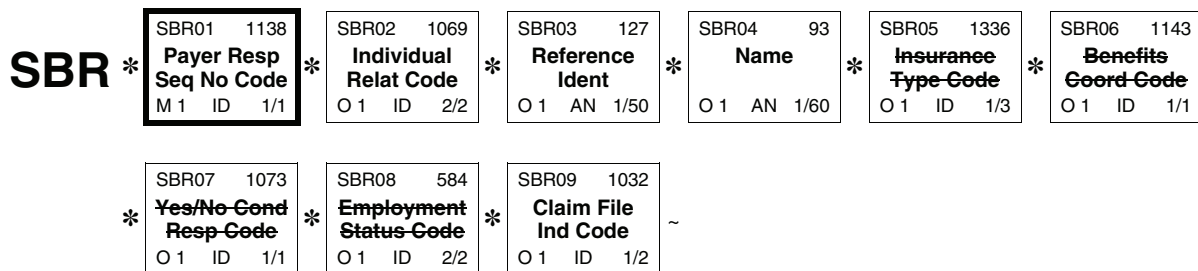
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HL01	628	Hierarchical ID Number A unique number assigned by the sender to identify a particular data segment in a hierarchical structure COMMENT: HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction 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. The first HL01 within each ST-SE envelope 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 1 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 1 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 1 ID 1/2		
			<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>	CODE	DEFINITION	
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.	O 1 ID 1/1		
			The claim (Loop ID-2300) can be used 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 for one or more dependents of the subscriber are being sent under the same billing provider HL (for example, a spouse and son are both treated by the same provider). In that case, the subscriber HL04 = 1 because there is at least one dependent to this subscriber. The dependent HL (spouse) would then be sent followed by the Loop ID-2300 for the spouse. The next HL would be the dependent HL for the son followed by the Loop ID-2300 for the son.			
			In order to send claims for the subscriber and one or more dependents, the Subscriber HL, with Relationship Code SBR02=18 (Self), would be followed by the Subscriber's Loop ID-2300 for the Subscriber's claims. Then the Subscriber HL would be repeated, followed by one or more Patient HL loops for the dependents, with the proper Relationship Code in PAT01, each followed by their respective Loop ID-2300 for each dependent's claims.			
			<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>	CODE	DEFINITION	
CODE	DEFINITION					
		0	No Subordinate HL Segment in This Hierarchical Structure.			
		1	Additional Subordinate HL Data Segment in This Hierarchical Structure.			

SEGMENT DETAIL

SBR - SUBSCRIBER INFORMATION**X12 Segment Name:** Subscriber Information**X12 Purpose:** To record information specific to the primary insured and the insurance carrier for that insured**Loop:** 2000B — SUBSCRIBER HIERARCHICAL LEVEL**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** SBR*P**GRP01020102*****CI~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SBR01	1138	Payer Responsibility Sequence Number Code	M 1 ID 1/1
Code identifying the insurance carrier's level of responsibility for a payment of a claim				
Within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value "U") may occur no more than once.				
		CODE	DEFINITION	
		A	Payer Responsibility Four	
		B	Payer Responsibility Five	
		C	Payer Responsibility Six	
		D	Payer Responsibility Seven	
		E	Payer Responsibility Eight	
		F	Payer Responsibility Nine	
		G	Payer Responsibility Ten	
		H	Payer Responsibility Eleven	
		P	Primary	
		S	Secondary	
		T	Tertiary	

			U	Unknown			
				This code may only be used in payer to payer COB claims when the original payer determined the presence of this coverage from eligibility files received from this payer or when the original claim did not provide the responsibility sequence for this payer.			
SITUATIONAL	SBR02	1069	Individual Relationship Code	O 1 ID 2/2			
			Code indicating the relationship between two individuals or entities				
			SEMANTIC: SBR02 specifies the relationship to the person insured.				
			SITUATIONAL RULE: <i>Required when the patient is the subscriber or is considered to be the subscriber. If not required by this implementation guide, do not send.</i>				
			CODE	DEFINITION			
			18	Self			
SITUATIONAL	SBR03	127	Reference Identification	O 1 AN 1/50			
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			SEMANTIC: SBR03 is policy or group number.				
			SITUATIONAL RULE: <i>Required when the subscriber's identification card for the destination payer (Loop ID-2010BB) shows a group number. If not required by this implementation guide, do not send.</i>				
			IMPLEMENTATION NAME: Subscriber Group or Policy Number				
			This is not the number uniquely identifying the subscriber. The unique subscriber number is submitted in Loop ID-2010BA-NM109.				
SITUATIONAL	SBR04	93	Name	O 1 AN 1/60			
			Free-form name				
			SEMANTIC: SBR04 is plan name.				
			SITUATIONAL RULE: <i>Required when SBR03 is not used and the group name is available. If not required by this implementation guide, do not send.</i>				
			IMPLEMENTATION NAME: Subscriber Group Name				
NOT USED	SBR05	1336	Insurance Type Code	O 1 ID 1/3			
NOT USED	SBR06	1143	Coordination of Benefits Code	O 1 ID 1/1			
NOT USED	SBR07	1073	Yes/No Condition or Response Code	O 1 ID 1/1			
NOT USED	SBR08	584	Employment Status Code	O 1 ID 2/2			
SITUATIONAL	SBR09	1032	Claim Filing Indicator Code	O 1 ID 1/2			
			Code identifying type of claim				
			SITUATIONAL RULE: <i>Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.</i>				
			CODE	DEFINITION			
			11	Other Non-Federal Programs			
			12	Preferred Provider Organization (PPO)			
			13	Point of Service (POS)			

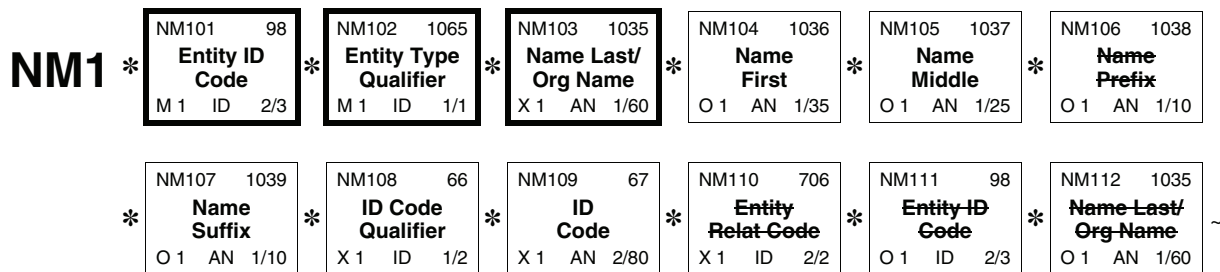
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
FI	Federal Employees Program
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
Use code OF when submitting Medicare Part D claims.	
TV	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
Use Code ZZ when Type of Insurance is not known.	

SEGMENT DETAIL

NM1 - SUBSCRIBER NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2010BA — SUBSCRIBER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (for example, the employer). However, this varies by state.**TR3 Example:** NM1*IL*1*DOE*JOHN*T**JR*MI*123456~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			IL	Insured or Subscriber

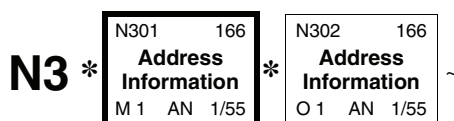
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. <table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	1	Person	2	Non-Person Entity	M 1	ID	1/1
CODE	DEFINITION											
1	Person											
2	Non-Person Entity											
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: Subscriber Last Name	X 1	AN	1/60						
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Subscriber First Name	O 1	AN	1/35						
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Subscriber Middle Name or Initial	O 1	AN	1/25						
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10						
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the name suffix of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Subscriber Name Suffix Examples: I, II, III, IV, Jr, Sr This data element is used only to indicate generation or patronymic.	O 1	AN	1/10						
SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required when NM102 = 1 (person). If not required by this implementation guide, do not send.</i> <table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>II</td><td>Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value ‘MI’ instead.</td></tr></table>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value ‘MI’ instead.	X 1	ID	1/2		
CODE	DEFINITION											
II	Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value ‘MI’ instead.											

			MI	Member Identification Number			
				The code MI is intended to be the subscriber's identification number as assigned by the payer. (For example, Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.) MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number (SSN) is also available on an IHS/CHS claim, put the SSN in REF02. When sending the Social Security Number as the Member ID, it must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.			
SITUATIONAL	NM109	67	Identification Code		X 1	AN	2/80
			Code identifying a party or other code				
			SYNTAX: P0809				
			SITUATIONAL RULE: <i>Required when NM102 = 1 (person). If not required by this implementation guide, do not send.</i>				
			IMPLEMENTATION NAME: Subscriber Primary Identifier				
NOT USED	NM110	706	Entity Relationship Code		X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code		O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name		O 1	AN	1/60

SEGMENT DETAIL

N3 - SUBSCRIBER ADDRESS**X12 Segment Name:** Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2010BA — SUBSCRIBER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
			IMPLEMENTATION NAME: Subscriber Address Line	
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
			SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>	
			IMPLEMENTATION NAME: Subscriber Address Line	

SEGMENT DETAIL

N4 - SUBSCRIBER CITY, STATE, ZIP CODE**X12 Segment Name:** Geographic Location**X12 Purpose:** To specify the geographic place of the named party**X12 Syntax:** 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

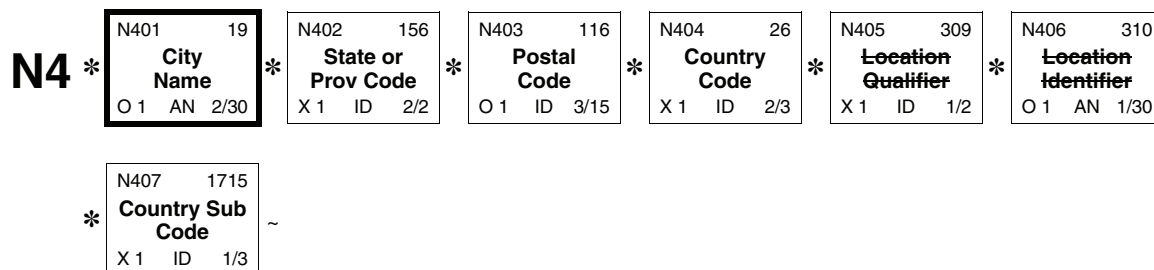
If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2010BA — SUBSCRIBER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.**TR3 Example:** N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	O 1 AN 2/30
IMPLEMENTATION NAME: Subscriber City Name				

SITUATIONAL	N402	156	State or Province Code X 1 ID 2/2 Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Subscriber State Code CODE SOURCE 22: States and Provinces
SITUATIONAL	N403	116	Postal Code O 1 ID 3/15 Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Subscriber Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes
SITUATIONAL	N404	26	Country Code X 1 ID 2/3 Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.
NOT USED	N405	309	Location Qualifier X 1 ID 1/2
NOT USED	N406	310	Location Identifier O 1 AN 1/30
SITUATIONAL	N407	1715	Country Subdivision Code X 1 ID 1/3 Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

DMG - SUBSCRIBER DEMOGRAPHIC INFORMATION**X12 Segment Name:** Demographic Information**X12 Purpose:** To supply demographic information**X12 Syntax:** 1. **P0102**

If either DMG01 or DMG02 is present, then the other is required.

2. **P0111**

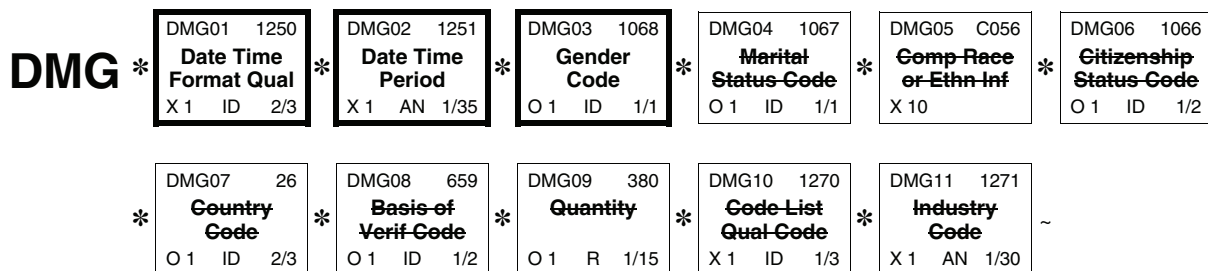
If either DMG10 or DMG11 is present, then the other is required.

3. **C1105**

If DMG11 is present, then DMG05 is required.

Loop: 2010BA — SUBSCRIBER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the patient is the subscriber or considered to be the subscriber. If not required by this implementation guide, do not send.**TR3 Example:** DMG*D8*19690815*M~

DIAGRAM



ELEMENT DETAIL

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 1 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 SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.	X 1 AN 1/35
			IMPLEMENTATION NAME: Subscriber Birth Date	

REQUIRED	DMG03	1068	Gender Code Code indicating the sex of the individual	O 1	ID	1/1
IMPLEMENTATION NAME: Subscriber Gender Code						
			CODE	DEFINITION		
			F	Female		
			M	Male		
			U	Unknown		
NOT USED	DMG04	1067	Marital Status Code	O 1	ID	1/1
NOT USED	DMG05	C056	COMPOSITE RACE OR ETHNICITY INFORMATION	X 10		
NOT USED	DMG06	1066	Citizenship Status Code	O 1	ID	1/2
NOT USED	DMG07	26	Country Code	O 1	ID	2/3
NOT USED	DMG08	659	Basis of Verification Code	O 1	ID	1/2
NOT USED	DMG09	380	Quantity	O 1	R	1/15
NOT USED	DMG10	1270	Code List Qualifier Code	X 1	ID	1/3
NOT USED	DMG11	1271	Industry Code	X 1	AN	1/30

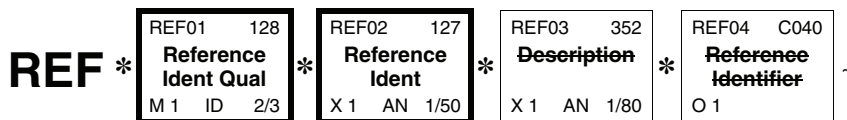
SEGMENT DETAIL

REF - SUBSCRIBER SECONDARY
IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010BA — SUBSCRIBER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when an additional identification number to that provided in NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.**TR3 Example:** REF*SY*123456789~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			SY	Social Security Number The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Subscriber Supplemental Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - PROPERTY AND CASUALTY CLAIM NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010BA — SUBSCRIBER NAME

Segment Repeat: 1

Usage: SITUATIONAL

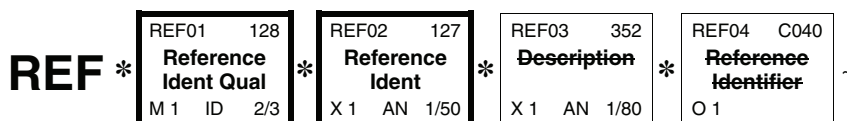
Situational Rule: Required when the services included in this claim are to be considered as part of a property and casualty claim. If not required by this implementation guide, do not send.

TR3 Notes: 1. This is a property and casualty payer-assigned claim number. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 1.4.2, Property and Casualty, for additional information about property and casualty claims.

2. This segment is not a HIPAA requirement as of this writing.

TR3 Example: REF*Y4*4445555~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Property Casualty Claim Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

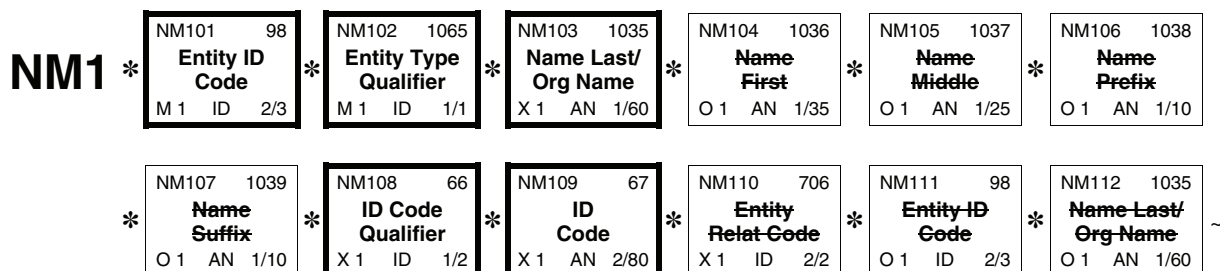
NM1 - PAYER NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2010BB — PAYER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. This is the destination payer.

2. For the purposes of this implementation the term payer is synonymous with several other terms, such as, repricer and third party administrator.

TR3 Example: NM1*PR*2*ABC INSURANCE CO*****PI*11122333~

DIAGRAM



ELEMENT DETAIL

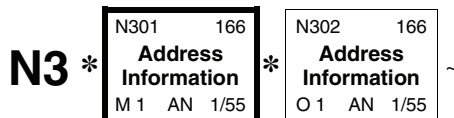
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M 1 ID 2/3
			CODE	DEFINITION
			PR	Payer

REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1								
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	2	Non-Person Entity							
CODE	DEFINITION													
2	Non-Person Entity													
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60								
			IMPLEMENTATION NAME: Payer Name											
NOT USED	NM104	1036	Name First	O 1	AN	1/35								
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25								
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10								
NOT USED	NM107	1039	Name Suffix	O 1	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 1	ID	1/2								
			On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent. Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent. If a phase-in period is designated, PI must be sent unless: 1. Both the sender and receiver agree to use the National Plan ID, 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the National Plan ID. If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.											
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>PI</td><td>Payor Identification</td></tr><tr><td>XV</td><td>Centers for Medicare and Medicaid Services PlanID</td></tr><tr><td></td><td>CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID</td></tr></table>	CODE	DEFINITION	PI	Payor Identification	XV	Centers for Medicare and Medicaid Services PlanID		CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID			
CODE	DEFINITION													
PI	Payor Identification													
XV	Centers for Medicare and Medicaid Services PlanID													
	CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID													
REQUIRED	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809	X 1	AN	2/80								
			IMPLEMENTATION NAME: Payer Identifier											
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2								
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3								
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60								

SEGMENT DETAIL

N3 - PAYER ADDRESS**X12 Segment Name:** Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2010BB — PAYER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide, do not send.**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Payer Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Payer Address Line				

SEGMENT DETAIL

N4 - PAYER CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

X12 Syntax: 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2010BB — PAYER NAME

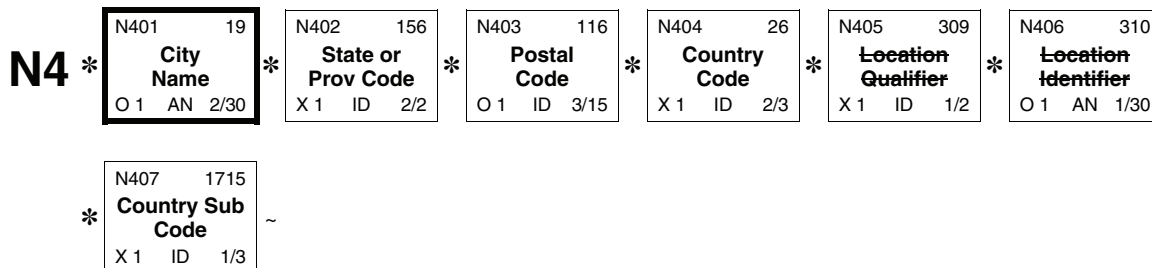
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide, do not send.

TR3 Example: N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	O 1 AN 2/30
IMPLEMENTATION NAME: Payer City Name				

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Payer State Code CODE SOURCE 22: States and Provinces	X 1	ID	2/2
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Payer Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	O 1	ID	3/15
SITUATIONAL	N404	26	Country Code Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.	X 1	ID	2/3
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	O 1	AN	1/30
SITUATIONAL	N407	1715	Country Subdivision Code Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.	X 1	ID	1/3

SEGMENT DETAIL

REF - PAYER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

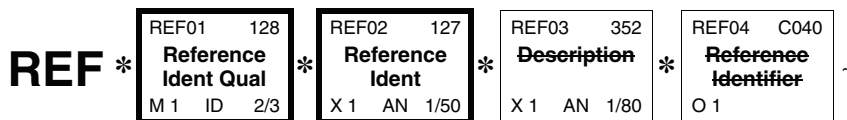
At least one of REF02 or REF03 is required.

Loop: 2010BB — PAYER NAME**Segment Repeat:** 3**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.

TR3 Example: REF*FY*435261708~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			2U	Payer Identification Number This code is only allowed when the National Plan Identifier is reported in NM109 of this loop.
			EI	Employer's Identification Number The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.
			FY	Claim Office Number
			NF	National Association of Insurance Commissioners (NAIC) Code CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Payer Additional Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - BILLING PROVIDER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010BB — PAYER NAME

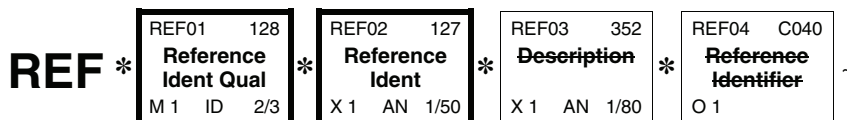
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required prior to the mandated NPI Implementation Date when an additional identification number is necessary for the receiver to identify the provider.
OR
Required on or after the mandated NPI Implementation Date when NM109 in Loop 2010AA is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.
If not required by this implementation guide, do not send.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			G2	Provider Commercial Number This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
			LU	Location Number

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Billing Provider Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

HL - PATIENT HIERARCHICAL LEVEL**X12 Segment Name:** Hierarchical Level**X12 Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments

- X12 Comments:**
1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
 2. The HL segment defines a top-down/left-right ordered structure.

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

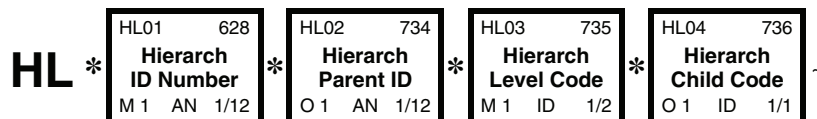
Situational Rule: Required when the patient is a dependent of the subscriber identified in Loop ID-2000B and cannot be uniquely identified to the payer using the subscriber's identifier in the Subscriber Level. If not required by this implementation guide, do not send.

TR3 Notes: 1. There are no HLs subordinate to the Patient HL.

2. If a patient is a dependent of a subscriber and can be uniquely identified to the payer by a unique Identification Number, then the patient is considered the subscriber and is to be identified in the Subscriber Level.

TR3 Example: HL*3*2*23*0~

DIAGRAM



ELEMENT DETAIL

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	M 1 AN 1/12
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.				

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 1 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 1 ID 1/2				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>23</td><td>Dependent The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.</td></tr></table>					CODE	DEFINITION	23	Dependent The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.
CODE	DEFINITION							
23	Dependent The code DEPENDENT conveys that the information in this HL applies to the patient when the subscriber and the patient are not the same person.							
REQUIRED	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child data segments subordinate to the level being described COMMENT: HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	O 1 ID 1/1				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0</td><td>No Subordinate HL Segment in This Hierarchical Structure.</td></tr></table>					CODE	DEFINITION	0	No Subordinate HL Segment in This Hierarchical Structure.
CODE	DEFINITION							
0	No Subordinate HL Segment in This Hierarchical Structure.							

SEGMENT DETAIL

PAT - PATIENT INFORMATION

X12 Segment Name: Patient Information

X12 Purpose: To supply patient information

X12 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.

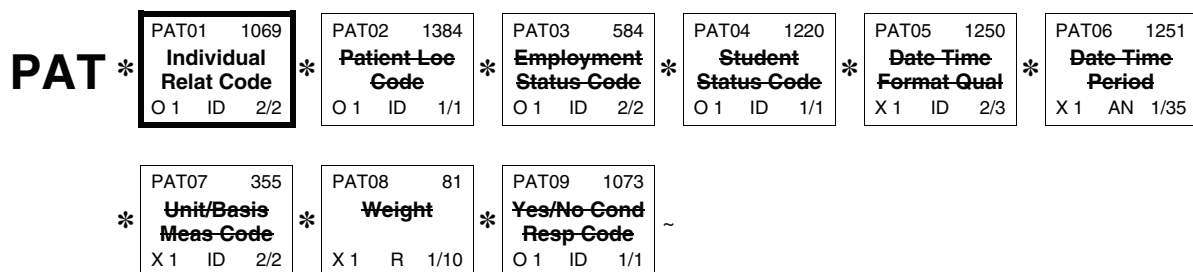
Loop: 2000C — PATIENT HIERARCHICAL LEVEL

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: PAT*01~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	PAT01	1069	Individual Relationship Code	O 1	ID	2/2
Code indicating the relationship between two individuals or entities						
Specifies the patient's relationship to the person insured.						
			CODE	DEFINITION		
			01	Spouse		
			19	Child		
			20	Employee		
			21	Unknown		
			39	Organ Donor		
			40	Cadaver Donor		
			53	Life Partner		
			G8	Other Relationship		
NOT USED	PAT02	1384	Patient Location Code	O 1	ID	1/1
NOT USED	PAT03	584	Employment Status Code	O 1	ID	2/2
NOT USED	PAT04	1220	Student Status Code	O 1	ID	1/1

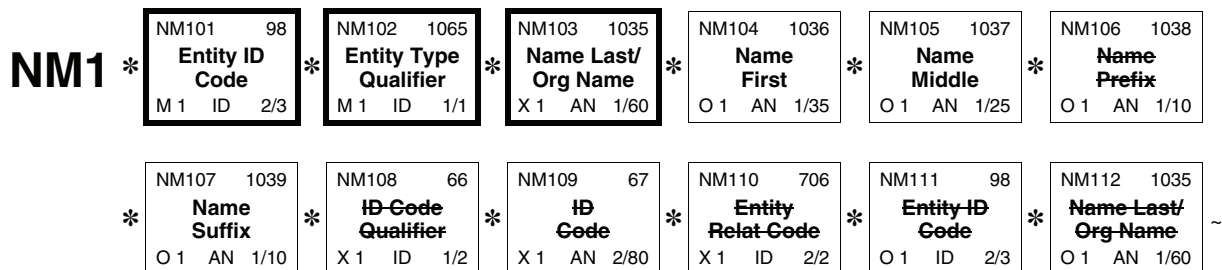
NOT USED	PAT05	1250	Date Time Period Format Qualifier	X 1	ID	2/3
NOT USED	PAT06	1251	Date Time Period	X 1	AN	1/35
NOT USED	PAT07	355	Unit or Basis for Measurement Code	X 1	ID	2/2
NOT USED	PAT08	81	Weight	X 1	R	1/10
NOT USED	PAT09	1073	Yes/No Condition or Response Code	O 1	ID	1/1

SEGMENT DETAIL

NM1 - PATIENT NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2010CA — PATIENT NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** NM1*QC*1*DOE*SALLY*J~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			QC	Patient
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1
			CODE	DEFINITION
			1	Person

REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: Patient Last Name	X 1	AN	1/60
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Patient First Name	O 1	AN	1/35
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Patient Middle Name or Initial	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Patient Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

N3 - PATIENT ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

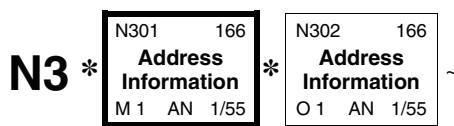
Loop: 2010CA — PATIENT NAME

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Patient Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Patient Address Line				

SEGMENT DETAIL

N4 - PATIENT CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location**X12 Purpose:** To specify the geographic place of the named party**X12 Syntax:** 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

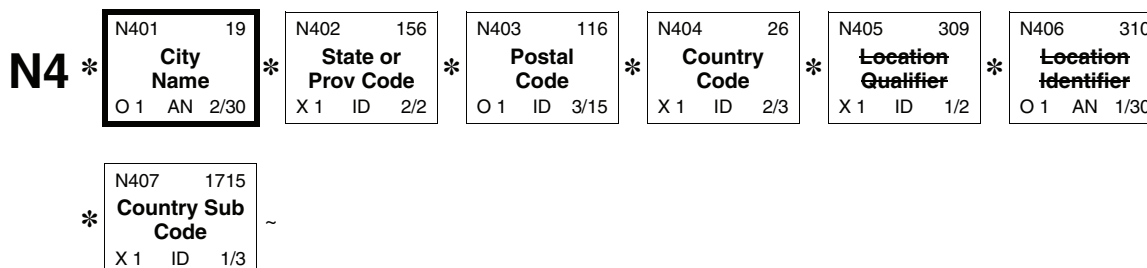
If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2010CA — PATIENT NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. IMPLEMENTATION NAME: Patient City Name	O 1 AN 2/30
SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Patient State Code CODE SOURCE 22: States and Provinces	X 1 ID 2/2

SITUATIONAL	N403	116	Postal Code O 1 ID 3/15 Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Patient Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes
SITUATIONAL	N404	26	Country Code X 1 ID 2/3 Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.
NOT USED	N405	309	Location Qualifier X 1 ID 1/2
NOT USED	N406	310	Location Identifier O 1 AN 1/30
SITUATIONAL	N407	1715	Country Subdivision Code X 1 ID 1/3 Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.

SEGMENT DETAIL

DMG - PATIENT DEMOGRAPHIC INFORMATION**X12 Segment Name:** Demographic Information**X12 Purpose:** To supply demographic information**X12 Syntax:** 1. **P0102**

If either DMG01 or DMG02 is present, then the other is required.

2. **P1011**

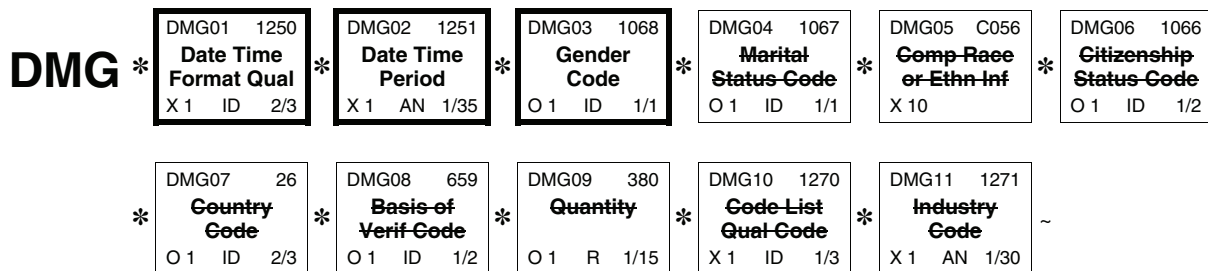
If either DMG10 or DMG11 is present, then the other is required.

3. **C1105**

If DMG11 is present, then DMG05 is required.

Loop: 2010CA — PATIENT NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** DMG*D8*19690815*M~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>D8</td><td>Date Expressed in Format CCYYMMDD</td></tr></table>	CODE	DEFINITION	D8	Date Expressed in Format CCYYMMDD			
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 SYNTAX: P0102 SEMANTIC: DMG02 is the date of birth.	X 1	AN	1/35				
			IMPLEMENTATION NAME: Patient Birth Date							

REQUIRED	DMG03	1068	Gender Code Code indicating the sex of the individual	O 1	ID	1/1
IMPLEMENTATION NAME: Patient Gender Code						
			CODE	DEFINITION		
			F	Female		
			M	Male		
			U	Unknown		
NOT USED	DMG04	1067	Marital Status Code	O 1	ID	1/1
NOT USED	DMG05	C056	COMPOSITE RACE OR ETHNICITY INFORMATION	X 10		
NOT USED	DMG06	1066	Citizenship Status Code	O 1	ID	1/2
NOT USED	DMG07	26	Country Code	O 1	ID	2/3
NOT USED	DMG08	659	Basis of Verification Code	O 1	ID	1/2
NOT USED	DMG09	380	Quantity	O 1	R	1/15
NOT USED	DMG10	1270	Code List Qualifier Code	X 1	ID	1/3
NOT USED	DMG11	1271	Industry Code	X 1	AN	1/30

SEGMENT DETAIL

REF - PROPERTY AND CASUALTY CLAIM
NUMBER**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

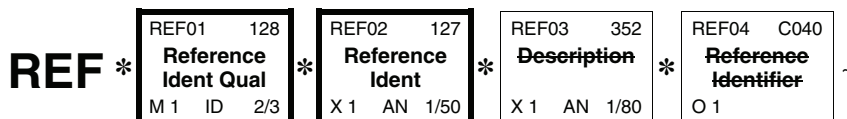
At least one of REF02 or REF03 is required.

Loop: 2010CA — PATIENT NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the services included in this claim are to be considered as part of a property and casualty claim. If not required by this implementation guide, do not send.**TR3 Notes:** 1. This is a property and casualty payer-assigned claim number. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. See Section 1.4.2, Property and Casualty, for additional information about property and casualty claims.

2. This segment is not a HIPAA requirement as of this writing.

TR3 Example: REF*Y4*4445555~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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 SYNTAX: R0203 IMPLEMENTATION NAME: Property Casualty Claim Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

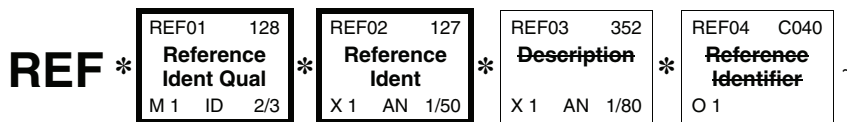
REF - PROPERTY AND CASUALTY PATIENT IDENTIFIER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2010CA — PATIENT NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when an identification number is needed by the receiver to identify the patient for Property and Casualty claims. If not required by this implementation guide, do not send.**TR3 Example:** REF*SY*123456789~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			1W	Member Identification Number This code designates a patient identification number used by the destination payer identified in the Payer Name loop, Loop ID 2010BB, associated with this claim.
			SY	Social Security Number The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Property and Casualty Patient Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80

NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

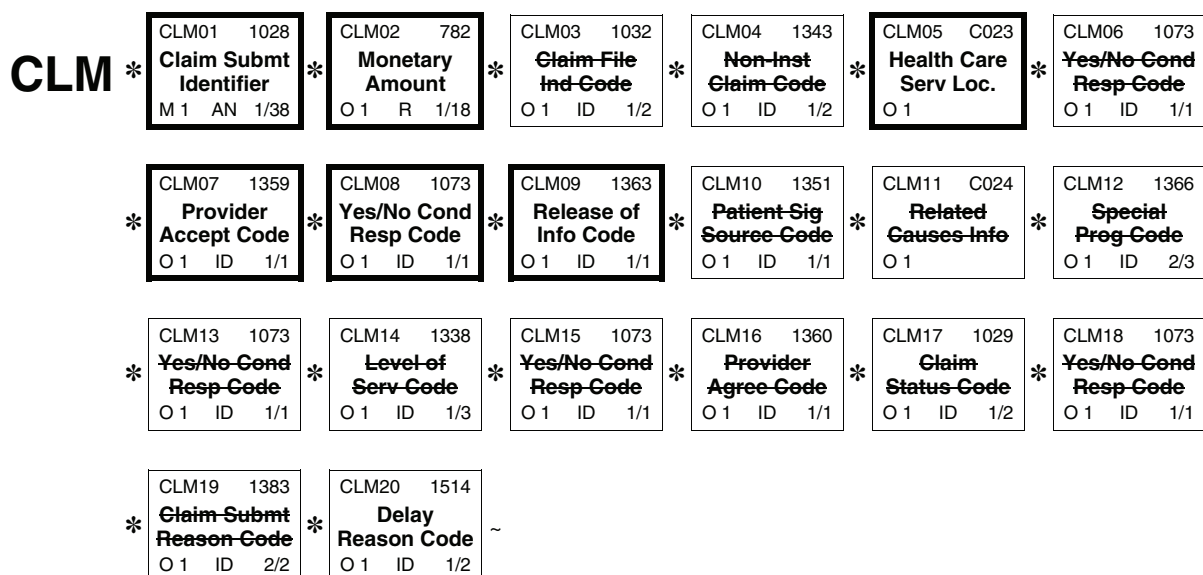
SEGMENT DETAIL

CLM - CLAIM INFORMATION**X12 Segment Name:** Health Claim**X12 Purpose:** To specify basic data about the claim**Loop:** 2300 — CLAIM INFORMATION **Loop Repeat:** 100**Segment Repeat:** 1**Usage:** REQUIRED

TR3 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 ID-2300, is placed following Loop ID-2010BB in the Subscriber Hierarchical Level (HL) when patient information is sent in Loop ID-2010BA of the Subscriber HL. Claim information is placed in the Patient HL when the patient information is sent in Loop ID-2010CA of the Patient HL. When the patient is the subscriber or is considered to be the subscriber, Loop ID-2000C and Loop ID-2010CA are not sent. See Subscriber/Patient HL Segment explanation in section 1.4.3.2.2.1 for details.

TR3 Example: CLM*12345656*500***11:A:1*Y*A*Y*I~

DIAGRAM

ELEMENT DETAIL

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	M 1 AN 1/38
IMPLEMENTATION NAME: Patient Control Number				
The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use unique numbers for this field for each individual claim.				
When Loop ID-2010AC is present, CLM01 represents the subrogated Medicaid agency's claim number (ICN/DCN) from their original 835 CLP07 - Payer Claim Control Number. See Section 1.4.1.4 of the front matter for a description of post payment recovery claims for subrogated Medicaid agencies.				
The maximum number of characters to be supported for this field is '20'. Characters beyond the maximum are not required to be stored nor returned by any 837-receiving system.				

REQUIRED	CLM02	782	Monetary Amount Monetary amount SEMANTIC: CLM02 is the total amount of all submitted charges of service segments for this claim. IMPLEMENTATION NAME: Total Claim Charge Amount The Total Claim Charge Amount must be greater than or equal to zero. The total claim charge amount must balance to the sum of all service line charge amounts reported in the Institutional Service Line (SV2) segments for this claim.	O 1	R	1/18				
NOT USED	CLM03	1032	Claim Filing Indicator Code	O 1	ID	1/2				
NOT USED	CLM04	1343	Non-Institutional Claim Type Code	O 1	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 1						
REQUIRED	CLM05 - 1	1331	Facility Code Value Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. IMPLEMENTATION NAME: Facility Type Code	M	AN	1/2				
REQUIRED	CLM05 - 2	1332	Facility Code Qualifier Code identifying the type of facility referenced SEMANTIC: C023-02 qualifies C023-01 and C023-03.	O	ID	1/2				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>A</td><td>Uniform Billing Claim Form Bill Type CODE SOURCE 236: Uniform Billing Claim Form Bill Type</td></tr></table>							CODE	DEFINITION	A	Uniform Billing Claim Form Bill Type CODE SOURCE 236: Uniform Billing Claim Form Bill Type
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 IMPLEMENTATION NAME: Claim Frequency Code CODE SOURCE 235: Claim Frequency Type Code	O	ID	1/1				
NOT USED	CLM06	1073	Yes/No Condition or Response Code	O 1	ID	1/1				

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

IMPLEMENTATION NAME: **Assignment or Plan Participation Code**

Within this element the context of the word assignment is related to the relationship between the provider and the payer. This is NOT the field for reporting whether the patient has or has not assigned benefits to the provider. The benefit assignment indicator is in CLM08.

CODE	DEFINITION
A	Assigned Required when the provider accepts assignment and/or has a participation agreement with the destination payer. OR Required when the provider does not accept assignment and/or have a participation agreement, but is advising the payer to adjudicate this specific claim under participating provider benefits as allowed under certain plans.
B	Assignment Accepted on Clinical Lab Services Only Required when the provider accepts assignment for Clinical Lab Services only.
C	Not Assigned Required when neither codes 'A' nor 'B' apply.

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

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.

IMPLEMENTATION NAME: **Benefits Assignment Certification Indicator**

This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider.

CODE	DEFINITION
N	No
W	Not Applicable Use code 'W' when the patient refuses to assign benefits.
Y	Yes

REQUIRED	CLM09	1363	Release of Information Code	O 1	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			
			The Release of Information response is limited to the information carried in this claim.			
			CODE	DEFINITION		
			I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes		
				Required when the provider has not collected a signature AND state or federal laws do not require a signature be collected.		
			Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim		
				Required when the provider has collected a signature. OR Required when state or federal laws require a signature be collected.		
NOT USED	CLM10	1351	Patient Signature Source Code	O 1	ID	1/1
NOT USED	CLM11	C024	RELATED CAUSES INFORMATION	O 1		
NOT USED	CLM12	1366	Special Program Code	O 1	ID	2/3
NOT USED	CLM13	1073	Yes/No Condition or Response Code	O 1	ID	1/1
NOT USED	CLM14	1338	Level of Service Code	O 1	ID	1/3
NOT USED	CLM15	1073	Yes/No Condition or Response Code	O 1	ID	1/1
NOT USED	CLM16	1360	Provider Agreement Code	O 1	ID	1/1
NOT USED	CLM17	1029	Claim Status Code	O 1	ID	1/2
NOT USED	CLM18	1073	Yes/No Condition or Response Code	O 1	ID	1/1
NOT USED	CLM19	1383	Claim Submission Reason Code	O 1	ID	2/2
SITUATIONAL	CLM20	1514	Delay Reason Code	O 1	ID	1/2
			Code indicating the reason why a request was delayed			
			SITUATIONAL RULE: <i>Required when the claim is submitted late (past contracted date of filing limitations). If not required by this implementation guide, do not send.</i>			
			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
15	Natural Disaster

SEGMENT DETAIL

DTP - DISCHARGE HOUR

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: 2300 — CLAIM INFORMATION

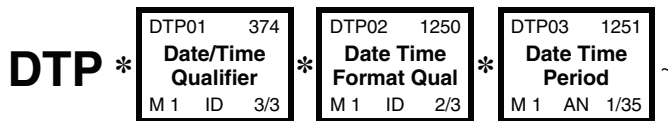
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required on all final inpatient claims. If not required by this implementation guide, do not send.

TR3 Example: DTP*096*TM*1130~

DIAGRAM



ELEMENT DETAIL

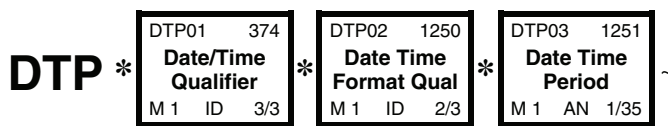
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time	M 1 ID 3/3
IMPLEMENTATION NAME: Date Time Qualifier				
		CODE	DEFINITION	
		096	Discharge	
REQUIRED	DTP02	1250	Date Time Period Format Qualifier Code indicating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

SEGMENT DETAIL

DTP - STATEMENT DATES

X12 Segment Name: Date or Time or Period**X12 Purpose:** To specify any or all of a date, a time, or a time period**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** DTP*434*RD8*20041209-20041214~

DIAGRAM



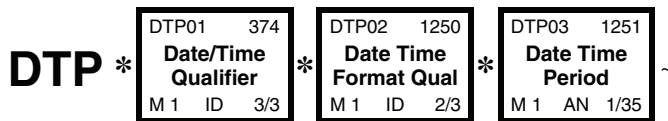
ELEMENT DETAIL

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 1	ID	3/3
IMPLEMENTATION NAME: 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 1	ID	2/3
SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.						
			CODE	DEFINITION		
			RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		
			Use RD8 to indicate the from and through date of the statement. When the statement is for a single date of service, the from and through date are the same.			
REQUIRED	DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	M 1	AN	1/35
IMPLEMENTATION NAME: Statement From and To Date						

SEGMENT DETAIL

DTP - ADMISSION DATE/HOUR**X12 Segment Name:** Date or Time or Period**X12 Purpose:** To specify any or all of a date, a time, or a time period**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required on inpatient claims.
If not required by this implementation guide, do not send.**TR3 Example:** DTP*435*DT*200410131242~

DIAGRAM



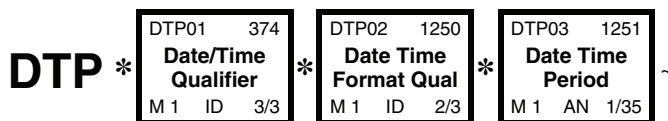
ELEMENT DETAIL

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 1 ID 3/3
IMPLEMENTATION NAME: Date Time Qualifier				
		CODE	DEFINITION	
		435	Admission	
REQUIRED	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	M 1 ID 2/3
SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.				
Selection of the appropriate qualifier is designated by the NUBC Billing Manual.				
		CODE	DEFINITION	
		D8	Date Expressed in Format CCYYMMDD	
		DT	Date and Time Expressed in Format CCYYMMDDHHMM	
REQUIRED	DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	M 1 AN 1/35
IMPLEMENTATION NAME: Admission Date and Hour				

SEGMENT DETAIL

DTP - DATE - REPRICER RECEIVED DATE**X12 Segment Name:** Date or Time or Period**X12 Purpose:** To specify any or all of a date, a time, or a time period**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when a repricer is passing the claim onto the payer. If not required by this implementation guide, do not send.**TR3 Example:** DTP*050*D8*20051030~

DIAGRAM



ELEMENT DETAIL

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 1 ID 3/3
IMPLEMENTATION NAME: Date Time Qualifier				
		CODE	DEFINITION	
		050	Received	
REQUIRED	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	M 1 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 1 AN 1/35
IMPLEMENTATION NAME: Repricer Received Date				

SEGMENT DETAIL

CL1 - INSTITUTIONAL CLAIM CODE

X12 Segment Name: Claim Codes

X12 Purpose: To supply information specific to hospital claims

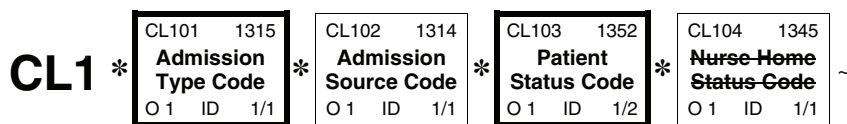
Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: CL1*1*7*30~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	CL101	1315	Admission Type Code Code indicating the priority of this admission CODE SOURCE 231: Priority (Type) of Admission or Visit	O 1 ID 1/1
SITUATIONAL	CL102	1314	Admission Source Code Code indicating the source of this admission SITUATIONAL RULE: <i>Required for all inpatient and outpatient services. If not required by this implementation guide, do not send.</i>	O 1 ID 1/1
REQUIRED	CL103	1352	Patient Status Code Code indicating patient status as of the "statement covers through date" CODE SOURCE 239: Patient Status Code	O 1 ID 1/2
NOT USED	CL104	1345	Nursing Home Residential Status Code	O 1 ID 1/1

SEGMENT DETAIL

PWK - CLAIM SUPPLEMENTAL INFORMATION**X12 Segment Name:** Paperwork**X12 Purpose:** To identify the type or transmission or both of paperwork or supporting information**X12 Syntax:** 1. P0506

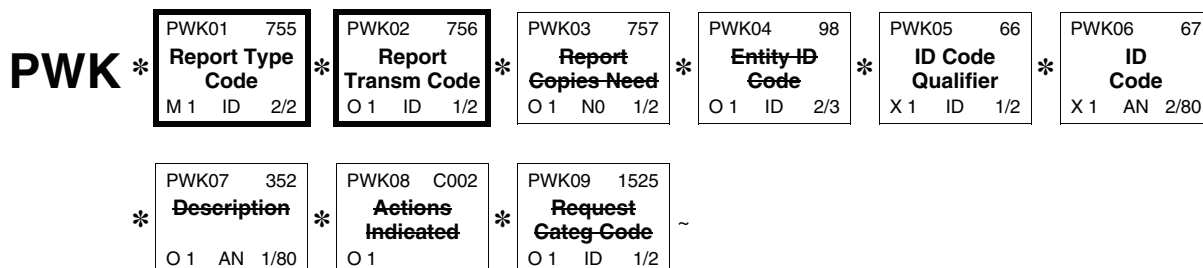
If either PWK05 or PWK06 is present, then the other is required.

Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 10**Usage:** SITUATIONAL

Situational Rule: Required when there is a paper attachment following this claim.
OR
Required when attachments are sent electronically (PWK02 = EL) but are transmitted in another functional group (for example, 275) rather than by paper. PWK06 is then used to identify the attached electronic documentation. The number in PWK06 is carried in the TRN of the electronic attachment.
OR
Required when the provider deems it necessary to identify additional information that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but the information is not being submitted with the claim. Use the value of "AA" in PWK02 to convey this specific use of the PWK segment.
If not required by this implementation guide, do not send.

TR3 Example: PWK*OZ*BM***AC*DMN0012~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/2
IMPLEMENTATION NAME: Attachment Report Type Code				
			CODE	DEFINITION
			03	Report Justifying Treatment Beyond Utilization Guidelines
			04	Drugs Administered
			05	Treatment Diagnosis
			06	Initial Assessment
			07	Functional Goals
			08	Plan of Treatment
			09	Progress Report
			10	Continued Treatment
			11	Chemical Analysis
			13	Certified Test Report
			15	Justification for Admission
			21	Recovery Plan
			A3	Allergies/Sensitivities Document
			A4	Autopsy Report
			AM	Ambulance Certification
			AS	Admission Summary
			B2	Prescription
			B3	Physician Order
			B4	Referral Form
			BR	Benchmark Testing Results
			BS	Baseline
			BT	Blanket Test Results
			CB	Chiropractic Justification
			CK	Consent Form(s)
			CT	Certification
			D2	Drug Profile Document
			DA	Dental Models
			DB	Durable Medical Equipment Prescription
			DG	Diagnostic Report
			DJ	Discharge Monitoring Report
			DS	Discharge Summary
			EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
			HC	Health Certificate
			HR	Health Clinic Records
			I5	Immunization Record

IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

REQUIRED

PWK02

756

Report Transmission Code

O 1 ID 1/2

Code defining timing, transmission method or format by which reports are to be sent

IMPLEMENTATION NAME: Attachment Transmission Code

CODE	DEFINITION
AA	Available on Request at Provider Site
	This means that the additional information is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.
BM	By Mail
EL	Electronically Only
	Indicates that the attachment is being transmitted in a separate X12 functional group.
EM	E-Mail
FT	File Transfer
	Required when the actual attachment is maintained by an attachment warehouse or similar vendor.

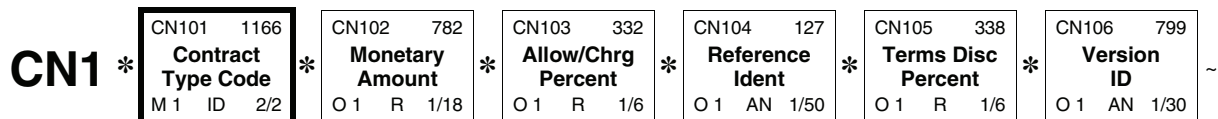
			FX	By Fax			
NOT USED	PWK03	757	Report Copies Needed		O 1	NO	1/2
NOT USED	PWK04	98	Entity Identifier Code		O 1	ID	2/3
SITUATIONAL	PWK05	66	Identification Code Qualifier		X 1	ID	1/2
Code designating the system/method of code structure used for Identification Code (67)							
SYNTAX: P0506							
COMMENT: PWK05 and PWK06 may be used to identify the addressee by a code number.							
SITUATIONAL RULE: <i>Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.</i>							
			CODE	DEFINITION			
			AC	Attachment Control Number			
SITUATIONAL	PWK06	67	Identification Code		X 1	AN	2/80
Code identifying a party or other code							
SYNTAX: P0506							
SITUATIONAL RULE: <i>Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.</i>							
IMPLEMENTATION NAME: Attachment Control Number							
PWK06 is used to identify the attached electronic documentation. The number in PWK06 is carried in the TRN of the electronic attachment.							
For the purpose of this implementation, the maximum field length is 50.							
NOT USED	PWK07	352	Description		O 1	AN	1/80
NOT USED	PWK08	C002	ACTIONS INDICATED		O 1		
NOT USED	PWK09	1525	Request Category Code		O 1	ID	1/2

SEGMENT DETAIL

CN1 - CONTRACT INFORMATION

X12 Segment Name: Contract Information**X12 Purpose:** To specify basic data about the contract or contract line item**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the submitter is contractually obligated to supply this information on post-adjudicated claims. If not required by this implementation guide, do not send.**TR3 Notes:** 1. The developers of this implementation guide note that the CN1 segment is for use only for post-adjudicated claims, which do not meet the definition of a health care claim under HIPAA. Consequently, at the time of this writing, the CN1 segment is for non-HIPAA use only.**TR3 Example:** CN1*02*550~

DIAGRAM



ELEMENT DETAIL

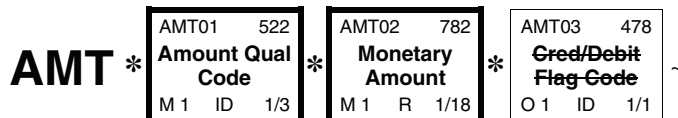
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																		
REQUIRED	CN101	1166	Contract Type Code Code identifying a contract type	M 1	ID	2/2																
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>01</td><td>Diagnosis Related Group (DRG)</td></tr><tr><td>02</td><td>Per Diem</td></tr><tr><td>03</td><td>Variable Per Diem</td></tr><tr><td>04</td><td>Flat</td></tr><tr><td>05</td><td>Capitated</td></tr><tr><td>06</td><td>Percent</td></tr><tr><td>09</td><td>Other</td></tr></tbody></table>	CODE	DEFINITION	01	Diagnosis Related Group (DRG)	02	Per Diem	03	Variable Per Diem	04	Flat	05	Capitated	06	Percent	09	Other			
CODE	DEFINITION																					
01	Diagnosis Related Group (DRG)																					
02	Per Diem																					
03	Variable Per Diem																					
04	Flat																					
05	Capitated																					
06	Percent																					
09	Other																					
SITUATIONAL	CN102	782	Monetary Amount Monetary amount	O 1	R	1/18																
			SEMANTIC: CN102 is the contract amount.																			
			SITUATIONAL RULE: <i>Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.</i>																			
			IMPLEMENTATION NAME: Contract Amount																			

SITUATIONAL	CN103	332	Percent, Decimal Format O 1 R 1/6 Percent given in decimal format (e.g., 0.0 through 100.0 represents 0% through 100%) SEMANTIC: CN103 is the allowance or charge percent. SITUATIONAL RULE: <i>Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Contract Percentage
SITUATIONAL	CN104	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: CN104 is the contract code. SITUATIONAL RULE: <i>Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Contract Code
SITUATIONAL	CN105	338	Terms Discount Percent O 1 R 1/6 Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date SITUATIONAL RULE: <i>Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Terms Discount Percentage
SITUATIONAL	CN106	799	Version Identifier O 1 AN 1/30 Revision level of a particular format, program, technique or algorithm SEMANTIC: CN106 is an additional identifying number for the contract. SITUATIONAL RULE: <i>Required when the provider is required by contract to supply this information on the claim. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Contract Version Identifier

SEGMENT DETAIL

AMT - PATIENT ESTIMATED AMOUNT DUE**X12 Segment Name:** Monetary Amount Information**X12 Purpose:** To indicate the total monetary amount**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the Patient Responsibility Amount is applicable to this claim.
If not required by this implementation guide, do not send.**TR3 Example:** AMT*F3*123~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBUTES			
REQUIRED	AMT01	522	Amount Qualifier Code			M 1	ID	1/3
			Code to qualify amount					
			CODE	DEFINITION				
			F3	Patient Responsibility - Estimated				
REQUIRED	AMT02	782	Monetary Amount			M 1	R	1/18
			Monetary amount					
			IMPLEMENTATION NAME: Patient Responsibility Amount					
NOT USED	AMT03	478	Credit/Debit Flag Code			O 1	ID	1/1

SEGMENT DETAIL

REF - SERVICE AUTHORIZATION EXCEPTION CODE

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION

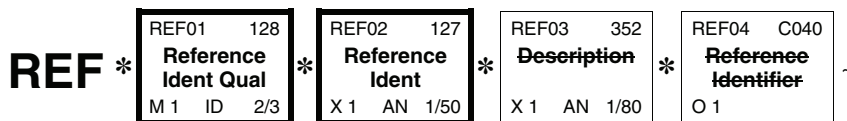
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when mandated by government law or regulation to obtain authorization for specific service(s) but, for the reasons listed in REF02, the service was performed without obtaining the authorization. If not required by this implementation guide, do not send.

TR3 Example: REF*4N*1~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Service Authorization Exception Code	
			Allowable values for this element are:	
			1 Immediate/Urgent Care 2 Services Rendered in a Retroactive Period 3 Emergency Care 4 Client has Temporary Medicaid 5 Request from County for Second Opinion to Determine if Recipient Can Work 6 Request for Override Pending 7 Special Handling	

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

SEGMENT DETAIL

REF - REFERRAL NUMBER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

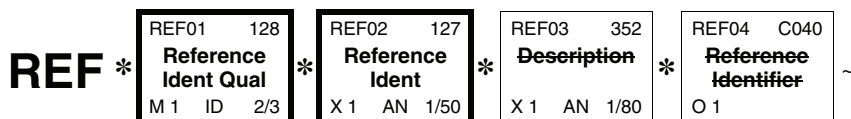
Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required when a referral number is assigned by the payer or Utilization Management Organization (UMO)
AND
 a referral is involved.
 If not required by this implementation guide, do not send.

TR3 Notes: 1. Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.

TR3 Example: REF*9F*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			9F	Referral Number
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Referral Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - PRIOR AUTHORIZATION

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

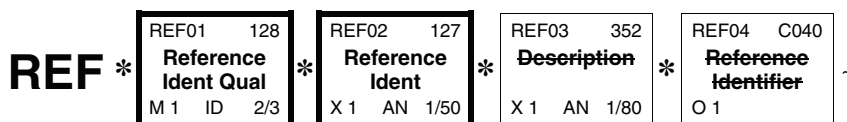
Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required when an authorization number is assigned by the payer or UMO AND the services on this claim were preauthorized. If not required by this implementation guide, do not send.

- TR3 Notes:**
1. Generally, preauthorization numbers are assigned by the payer or 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 prior authorization number carried in this REF is specific to the destination payer reported in the Loop ID-2010BB. If other payers have similar numbers for this claim, report that information in the Loop ID-2330 loop REF which holds that payer's information.
 2. Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.

TR3 Example: REF*G1*13579~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			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 SYNTAX: R0203	X 1 AN 1/50
IMPLEMENTATION NAME: Prior Authorization Number				
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

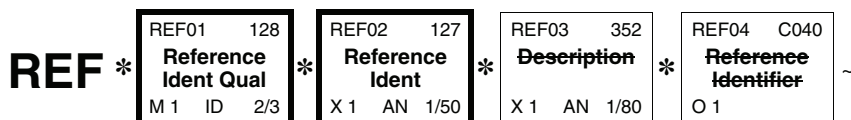
REF - PAYER CLAIM CONTROL NUMBER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when CLM05-3 (Claim Frequency Code) indicates this claim is a replacement or void to a previously adjudicated claim. If not required by this implementation guide, do not send.**TR3 Notes:** 1. This information is specific to the destination payer reported in Loop ID-2010BB.**TR3 Example:** REF*F8*R555588~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Payer Claim Control Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - REPRICED CLAIM NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

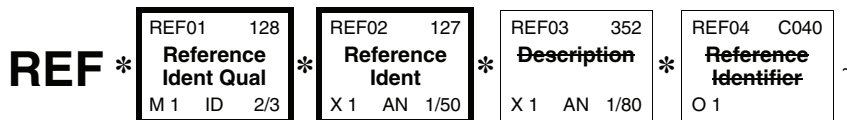
Usage: SITUATIONAL

Situational Rule: Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.

TR3 Notes: 1. This information is specific to the destination payer reported in Loop ID-2010BB.

TR3 Example: REF*9A*RJ5555~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			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 SYNTAX: R0203 IMPLEMENTATION NAME: Repriced Claim Reference Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

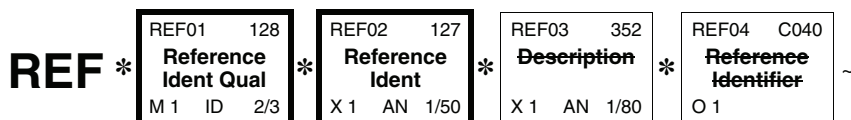
REF - ADJUSTED REPRICED CLAIM NUMBER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.**TR3 Notes:** 1. This information is specific to the destination payer reported in Loop ID-2010BB.**TR3 Example:** REF*9C*RP4444444~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
CODEDEFINITION				
REQUIRED	REF02	127	9C Adjusted Repriced Claim Reference Number Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Adjusted Repriced Claim Reference Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - INVESTIGATIONAL DEVICE EXEMPTION NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION

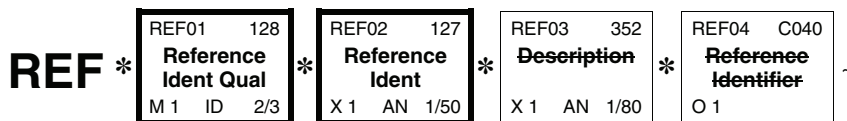
Segment Repeat: 5

Usage: SITUATIONAL

Situational Rule: Required when claim involves a Food and Drug Administration (FDA) assigned investigational device exemption (IDE) number. When more than one IDE applies, they must be split into separate claims. If not required by this implementation guide, do not send.

TR3 Example: REF*LX*432907~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Investigational Device Exemption Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

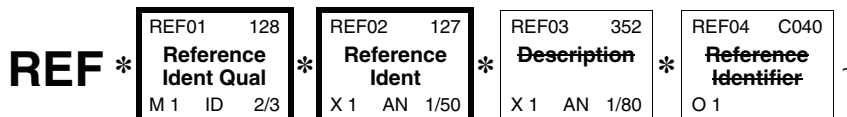
SEGMENT DETAIL

REF - CLAIM IDENTIFIER FOR
TRANSMISSION INTERMEDIARIES**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when this information is deemed necessary by transmission intermediaries (Automated Clearinghouses, and others) who need to attach their own unique claim number. If not required by this implementation guide, do not send.**TR3 Notes:** 1. Although this REF is supplied for transmission intermediaries to attach their own unique claim number to a claim, 837-recipients are not required under HIPAA to return this number in any HIPAA transaction. Trading partners may voluntarily agree to this interaction if they wish.**TR3 Example:** REF*D9*TJ98UU321~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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 SYNTAX: R0203 IMPLEMENTATION NAME: Value Added Network Trace Number The value carried in this element is limited to a maximum of 20 positions.	X 1	AN	1/50
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1		

SEGMENT DETAIL

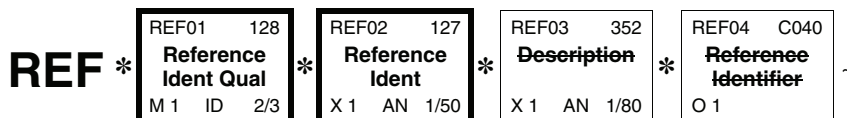
REF - AUTO ACCIDENT STATE

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code named in code source 22. If not required by this implementation guide, do not send.**TR3 Example:** REF*LU*MD~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>LU</td><td>Location Number</td></tr></table>	CODE	DEFINITION	LU	Location Number			
CODE	DEFINITION									
LU	Location Number									
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Auto Accident State or Province Code Values in this field must be valid codes found in code source 22.	X 1	AN	1/50				
NOT USED	REF03	352	Description	X 1	AN	1/80				
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1						

SEGMENT DETAIL

REF - MEDICAL RECORD NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION

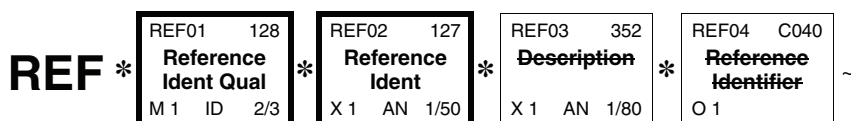
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when the provider needs to identify for future inquiries, the actual medical record of the patient identified in either Loop ID-2010BA or Loop ID-2010CA for this episode of care. If not required by this implementation guide, do not send.

TR3 Example: REF*EA*44444TH56~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Medical Record Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

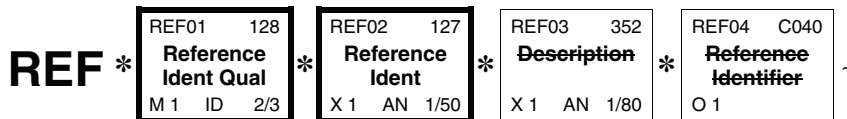
REF - DEMONSTRATION PROJECT IDENTIFIER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when it is necessary to identify claims which are atypical in ways such as content, purpose, and/or payment, as could be the case for a demonstration or other special project, or a clinical trial. If not required by this implementation guide, do not send.**TR3 Example:** REF*P4*THJ1222~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Demonstration Project Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - PEER REVIEW ORGANIZATION (PRO) APPROVAL NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2300 — CLAIM INFORMATION

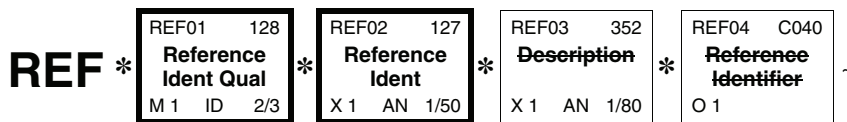
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when an external Peer Review Organization assigns an Approval Number to services deemed medically necessary by that organization. If not required by this implementation guide, do not send.

TR3 Example: REF*G4*284746~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Peer Review Authorization Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

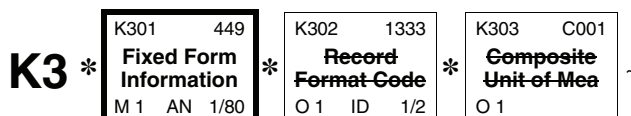
K3 - FILE INFORMATION**X12 Segment Name:** File Information**X12 Purpose:** To transmit a fixed-format record or matrix contents**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 10**Usage:** SITUATIONAL**Situational Rule:** Required when ALL of the following conditions are met:

- A regulatory agency concludes it must use the K3 to meet an emergency legislative requirement;
 - The administering regulatory agency or other state organization has completed each one of the following steps:
 - 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
 - X12N determines that there is no method to meet the requirement.
- If not required by this implementation guide, do not send.

- TR3 Notes:**
1. At the time of publication of this implementation, K3 segments have no specific use. The K3 segment is expected to be used only when necessary to meet the unexpected data requirement of a legislative authority. Before this segment can be used :
 - The X12N Health Care Claim workgroup must conclude there is no other available option in the implementation guide to meet the emergency legislative requirement.
 - The requestor must submit a proposal for approval accompanied by the relevant business documentation to the X12N Health Care Claim workgroup chairs and receive approval for the request.Upon review of the request, X12N will issue an approval or denial decision to the requesting entity. Approved usage(s) of the K3 segment will be reviewed by the X12N Health Care Claim workgroup to develop a permanent change to include the business case in future transaction implementations.
 2. Only when all of the requirements above have been met, may the regulatory agency require the temporary use of the K3 segment.
 3. X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee(s).

TR3 Example: K3*STATE DATA REQUIREMENT~

DIAGRAM



ELEMENT DETAIL

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

SEGMENT DETAIL

NTE - CLAIM NOTE

X12 Segment Name: Note/Special Instruction**X12 Purpose:** To transmit information in a free-form format, if necessary, for comment or special instruction**X12 Comments:** 1. The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processible. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 10**Usage:** SITUATIONAL**Situational Rule:** Required when in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.

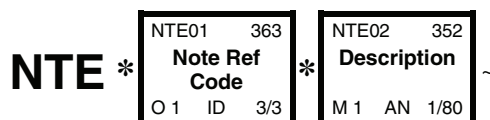
OR

Required when in the judgment of the provider, narrative information from the forms "Home Health Certification and Plan of Treatment" or "Medical Update and Patient Information" is needed to substantiate home health services.

If not required by this implementation guide, do not send.

TR3 Notes: 1. The developers of this implementation guide discourage using narrative information within the 837. Trading partners who use narrative information with claims are strongly encouraged to codify that information within the X12 environment.**TR3 Example:** NTE*NTR*PATIENT REQUIRES TUBE FEEDING~

DIAGRAM



ELEMENT DETAIL

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 1	ID	3/3										
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ALG</td><td>Allergies</td></tr><tr><td>DCP</td><td>Goals, Rehabilitation Potential, or Discharge Plans</td></tr><tr><td>DGN</td><td>Diagnosis Description</td></tr><tr><td>DME</td><td>Durable Medical Equipment (DME) and Supplies</td></tr></table>	CODE	DEFINITION	ALG	Allergies	DCP	Goals, Rehabilitation Potential, or Discharge Plans	DGN	Diagnosis Description	DME	Durable Medical Equipment (DME) and Supplies			
CODE	DEFINITION															
ALG	Allergies															
DCP	Goals, Rehabilitation Potential, or Discharge Plans															
DGN	Diagnosis Description															
DME	Durable Medical Equipment (DME) and Supplies															

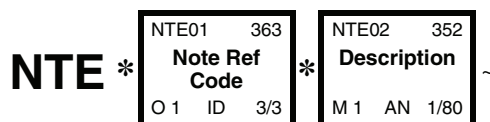
			MED	Medications			
			NTR	Nutritional Requirements			
			ODT	Orders for Disciplines and Treatments			
			RHB	Functional Limitations, Reason Homebound, or Both			
			RLH	Reasons Patient Leaves Home			
			RNH	Times and Reasons Patient Not at Home			
			SET	Unusual Home, Social Environment, or Both			
			SFM	Safety Measures			
			SPT	Supplementary Plan of Treatment			
			UPI	Updated Information			
REQUIRED	NTE02	352	Description		M 1	AN	1/80
			A free-form description to clarify the related data elements and their content				
			IMPLEMENTATION NAME: Claim Note Text				

SEGMENT DETAIL

NTE - BILLING NOTE

X12 Segment Name: Note/Special Instruction**X12 Purpose:** To transmit information in a free-form format, if necessary, for comment or special instruction**X12 Comments:** 1. The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processible. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.
If not required by this implementation guide, do not send.**TR3 Example:** NTE*ADD*NO LIABILITY, PATIENT FELL AT HOME~

DIAGRAM



ELEMENT DETAIL

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 1 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 1 AN 1/80
			IMPLEMENTATION NAME: Billing Note Text	

SEGMENT DETAIL

CRC - EPSDT REFERRAL

X12 Segment Name: Conditions Indicator

X12 Purpose: To supply information on conditions

Loop: 2300 — CLAIM INFORMATION

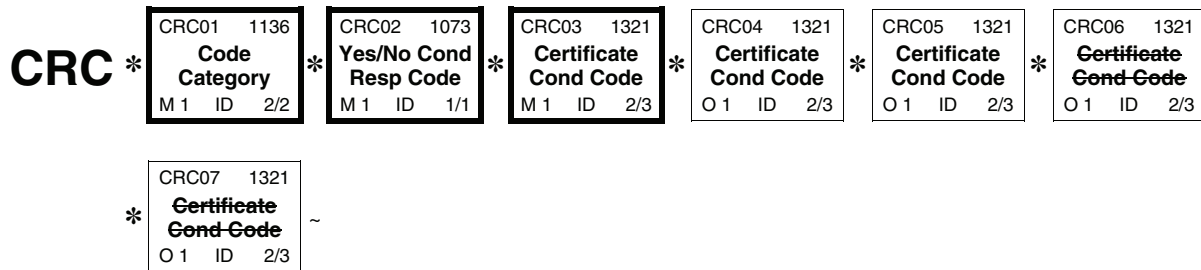
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required on Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) claims when the screening service is being billed in this claim. If not required by this implementation guide, do not send.

TR3 Example: CRC*ZZ*Y*ST~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/2
IMPLEMENTATION NAME: Code Qualifier						
CODE			DEFINITION			
ZZ			Mutually Defined			
EPSDT Screening referral information.						

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

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.

IMPLEMENTATION NAME: Certification Condition Code Applies Indicator

The response answers the question: Was an EPSDT referral given to the patient?

CODE	DEFINITION
N	No
	If no, then choose “NU” in CRC03 indicating no referral given.
Y	Yes

REQUIRED	CRC03	1321	Condition Indicator Code indicating a condition	M 1	ID	2/3

The codes for CRC03 also can be used for CRC04 through CRC05.

CODE	DEFINITION
AV	Available - Not Used
	Patient refused referral.
NU	Not Used
	This conditioner indicator must be used when the submitter answers “N” in CRC02.
S2	Under Treatment
	Patient is currently under treatment for referred diagnostic or corrective health problem.
ST	New Services Requested
	Patient is referred to another provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals). OR Patient is scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service (not including dental referrals).

SITUATIONAL	CRC04	1321	Condition Indicator Code indicating a condition	O 1	ID	2/3

SITUATIONAL RULE: *Required when a second condition code is necessary. If not required by this implementation guide, do not send.*

Use the codes listed in CRC03.

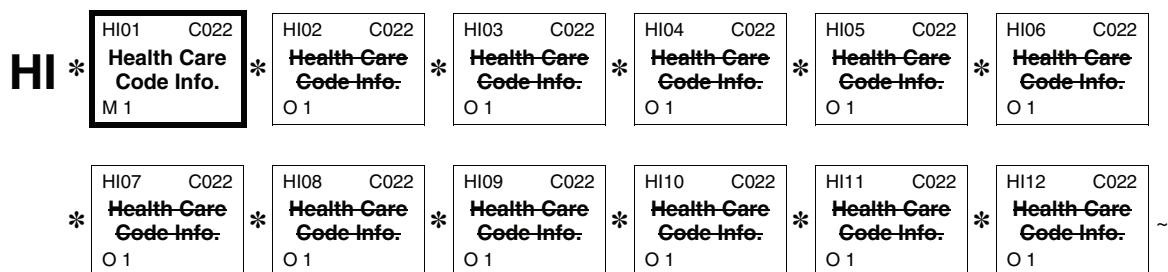
SITUATIONAL	CRC05	1321	Condition Indicator Code indicating a condition	O 1	ID	2/3
SITUATIONAL RULE: <i>Required when a third condition code is necessary. If not required by this implementation guide, do not send.</i>						
Use the codes listed in CRC03.						
NOT USED	CRC06	1321	Condition Indicator	O 1	ID	2/3
NOT USED	CRC07	1321	Condition Indicator	O 1	ID	2/3

SEGMENT DETAIL

HI - PRINCIPAL DIAGNOSIS

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.**TR3 Example:** HI*BK:99761~**TR3 Example:** HI*ABK:T8731~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
To send health care codes and their associated dates, amounts and quantities				
SYNTAX:				
P0304				
If either C02203 or C02204 is present, then the other is required.				
E0809				
Only one of C02208 or C02209 may be present.				
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3
Code identifying a specific industry code list				
SEMANTIC:				
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.				

		CODE	DEFINITION			
		ABK	International Classification of Diseases Clinical Modification (ICD-10-CM) Principal Diagnosis			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
			CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)			
		BK	International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Diagnosis			
			CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI01 - 2	1271	Industry Code	M	AN	1/30
		Code indicating a code from a specific industry code list				
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.				
		IMPLEMENTATION NAME: Principal Diagnosis Code				
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	HI01 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
		Code indicating a Yes or No condition or response				
		SYNTAX: E0809				
		SEMANTIC: C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.				
		COMMENTS: C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.				
		SITUATIONAL RULE: Required as directed by the NUBC billing manual.				
		IMPLEMENTATION NAME: Present on Admission Indicator				
		CODE	DEFINITION			
		N	No			

			U W Y	Unknown Not Applicable Yes	
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION		O 1
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION		O 1

SEGMENT DETAIL

HI - ADMITTING DIAGNOSIS

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

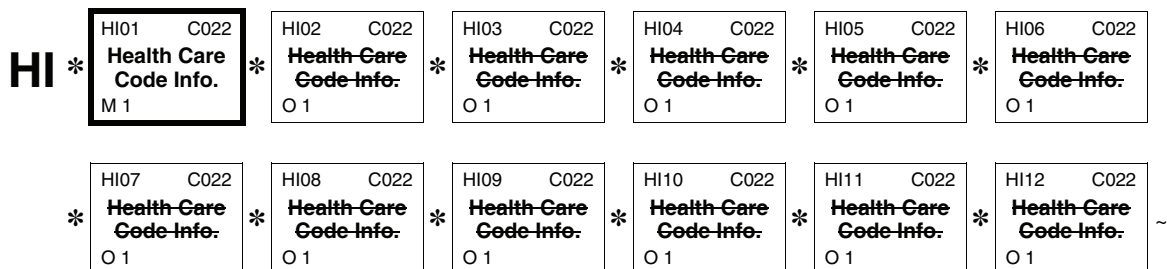
Situational Rule: Required when claim involves an inpatient admission.
If not required by this implementation guide, do not send.

TR3 Notes: 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.

TR3 Example: HI*BJ:99762~

TR3 Example: HI*ABJ:T8741~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
			To send health care codes and their associated dates, amounts and quantities	
			SYNTAX:	
			P0304	
			If either C02203 or C02204 is present, then the other is required.	
			E0809	
			Only one of C02208 or C02209 may be present.	

REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABJ	International Classification of Diseases Clinical Modification (ICD-10-CM) Admitting Diagnosis			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
			CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)			
		BJ	International Classification of Diseases Clinical Modification (ICD-9-CM) Admitting Diagnosis			
			CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: Admitting Diagnosis Code						
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	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	

SEGMENT DETAIL

HI - PATIENT'S REASON FOR VISIT

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

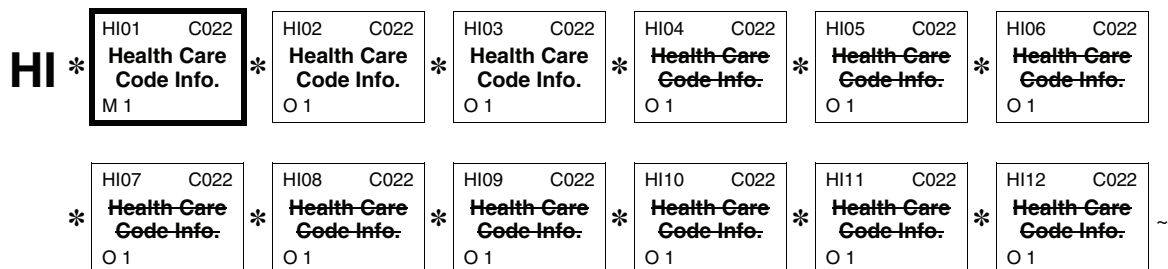
Situational Rule: Required when claim involves outpatient visits. If not required by this implementation guide, do not send.

TR3 Notes: 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.

TR3 Example: HI*PR:78701~

TR3 Example: HI*APR:R110~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
			To send health care codes and their associated dates, amounts and quantities	
			SYNTAX:	
			P0304	
			If either C02203 or C02204 is present, then the other is required.	
			E0809	
			Only one of C02208 or C02209 may be present.	

REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>APR</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>PR</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	APR	International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	PR	International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
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PR	International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Patient Reason For Visit												
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	HI01 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O	1							
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: <i>Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. If not required by this implementation guide, do not send.</i>												

REQUIRED	HI02 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION
APR	International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
	CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
PR	International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit
	CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	HI02 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: Patient Reason For Visit

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
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.			

SITUATIONAL RULE: Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. If not required by this implementation guide, do not send.

REQUIRED	HI03 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3																					
<table><tr><th>CODE</th><th colspan="6">DEFINITION</th></tr><tr><td>APR</td><td colspan="6">International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>PR</td><td colspan="6">International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION						APR	International Classification of Diseases Clinical Modification (ICD-10-CM) Patient's Reason for Visit This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)						PR	International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)					
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PR	International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Visit CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)																										
REQUIRED	HI03 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	M	AN	1/30																					
IMPLEMENTATION NAME: Patient Reason For Visit																											
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	HI03 - 8	1271	Industry Code	X	AN	1/30																					
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1																					
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O	1																						
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O	1																						

SEGMENT DETAIL

HI - EXTERNAL CAUSE OF INJURY

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when an external Cause of Injury is needed to describe an injury, poisoning, or adverse effect. If not required by this implementation guide, do not send.

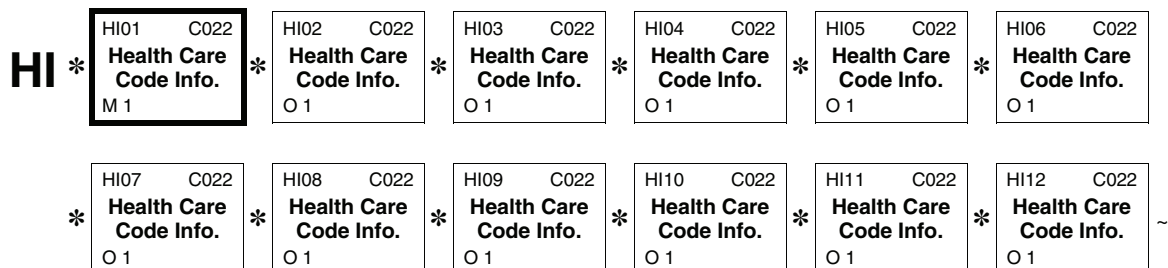
TR3 Notes: 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.

2. In order to fully describe an injury using ICD-10-CM, it will be necessary to report a series of 3 external cause of injury codes.

TR3 Example: HI*BN:E8660~

TR3 Example: HI*ABN:T560X1~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
To send health care codes and their associated dates, amounts and quantities				
SYNTAX:				
P0304				
If either C02203 or C02204 is present, then the other is required.				
E0809				
Only one of C02208 or C02209 may be present.				

REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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	HI01 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI01 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI02** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
			CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes)			
			CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI02 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI02 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI03** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI03 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABN</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>BN</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)											
BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI03 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: External Cause of Injury Code												
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	HI03 - 8	1271	Industry Code	X	AN	1/30						

SITUATIONAL **HI03 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI04** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI04 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI04 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI04 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI05** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABN</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>BN</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)											
BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI05 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: External Cause of Injury Code												
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						
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30						

SITUATIONAL **HI05 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI06** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI06 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI06 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
NOT USED	HI06 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI06 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI06 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI06 - 6	380	Quantity	O	R	1/15
NOT USED	HI06 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI06 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI07** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI07 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI07 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
NOT USED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI07 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI07 - 6	380	Quantity	O	R	1/15
NOT USED	HI07 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI07 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI08** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI08 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABN</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>BN</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)											
BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI08 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: External Cause of Injury Code												
NOT USED	HI08 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3						
NOT USED	HI08 - 4	1251	Date Time Period	X	AN	1/35						
NOT USED	HI08 - 5	782	Monetary Amount	O	R	1/18						
NOT USED	HI08 - 6	380	Quantity	O	R	1/15						
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30						
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30						

SITUATIONAL **HI08 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI09** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI09 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI09 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI09 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI10** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI10 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI10 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI10 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI11** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI11 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI11 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL **HI11 - 9** **1073** **Yes/No Condition or Response Code** **X** **ID** **1/1**
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL **HI12** **C022** **HEALTH CARE CODE INFORMATION** **O 1**
To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when an additional External Cause of Injury must be sent and the preceding HI data elements have been used to report other causes of injury. If not required by this implementation guide, do not send.*

REQUIRED	HI12 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		ABN	International Classification of Diseases Clinical Modification (ICD-10-CM) External Cause of Injury Code			
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.			
		BN	International Classification of Diseases Clinical Modification (ICD-9-CM) External Cause of Injury Code (E-codes) CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI12 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: External Cause of Injury Code						
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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30

SITUATIONAL HI12 - 9 **1073** **Yes/No Condition or Response Code** X ID 1/1
Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

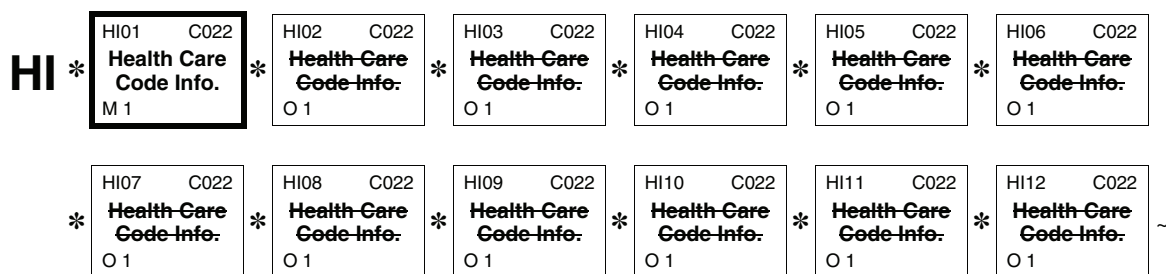
IMPLEMENTATION NAME: Present on Admission Indicator

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SEGMENT DETAIL

**HI - DIAGNOSIS RELATED GROUP (DRG)
INFORMATION****X12 Segment Name:** Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** 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. If not required by this implementation guide, do not send.**TR3 Example:** HI*DR:123~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION		M	1
To send health care codes and their associated dates, amounts and quantities						
SYNTAX:						
P0304						
If either C02203 or C02204 is present, then the other is required.						
E0809						
Only one of C02208 or C02209 may be present.						
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC:						
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
		DR	Diagnosis Related Group (DRG)			
		CODE SOURCE 229: Diagnosis Related Group Number (DRG)				

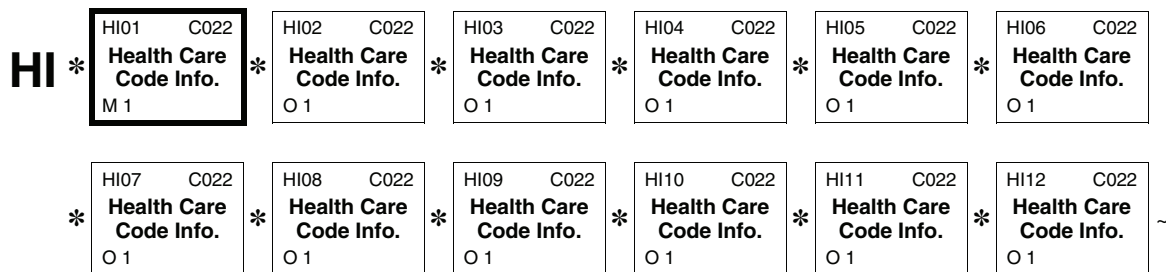
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: Diagnosis Related Group (DRG) Code						
NOT USED	HI01 - 3	1250	Date Time 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	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O	1	
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	

SEGMENT DETAIL

HI - OTHER DIAGNOSIS INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment. If not required by this implementation guide, do not send.**TR3 Notes:** 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.**TR3 Example:** HI*BF:4821:.....N*HI*BF:25000:.....Y~**TR3 Example:** HI*ABF:J151:.....N*ABF:E119:.....Y~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
To send health care codes and their associated dates, amounts and quantities				
SYNTAX:				
P0304				
If either C02203 or C02204 is present, then the other is required.				
E0809				
Only one of C02208 or C02209 may be present.				

REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
	CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis
	CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	HI01 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: Other Diagnosis

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	HI01 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
			Code indicating a Yes or No condition or response			

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: Required as directed by the NUBC billing manual.

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL

HI02

C022

HEALTH CARE CODE INFORMATION**O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:**P0304**

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.*

REQUIRED

HI02 - 1

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.

CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

BF
International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED

HI02 - 2

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

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Other Diagnosis****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
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: ***Required as directed by the NUBC billing manual.***

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

REQUIRED	HI03 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABF</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>BF</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)											
BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI03 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Other Diagnosis												
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	HI03 - 8	1271	Industry Code	X	AN	1/30						
SITUATIONAL	HI03 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	X	ID	1/1						
SYNTAX: E0809												
SEMANTIC: C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.												
COMMENTS: C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.												
SITUATIONAL RULE: Required as directed by the NUBC billing manual.												

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL

HI04

C022

HEALTH CARE CODE INFORMATION

O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.*

REQUIRED

HI04 - 1

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION

ABF International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:

If a new rule names the ICD-10-CM as an allowable code set under HIPAA,

OR

The Secretary grants an exception to use the code set as a pilot project as allowed under the law,

OR

For claims which are not covered under HIPAA.

CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

BF International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED

HI04 - 2

1271 Industry Code M AN 1/30
Code indicating a code from a specific industry code list

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Other Diagnosis****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
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI04 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: ***Required as directed by the NUBC billing manual.***

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

REQUIRED	HI05 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
	CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis
	CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	HI05 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: Other Diagnosis

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
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
			Code indicating a Yes or No condition or response			

SYNTAX:
E0809**SEMANTIC:**
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.**COMMENTS:**
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.**SITUATIONAL RULE: Required as directed by the NUBC billing manual.**

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL

HI06

C022

HEALTH CARE CODE INFORMATION**O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:**P0304**

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.*

REQUIRED

HI06 - 1

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.

CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

BF
International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED

HI06 - 2

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

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Other Diagnosis****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
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: **Required as directed by the NUBC billing manual.**

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION	O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**

REQUIRED	HI07 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3						
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABF</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>BF</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)											
BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI07 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Other Diagnosis	M	AN	1/30						
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						
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30						
SITUATIONAL	HI07 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response SYNTAX: E0809 SEMANTIC: C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not. COMMENTS: C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08. SITUATIONAL RULE: Required as directed by the NUBC billing manual.	X	ID	1/1						

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL

HI08

C022

HEALTH CARE CODE INFORMATION

O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.*

REQUIRED

HI08 - 1

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION

ABF International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:

If a new rule names the ICD-10-CM as an allowable code set under HIPAA,

OR

The Secretary grants an exception to use the code set as a pilot project as allowed under the law,

OR

For claims which are not covered under HIPAA.

CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

BF International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED

HI08 - 2

1271 Industry Code M AN 1/30
Code indicating a code from a specific industry code list

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Other Diagnosis**

NOT USED

HI08 - 3

1250 Date Time Period Format Qualifier X ID 2/3

NOT USED

HI08 - 4

1251 Date Time Period X AN 1/35

NOT USED

HI08 - 5

782 Monetary Amount O R 1/18

NOT USED

HI08 - 6

380 Quantity O R 1/15

NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI08 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: ***Required as directed by the NUBC billing manual.***

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION	O 1
To send health care codes and their associated dates, amounts and quantities				

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: ***Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.***

REQUIRED	HI09 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)
BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED	HI09 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: Other Diagnosis

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
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
			Code indicating a Yes or No condition or response			

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: Required as directed by the NUBC billing manual.

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL

HI10

C022

HEALTH CARE CODE INFORMATION**O 1**

To send health care codes and their associated dates, amounts and quantities

SYNTAX:**P0304**

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.*

REQUIRED

HI10 - 1

1270 Code List Qualifier Code**M****ID****1/3**

Code identifying a specific industry code list

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.

CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

BF
International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED

HI10 - 2

1271 Industry Code**M****AN****1/30**

Code indicating a code from a specific industry code list

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Other Diagnosis****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
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: **Required as directed by the NUBC billing manual.**

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION	O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: **Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.**

REQUIRED	HI11 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ABF</td><td>International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)</td></tr><tr><td>BF</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)	BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
ABF	International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-CM as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)											
BF	International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI11 - 2	1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Other Diagnosis												
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						
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30						
SITUATIONAL	HI11 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	X	ID	1/1						
SYNTAX: E0809												
SEMANTIC: C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.												
COMMENTS: C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.												
SITUATIONAL RULE: Required as directed by the NUBC billing manual.												

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SITUATIONAL

HI12

C022

HEALTH CARE CODE INFORMATION

O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional diagnosis and the preceding HI data elements have been used to report other diagnoses. If not required by this implementation guide, do not send.*

REQUIRED

HI12 - 1

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION

ABF International Classification of Diseases Clinical Modification (ICD-10-CM) Diagnosis

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:

If a new rule names the ICD-10-CM as an allowable code set under HIPAA,

OR

The Secretary grants an exception to use the code set as a pilot project as allowed under the law,

OR

For claims which are not covered under HIPAA.

CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

BF International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis

CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

REQUIRED

HI12 - 2

1271 Industry Code M AN 1/30
Code indicating a code from a specific industry code list

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Other Diagnosis**

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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
SITUATIONAL	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

Code indicating a Yes or No condition or response

SYNTAX:
E0809

SEMANTIC:
C022-09 is used to identify the diagnosis onset as it relates to the diagnosis reported in C022-02. A "Y" indicates that the onset occurred prior to admission to the hospital; an "N" indicates that the onset did NOT occur prior to admission to the hospital; a "U" indicates that it is unknown whether the onset occurred prior to admission to the hospital or not.

COMMENTS:
C022-09 would only need to be reported to data collectors requiring this information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.

SITUATIONAL RULE: *Required as directed by the NUBC billing manual.*

IMPLEMENTATION NAME: **Present on Admission Indicator**

CODE	DEFINITION
N	No
U	Unknown
W	Not Applicable
Y	Yes

SEGMENT DETAIL

HI - PRINCIPAL PROCEDURE INFORMATION

X12 Segment Name: Health Care Information Codes

X12 Purpose: To supply information related to the delivery of health care

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

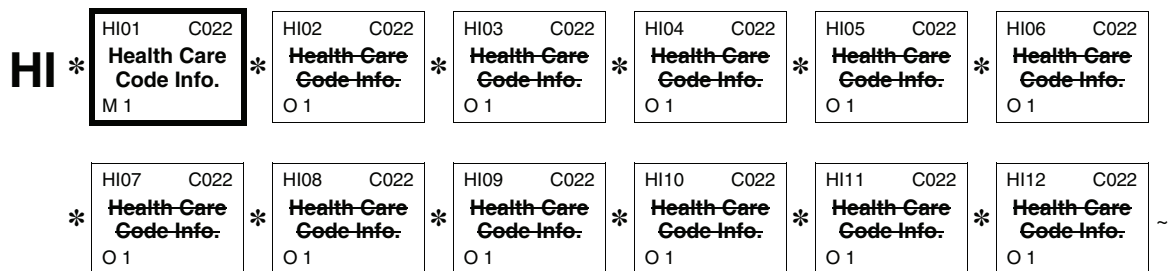
Situational Rule: Required on inpatient claims when a procedure was performed. If not required by this implementation guide, do not send.

TR3 Notes: 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.

TR3 Example: HI*BR:3121:D8:20051119~

TR3 Example: HI*BRR:0B110F5:D8:20050321~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
			To send health care codes and their associated dates, amounts and quantities	
			SYNTAX:	
			P0304	
			If either C02203 or C02204 is present, then the other is required.	
			E0809	
			Only one of C02208 or C02209 may be present.	

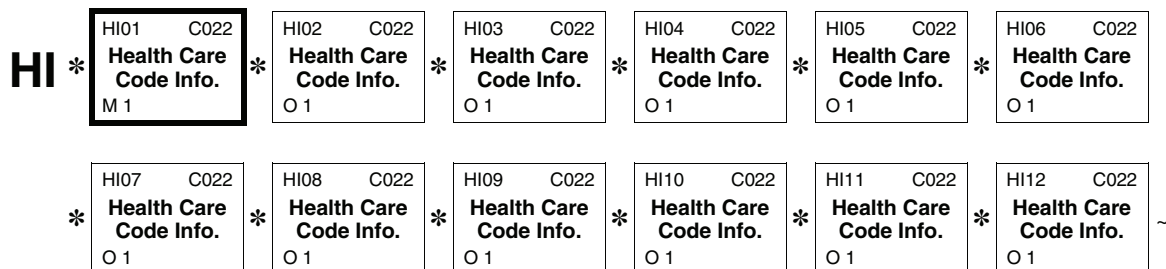
NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	O 1
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	O 1

SEGMENT DETAIL

HI - OTHER PROCEDURE INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required on inpatient claims when additional procedures must be reported. If not required by this implementation guide, do not send.**TR3 Notes:** 1. Do not transmit the decimal point for ICD codes. The decimal point is implied.**TR3 Example:** HI*BQ:3614:D8:20051117*BQ:3723:D8:20051119~**TR3 Example:** HI*BBQ:02139Y3:D8:20050321*BBQ:4A025N8:D8:20050310~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
To send health care codes and their associated dates, amounts and quantities				
SYNTAX:				
P0304				
If either C02203 or C02204 is present, then the other is required.				
E0809				
Only one of C02208 or C02209 may be present.				

REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3
		CODE	DEFINITION			
		BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)			
		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	M	AN	1/30
		IMPLEMENTATION NAME: Procedure Code				
REQUIRED	HI01 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format SYNTAX: P0304 SEMANTIC: C022-03 is the date format that will appear in C022-04.	X	ID	2/3
		CODE	DEFINITION			
		D8	Date Expressed in Format CCYYMMDD			
REQUIRED	HI01 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times SYNTAX: P0304	X	AN	1/35
		IMPLEMENTATION NAME: Procedure Date				
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	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION				O 1	
			To send health care codes and their associated dates, amounts and quantities					
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.					
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>					
REQUIRED	HI02 - 1	1270	Code List Qualifier Code		M	ID	1/3	
		Code identifying a specific industry code list						
		SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION					
		BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes					
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.					
		BQ	CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)					
REQUIRED	HI02 - 2	1271	Industry Code		M	AN	1/30	
		Code indicating a code from a specific industry code list						
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
		IMPLEMENTATION NAME: Procedure Code						
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						
		SYNTAX: P0304						
		SEMANTIC: C022-03 is the date format that will appear in C022-04.						
		CODE	DEFINITION					
		D8	Date Expressed in Format CCYYMMDD					

REQUIRED	HI02 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times SYNTAX: P0304 IMPLEMENTATION NAME: Procedure Date	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						
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present. SITUATIONAL RULE: Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.	O	1							
REQUIRED	HI03 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3						
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BBQ</td><td>International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)</td></tr><tr><td>BQ</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
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BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI03 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Procedure Code	M	AN	1/30						

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										
SYNTAX: P0304										
SEMANTIC: C022-03 is the date format that will appear in C022-04.										
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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										
SYNTAX: P0304										
IMPLEMENTATION NAME: Procedure Date										
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	HI03 - 8	1271	Industry Code	X	AN	1/30				
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1				
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION	O	1					
To send health care codes and their associated dates, amounts and quantities										
SYNTAX: P0304										
If either C02203 or C02204 is present, then the other is required.										
E0809										
Only one of C02208 or C02209 may be present.										
SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>										
REQUIRED	HI04 - 1	1270	Code List Qualifier Code	M	ID	1/3				
Code identifying a specific industry code list										
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BBQ</td><td>International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes</td></tr></table>							CODE	DEFINITION	BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes
CODE	DEFINITION									
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OR										
The Secretary grants an exception to use the code set as a pilot project as allowed under the law,										
OR										
For claims which are not covered under HIPAA.										
CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)										

		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes		
		CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI04 - 2	1271	Industry Code	M AN 1/30	Code indicating a code from a specific industry code list
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
		IMPLEMENTATION NAME: Procedure Code			
REQUIRED	HI04 - 3	1250	Date Time Period Format Qualifier	X ID 2/3	Code indicating the date format, time format, or date and time format
		SYNTAX: P0304			
		SEMANTIC: C022-03 is the date format that will appear in C022-04.			
		CODE	DEFINITION		
		D8	Date Expressed in Format CCYYMMDD		
REQUIRED	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
		SYNTAX: P0304			
		IMPLEMENTATION NAME: Procedure Date			
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	
NOT USED	HI04 - 8	1271	Industry Code	X AN 1/30	
NOT USED	HI04 - 9	1073	Yes/No Condition or Response Code	X ID 1/1	
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O 1	To send health care codes and their associated dates, amounts and quantities
		SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.			
		SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>			

REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3						
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BBQ</td><td>International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)</td></tr><tr><td>BQ</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CODE	DEFINITION											
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BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI05 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Procedure Code	M	AN	1/30						
REQUIRED	HI05 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format SYNTAX: P0304 SEMANTIC: C022-03 is the date format that will appear in C022-04.	X	ID	2/3						
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CODE	DEFINITION											
D8	Date Expressed in Format CCYYMMDD											
1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times SYNTAX: P0304 IMPLEMENTATION NAME: Procedure Date											
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						
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						

SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION				O 1					
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>												
REQUIRED	HI06 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
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REQUIRED	HI06 - 2	1271	Industry Code	M	AN	1/30						
Code indicating a code from a specific industry code list												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Procedure Code												
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												
SYNTAX: P0304												
SEMANTIC: C022-03 is the date format that will appear in C022-04.												
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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 SYNTAX: P0304 IMPLEMENTATION NAME: Procedure Date	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						
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present. SITUATIONAL RULE: Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.	O	1							
REQUIRED	HI07 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3						
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BBQ</td><td>International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)</td></tr><tr><td>BQ</td><td>International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)</td></tr></table>							CODE	DEFINITION	BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)	BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
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BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)											
REQUIRED	HI07 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Procedure Code	M	AN	1/30						

REQUIRED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
			Code indicating the date format, time format, or date and time format			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Procedure Date			
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
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI07 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304			
			If either C02203 or C02204 is present, then the other is required.			
			E0809			
			Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI08 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes			
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			If a new rule names the ICD-10-PCS as an allowable code set under HIPAA,			
			OR			
			The Secretary grants an exception to use the code set as a pilot project as allowed under the law,			
			OR			
			For claims which are not covered under HIPAA.			
			CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)			

		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes		
		CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI08 - 2	1271	Industry Code	M AN 1/30	
		Code indicating a code from a specific industry code list			
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
		IMPLEMENTATION NAME: Procedure Code			
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			
		SYNTAX: P0304			
		SEMANTIC: C022-03 is the date format that will appear in C022-04.			
		CODE	DEFINITION		
		D8	Date Expressed in Format 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			
		SYNTAX: P0304			
		IMPLEMENTATION NAME: Procedure Date			
NOT USED	HI08 - 5	782	Monetary Amount	O R 1/18	
NOT USED	HI08 - 6	380	Quantity	O R 1/15	
NOT USED	HI08 - 7	799	Version Identifier	O AN 1/30	
NOT USED	HI08 - 8	1271	Industry Code	X AN 1/30	
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	X ID 1/1	
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION	O 1	
		To send health care codes and their associated dates, amounts and quantities			
		SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.			
SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>					

REQUIRED	HI09 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3
		CODE	DEFINITION			
		BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)			
		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)			
REQUIRED	HI09 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	M	AN	1/30
		IMPLEMENTATION NAME: Procedure Code				
REQUIRED	HI09 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format SYNTAX: P0304 SEMANTIC: C022-03 is the date format that will appear in C022-04.	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 SYNTAX: P0304	X	AN	1/35
		IMPLEMENTATION NAME: Procedure Date				
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
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION				O 1	
			To send health care codes and their associated dates, amounts and quantities					
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.					
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.</i>					
REQUIRED	HI10 - 1	1270	Code List Qualifier Code		M	ID	1/3	
		Code identifying a specific industry code list						
		SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION					
		BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes					
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.					
			CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)					
		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes					
			CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)					
REQUIRED	HI10 - 2	1271	Industry Code		M	AN	1/30	
		Code indicating a code from a specific industry code list						
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
		IMPLEMENTATION NAME: Procedure Code						
REQUIRED	HI10 - 3	1250	Date Time Period Format Qualifier		X	ID	2/3	
		Code indicating the date format, time format, or date and time format						
		SYNTAX: P0304						
		SEMANTIC: C022-03 is the date format that will appear in C022-04.						
		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 SYNTAX: P0304 IMPLEMENTATION NAME: Procedure Date	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
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.	O	1	

SITUATIONAL RULE: *Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.*

REQUIRED	HI11 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3

CODE	DEFINITION
BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)
BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
1271	Industry Code M AN 1/30 Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Procedure Code

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						
SYNTAX: P0304						
SEMANTIC: C022-03 is the date format that will appear in C022-04.						
		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						
SYNTAX: P0304						
IMPLEMENTATION NAME: Procedure Date						
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
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	
To send health care codes and their associated dates, amounts and quantities						
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.						
SITUATIONAL RULE: Required when it is necessary to report an additional procedure and the preceding HI data elements have been used to report other procedures. If not required by this implementation guide, do not send.						
REQUIRED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
BBQ International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes						
This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.						
CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)						

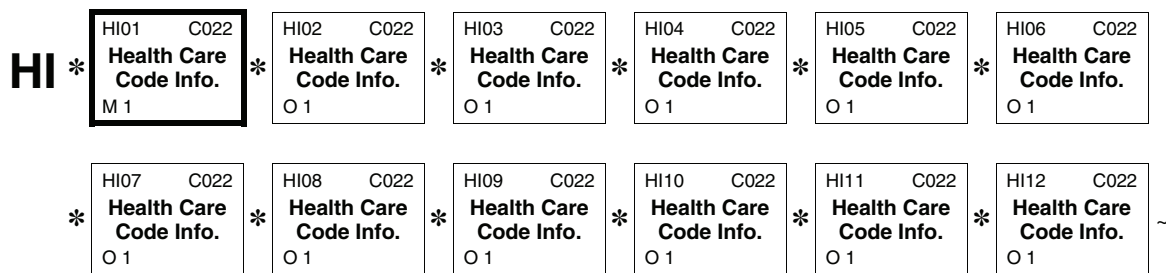
		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes			
		CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)				
REQUIRED	HI12 - 2	1271	Industry Code	M	AN	1/30
		Code indicating a code from a specific industry code list				
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.				
		IMPLEMENTATION NAME: Procedure Code				
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				
		SYNTAX: P0304				
		SEMANTIC: C022-03 is the date format that will appear in C022-04.				
		CODE	DEFINITION			
		D8	Date Expressed in Format CCYYMMDD			
REQUIRED	HI12 - 4	1251	Date Time Period	X	AN	1/35
		Expression of a date, a time, or range of dates, times or dates and times				
		SYNTAX: P0304				
		IMPLEMENTATION NAME: Procedure Date				
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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SEGMENT DETAIL

HI - OCCURRENCE SPAN INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when there is an Occurrence Span Code that applies to this claim. If not required by this implementation guide, do not send.**TR3 Example:** HI*BI:70:RD8:20051202-20051212*BI:74:RD8:20051214-20051216~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1 To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3 Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
		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 SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.
		IMPLEMENTATION NAME: Occurrence Span Code		

REQUIRED HI01 - 3**1250 Date Time Period Format Qualifier** X ID 2/3
Code indicating the date format, time format, or date and time formatSYNTAX:
P0304SEMANTIC:
C022-03 is the date format that will appear in C022-04.

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 timesSYNTAX:
P0304

IMPLEMENTATION NAME: Occurrence Span Code Date

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** HI01 - 8**1271 Industry Code** X AN 1/30**NOT USED** HI01 - 9**1073 Yes/No Condition or Response Code** X ID 1/1**SITUATIONAL** HI02 C022**HEALTH CARE CODE INFORMATION** O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.***REQUIRED** HI02 - 1**1270 Code List Qualifier Code** M ID 1/3
Code identifying a specific industry code listSEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE DEFINITION

BI Occurrence SpanCODE 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 listSEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Occurrence Span Code

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												
SYNTAX: P0304												
SEMANTIC: C022-03 is the date format that will appear in C022-04.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>RD8</td><td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td></tr></table>							CODE	DEFINITION	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		
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												
SYNTAX: P0304												
IMPLEMENTATION NAME: Occurrence Span Code Date												
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						
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O	1							
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304												
If either C02203 or C02204 is present, then the other is required.												
E0809												
Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.												
REQUIRED	HI03 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BI</td><td>Occurrence Span</td></tr><tr><td colspan="2">CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BI	Occurrence Span	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
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												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Occurrence Span Code												

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			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		RD8	Range of Dates Expressed in Format CCYYMMDD-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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Span Code Date			
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	HI03 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304			
			If either C02203 or C02204 is present, then the other is required.			
			E0809			
			Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.			
REQUIRED	HI04 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BI	Occurrence Span			
			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			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Span Code			

REQUIRED	HI04 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
			Code indicating the date format, time format, or date and time format			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD			
REQUIRED	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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Span Code Date			
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
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI04 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.			
REQUIRED	HI05 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BI	Occurrence Span			
			CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	HI05 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Span Code			

REQUIRED	HI05 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
			Code indicating the date format, time format, or date and time format			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		RD8	Range of Dates Expressed in Format CCYYMMDD-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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Span Code Date			
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
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI06 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			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			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Span Code			

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												
SYNTAX: P0304												
SEMANTIC: C022-03 is the date format that will appear in C022-04.												
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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												
SYNTAX: P0304												
IMPLEMENTATION NAME: Occurrence Span Code Date												
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						
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION	O	1							
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304												
If either C02203 or C02204 is present, then the other is required.												
E0809												
Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.</i>												
REQUIRED	HI07 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
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CODE	DEFINITION											
BI	Occurrence Span											
CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes												
REQUIRED	HI07 - 2	1271	Industry Code	M	AN	1/30						
Code indicating a code from a specific industry code list												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Occurrence Span Code												

REQUIRED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3				
Code indicating the date format, time format, or date and time format										
SYNTAX: P0304										
SEMANTIC: C022-03 is the date format that will appear in C022-04.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>RD8</td><td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td></tr></table>							CODE	DEFINITION	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
CODE	DEFINITION									
RD8	Range of Dates Expressed in Format CCYYMMDD-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										
SYNTAX: P0304										
IMPLEMENTATION NAME: Occurrence Span Code Date										
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				
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30				
NOT USED	HI07 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1				
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION	O	1					
To send health care codes and their associated dates, amounts and quantities										
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.										
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.										
REQUIRED	HI08 - 1	1270	Code List Qualifier Code	M	ID	1/3				
Code identifying a specific industry code list										
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.										
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CODE	DEFINITION									
BI	Occurrence Span 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										
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.										
IMPLEMENTATION NAME: Occurrence Span Code										

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												
SYNTAX: P0304												
SEMANTIC: C022-03 is the date format that will appear in C022-04.												
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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												
SYNTAX: P0304												
IMPLEMENTATION NAME: Occurrence Span Code Date												
NOT USED	HI08 - 5	782	Monetary Amount	O	R	1/18						
NOT USED	HI08 - 6	380	Quantity	O	R	1/15						
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30						
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION	O	1							
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304												
If either C02203 or C02204 is present, then the other is required.												
E0809												
Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.</i>												
REQUIRED	HI09 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BI</td><td>Occurrence Span</td></tr><tr><td colspan="2">CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BI	Occurrence Span	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
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												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Occurrence Span Code												

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												
SYNTAX: P0304												
SEMANTIC: C022-03 is the date format that will appear in C022-04.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>RD8</td><td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td></tr></table>							CODE	DEFINITION	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		
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												
SYNTAX: P0304												
IMPLEMENTATION NAME: Occurrence Span Code Date												
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						
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION	O	1							
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.												
REQUIRED	HI10 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BI</td><td>Occurrence Span</td></tr><tr><td colspan="2">CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BI	Occurrence Span	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
CODE	DEFINITION											
BI	Occurrence Span											
CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes												
REQUIRED	HI10 - 2	1271	Industry Code	M	AN	1/30						
Code indicating a code from a specific industry code list												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Occurrence Span Code												

REQUIRED	HI10 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3						
Code indicating the date format, time format, or date and time format												
SYNTAX: P0304												
SEMANTIC: C022-03 is the date format that will appear in C022-04.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>RD8</td><td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td></tr></table>							CODE	DEFINITION	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD		
CODE	DEFINITION											
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD											
REQUIRED	HI10 - 4	1251	Date Time Period	X	AN	1/35						
Expression of a date, a time, or range of dates, times or dates and times												
SYNTAX: P0304												
IMPLEMENTATION NAME: Occurrence Span Code Date												
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						
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION	O	1							
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304												
If either C02203 or C02204 is present, then the other is required.												
E0809												
Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.												
REQUIRED	HI11 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BI</td><td>Occurrence Span</td></tr><tr><td colspan="2">CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BI	Occurrence Span	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
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												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Occurrence Span Code												

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			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Span Code Date			
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
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BI	Occurrence Span			
			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			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Span Code			

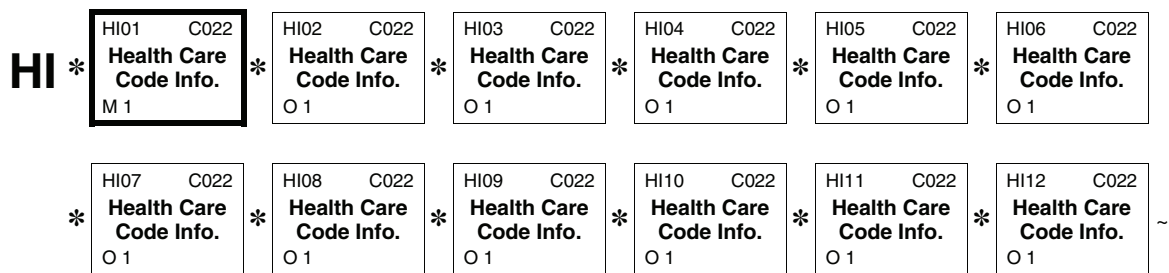
REQUIRED	HI12 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
Code indicating the date format, time format, or date and time format						
SYNTAX: P0304						
SEMANTIC: C022-03 is the date format that will appear in C022-04.						
		CODE	DEFINITION			
		RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD			
REQUIRED	HI12 - 4	1251	Date Time Period	X	AN	1/35
Expression of a date, a time, or range of dates, times or dates and times						
SYNTAX: P0304						
IMPLEMENTATION NAME: Occurrence Span Code Date						
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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SEGMENT DETAIL

HI - OCCURRENCE INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when there is a Occurrence Code that applies to this claim. If not required by this implementation guide, do not send.**TR3 Example:** HI*BH:42:D8:20051208*BH:A3:D8:20051203~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1 To send health care codes and their associated dates, amounts and quantities
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.				
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3 Code identifying a specific industry code list
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.				
		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
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.				
IMPLEMENTATION NAME: Occurrence Code				

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								
SYNTAX: P0304								
SEMANTIC: C022-03 is the date format that will appear in C022-04.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SYNTAX: P0304								
IMPLEMENTATION NAME: Occurrence Code Date								
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	HI01 - 8	1271	Industry Code	X	AN	1/30		
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1		
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION	O	1			
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304								
If either C02203 or C02204 is present, then the other is required.								
E0809								
Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.								
REQUIRED	HI02 - 1	1270	Code List Qualifier Code	M	ID	1/3		
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Occurrence Code								

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			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Code Date			
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
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304			
			If either C02203 or C02204 is present, then the other is required.			
			E0809			
			Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI03 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			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			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Code			

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								
SYNTAX: P0304								
SEMANTIC: C022-03 is the date format that will appear in C022-04.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SYNTAX: P0304								
IMPLEMENTATION NAME: Occurrence Code Date								
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	HI03 - 8	1271	Industry Code	X	AN	1/30		
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1		
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION	O	1			
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.								
REQUIRED	HI04 - 1	1270	Code List Qualifier Code	M	ID	1/3		
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Occurrence Code								

REQUIRED	HI04 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
			Code indicating the date format, time format, or date and time format			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		D8	Date Expressed in Format CCYYMMDD			
REQUIRED	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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Code Date			
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
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI04 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304			
			If either C02203 or C02204 is present, then the other is required.			
			E0809			
			Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI05 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BH	Occurrence			
			CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	HI05 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Code			

REQUIRED	HI05 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3		
Code indicating the date format, time format, or date and time format								
SYNTAX: P0304								
SEMANTIC: C022-03 is the date format that will appear in C022-04.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SYNTAX: P0304								
IMPLEMENTATION NAME: Occurrence Code Date								
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		
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30		
NOT USED	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1		
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION	O	1			
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.								
REQUIRED	HI06 - 1	1270	Code List Qualifier Code	M	ID	1/3		
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Occurrence Code								

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			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		D8	Date Expressed in Format 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			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Code Date			
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
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304			
			If either C02203 or C02204 is present, then the other is required.			
			E0809			
			Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI07 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BH	Occurrence			
			CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	HI07 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Code			

REQUIRED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3		
Code indicating the date format, time format, or date and time format								
SYNTAX: P0304								
SEMANTIC: C022-03 is the date format that will appear in C022-04.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SYNTAX: P0304								
IMPLEMENTATION NAME: Occurrence Code Date								
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		
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30		
NOT USED	HI07 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1		
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION	O	1			
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.								
REQUIRED	HI08 - 1	1270	Code List Qualifier Code	M	ID	1/3		
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Occurrence Code								

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						
SYNTAX: P0304						
SEMANTIC: C022-03 is the date format that will appear in C022-04.						
		CODE	DEFINITION			
D8						
Date Expressed in Format 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						
SYNTAX: P0304						
IMPLEMENTATION NAME: Occurrence Code Date						
NOT USED	HI08 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI08 - 6	380	Quantity	O	R	1/15
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION	O	1	
To send health care codes and their associated dates, amounts and quantities						
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.						
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.						
REQUIRED	HI09 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		CODE	DEFINITION			
BH						
Occurrence						
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						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						
IMPLEMENTATION NAME: Occurrence Code						

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								
SYNTAX: P0304								
SEMANTIC: C022-03 is the date format that will appear in C022-04.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
CODE	DEFINITION							
D8 Date Expressed in Format 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								
SYNTAX: P0304								
IMPLEMENTATION NAME: Occurrence Code Date								
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		
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30		
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1		
SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION	O	1			
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.								
REQUIRED	HI10 - 1	1270	Code List Qualifier Code	M	ID	1/3		
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
CODE	DEFINITION							
BH Occurrence								
CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes								
REQUIRED	HI10 - 2	1271	Industry Code	M	AN	1/30		
Code indicating a code from a specific industry code list								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Occurrence Code								

REQUIRED	HI10 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
			Code indicating the date format, time format, or date and time format			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		D8	Date Expressed in Format CCYYMMDD			
REQUIRED	HI10 - 4	1251	Date Time Period	X	AN	1/35
			Expression of a date, a time, or range of dates, times or dates and times			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Code Date			
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
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION	O	1	
			To send health care codes and their associated dates, amounts and quantities			
			SYNTAX: P0304			
			If either C02203 or C02204 is present, then the other is required.			
			E0809			
			Only one of C02208 or C02209 may be present.			
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.</i>			
REQUIRED	HI11 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
			CODE	DEFINITION		
		BH	Occurrence			
			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			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Occurrence Code			

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								
SYNTAX: P0304								
SEMANTIC: C022-03 is the date format that will appear in C022-04.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SYNTAX: P0304								
IMPLEMENTATION NAME: Occurrence Code Date								
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		
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30		
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1		
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	O	1			
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: Required when it is necessary to report an additional occurrence code and the preceding HI data elements have been used to report other occurrence codes. If not required by this implementation guide, do not send.								
REQUIRED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3		
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr></table>							CODE	DEFINITION
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								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Occurrence Code								

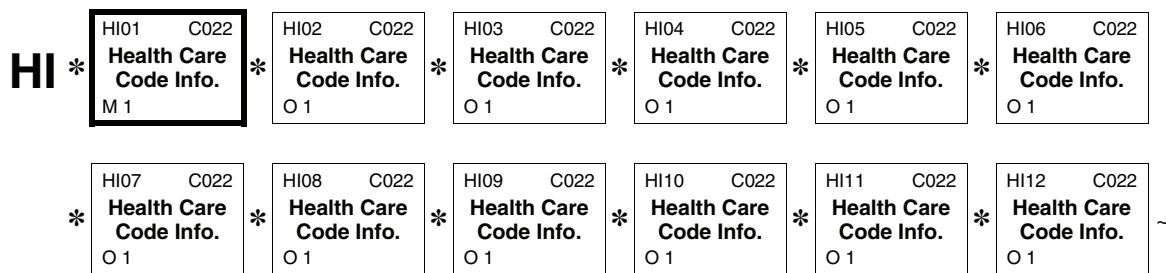
REQUIRED	HI12 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
			Code indicating the date format, time format, or date and time format			
			SYNTAX: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C022-04.			
			CODE	DEFINITION		
		D8	Date Expressed in Format CCYYMMDD			
REQUIRED	HI12 - 4	1251	Date Time Period	X	AN	1/35
			Expression of a date, a time, or range of dates, times or dates and times			
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Occurrence Code Date			
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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SEGMENT DETAIL

HI - VALUE INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when there is a Value Code that applies to this claim. If not required by this implementation guide, do not send.**TR3 Example:** HI*BE:08::1740*BE:A7::940~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES				
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1 To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.				
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3 Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.				
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>BE</td><td>Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></tbody></table>	CODE	DEFINITION	BE	Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
CODE	DEFINITION							
BE	Value 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 SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.				
			IMPLEMENTATION NAME: Value Code					

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

IMPLEMENTATION NAME: Value Code Amount

NOT USED	HI01 - 6	380	Quantity	O	R	1/15
NOT USED	HI01 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL HI02 C022

HEALTH CARE CODE INFORMATION

O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE DEFINITION

BE ValueCODE 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			

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Value Code

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

IMPLEMENTATION NAME: Value Code Amount

NOT USED	HI02 - 6	380	Quantity	O	R	1/15
NOT USED	HI02 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O 1				
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: <i>Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.</i>								
REQUIRED	HI03 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M ID 1/3				
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BE</td><td>Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>					CODE	DEFINITION	BE	Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
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				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Value Code								
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				
IMPLEMENTATION NAME: Value Code Amount								
NOT USED	HI03 - 6	380	Quantity	O R 1/15				
NOT USED	HI03 - 7	799	Version Identifier	O AN 1/30				
NOT USED	HI03 - 8	1271	Industry Code	X AN 1/30				
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X ID 1/1				
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION	O 1				
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: <i>Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.</i>								

REQUIRED	HI04 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION

BE	Value

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			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: **Value Code**

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	O	R	1/18
			Monetary amount			

IMPLEMENTATION NAME: **Value Code Amount**

NOT USED	HI04 - 6	380	Quantity	O	R	1/15
NOT USED	HI04 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI04 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

REQUIRED	HI05 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

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				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.										
IMPLEMENTATION NAME: Value Code										
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				
IMPLEMENTATION NAME: Value Code Amount										
NOT USED	HI05 - 6	380	Quantity	O	R	1/15				
NOT USED	HI05 - 7	799	Version Identifier	O	AN	1/30				
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30				
NOT USED	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1				
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O	1					
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.										
SITUATIONAL RULE: Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.										
REQUIRED	HI06 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3				
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BE</td><td>Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BE	Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
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				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.										
IMPLEMENTATION NAME: Value Code										
NOT USED	HI06 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3				
NOT USED	HI06 - 4	1251	Date Time Period	X	AN	1/35				
REQUIRED	HI06 - 5	782	Monetary Amount Monetary amount	O	R	1/18				
IMPLEMENTATION NAME: Value Code Amount										
NOT USED	HI06 - 6	380	Quantity	O	R	1/15				

NOT USED	HI06 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

REQUIRED	HI07 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC:			
			C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE DEFINITION

BE **Value**
CODE SOURCE 132: National Uniform Billing Committee (NUBC)
Codes

REQUIRED	HI07 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC:			
			If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: Value Code

NOT USED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07 - 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI07 - 5	782	Monetary Amount	O	R	1/18
			Monetary amount			

IMPLEMENTATION NAME: Value Code Amount

NOT USED	HI07 - 6	380	Quantity	O	R	1/15
NOT USED	HI07 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI07 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

REQUIRED	HI08 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3				
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BE</td><td>Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BE	Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
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				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.										
IMPLEMENTATION NAME: Value Code										
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				
IMPLEMENTATION NAME: Value Code Amount										
NOT USED	HI08 - 6	380	Quantity	O	R	1/15				
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30				
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30				
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1				
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O	1					
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.										
SITUATIONAL RULE: Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.										

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

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Value Code

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	O	R	1/18
			Monetary amount			

IMPLEMENTATION NAME: Value Code Amount

NOT USED	HI09 - 6	380	Quantity	O	R	1/15

NOT USED	HI09 - 7	799	Version Identifier	O	AN	1/30

NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30

NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION	O 1		
			To send health care codes and their associated dates, amounts and quantities			

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

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

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION

BE	Value
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

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

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Value Code

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	O	R	1/18
			Monetary amount			

IMPLEMENTATION NAME: Value Code Amount

NOT USED	HI10 - 6	380	Quantity	O	R	1/15

NOT USED	HI10 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

REQUIRED	HI11 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC:						
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						

CODE	DEFINITION

BE	Value
	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						
SEMANTIC:						
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						

IMPLEMENTATION NAME: Value Code

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	O	R	1/18
Monetary amount						

IMPLEMENTATION NAME: Value Code Amount

NOT USED	HI11 - 6	380	Quantity	O	R	1/15
NOT USED	HI11 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional value code and the preceding HI data elements have been used to report other value codes. If not required by this implementation guide, do not send.*

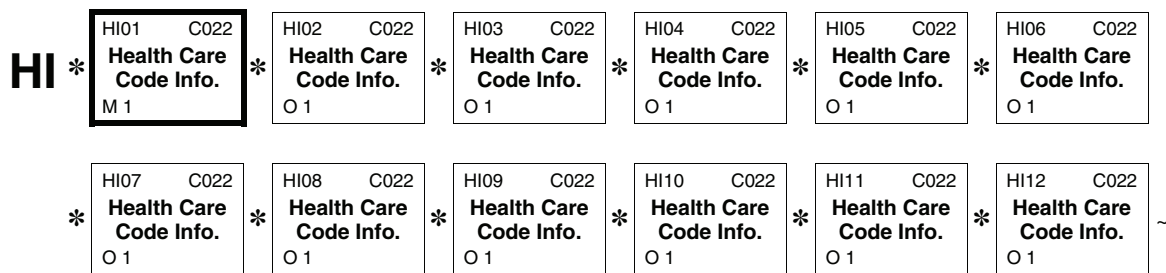
REQUIRED	HI12 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BE</td><td>Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BE	Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
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 SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	M	AN	1/30				
IMPLEMENTATION NAME: Value Code										
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	O	R	1/18				
IMPLEMENTATION NAME: Value Code Amount										
NOT USED	HI12 - 6	380	Quantity	O	R	1/15				
NOT USED	HI12 - 7	799	Version Identifier	O	AN	1/30				
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30				
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1				

SEGMENT DETAIL

HI - CONDITION INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when there is a Condition Code that applies to this claim. If not required by this implementation guide, do not send.**TR3 Example:** HI*BG:17*BG:67~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1 To send health care codes and their associated dates, amounts and quantities SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3 Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
		CODE	DEFINITION	
		BG	Condition 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 SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.
		IMPLEMENTATION NAME: Condition Code		

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	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.*

REQUIRED	HI02 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC:			
			C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE DEFINITION

BG**Condition**

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			
			SEMANTIC:			
			If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: **Condition Code**

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
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION	O 1				
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: <i>Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.</i>								
REQUIRED	HI03 - 1	1270	Code List Qualifier Code	M ID 1/3				
Code identifying a specific industry code list								
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BG</td><td>Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>					CODE	DEFINITION	BG	Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
CODE	DEFINITION							
BG	Condition 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								
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.								
IMPLEMENTATION NAME: Condition Code								
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	HI03 - 8	1271	Industry Code	X AN 1/30				
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X ID 1/1				
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION	O 1				
To send health care codes and their associated dates, amounts and quantities								
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.								
SITUATIONAL RULE: <i>Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.</i>								

REQUIRED	HI04 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						

CODE	DEFINITION

BG ConditionCODE 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						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						

IMPLEMENTATION NAME: **Condition Code**

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
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI04 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O 1	To send health care codes and their associated dates, amounts and quantities	

SYNTAX:
P0304
 If either C02203 or C02204 is present, then the other is required.
E0809
 Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.*

REQUIRED	HI05 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						

CODE	DEFINITION

BG ConditionCODE SOURCE 132: National Uniform Billing Committee (NUBC)
Codes

CODE SOURCE 641: Condition Code List

REQUIRED	HI05 - 2	1271	Industry Code	M	AN	1/30
Code indicating a code from a specific industry code list						
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.						

IMPLEMENTATION NAME: **Condition Code**

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
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL HI06 C022 **HEALTH CARE CODE INFORMATION** O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.*

REQUIRED	HI06 - 1	1270	Code List Qualifier Code	M	ID	1/3

Code identifying a specific industry code list

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION

BG **Condition**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

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Condition Code**

NOT USED	HI06 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI06 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI06 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI06 - 6	380	Quantity	O	R	1/15
NOT USED	HI06 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION				O 1					
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.												
REQUIRED	HI07 - 1	1270	Code List Qualifier Code	M	ID	1/3						
Code identifying a specific industry code list												
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BG</td><td>Condition</td></tr><tr><td colspan="2">CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BG	Condition	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes	
CODE	DEFINITION											
BG	Condition											
CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes												
REQUIRED	HI07 - 2	1271	Industry Code	M	AN	1/30						
Code indicating a code from a specific industry code list												
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.												
IMPLEMENTATION NAME: Condition Code												
NOT USED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3						
NOT USED	HI07 - 4	1251	Date Time Period	X	AN	1/35						
NOT USED	HI07 - 5	782	Monetary Amount	O	R	1/18						
NOT USED	HI07 - 6	380	Quantity	O	R	1/15						
NOT USED	HI07 - 7	799	Version Identifier	O	AN	1/30						
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30						
NOT USED	HI07 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1						
SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION				O 1					
To send health care codes and their associated dates, amounts and quantities												
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.												
SITUATIONAL RULE: Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.												

REQUIRED	HI08 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3				
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BG</td><td>Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BG	Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
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				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.										
IMPLEMENTATION NAME: Condition Code										
NOT USED	HI08 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3				
NOT USED	HI08 - 4	1251	Date Time Period	X	AN	1/35				
NOT USED	HI08 - 5	782	Monetary Amount	O	R	1/18				
NOT USED	HI08 - 6	380	Quantity	O	R	1/15				
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30				
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30				
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1				
SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O	1					
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.										
SITUATIONAL RULE: Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.										
REQUIRED	HI09 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3				
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.										
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>BG</td><td>Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes</td></tr></table>							CODE	DEFINITION	BG	Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
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				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.										
IMPLEMENTATION NAME: Condition Code										
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
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION	O	1	
To send health care codes and their associated dates, amounts and quantities						

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.*

REQUIRED	HI10 - 1	1270	Code List Qualifier Code	M	ID	1/3
Code identifying a specific industry code list						
SEMANTIC:						
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						

CODE	DEFINITION

BG	Condition				
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes				
1271	Industry Code	M	AN	1/30	
	Code indicating a code from a specific industry code list				
	SEMANTIC:				
	If C022-08 is used, then C022-02 represents the beginning value in a range of codes.				

IMPLEMENTATION NAME: **Condition Code**

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
NOT USED	HI10 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI10 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI11	C022	HEALTH CARE CODE INFORMATION	O 1
To send health care codes and their associated dates, amounts and quantities				
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.				
SITUATIONAL RULE: <i>Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.</i>				
REQUIRED	HI11 - 1	1270	Code List Qualifier Code	M ID 1/3
		Code identifying a specific industry code list		
		SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.		
		CODE	DEFINITION	
		BG	Condition	
		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		
		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.		
		IMPLEMENTATION NAME: Condition Code		
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
NOT USED	HI11 - 8	1271	Industry Code	X AN 1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X ID 1/1
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	O 1
To send health care codes and their associated dates, amounts and quantities				
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.				
SITUATIONAL RULE: <i>Required when it is necessary to report an additional condition code and the preceding HI data elements have been used to report other condition codes. If not required by this implementation guide, do not send.</i>				

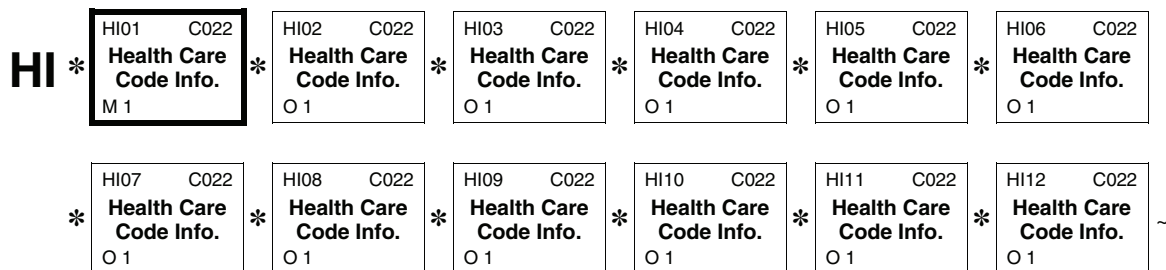
REQUIRED	HI12 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	M	ID	1/3
		CODE	DEFINITION			
		BG	Condition CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	HI12 - 2	1271	Industry Code Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	M	AN	1/30
IMPLEMENTATION NAME: Condition Code						
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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SEGMENT DETAIL

HI - TREATMENT CODE INFORMATION

X12 Segment Name: Health Care Information Codes**X12 Purpose:** To supply information related to the delivery of health care**Loop:** 2300 — CLAIM INFORMATION**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when Home Health Agencies need to report Plan of Treatment information under various payer contracts. If not required by this implementation guide, do not send.**TR3 Example:** HI*TC:A01~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	HI01	C022	HEALTH CARE CODE INFORMATION	M 1
			To send health care codes and their associated dates, amounts and quantities	
			SYNTAX:	
			P0304	
			If either C02203 or C02204 is present, then the other is required.	
			E0809	
			Only one of C02208 or C02209 may be present.	
REQUIRED	HI01 - 1	1270	Code List Qualifier Code	M ID 1/3
			Code identifying a specific industry code list	
			SEMANTIC:	
			C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.	
			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
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Treatment Code			
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	HI01 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI02	C022	HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amounts and quantities	O	1	

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	M	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

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
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			
			IMPLEMENTATION NAME: Treatment Code			
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
NOT USED	HI02 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI03	C022	HEALTH CARE CODE INFORMATION			O 1														
To send health care codes and their associated dates, amounts and quantities																				
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.																				
SITUATIONAL RULE: <i>Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.</i>																				
REQUIRED	HI03 - 1	1270	Code List Qualifier Code	M	ID	1/3														
Code identifying a specific industry code list																				
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.																				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>TC</td><td>Treatment Codes</td></tr><tr><td colspan="2">CODE SOURCE 359: Treatment Codes</td></tr><tr><td>1271</td><td>Industry Code</td></tr><tr><td colspan="2">Code indicating a code from a specific industry code list</td></tr><tr><td colspan="2">SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.</td></tr><tr><td colspan="2">IMPLEMENTATION NAME: Treatment Code</td></tr></table>							CODE	DEFINITION	TC	Treatment Codes	CODE SOURCE 359: Treatment Codes		1271	Industry Code	Code indicating a code from a specific industry code list		SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.		IMPLEMENTATION NAME: Treatment Code	
CODE	DEFINITION																			
TC	Treatment Codes																			
CODE SOURCE 359: Treatment Codes																				
1271	Industry Code																			
Code indicating a code from a specific industry code list																				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.																				
IMPLEMENTATION NAME: Treatment Code																				
REQUIRED	HI03 - 2	1271	Industry Code	M	AN	1/30														
Code indicating a code from a specific industry code list																				
SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.																				
IMPLEMENTATION NAME: Treatment Code																				
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	HI03 - 8	1271	Industry Code	X	AN	1/30														
NOT USED	HI03 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1														
SITUATIONAL	HI04	C022	HEALTH CARE CODE INFORMATION			O 1														
To send health care codes and their associated dates, amounts and quantities																				
SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.																				
SITUATIONAL RULE: <i>Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.</i>																				

REQUIRED	HI04 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

REQUIRED	HI04 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: **Treatment Code**

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
NOT USED	HI04 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI04 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI05	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:**P0304**

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED	HI05 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

REQUIRED	HI05 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: **Treatment Code**

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
NOT USED	HI05 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI05 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI06	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED	HI06 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC:			
			C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

REQUIRED	HI06 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			
			SEMANTIC:			
			If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: **Treatment Code**

NOT USED	HI06 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI06 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI06 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI06 - 6	380	Quantity	O	R	1/15
NOT USED	HI06 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI06 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI06 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI07	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED	HI07 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

REQUIRED	HI07 - 2	1271	Industry Code	M	AN	1/30
			Code indicating a code from a specific industry code list			

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Treatment Code**

NOT USED	HI07 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI07 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI07 - 5	782	Monetary Amount	O	R	1/18
NOT USED	HI07 - 6	380	Quantity	O	R	1/15
NOT USED	HI07 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI07 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI07 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI08	C022	HEALTH CARE CODE INFORMATION	O 1		
			To send health care codes and their associated dates, amounts and quantities			

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED	HI08 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

CODE	DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

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

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: **Treatment Code**

NOT USED	HI08 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI08 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI08 - 5	782	Monetary Amount	O	R	1/18

NOT USED	HI08 - 6	380	Quantity	O	R	1/15
NOT USED	HI08 - 7	799	Version Identifier	O	AN	1/30
NOT USED	HI08 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI09	C022	HEALTH CARE CODE INFORMATION	O	1	
To send health care codes and their associated dates, amounts and quantities						

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

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

SEMANTIC:

C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE	DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

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

SEMANTIC:

If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Treatment Code

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
NOT USED	HI09 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SITUATIONAL	HI10	C022	HEALTH CARE CODE INFORMATION	O	1	
To send health care codes and their associated dates, amounts and quantities						

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED HI10 - 1

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

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

REQUIRED HI10 - 2

1271 Industry Code M AN 1/30
Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Treatment Code

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

NOT USED HI10 - 8

1271 Industry Code X AN 1/30

NOT USED HI10 - 9

1073 Yes/No Condition or Response Code X ID 1/1

SITUATIONAL HI11

C022

HEALTH CARE CODE INFORMATION O 1

To send health care codes and their associated dates, amounts and quantities

SYNTAX:
P0304
If either C02203 or C02204 is present, then the other is required.
E0809
Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED HI11 - 1

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

SEMANTIC:
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.

CODE DEFINITION

TC Treatment Codes

CODE SOURCE 359: Treatment Codes

REQUIRED HI11 - 2

1271 Industry Code M AN 1/30
Code indicating a code from a specific industry code list

SEMANTIC:
If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Treatment Code

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
NOT USED	HI11 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
SITUATIONAL	HI12	C022	HEALTH CARE CODE INFORMATION	O	1	

To send health care codes and their associated dates, amounts and quantities

SYNTAX:

P0304

If either C02203 or C02204 is present, then the other is required.

E0809

Only one of C02208 or C02209 may be present.

SITUATIONAL RULE: *Required when it is necessary to report an additional treatment code and the preceding HI data elements have been used to report other treatment codes. If not required by this implementation guide, do not send.*

REQUIRED	HI12 - 1	1270	Code List Qualifier Code	M	ID	1/3
			Code identifying a specific industry code list			
			SEMANTIC:			
			C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			

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			
			SEMANTIC:			
			If C022-08 is used, then C022-02 represents the beginning value in a range of codes.			

IMPLEMENTATION NAME: Treatment Code

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
NOT USED	HI12 - 8	1271	Industry Code	X	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1

SEGMENT DETAIL

HCP - CLAIM PRICING/REPRICING INFORMATION

X12 Segment Name: Health Care Pricing

X12 Purpose: To specify pricing or repricing information about a health care claim or line item

X12 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.

Loop: 2300 — CLAIM INFORMATION

Segment Repeat: 1

Usage: SITUATIONAL

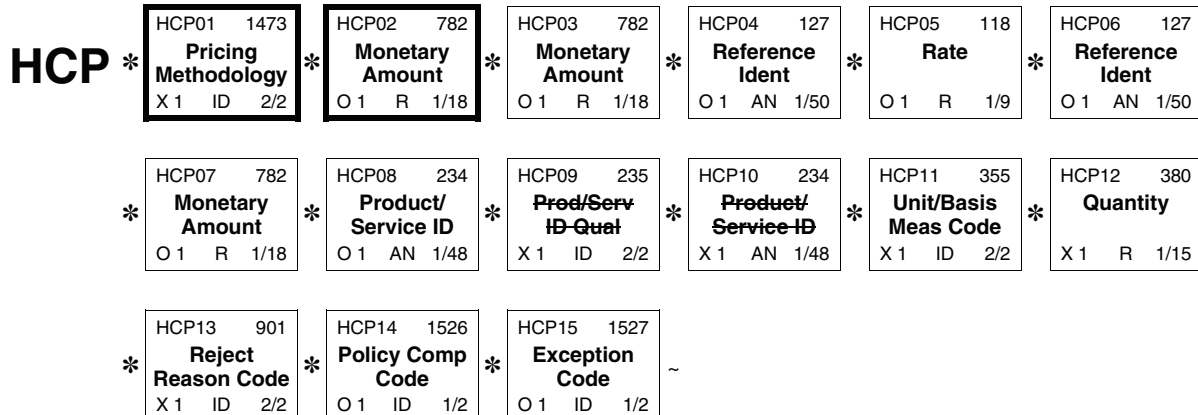
Situational Rule: Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.

TR3 Notes: 1. This information is specific to the destination payer reported in Loop ID-2010BB.

2. For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.

TR3 Example: HCP*03*100*10*RPO12345~

DIAGRAM



ELEMENT DETAIL

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 SYNTAX: R0113 Specific code use is determined by Trading Partner Agreement due to the variances in contracting policies in the industry.	X 1	ID	2/2																																
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>00</td><td>Zero Pricing (Not Covered Under Contract)</td></tr><tr><td>01</td><td>Priced as Billed at 100%</td></tr><tr><td>02</td><td>Priced at the Standard Fee Schedule</td></tr><tr><td>03</td><td>Priced at a Contractual Percentage</td></tr><tr><td>04</td><td>Bundled Pricing</td></tr><tr><td>05</td><td>Peer Review Pricing</td></tr><tr><td>06</td><td>Per Diem Pricing</td></tr><tr><td>07</td><td>Flat Rate Pricing</td></tr><tr><td>08</td><td>Combination Pricing</td></tr><tr><td>09</td><td>Maternity Pricing</td></tr><tr><td>10</td><td>Other Pricing</td></tr><tr><td>11</td><td>Lower of Cost</td></tr><tr><td>12</td><td>Ratio of Cost</td></tr><tr><td>13</td><td>Cost Reimbursed</td></tr><tr><td>14</td><td>Adjustment Pricing</td></tr></table>	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			
CODE	DEFINITION																																					
00	Zero Pricing (Not Covered Under Contract)																																					
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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																																					
REQUIRED	HCP02	782	Monetary Amount Monetary amount SEMANTIC: HCP02 is the allowed amount. IMPLEMENTATION NAME: Repriced Allowed Amount	O 1	R	1/18																																
SITUATIONAL	HCP03	782	Monetary Amount Monetary amount SEMANTIC: HCP03 is the savings amount. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repriced Saving Amount This information is specific to the destination payer reported in Loop ID-2010BB.	O 1	R	1/18																																

SITUATIONAL	HCP04	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: HCP04 is the repricing organization identification number. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repricing Organization Identifier This information is specific to the destination payer reported in Loop ID-2010BB.
SITUATIONAL	HCP05	118	Rate O 1 R 1/9 Rate expressed in the standard monetary denomination for the currency specified SEMANTIC: HCP05 is the pricing rate associated with per diem or flat rate repricing. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repricing Per Diem or Flat Rate Amount This information is specific to the destination payer reported in Loop ID-2010BB.
SITUATIONAL	HCP06	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repriced Approved DRG Code This information is specific to the destination payer reported in Loop ID-2010BB.
SITUATIONAL	HCP07	782	Monetary Amount O 1 R 1/18 Monetary amount SEMANTIC: HCP07 is the approved DRG amount. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repriced Approved Amount This information is specific to the destination payer reported in Loop ID-2010BB.

SITUATIONAL	HCP08	234	Product/Service ID Identifying number for a product or service SEMANTIC: HCP08 is the approved revenue code. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repriced Approved Revenue Code This information is specific to the destination payer reported in Loop ID-2010BB.	O 1	AN	1/48						
NOT USED	HCP09	235	Product/Service ID Qualifier	X 1	ID	2/2						
NOT USED	HCP10	234	Product/Service ID	X 1	AN	1/48						
SITUATIONAL	HCP11	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken SYNTAX: P1112 SITUATIONAL RULE: <i>Required when HCP12 exists. If not required by this implementation guide, do not send.</i>	X 1	ID	2/2						
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>DA</td><td>Days</td></tr><tr><td>UN</td><td>Unit</td></tr></table>							CODE	DEFINITION	DA	Days	UN	Unit
CODE	DEFINITION											
DA	Days											
UN	Unit											
SITUATIONAL	HCP12	380	Quantity Numeric value of quantity SYNTAX: P1112 SEMANTIC: HCP12 is the approved service units or inpatient days. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Repriced Approved Service Unit Count This information is specific to the destination payer reported in Loop ID-2010BB. The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.	X 1	R	1/15						

SITUATIONAL **HCP13** **901** **Reject Reason Code** **X 1** **ID** **2/2**

Code assigned by issuer to identify reason for rejection

SYNTAX: R0113

SEMANTIC: HCP13 is the rejection message returned from the third party organization.

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

This information is specific to the destination payer reported in Loop ID-2010BB.

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 1** **ID** **1/2**

Code specifying policy compliance

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

This information is specific to the destination payer reported in Loop ID-2010BB.

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 1 ID 1/2

Code specifying the exception reason for consideration of out-of-network health care services

SEMANTIC: HCP15 is the exception reason generated by a third party organization.

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

This information is specific to the destination payer reported in Loop ID-2010BB.

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

SEGMENT DETAIL

NM1 - ATTENDING PROVIDER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Set Notes: 1. Loop 2310 contains information about the rendering, referring, or attending provider.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2310A — ATTENDING PROVIDER NAME **Loop Repeat:** 1

Segment Repeat: 1

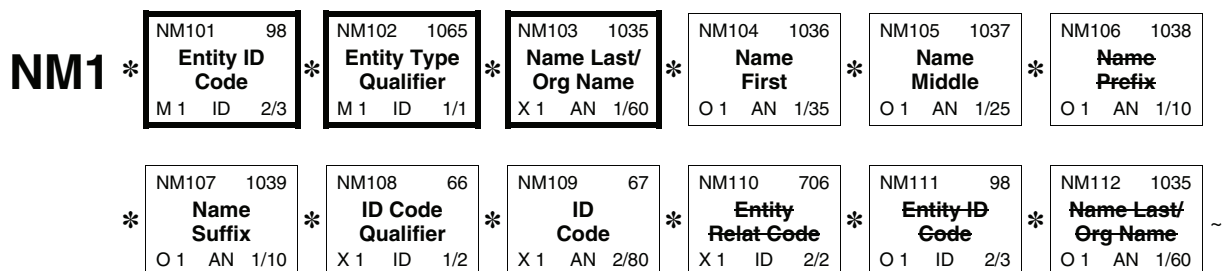
Usage: SITUATIONAL

Situational Rule: Required when the claim contains any services other than non-scheduled transportation claims. If not required by this implementation guide, do not send.

TR3 Notes: 1. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

TR3 Example: NM1*71*1*JONES*JOHN*****XX*1234567891~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			71	Attending Physician When used, the term physician is any type of provider filling this role.

REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. <table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr></table>	CODE	DEFINITION	1	Person	M 1	ID	1/1
CODE	DEFINITION									
1	Person									
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: Attending Provider Last Name	X 1	AN	1/60				
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Attending Provider First Name	O 1	AN	1/35				
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Attending Provider Middle Name or Initial	O 1	AN	1/25				
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Attending Provider Name Suffix	O 1	AN	1/10				

SITUATIONAL	NM108	66	Identification Code Qualifier	X 1	ID	1/2						
Code designating the system/method of code structure used for Identification Code (67)												
SYNTAX: P0809												
SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i>												
OR												
<i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i>												
OR												
<i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i>												
<i>If not required by this implementation guide, do not send.</i>												
<table><tr><td>CODE</td><td>DEFINITION</td></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier</td></tr><tr><td colspan="2">CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>							CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier	CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier	
CODE	DEFINITION											
XX	Centers for Medicare and Medicaid Services National Provider Identifier											
CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier												
SITUATIONAL	NM109	67	Identification Code	X 1	AN	2/80						
Code identifying a party or other code												
SYNTAX: P0809												
SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i>												
OR												
<i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i>												
OR												
<i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i>												
<i>If not required by this implementation guide, do not send.</i>												
IMPLEMENTATION NAME: Attending Provider Primary Identifier												
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2						
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3						
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60						

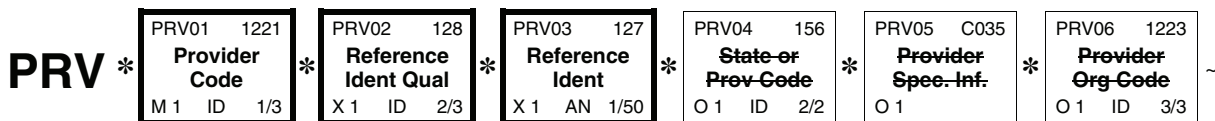
SEGMENT DETAIL

PRV - ATTENDING PROVIDER SPECIALTY
INFORMATION**X12 Segment Name:** Provider Information**X12 Purpose:** To specify the identifying characteristics of a provider**X12 Syntax:** 1. P0203

If either PRV02 or PRV03 is present, then the other is required.

Loop: 2310A — ATTENDING PROVIDER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when adjudication of the destination payer, or any subsequent payer listed on this claim, is known to be impacted by the attending provider taxonomy code. If not required by this implementation guide, do not send.**TR3 Example:** PRV*AT*PXC*208D00000X~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	PRV01	1221	Provider Code Code identifying the type of provider	M 1 ID 1/3
			CODE DEFINITION	
			AT Attending	
REQUIRED	PRV02	128	Reference Identification Qualifier Code qualifying the Reference Identification	X 1 ID 2/3
			SYNTAX: P0203	
			CODE DEFINITION	
			PXC Health Care Provider Taxonomy Code	
			CODE SOURCE 682: Health Care Provider Taxonomy	
REQUIRED	PRV03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: P0203	
			IMPLEMENTATION NAME: Provider Taxonomy Code	
NOT USED	PRV04	156	State or Province Code	O 1 ID 2/2
NOT USED	PRV05	C035	PROVIDER SPECIALTY INFORMATION	O 1

NOT USED	PRV06	1223	Provider Organization Code	O 1	ID	3/3

SEGMENT DETAIL

REF - ATTENDING PROVIDER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2310A — ATTENDING PROVIDER NAME**Segment Repeat:** 4**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

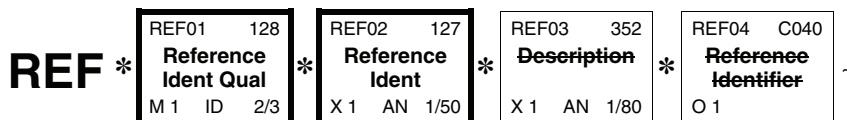
OR

Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Example: REF*1G*A12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			0B	State License Number
			1G	Provider UPIN Number
				UPINs must be formatted as either X99999 or XXX999.
			G2	Provider Commercial Number
				This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
			LU	Location Number

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Attending Provider Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OPERATING PHYSICIAN NAME**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Loop 2310 contains information about the rendering, referring, or attending provider.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

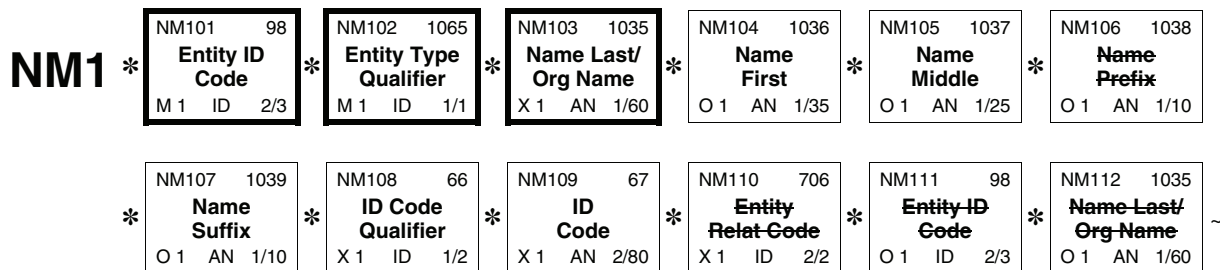
Loop: 2310B — OPERATING PHYSICIAN NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when a surgical procedure code is listed on this claim. If not required by this implementation guide, do not send.

TR3 Notes: 1. The Operating Physician is the individual with primary responsibility for performing the surgical procedure(s).

2. 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.

TR3 Example: NM1*72*1*MEYERS*JANE****XX*1234567891~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			72	Operating Physician
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1
			CODE	DEFINITION
			1	Person
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1 AN 1/60
			IMPLEMENTATION NAME: Operating Physician Last Name	
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1 AN 1/35
			IMPLEMENTATION NAME: Operating Physician First Name	
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1 AN 1/25
			IMPLEMENTATION NAME: Operating Physician Middle Name or Initial	
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1 AN 1/10
			IMPLEMENTATION NAME: Operating Physician Name Suffix	

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Operating Physician Primary Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - OPERATING PHYSICIAN SECONDARY IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2310B — OPERATING PHYSICIAN NAME**Segment Repeat:** 4**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

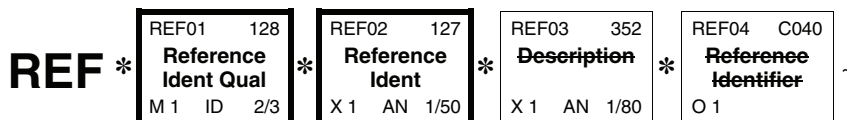
OR

Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Example: REF*1G*A12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			0B	State License Number
			1G	Provider UPIN Number
				UPINs must be formatted as either X99999 or XXX999.
			G2	Provider Commercial Number
				This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.
			LU	Location Number

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Operating Physician Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OTHER OPERATING PHYSICIAN NAME**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Loop 2310 contains information about the rendering, referring, or attending provider.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2310C — OTHER OPERATING PHYSICIAN NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when another Operating Physician is involved. If not required by the implementation guide, do not send.

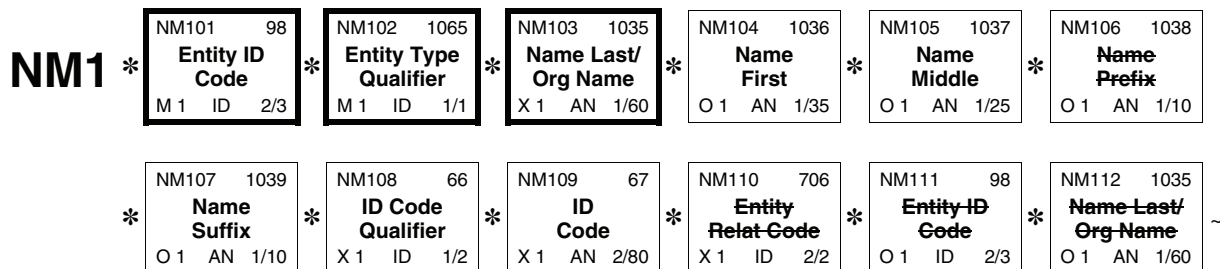
TR3 Notes: 1. The Other Operating Physician is the individual performing a secondary surgical procedure or assisting the Operating Physician.

2. This Other Operating Physician segment can only be used when Operating Physician information (Loop ID-2310B) is also sent on this claim.

3. 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.

TR3 Example: NM1*ZZ*1*DOE*JOHN*A***XX*1234567891~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ZZ</td><td>Mutually Defined ZZ is used to indicate Other Operating Physician.</td></tr></table>	CODE	DEFINITION	ZZ	Mutually Defined ZZ is used to indicate Other Operating Physician.			
CODE	DEFINITION									
ZZ	Mutually Defined ZZ is used to indicate Other Operating Physician.									
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr></table>	CODE	DEFINITION	1	Person			
CODE	DEFINITION									
1	Person									
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: Other Operating Physician Last Name	X 1	AN	1/60				
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Operating Physician First Name	O 1	AN	1/35				
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Operating Physician Middle Name or Initial	O 1	AN	1/25				
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Operating Physician Name Suffix	O 1	AN	1/10				

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> <i>OR</i> <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> <i>OR</i> <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td> Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier </td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> <i>OR</i> <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> <i>OR</i> <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Other Operating Physician Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - OTHER OPERATING PHYSICIAN
SECONDARY IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2310C — OTHER OPERATING PHYSICIAN NAME**Segment Repeat:** 4**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

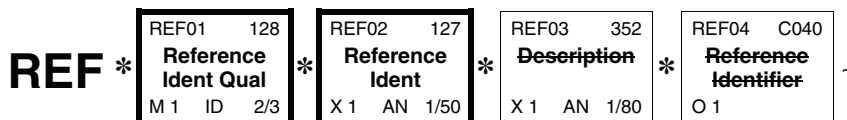
OR

Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Example: REF*1G*A12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3														
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr><tr><td>1G</td><td>Provider UPIN Number</td></tr><tr><td></td><td>UPINs must be formatted as either X99999 or XXX999.</td></tr><tr><td>G2</td><td>Provider Commercial Number</td></tr><tr><td></td><td>This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.</td></tr><tr><td>LU</td><td>Location Number</td></tr></table>	CODE	DEFINITION	0B	State License Number	1G	Provider UPIN Number		UPINs must be formatted as either X99999 or XXX999.	G2	Provider Commercial Number		This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.	LU	Location Number			
CODE	DEFINITION																			
0B	State License Number																			
1G	Provider UPIN Number																			
	UPINs must be formatted as either X99999 or XXX999.																			
G2	Provider Commercial Number																			
	This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.																			
LU	Location Number																			

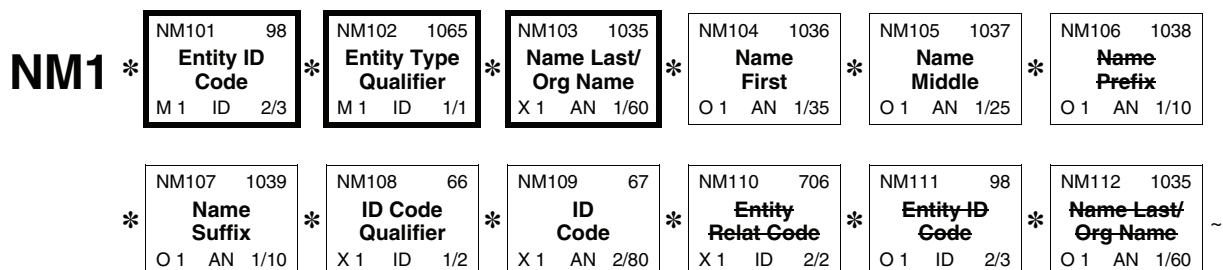
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Provider Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - RENDERING PROVIDER NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Loop 2310 contains information about the rendering, referring, or attending provider.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2310D — RENDERING PROVIDER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the Rendering Provider is different than the Attending Provider reported in Loop ID-2310A of this claim.
AND
When state or federal regulatory requirements call for a “combined claim”, that is, a claim that includes both facility and professional components (for example, a Medicaid clinic bill or Critical Access Hospital Claim.)
If not required by this implementation guide, do not send.**TR3 Notes:** 1. The Rendering Provider is the health care professional who delivers or completes a particular medical service or non-surgical procedure.
2. 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.**TR3 Example:** NM1*82*1*DOE*JANE*C***XX*1234567804~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			82	Rendering Provider
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1
			CODE	DEFINITION
			1	Person
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1 AN 1/60
			IMPLEMENTATION NAME: Rendering Provider Last Name	
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1 AN 1/35
			IMPLEMENTATION NAME: Rendering Provider First Name	
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1 AN 1/25
			IMPLEMENTATION NAME: Rendering Provider Middle Name or Initial	
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1 AN 1/10
			IMPLEMENTATION NAME: Rendering Provider Name Suffix	

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Rendering Provider Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2310D — RENDERING PROVIDER NAME**Segment Repeat:** 4**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

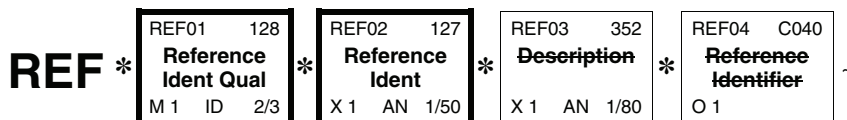
OR

Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Example: REF*1G*A12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION		
			0B	State License Number		
			1G	Provider UPIN Number		
				UPINs must be formatted as either X99999 or XXX999.		
			G2	Provider Commercial Number		
				This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.		
			LU	Location Number		

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Rendering Provider Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - SERVICE FACILITY LOCATION NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Set Notes: 1. Loop 2310 contains information about the rendering, referring, or attending provider.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2310E — SERVICE FACILITY LOCATION NAME **Loop Repeat:** 1

Segment Repeat: 1

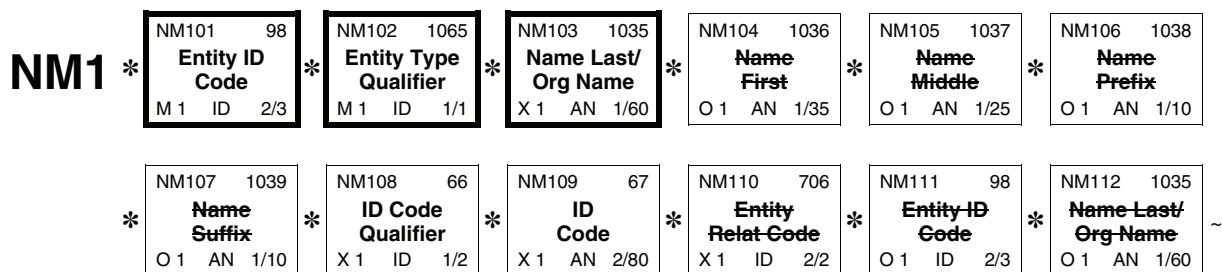
Usage: SITUATIONAL

Situational Rule: Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).
If not required by this implementation guide, do not send.

TR3 Notes: 1. When an organization health care provider's NPI is provided to identify the Service Location, the organization health care provider must be external to the entity identified as the Billing Provider (for example, reference lab). It is not permissible to report an organization health care provider NPI as the Service Location if the entity being identified is a component (for example, subpart) of the Billing Provider. In that case, the subpart must be the Billing Provider.

TR3 Example: NM1*77*2*ABC CLINIC*****XX*1234567891~

DIAGRAM



ELEMENT DETAIL

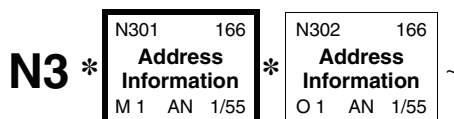
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual	M 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>77</td><td>Service Location</td></tr></table>	CODE	DEFINITION	77	Service Location			
CODE	DEFINITION									
77	Service Location									
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	2	Non-Person Entity			
CODE	DEFINITION									
2	Non-Person Entity									
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60				
			IMPLEMENTATION NAME: Laboratory or Facility Name							
NOT USED	NM104	1036	Name First	O 1	AN	1/35				
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25				
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10				
SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809	X 1	ID	1/2				
			SITUATIONAL RULE: <i>Required when the service location to be identified has an NPI and is not a component or subpart of the Billing Provider entity. If not required by this implementation guide, do not send.</i>							
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809	X 1	AN	2/80				
			SITUATIONAL RULE: <i>Required when the service location to be identified has an NPI and is not a component or subpart of the Billing Provider entity. If not required by this implementation guide, do not send.</i>							
			IMPLEMENTATION NAME: Laboratory or Facility Primary Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				

NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

N3 - SERVICE FACILITY LOCATION ADDRESS**X12 Segment Name:** Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2310E — SERVICE FACILITY LOCATION NAME**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (for example, “crossroad of State Road 34 and 45” or “Exit near Mile marker 265 on Interstate 80”).**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Laboratory or Facility Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Laboratory or Facility Address Line				

SEGMENT DETAIL

N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE

X12 Segment Name: Geographic Location

X12 Purpose: To specify the geographic place of the named party

- X12 Syntax:**
- E0207**
Only one of N402 or N407 may be present.
 - C0605**
If N406 is present, then N405 is required.
 - C0704**
If N407 is present, then N404 is required.

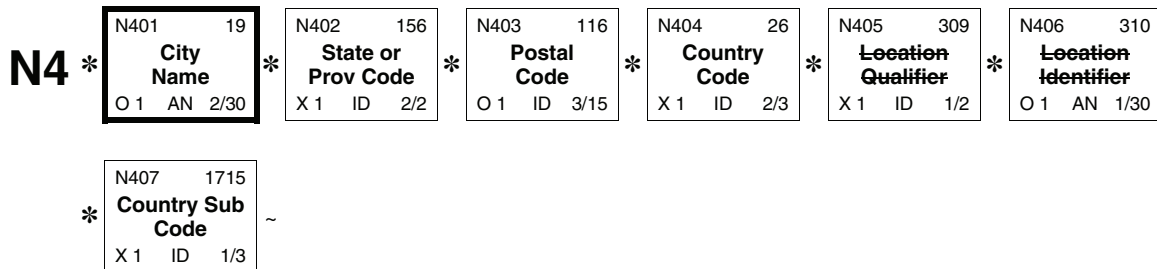
Loop: 2310E — SERVICE FACILITY LOCATION NAME

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30
COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.				
IMPLEMENTATION NAME: Laboratory or Facility City Name				

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Laboratory or Facility State or Province Code CODE SOURCE 22: States and Provinces	X 1	ID	2/2
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Laboratory or Facility Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes When reporting the ZIP code for U.S. addresses, the full nine digit ZIP code must be provided.	O 1	ID	3/15
SITUATIONAL	N404	26	Country Code Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.	X 1	ID	2/3
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	O 1	AN	1/30
SITUATIONAL	N407	1715	Country Subdivision Code Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.	X 1	ID	1/3

SEGMENT DETAIL

REF - SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2310E — SERVICE FACILITY LOCATION NAME

Segment Repeat: 3

Usage: SITUATIONAL

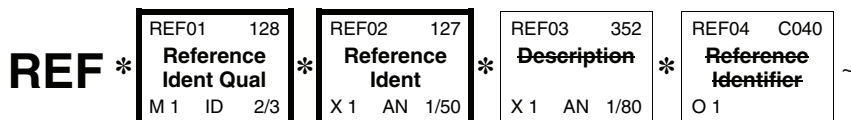
Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

OR

Required on or after the mandated NPI implementation date when the entity is not a Health Care provider (a.k.a. an atypical provider), and an identifier is necessary for the claims processor to identify the entity. If not required by this implementation guide, do not send.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION		
			0B	State License Number		
			G2	Provider Commercial Number		
				This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.		
			LU	Location Number		

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	X 1 AN 1/50
IMPLEMENTATION NAME: Laboratory or Facility Secondary Identifier				
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - REFERRING PROVIDER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Set Notes: 1. Loop 2310 contains information about the rendering, referring, or attending provider.

X12 Syntax:

- P0809**
If either NM108 or NM109 is present, then the other is required.
- C1110**
If NM111 is present, then NM110 is required.
- C1203**
If NM112 is present, then NM103 is required.

Loop: 2310F — REFERRING PROVIDER NAME **Loop Repeat:** 1

Segment Repeat: 1

Usage: SITUATIONAL

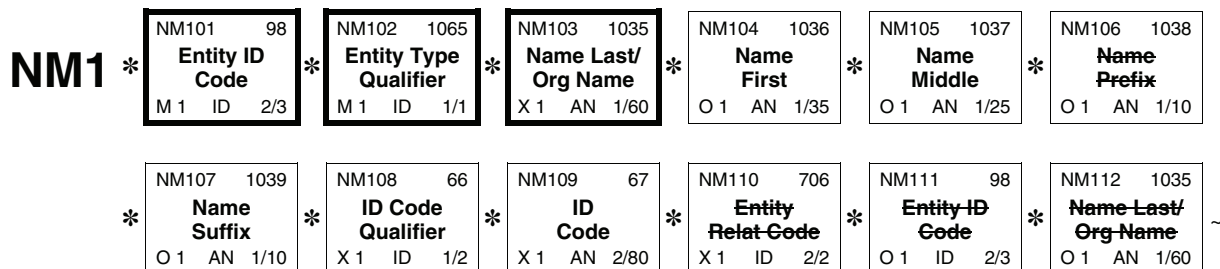
Situational Rule: Required on an outpatient claim when the Referring Provider is different than the Attending Provider. If not required by this implementation guide, do not send.

TR3 Notes:

- The Referring Provider is provider who sends the patient to another provider for services.
- 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.

TR3 Example: NM1*DN*1*WELBY*MARCUS*W**JR*XX*1234567891~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>DN</td><td>Referring Provider</td></tr></table>	CODE	DEFINITION	DN	Referring Provider			
CODE	DEFINITION									
DN	Referring Provider									
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr></table>	CODE	DEFINITION	1	Person			
CODE	DEFINITION									
1	Person									
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60				
			IMPLEMENTATION NAME: Referring Provider Last Name							
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1	AN	1/35				
			IMPLEMENTATION NAME: Referring Provider First Name							
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/25				
			IMPLEMENTATION NAME: Referring Provider Middle Name or Initial							
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/10				
			IMPLEMENTATION NAME: Referring Provider Name Suffix							

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI and the NPI is available to the submitter.</i> <i>OR</i> <i>Required for providers prior to the mandated HIPAA NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI and the NPI is available to the submitter.</i> <i>OR</i> <i>Required for providers prior to the mandated HIPAA NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Referring Provider Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - REFERRING PROVIDER SECONDARY IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2310F — REFERRING PROVIDER NAME**Segment Repeat:** 3**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

OR

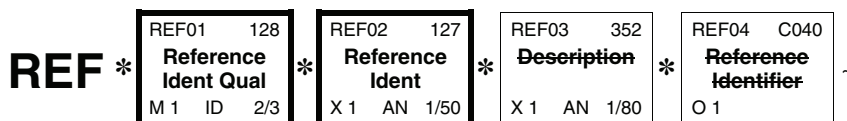
Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. The REF segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a REF segment with the same value in REF01.

TR3 Example: REF*1G*A12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES										
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3								
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr><tr><td>1G</td><td>Provider UPIN Number</td></tr><tr><td colspan="2">UPINs must be formatted as either X99999 or XXX999.</td></tr></table>	CODE	DEFINITION	0B	State License Number	1G	Provider UPIN Number	UPINs must be formatted as either X99999 or XXX999.				
CODE	DEFINITION													
0B	State License Number													
1G	Provider UPIN Number													
UPINs must be formatted as either X99999 or XXX999.														

			G2	Provider Commercial Number			
				This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.			
REQUIRED	REF02	127	Reference Identification	X 1	AN	1/50	
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			SYNTAX: R0203				
			IMPLEMENTATION NAME: Referring Provider Secondary Identifier				
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1			

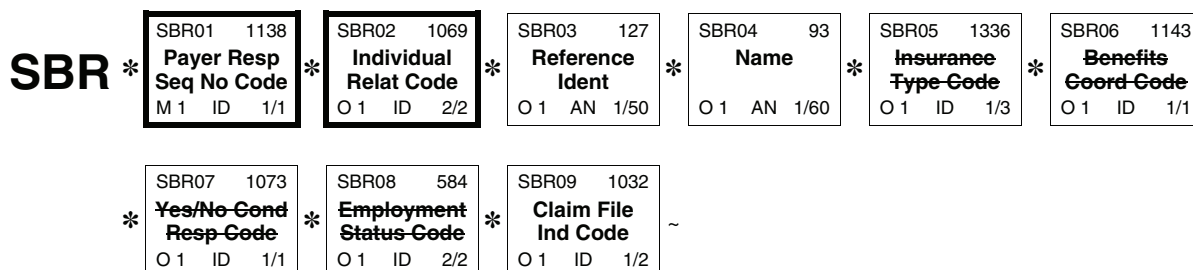
SEGMENT DETAIL

SBR - OTHER SUBSCRIBER INFORMATION**X12 Segment Name:** Subscriber Information**X12 Purpose:** To record information specific to the primary insured and the insurance carrier for that insured**X12 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.**Loop:** 2320 — OTHER SUBSCRIBER INFORMATION **Loop Repeat:** 10**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when other payers are known to potentially be involved in paying on this claim. If not required by this implementation guide, do not send.**TR3 Notes:** 1. All information contained in Loop ID-2320 applies only to the payer identified in Loop ID-2330B of this iteration of Loop ID-2320. It is specific only to that payer. If information for an additional payer is necessary, repeat Loop ID-2320 with its respective 2330 Loops.

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: SBR*S*01*GR00786*****13~

DIAGRAM



ELEMENT DETAIL

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 1 ID 1/1
Within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value "U") may occur no more than once.				
			CODE	DEFINITION
			A	Payer Responsibility Four
			B	Payer Responsibility Five
			C	Payer Responsibility Six
			D	Payer Responsibility Seven
			E	Payer Responsibility Eight
			F	Payer Responsibility Nine
			G	Payer Responsibility Ten
			H	Payer Responsibility Eleven
			P	Primary
			S	Secondary
			T	Tertiary
			U	Unknown
			This code may only be used in payer to payer COB claims when the original payer determined the presence of this coverage from eligibility files received from this payer or when the original claim did not provide the responsibility sequence for this payer.	
REQUIRED	SBR02	1069	Individual Relationship Code Code indicating the relationship between two individuals or entities	O 1 ID 2/2
SEMANTIC: SBR02 specifies the relationship to the person insured.				
			CODE	DEFINITION
			01	Spouse
			18	Self
			19	Child
			20	Employee
			21	Unknown
			39	Organ Donor
			40	Cadaver Donor
			53	Life Partner
			G8	Other Relationship

SITUATIONAL	SBR03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: SBR03 is policy or group number. SITUATIONAL RULE: <i>Required when the subscriber's identification card for the non-destination payer identified in Loop ID-2330B of this iteration of Loop ID-2320 shows a group number. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Insured Group or Policy Number This is not the number uniquely identifying the subscriber. The unique subscriber number is submitted in Loop 2330A-NM109 for this iteration of Loop ID-2320.	O 1	AN	1/50
SITUATIONAL	SBR04	93	Name Free-form name SEMANTIC: SBR04 is plan name. SITUATIONAL RULE: <i>Required when SBR03 is not used and the group name is available. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Insured Group Name	O 1	AN	1/60
NOT USED	SBR05	1336	Insurance Type Code	O 1	ID	1/3
NOT USED	SBR06	1143	Coordination of Benefits Code	O 1	ID	1/1
NOT USED	SBR07	1073	Yes/No Condition or Response Code	O 1	ID	1/1
NOT USED	SBR08	584	Employment Status Code	O 1	ID	2/2
SITUATIONAL	SBR09	1032	Claim Filing Indicator Code Code identifying type of claim SITUATIONAL RULE: <i>Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.</i>	O 1	ID	1/2
		CODE	DEFINITION			
		11	Other Non-Federal Programs			
		12	Preferred Provider Organization (PPO)			
		13	Point of Service (POS)			
		14	Exclusive Provider Organization (EPO)			
		15	Indemnity Insurance			
		16	Health Maintenance Organization (HMO) Medicare Risk			
		17	Dental Maintenance Organization			
		AM	Automobile Medical			
		BL	Blue Cross/Blue Shield			
		CH	Champus			
		CI	Commercial Insurance Co.			
		DS	Disability			
		FI	Federal Employees Program			
		HM	Health Maintenance Organization			

LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
	Use code OF when submitting Medicare Part D claims.
TV	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Use Code ZZ when Type of Insurance is not known.

SEGMENT DETAIL

CAS - CLAIM LEVEL ADJUSTMENTS**X12 Segment Name:** Claims Adjustment**X12 Purpose:** To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

- X12 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.

X12 Comments: 1. Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

Loop: 2320 — OTHER SUBSCRIBER INFORMATION**Segment Repeat:** 5**Usage:** SITUATIONAL

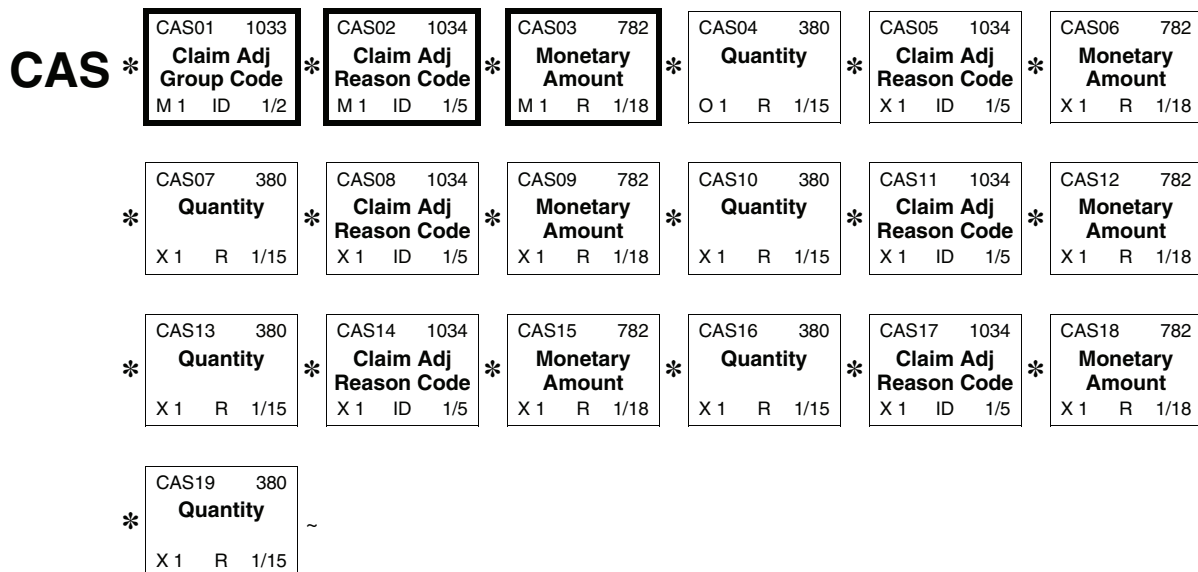
Situational Rule: Required when the claim has been adjudicated by the payer identified in this loop, and the claim has claim level adjustment information. If not required by this implementation guide, do not send.

- TR3 Notes:**
1. Submitters must 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.
 3. Codes and associated amounts must come from either paper remittance advice or 835s (Electronic Remittance Advice) received on the claim. When the information originates from a paper remittance advice that does not use the standard Claim Adjustment Reason Codes, the paper values must be converted to standard Claim Adjustment Reason Codes.
 4. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first non-zero adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

TR3 Example: CAS*PR*1*7.93~

TR3 Example: CAS*OA*93*15.06~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES														
REQUIRED	CAS01	1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment	M 1	ID	1/2												
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>CO</td><td>Contractual Obligations</td></tr><tr><td>CR</td><td>Correction and Reversals</td></tr><tr><td>OA</td><td>Other adjustments</td></tr><tr><td>PI</td><td>Payor Initiated Reductions</td></tr><tr><td>PR</td><td>Patient Responsibility</td></tr></table>	CODE	DEFINITION	CO	Contractual Obligations	CR	Correction and Reversals	OA	Other adjustments	PI	Payor Initiated Reductions	PR	Patient Responsibility			
CODE	DEFINITION																	
CO	Contractual Obligations																	
CR	Correction and Reversals																	
OA	Other adjustments																	
PI	Payor Initiated Reductions																	
PR	Patient Responsibility																	
REQUIRED	CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made	M 1	ID	1/5												
			IMPLEMENTATION NAME: Adjustment Reason Code															
			CODE SOURCE 139: Claim Adjustment Reason Code															
			See CODE SOURCE 139: Claim Adjustment Reason Code															
REQUIRED	CAS03	782	Monetary Amount Monetary amount	M 1	R	1/18												
			SEMANTIC: CAS03 is the amount of adjustment.															
			IMPLEMENTATION NAME: Adjustment Amount															
SITUATIONAL	CAS04	380	Quantity Numeric value of quantity	O 1	R	1/15												
			SEMANTIC: CAS04 is the units of service being adjusted.															
			SITUATIONAL RULE: <i>Required when the number of service units has been adjusted. If not required by this implementation guide, do not send.</i>															
			IMPLEMENTATION NAME: Adjustment Quantity															
SITUATIONAL	CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made	X 1	ID	1/5												
			SYNTAX: L050607, C0605, C0705															
			SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this claim for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i>															
			IMPLEMENTATION NAME: Adjustment Reason Code															
			CODE SOURCE 139: Claim Adjustment Reason Code															
SITUATIONAL	CAS06	782	Monetary Amount Monetary amount	X 1	R	1/18												
			SYNTAX: L050607, C0605															
			SEMANTIC: CAS06 is the amount of the adjustment.															
			SITUATIONAL RULE: <i>Required when CAS05 is present. If not required by this implementation guide, do not send.</i>															
			IMPLEMENTATION NAME: Adjustment Amount															

SITUATIONAL	CAS07	380	Quantity Numeric value of quantity SYNTAX: L050607, C0705 SEMANTIC: CAS07 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS05 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity	X 1	R	1/15
SITUATIONAL	CAS08	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made SYNTAX: L080910, C0908, C1008 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this claim for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code	X 1	ID	1/5
SITUATIONAL	CAS09	782	Monetary Amount Monetary amount SYNTAX: L080910, C0908 SEMANTIC: CAS09 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS08 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount	X 1	R	1/18
SITUATIONAL	CAS10	380	Quantity Numeric value of quantity SYNTAX: L080910, C1008 SEMANTIC: CAS10 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS08 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity	X 1	R	1/15
SITUATIONAL	CAS11	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made SYNTAX: L111213, C1211, C1311 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this claim for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code	X 1	ID	1/5

SITUATIONAL	CAS12	782	Monetary Amount Monetary amount SYNTAX: L111213, C1211 SEMANTIC: CAS12 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS11 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount	X 1	R	1/18
SITUATIONAL	CAS13	380	Quantity Numeric value of quantity SYNTAX: L111213, C1311 SEMANTIC: CAS13 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS11 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity	X 1	R	1/15
SITUATIONAL	CAS14	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made SYNTAX: L141516, C1514, C1614 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this claim for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code	X 1	ID	1/5
SITUATIONAL	CAS15	782	Monetary Amount Monetary amount SYNTAX: L141516, C1514 SEMANTIC: CAS15 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS14 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount	X 1	R	1/18
SITUATIONAL	CAS16	380	Quantity Numeric value of quantity SYNTAX: L141516, C1614 SEMANTIC: CAS16 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS14 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity	X 1	R	1/15

SITUATIONAL	CAS17	1034	Claim Adjustment Reason Code X 1 ID 1/5 Code identifying the detailed reason the adjustment was made SYNTAX: L171819, C1817, C1917 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this claim for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code
SITUATIONAL	CAS18	782	Monetary Amount X 1 R 1/18 Monetary amount SYNTAX: L171819, C1817 SEMANTIC: CAS18 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS17 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount
SITUATIONAL	CAS19	380	Quantity X 1 R 1/15 Numeric value of quantity SYNTAX: L171819, C1917 SEMANTIC: CAS19 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS17 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity

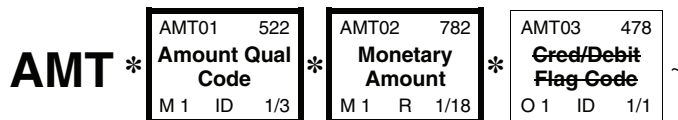
SEGMENT DETAIL

**AMT - COORDINATION OF BENEFITS (COB)
PAYER PAID AMOUNT****X12 Segment Name:** Monetary Amount Information**X12 Purpose:** To indicate the total monetary amount**Loop:** 2320 — OTHER SUBSCRIBER INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required when the claim has been adjudicated by the payer identified in Loop ID-2330B of this loop.
OR
Required when Loop ID-2010AC is present. In this case, the claim is a post payment recovery claim submitted by a subrogated Medicaid agency. If not required by this implementation guide, do not send.

TR3 Example: AMT*D*411~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1	ID	1/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>D</td><td>Payor Amount Paid</td></tr></table>	CODE	DEFINITION	D	Payor Amount Paid			
CODE	DEFINITION									
D	Payor Amount Paid									
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1	R	1/18				
			IMPLEMENTATION NAME: Payer Paid Amount							
			It is acceptable to show “0” as the amount paid.							
			When Loop ID-2010AC is present, this is the amount the Medicaid agency actually paid.							
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1	ID	1/1				

SEGMENT DETAIL

AMT - REMAINING PATIENT LIABILITY**X12 Segment Name:** Monetary Amount Information**X12 Purpose:** To indicate the total monetary amount**Loop:** 2320 — OTHER SUBSCRIBER INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the Other Payer identified in Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this claim and provided claim level information only.

OR

Required when the Other Payer identified in Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this claim and the provider received a paper remittance advice and the provider does not have the ability to report line item information.

If not required by this implementation guide, do not send.

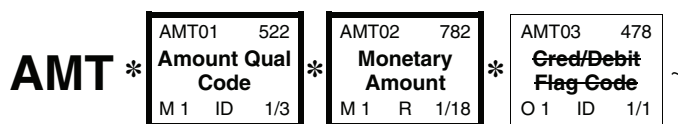
TR3 Notes: 1. In the judgment of the provider, this is the remaining amount to be paid after adjudication by the Other Payer identified in Loop ID-2330B of this iteration of Loop ID-2320.

2. This segment is only used in provider submitted claims. It is not used in Payer-to-Payer Coordination of Benefits (COB).

3. This segment is not used if the line level (Loop ID-2430) Remaining Patient Liability AMT segment is used for this Other Payer.

TR3 Example: AMT*EAF*75~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3
			CODE DEFINITION	
			EAF Amount Owed	
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18
			IMPLEMENTATION NAME: Remaining Patient Liability	
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1

SEGMENT DETAIL

AMT - COORDINATION OF BENEFITS (COB) TOTAL NON-COVERED AMOUNT

X12 Segment Name: Monetary Amount Information

X12 Purpose: To indicate the total monetary amount

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

Segment Repeat: 1

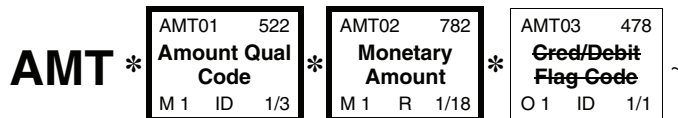
Usage: SITUATIONAL

Situational Rule: Required when the destination payer's cost avoidance policy allows providers to bypass claim submission to the otherwise prior payer identified in Loop ID-2330B. If not required by this implementation guide, do not send.

TR3 Notes: 1. When this segment is used, the amount reported in AMT02 must equal the total claim charge amount reported in CLM02. Neither the prior payer paid AMT, nor any CAS segments are used as this claim has not been adjudicated by this payer.

TR3 Example: AMT*A8*273~

DIAGRAM



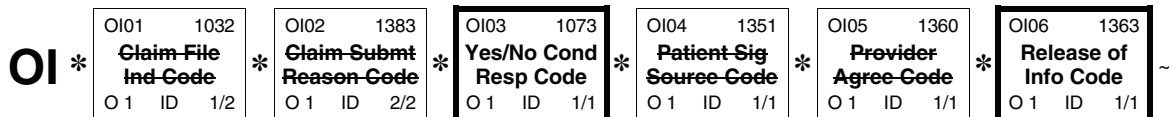
ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3
			CODE DEFINITION	
			A8 Noncovered Charges - Actual	
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18
			IMPLEMENTATION NAME: Non-Covered Charge Amount	
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1

SEGMENT DETAIL

OI - OTHER INSURANCE COVERAGE INFORMATION**X12 Segment Name:** Other Health Insurance Information**X12 Purpose:** To specify information associated with other health insurance coverage**Loop:** 2320 — OTHER SUBSCRIBER INFORMATION**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. All information contained in the OI segment applies only to the payer identified in Loop ID-2330B in this iteration of Loop ID-2320.**TR3 Example:** OI***Y*B**Y~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	OI01	1032	Claim Filing Indicator Code	O 1 ID 1/2
NOT USED	OI02	1383	Claim Submission Reason Code	O 1 ID 2/2
REQUIRED	OI03	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	O 1 ID 1/1
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.				
IMPLEMENTATION NAME: Benefits Assignment Certification Indicator				
This is a crosswalk from CLM08 when doing COB.				
This element answers the question whether or not the insured has authorized the plan to remit payment directly to the provider.				
			CODE	DEFINITION
			N	No
			W	Not Applicable
			Use code 'W' when the patient refuses to assign benefits.	
			Y	Yes
NOT USED	OI04	1351	Patient Signature Source Code	O 1 ID 1/1
NOT USED	OI05	1360	Provider Agreement Code	O 1 ID 1/1

REQUIRED	OI06	1363	Release of Information Code Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations	O 1	ID	1/1
This is a crosswalk from CLM09 when doing COB.						
The Release of Information response is limited to the information carried in this claim.						
		CODE	DEFINITION			
		I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes			
			Required when the provider has not collected a signature AND state or federal laws do not require a signature be collected.			
		Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim			
			Required when the provider has collected a signature. OR Required when state or federal laws require a signature be collected.			

SEGMENT DETAIL

MIA - INPATIENT ADJUDICATION INFORMATION

X12 Segment Name: Medicare Inpatient Adjudication

X12 Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims

Loop: 2320 — OTHER SUBSCRIBER INFORMATION

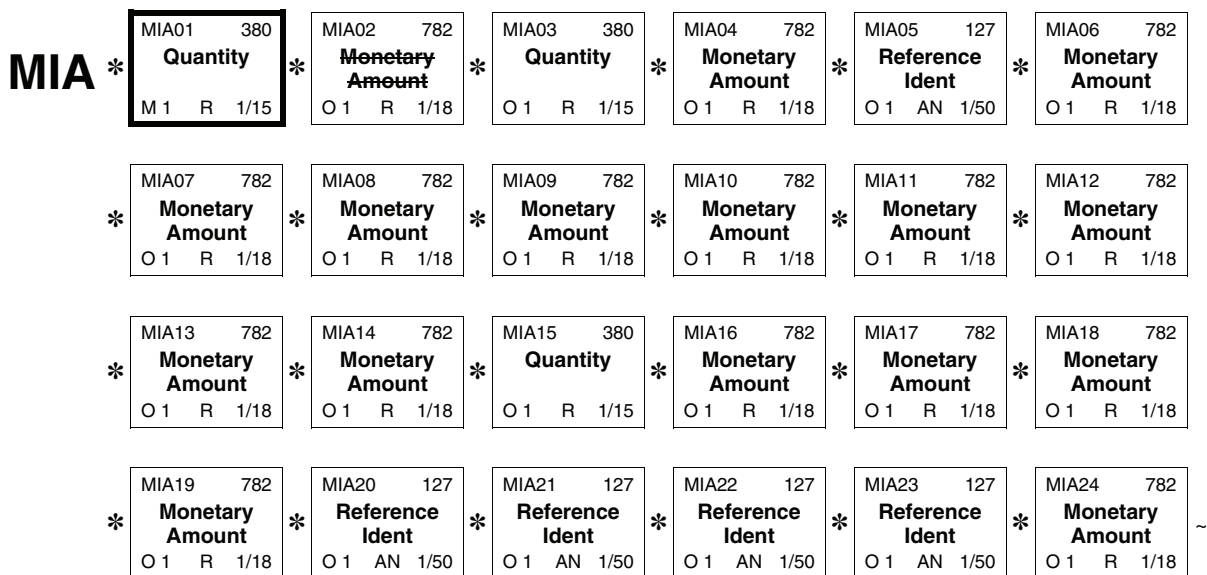
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when inpatient adjudication information is reported in the remittance advice.
OR
Required when it is necessary to report remark codes.
If not required by this implementation guide, do not send.

TR3 Example: MIA*1***3568.98*MA01*****21***MA25~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	MIA01	380	Quantity Numeric value of quantity SEMANTIC: MIA01 is the covered days. IMPLEMENTATION NAME: Covered Days or Visits Count	M 1 R 1/15
NOT USED	MIA02	782	Monetary Amount	O 1 R 1/18

SITUATIONAL	MIA03	380	Quantity Numeric value of quantity SEMANTIC: MIA03 is the lifetime psychiatric days. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Lifetime Psychiatric Days Count	O 1	R	1/15
SITUATIONAL	MIA04	782	Monetary Amount Monetary amount SEMANTIC: MIA04 is the Diagnosis Related Group (DRG) amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim DRG Amount	O 1	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 SEMANTIC: MIA05 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code	O 1	AN	1/50
SITUATIONAL	MIA06	782	Monetary Amount Monetary amount SEMANTIC: MIA06 is the disproportionate share amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Disproportionate Share Amount	O 1	R	1/18
SITUATIONAL	MIA07	782	Monetary Amount Monetary amount SEMANTIC: MIA07 is the Medicare Secondary Payer (MSP) pass-through amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim MSP Pass-through Amount	O 1	R	1/18
SITUATIONAL	MIA08	782	Monetary Amount Monetary amount SEMANTIC: MIA08 is the total Prospective Payment System (PPS) capital amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim PPS Capital Amount	O 1	R	1/18

SITUATIONAL	MIA09	782	Monetary Amount Monetary amount SEMANTIC: MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Capital FSP DRG Amount	O 1	R	1/18
SITUATIONAL	MIA10	782	Monetary Amount Monetary amount SEMANTIC: MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Capital HSP DRG Amount	O 1	R	1/18
SITUATIONAL	MIA11	782	Monetary Amount Monetary amount SEMANTIC: MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Capital DSH DRG Amount	O 1	R	1/18
SITUATIONAL	MIA12	782	Monetary Amount Monetary amount SEMANTIC: MIA12 is the old capital amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Old Capital Amount	O 1	R	1/18
SITUATIONAL	MIA13	782	Monetary Amount Monetary amount SEMANTIC: MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Capital IME amount	O 1	R	1/18
SITUATIONAL	MIA14	782	Monetary Amount Monetary amount SEMANTIC: MIA14 is hospital specific Diagnosis Related Group (DRG) Amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Operating Hospital Specific DRG Amount	O 1	R	1/18

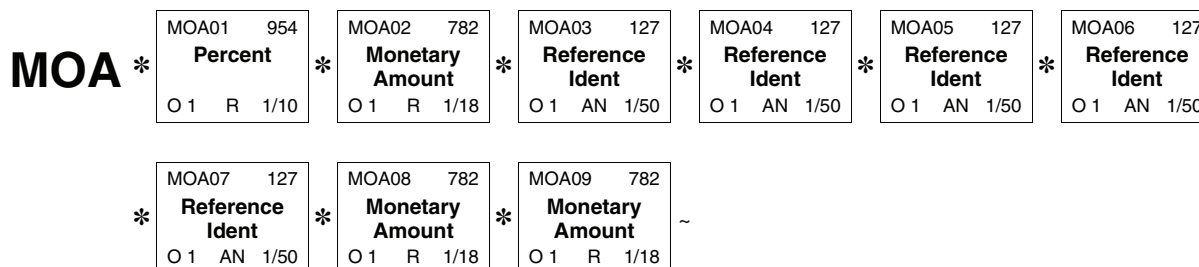
SITUATIONAL	MIA15	380	Quantity Numeric value of quantity SEMANTIC: MIA15 is the cost report days. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Cost Report Day Count	O 1	R	1/15
SITUATIONAL	MIA16	782	Monetary Amount Monetary amount SEMANTIC: MIA16 is the federal specific Diagnosis Related Group (DRG) amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Operating Federal Specific DRG Amount	O 1	R	1/18
SITUATIONAL	MIA17	782	Monetary Amount Monetary amount SEMANTIC: MIA17 is the Prospective Payment System (PPS) Capital Outlier amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim PPS Capital Outlier Amount	O 1	R	1/18
SITUATIONAL	MIA18	782	Monetary Amount Monetary amount SEMANTIC: MIA18 is the indirect teaching amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Indirect Teaching Amount	O 1	R	1/18
SITUATIONAL	MIA19	782	Monetary Amount Monetary amount SEMANTIC: MIA19 is the professional component amount billed but not payable. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Non-Payable Professional Component Billed Amount	O 1	R	1/18
SITUATIONAL	MIA20	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MIA20 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code	O 1	AN	1/50

SITUATIONAL	MIA21	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MIA21 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MIA22	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MIA22 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MIA23	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MIA23 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MIA24	782	Monetary Amount O 1 R 1/18 Monetary amount SEMANTIC: MIA24 is the capital exception amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: PPS-Capital Exception Amount

SEGMENT DETAIL

MOA - OUTPATIENT ADJUDICATION
INFORMATION**X12 Segment Name:** Medicare Outpatient Adjudication**X12 Purpose:** To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting**Loop:** 2320 — OTHER SUBSCRIBER INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when outpatient adjudication information is reported in the remittance advice
OR
Required when it is necessary to report remark codes.
If not required by this implementation guide, do not send.**TR3 Example:** MOA***A4~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	MOA01	954	Percentage as Decimal Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%) SEMANTIC: MOA01 is the reimbursement rate. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Reimbursement Rate	O 1 R 1/10

SITUATIONAL	MOA02	782	Monetary Amount O 1 R 1/18 Monetary amount SEMANTIC: MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: HCPCS Payable Amount
SITUATIONAL	MOA03	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MOA03 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MOA04	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MOA04 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MOA05	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MOA05 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MOA06	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MOA06 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code
SITUATIONAL	MOA07	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SEMANTIC: MOA07 is the Claim Payment Remark Code. See Code Source 411. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Claim Payment Remark Code

SITUATIONAL	MOA08	782	Monetary Amount	O 1 R 1/18
			Monetary amount	

SEMANTIC: MOA08 is the End Stage Renal Disease (ESRD) payment amount.

SITUATIONAL RULE: *Required when returned in the remittance advice. If not required by this implementation guide, do not send.*

IMPLEMENTATION NAME: **End Stage Renal Disease Payment Amount**

SITUATIONAL	MOA09	782	Monetary Amount	O 1 R 1/18
			Monetary amount	

SEMANTIC: MOA09 is the professional component amount billed but not payable.

SITUATIONAL RULE: *Required when returned in the remittance advice. If not required by this implementation guide, do not send.*

IMPLEMENTATION NAME: **Non-Payable Professional Component Billed Amount**

SEGMENT DETAIL

NM1 - OTHER SUBSCRIBER NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 Set Notes: 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 Syntax:

- P0809**
If either NM108 or NM109 is present, then the other is required.
- C1110**
If NM111 is present, then NM110 is required.
- C1203**
If NM112 is present, then NM103 is required.

Loop: 2330A — OTHER SUBSCRIBER NAME **Loop Repeat:** 1

Segment Repeat: 1

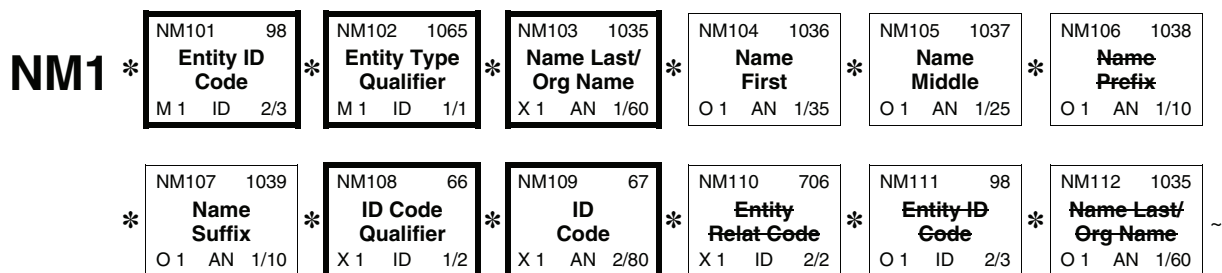
Usage: REQUIRED

TR3 Notes:

1. If the patient can be uniquely identified to the Other Payer indicated in this iteration of Loop ID-2320 by a unique Member Identification Number, then the patient is the subscriber or is considered to be the subscriber and is identified in this Other Subscriber's Name Loop ID-2330A.
2. If the patient is a dependent of the subscriber for this other coverage and cannot be uniquely identified to the Other Payer indicated in this iteration of Loop ID-2320 by a unique Member Identification Number, then the subscriber for this other coverage is identified in this Other Subscriber's Name Loop ID-2330A.
3. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: NM1*IL*1*DOE*JOHN*T**JR*MI*123456~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>IL</td><td>Insured or Subscriber</td></tr></table>	CODE	DEFINITION	IL	Insured or Subscriber					
CODE	DEFINITION											
IL	Insured or Subscriber											
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	1	Person	2	Non-Person Entity			
CODE	DEFINITION											
1	Person											
2	Non-Person Entity											
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60						
			IMPLEMENTATION NAME: Other Insured Last Name									
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.</i>	O 1	AN	1/35						
			IMPLEMENTATION NAME: Other Insured First Name									
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/25						
			IMPLEMENTATION NAME: Other Insured Middle Name									
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10						
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when NM102 = 1 (person) and the name suffix of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/10						
			IMPLEMENTATION NAME: Other Insured Name Suffix									

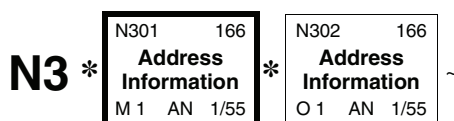
REQUIRED	NM108	66	Identification Code Qualifier X 1ID1/2 Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 <table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>II</td><td> Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value 'MI' instead. </td></tr><tr><td>MI</td><td> Member Identification Number The code MI is intended to be the subscriber's identification number as assigned by the payer. (For example, Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.) MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number (SSN) is also available on an IHS/CHS claim, put the SSN in REF02. When sending the Social Security Number as the Member ID, it must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid. </td></tr></tbody></table>	CODE	DEFINITION	II	Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value 'MI' instead.	MI	Member Identification Number The code MI is intended to be the subscriber's identification number as assigned by the payer. (For example, Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.) MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number (SSN) is also available on an IHS/CHS claim, put the SSN in REF02. When sending the Social Security Number as the Member ID, it must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.
CODE	DEFINITION								
II	Standard Unique Health Identifier for each Individual in the United States Required if the HIPAA Individual Patient Identifier is mandated use. If not required, use value 'MI' instead.								
MI	Member Identification Number The code MI is intended to be the subscriber's identification number as assigned by the payer. (For example, Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.) MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number (SSN) is also available on an IHS/CHS claim, put the SSN in REF02. When sending the Social Security Number as the Member ID, it must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.								
REQUIRED	NM109	67	Identification Code X 1AN2/80 Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: Other Insured Identifier						
NOT USED	NM110	706	Entity Relationship Code X 1ID2/2						
NOT USED	NM111	98	Entity Identifier Code O 1ID2/3						
NOT USED	NM112	1035	Name Last or Organization Name O 1AN1/60						

SEGMENT DETAIL

N3 - OTHER SUBSCRIBER ADDRESS

X12 Segment Name: Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2330A — OTHER SUBSCRIBER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the information is available. If not required by this implementation guide, do not send.**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Other Insured Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Other Insured Address Line				

SEGMENT DETAIL

N4 - OTHER SUBSCRIBER CITY, STATE, ZIP CODE**X12 Segment Name:** Geographic Location**X12 Purpose:** To specify the geographic place of the named party**X12 Syntax:** 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

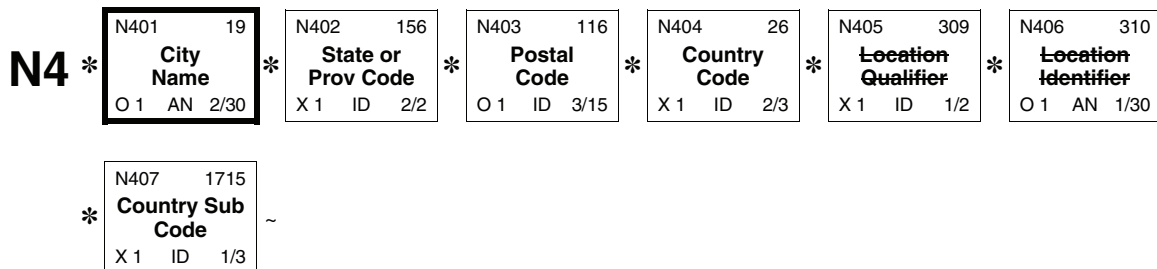
If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2330A — OTHER SUBSCRIBER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the information is available. If not required by this implementation guide, do not send.**TR3 Example:** N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30
COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.				
IMPLEMENTATION NAME: Other Insured City Name				

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Insured State Code CODE SOURCE 22: States and Provinces	X 1	ID	2/2
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Insured Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	O 1	ID	3/15
SITUATIONAL	N404	26	Country Code Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.	X 1	ID	2/3
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	O 1	AN	1/30
SITUATIONAL	N407	1715	Country Subdivision Code Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.	X 1	ID	1/3

SEGMENT DETAIL

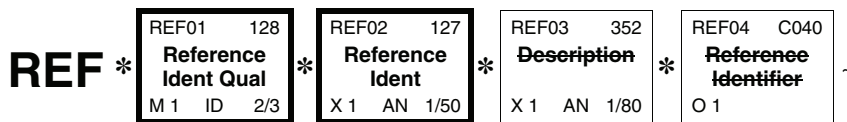
REF - OTHER SUBSCRIBER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330A — OTHER SUBSCRIBER NAME**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required when an additional identification number to that provided in NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.**TR3 Example:** REF*SY*123456789~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			SY	Social Security Number The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid.
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Other Insured Additional Identifier	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OTHER PAYER NAME

X12 Segment Name: Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

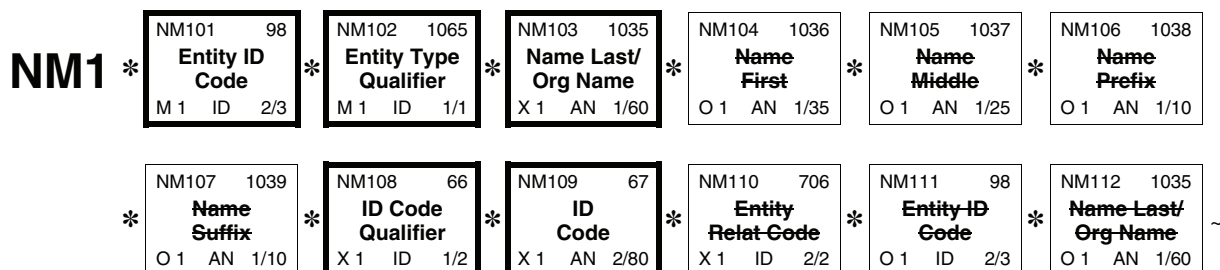
X12 Syntax: 1. **P0809**
If either NM108 or NM109 is present, then the other is required.

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

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330B — OTHER PAYER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Notes:** 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*PR*2*ABC INSURANCE CO*****PI*11122333~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>PR</td><td>Payer</td></tr></table>	CODE	DEFINITION	PR	Payer			
CODE	DEFINITION									
PR	Payer									
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>2</td><td>Non-Person Entity</td></tr></table>	CODE	DEFINITION	2	Non-Person Entity			
CODE	DEFINITION									
2	Non-Person Entity									

REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60

IMPLEMENTATION NAME: **Other Payer Last or Organization Name**

NOT USED	NM104	1036	Name First	O 1	AN	1/35

NOT USED	NM105	1037	Name Middle	O 1	AN	1/25

NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10

NOT USED	NM107	1039	Name Suffix	O 1	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 1	ID	1/2

On or after the mandated implementation date for the HIPAA National Plan Identifier (National Plan ID), XV must be sent.

Prior to the mandated implementation date and prior to any phase-in period identified by Federal regulation, PI must be sent.

If a phase-in period is designated, PI must be sent unless:

1. Both the sender and receiver agree to use the National Plan ID,
2. The receiver has a National Plan ID, and
3. The sender has the capability to send the National Plan ID.

If all of the above conditions are true, XV must be sent. In this case the Payer Identification Number that would have been sent using qualifier PI can be sent in the corresponding REF segment using qualifier 2U.

CODE	DEFINITION

PI	Payor Identification

XV	Centers for Medicare and Medicaid Services PlanID CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID

REQUIRED	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809	X 1	AN	2/80

IMPLEMENTATION NAME: **Other Payer Primary Identifier**

When sending Line Adjudication Information for this payer, the identifier sent in SVD01 (Payer Identifier) of Loop ID-2430 (Line Adjudication Information) must match this value.

NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2

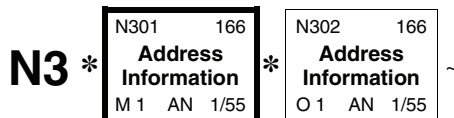
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3

NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

N3 - OTHER PAYER ADDRESS**X12 Segment Name:** Party Location**X12 Purpose:** To specify the location of the named party**Loop:** 2330B — OTHER PAYER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide, do not send.**TR3 Example:** N3*123 MAIN STREET~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N301	166	Address Information Address information	M 1 AN 1/55
IMPLEMENTATION NAME: Other Payer Address Line				
SITUATIONAL	N302	166	Address Information Address information	O 1 AN 1/55
SITUATIONAL RULE: <i>Required when there is a second address line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Other Payer Address Line				

SEGMENT DETAIL

N4 - OTHER PAYER CITY, STATE, ZIP CODE**X12 Segment Name:** Geographic Location**X12 Purpose:** To specify the geographic place of the named party**X12 Syntax:** 1. **E0207**

Only one of N402 or N407 may be present.

2. **C0605**

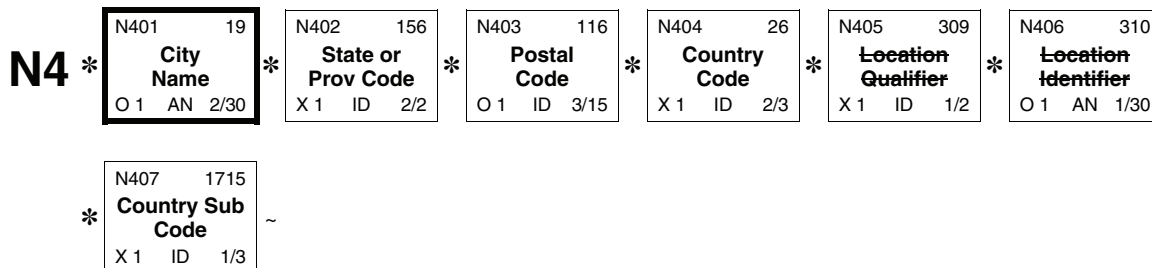
If N406 is present, then N405 is required.

3. **C0704**

If N407 is present, then N404 is required.

Loop: 2330B — OTHER PAYER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the payer address is available and the submitter intends for the claim to be printed on paper at the next EDI location (for example, a clearinghouse). If not required by this implementation guide, do not send.**TR3 Example:** N4*KANSAS CITY*MO*64108~

DIAGRAM



ELEMENT DETAIL

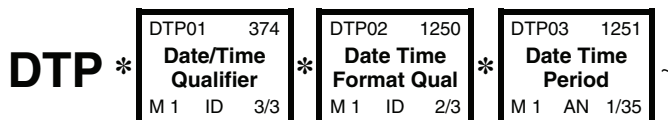
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	N401	19	City Name Free-form text for city name	O 1 AN 2/30
COMMENT: A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.				
IMPLEMENTATION NAME: Other Payer City Name				

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Payer State Code CODE SOURCE 22: States and Provinces	X 1	ID	2/2
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: <i>Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Other Payer Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	O 1	ID	3/15
SITUATIONAL	N404	26	Country Code Code identifying the country SYNTAX: C0704 SITUATIONAL RULE: <i>Required when the address is outside the United States of America. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.	X 1	ID	2/3
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	O 1	AN	1/30
SITUATIONAL	N407	1715	Country Subdivision Code Code identifying the country subdivision SYNTAX: E0207, C0704 SITUATIONAL RULE: <i>Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.</i> CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.	X 1	ID	1/3

SEGMENT DETAIL

DTP - CLAIM CHECK OR REMITTANCE DATE**X12 Segment Name:** Date or Time or Period**X12 Purpose:** To specify any or all of a date, a time, or a time period**Loop:** 2330B — OTHER PAYER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the payer identified in this loop has previously adjudicated the claim and Loop ID-2430, Line Check or Remittance Date, is not used. If not required by this implementation guide, do not send.**TR3 Example:** DTP*573*D8*20040203~

DIAGRAM



ELEMENT DETAIL

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 1 ID 3/3
IMPLEMENTATION NAME: Date Time Qualifier				
		CODE	DEFINITION	
		573	Date Claim Paid	
REQUIRED	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	M 1 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 1 AN 1/35
IMPLEMENTATION NAME: Adjudication or Payment Date				

SEGMENT DETAIL

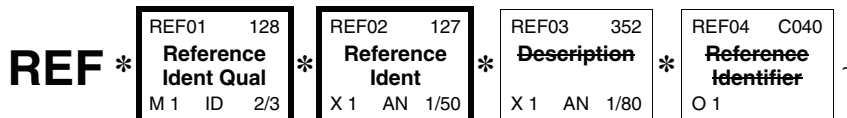
REF - OTHER PAYER SECONDARY IDENTIFIER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330B — OTHER PAYER NAME**Segment Repeat:** 2**Usage:** SITUATIONAL**Situational Rule:** Required prior to the mandated implementation date for the HIPAA National Plan Identifier when an additional identification number to that provided in the NM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.**TR3 Example:** REF*2U*98765~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3																
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>2U</td><td>Payer Identification Number</td></tr><tr><td>EI</td><td>Employer's Identification Number</td></tr><tr><td></td><td>The Employer's Identification Number must be a string of exactly nine numbers with no separators.</td></tr><tr><td></td><td>For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.</td></tr><tr><td>FY</td><td>Claim Office Number</td></tr><tr><td>NF</td><td>National Association of Insurance Commissioners (NAIC) Code</td></tr><tr><td colspan="2">CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code</td></tr></tbody></table>	CODE	DEFINITION	2U	Payer Identification Number	EI	Employer's Identification Number		The Employer's Identification Number must be a string of exactly nine numbers with no separators.		For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.	FY	Claim Office Number	NF	National Association of Insurance Commissioners (NAIC) Code	CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code				
CODE	DEFINITION																					
2U	Payer Identification Number																					
EI	Employer's Identification Number																					
	The Employer's Identification Number must be a string of exactly nine numbers with no separators.																					
	For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid.																					
FY	Claim Office Number																					
NF	National Association of Insurance Commissioners (NAIC) Code																					
CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code																						

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	X 1	AN	1/50
IMPLEMENTATION NAME: Other Payer Secondary Identifier						
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1		

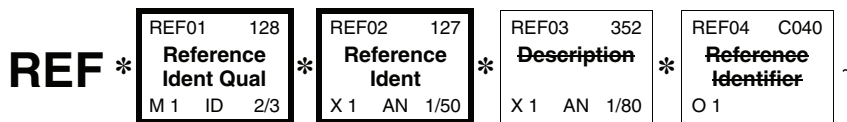
SEGMENT DETAIL

REF - OTHER PAYER PRIOR
AUTHORIZATION NUMBER**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330B — OTHER PAYER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the payer identified in this loop has assigned a prior authorization number to this claim.
If not required by this implementation guide, do not send.**TR3 Example:** REF*G1*AB333-Y5~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			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	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Other Payer Prior Authorization Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - OTHER PAYER REFERRAL NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330B — OTHER PAYER NAME

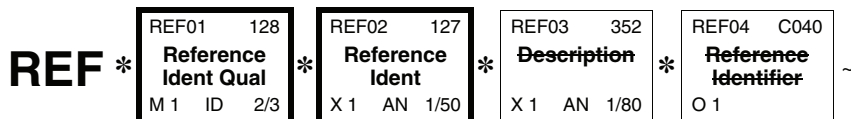
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when the payer identified in this loop has assigned a referral number to this claim.
If not required by this implementation guide, do not send.

TR3 Example: REF*9F*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			9F	Referral Number
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Other Payer Prior Authorization or Referral Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

REF - OTHER PAYER CLAIM ADJUSTMENT
INDICATOR**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

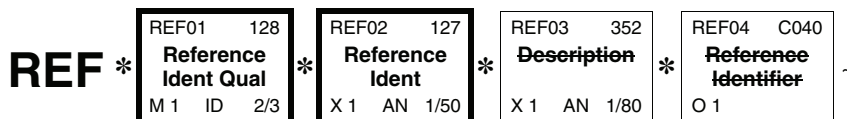
At least one of REF02 or REF03 is required.

Loop: 2330B — OTHER PAYER NAME**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required when the claim is being sent in the payer-to-payer COB model,
AND
the destination payer is secondary to the payer identified in this Loop ID-
2330B,
AND
the payer identified in this Loop ID-2330B has re-adjudicated the claim.
If not required by this implementation guide, do not send.

TR3 Example: REF*T4*Y~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3				
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>T4</td><td>Signal Code</td></tr></table>							CODE	DEFINITION	T4	Signal Code
CODE	DEFINITION									
T4	Signal Code									
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Payer Claim Adjustment Indicator Only allowed value is “Y”.	X 1	AN	1/50				
NOT USED	REF03	352	Description	X 1	AN	1/80				
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1						

SEGMENT DETAIL

REF - OTHER PAYER CLAIM CONTROL NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330B — OTHER PAYER NAME

Segment Repeat: 1

Usage: SITUATIONAL

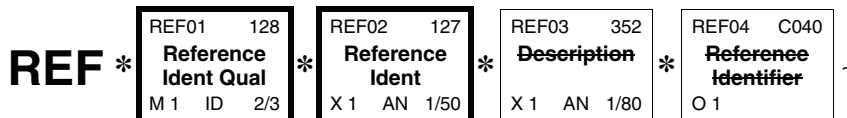
Situational Rule: Required when it is necessary to identify the Other Payer's Claim Control Number in a payer-to-payer COB situation.

OR

Required when the Other Payer's Claim Control Number is available.
If not required by this implementation guide, do not send.

TR3 Example: REF*F8*R555588~

DIAGRAM



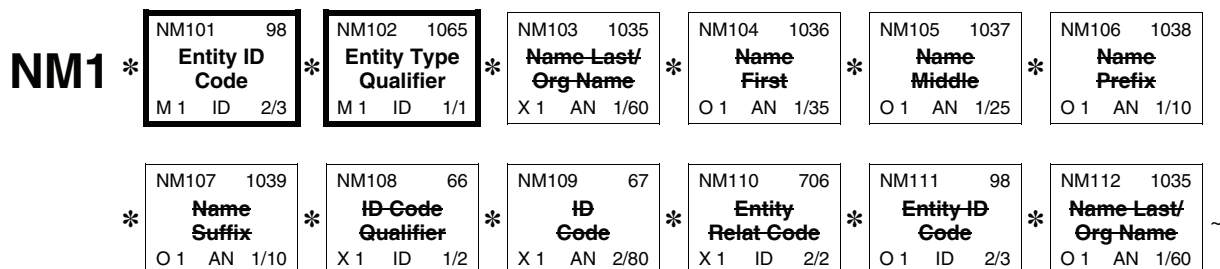
ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			F8	Original Reference Number This is the payer's internal Claim Control Number for this claim for the payer identified in this iteration of Loop ID-2330. This value is typically used in payer-to-payer COB situations only.
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Other Payer's Claim Control Number	
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OTHER PAYER ATTENDING PROVIDER**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2330C — OTHER PAYER ATTENDING PROVIDER **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.
OR
Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.
If not required by this implementation guide, do not send.**TR3 Notes:** 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*71*1~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			CODE	DEFINITION		
			71	Attending Physician		
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			CODE	DEFINITION		
			1	Person		
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

**REF - OTHER PAYER ATTENDING PROVIDER
SECONDARY IDENTIFICATION****X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

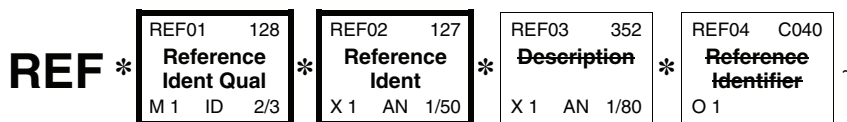
At least one of REF02 or REF03 is required.

Loop: 2330C — OTHER PAYER ATTENDING PROVIDER**Segment Repeat:** 4**Usage:** REQUIRED**TR3 Notes:** 1. Non-destination (COB) payer's provider identification number(s).

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3														
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr><tr><td>1G</td><td>Provider UPIN Number</td></tr><tr><td></td><td>UPINs must be formatted as either X99999 or XXX999.</td></tr><tr><td>G2</td><td>Provider Commercial Number</td></tr><tr><td></td><td>This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.</td></tr><tr><td>LU</td><td>Location Number</td></tr></table>	CODE	DEFINITION	0B	State License Number	1G	Provider UPIN Number		UPINs must be formatted as either X99999 or XXX999.	G2	Provider Commercial Number		This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.	LU	Location Number			
CODE	DEFINITION																			
0B	State License Number																			
1G	Provider UPIN Number																			
	UPINs must be formatted as either X99999 or XXX999.																			
G2	Provider Commercial Number																			
	This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.																			
LU	Location Number																			

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Payer Attending Provider Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OTHER PAYER OPERATING PHYSICIAN**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330D — OTHER PAYER OPERATING PHYSICIAN **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

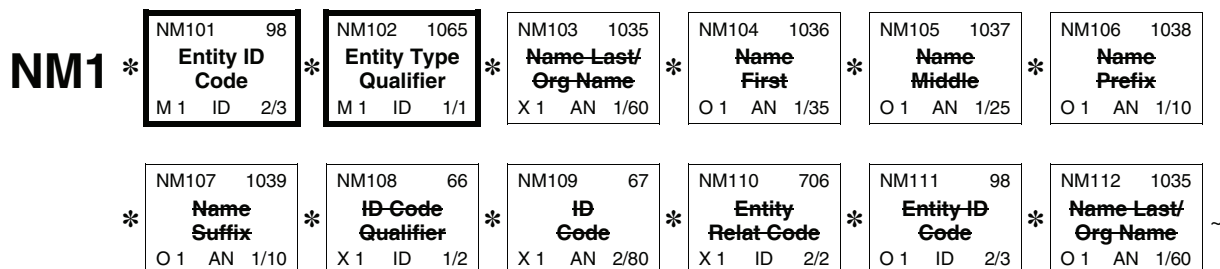
OR

Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*72*1~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			72			
			Operating Physician			
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			1			
			Person			
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

**REF - OTHER PAYER OPERATING
PHYSICIAN SECONDARY IDENTIFICATION****X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

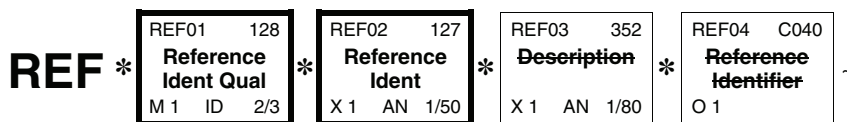
At least one of REF02 or REF03 is required.

Loop: 2330D — OTHER PAYER OPERATING PHYSICIAN**Segment Repeat:** 4**Usage:** REQUIRED**TR3 Notes:** 1. Non-destination (COB) payer's provider identification number(s).

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3														
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr><tr><td>1G</td><td>Provider UPIN Number</td></tr><tr><td></td><td>UPINs must be formatted as either X99999 or XXX999.</td></tr><tr><td>G2</td><td>Provider Commercial Number</td></tr><tr><td></td><td>This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.</td></tr><tr><td>LU</td><td>Location Number</td></tr></table>	CODE	DEFINITION	0B	State License Number	1G	Provider UPIN Number		UPINs must be formatted as either X99999 or XXX999.	G2	Provider Commercial Number		This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.	LU	Location Number			
CODE	DEFINITION																			
0B	State License Number																			
1G	Provider UPIN Number																			
	UPINs must be formatted as either X99999 or XXX999.																			
G2	Provider Commercial Number																			
	This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.																			
LU	Location Number																			

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Payer Operating Provider Secondary Identifier	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OTHER PAYER OTHER OPERATING PHYSICIAN**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330E — OTHER PAYER OTHER OPERATING PHYSICIAN **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

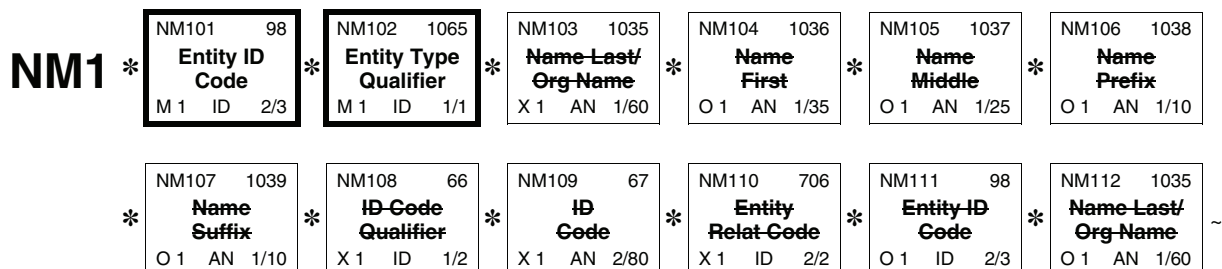
OR

Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*ZZ*1~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ZZ</td><td>Mutually Defined</td></tr><tr><td colspan="2">ZZ is used to indicate Other Operating Physician.</td></tr></table>	CODE	DEFINITION	ZZ	Mutually Defined	ZZ is used to indicate Other Operating Physician.				
CODE	DEFINITION											
ZZ	Mutually Defined											
ZZ is used to indicate Other Operating Physician.												
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr></table>	CODE	DEFINITION	1	Person					
CODE	DEFINITION											
1	Person											
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60						
NOT USED	NM104	1036	Name First	O 1	AN	1/35						
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25						
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10						
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10						
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2						
NOT USED	NM109	67	Identification Code	X 1	AN	2/80						
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2						
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3						
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60						

SEGMENT DETAIL

**REF - OTHER PAYER OTHER OPERATING
PHYSICIAN SECONDARY IDENTIFICATION****X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

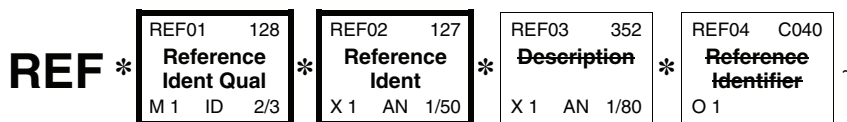
At least one of REF02 or REF03 is required.

Loop: 2330E — OTHER PAYER OTHER OPERATING PHYSICIAN**Segment Repeat:** 4**Usage:** REQUIRED**TR3 Notes:** 1. Non-destination (COB) payer's provider identification number(s).

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3														
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr><tr><td>1G</td><td>Provider UPIN Number</td></tr><tr><td></td><td>UPINs must be formatted as either X99999 or XXX999.</td></tr><tr><td>G2</td><td>Provider Commercial Number</td></tr><tr><td></td><td>This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.</td></tr><tr><td>LU</td><td>Location Number</td></tr></table>	CODE	DEFINITION	0B	State License Number	1G	Provider UPIN Number		UPINs must be formatted as either X99999 or XXX999.	G2	Provider Commercial Number		This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.	LU	Location Number			
CODE	DEFINITION																			
0B	State License Number																			
1G	Provider UPIN Number																			
	UPINs must be formatted as either X99999 or XXX999.																			
G2	Provider Commercial Number																			
	This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.																			
LU	Location Number																			

REQUIRED	REF02	127	Reference Identification X 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Payer Other Operating Physician Secondary Identifier
NOT USED	REF03	352	Description X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER O 1

SEGMENT DETAIL

NM1 - OTHER PAYER SERVICE FACILITY LOCATION**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330F — OTHER PAYER SERVICE FACILITY LOCATION **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

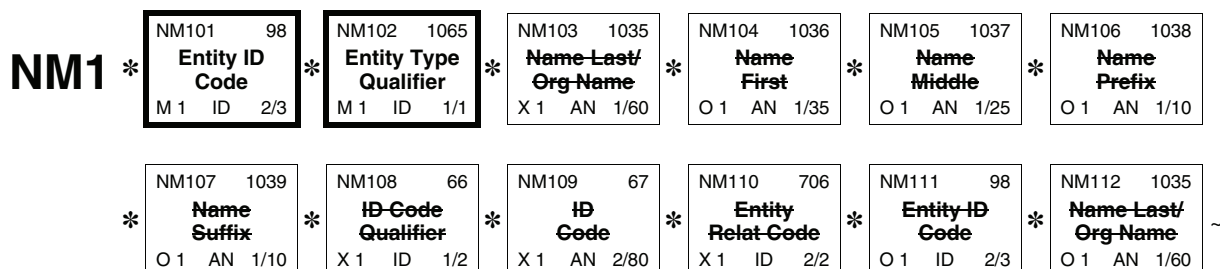
OR

Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*77*2~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			77 Service Location			
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			2 Non-Person Entity			
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

REF - OTHER PAYER SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330F — OTHER PAYER SERVICE FACILITY LOCATION

Segment Repeat: 3

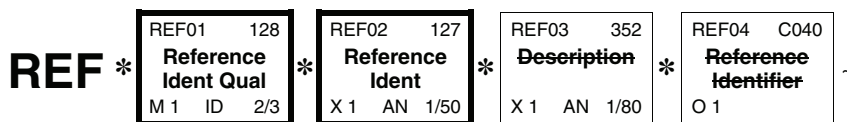
Usage: REQUIRED

TR3 Notes: 1. Non-destination (COB) payer's provider identification number(s).

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			0B	State License Number
			G2	Provider Commercial Number
				This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.
			LU	Location Number
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X 1 AN 1/50
			SYNTAX: R0203	
			IMPLEMENTATION NAME: Other Payer Service Facility Location Identifier	

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

SEGMENT DETAIL

**NM1 - OTHER PAYER RENDERING
PROVIDER NAME****X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330G — OTHER PAYER RENDERING PROVIDER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

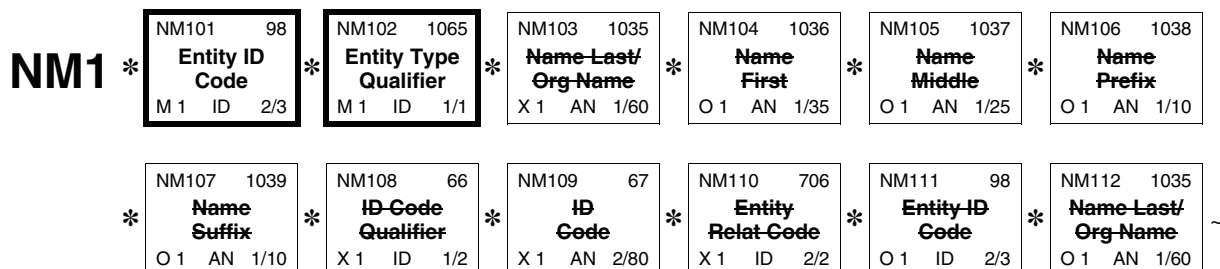
OR

Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*82*1~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			CODE	DEFINITION		
			82	Rendering Provider		
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			CODE	DEFINITION		
			1	Person		
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

**REF - OTHER PAYER RENDERING PROVIDER
SECONDARY IDENTIFICATION****X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

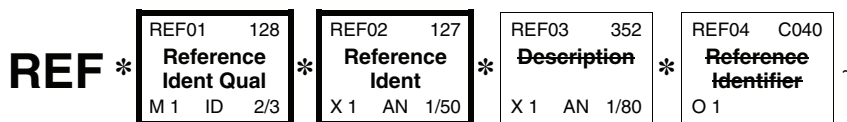
At least one of REF02 or REF03 is required.

Loop: 2330G — OTHER PAYER RENDERING PROVIDER NAME**Segment Repeat:** 4**Usage:** REQUIRED**TR3 Notes:** 1. Non-destination (COB) payer's provider identification number(s).

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES																
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3														
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>0B</td><td>State License Number</td></tr><tr><td>1G</td><td>Provider UPIN Number</td></tr><tr><td></td><td>UPINs must be formatted as either X99999 or XXX999.</td></tr><tr><td>G2</td><td>Provider Commercial Number</td></tr><tr><td></td><td>This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.</td></tr><tr><td>LU</td><td>Location Number</td></tr></table>	CODE	DEFINITION	0B	State License Number	1G	Provider UPIN Number		UPINs must be formatted as either X99999 or XXX999.	G2	Provider Commercial Number		This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.	LU	Location Number			
CODE	DEFINITION																			
0B	State License Number																			
1G	Provider UPIN Number																			
	UPINs must be formatted as either X99999 or XXX999.																			
G2	Provider Commercial Number																			
	This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.																			
LU	Location Number																			

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Payer Rendering Provider Secondary Identifier	X 1	AN	1/50
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1		

SEGMENT DETAIL

NM1 - OTHER PAYER REFERRING PROVIDER**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330H — OTHER PAYER REFERRING PROVIDER **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

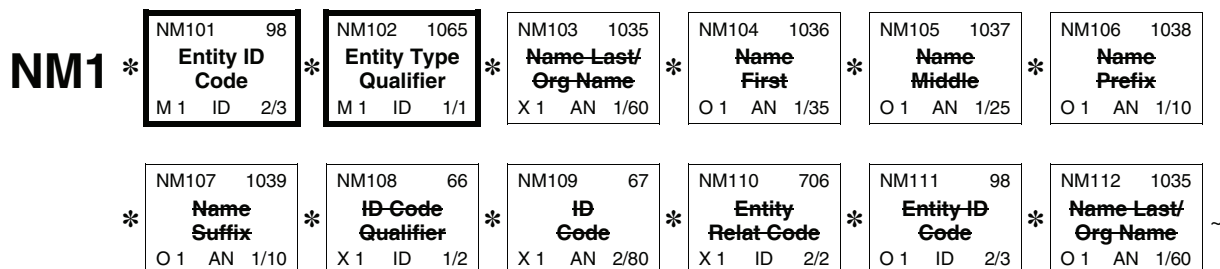
OR

Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*DN*1~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			CODE	DEFINITION		
			DN	Referring Provider		
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			CODE	DEFINITION		
			1	Person		
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

SEGMENT DETAIL

REF - OTHER PAYER REFERRING PROVIDER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330H — OTHER PAYER REFERRING PROVIDER

Segment Repeat: 3

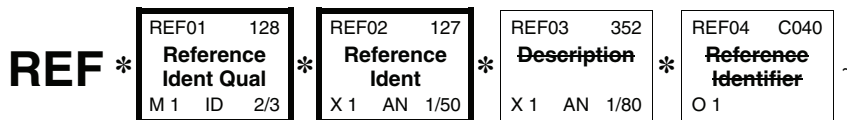
Usage: REQUIRED

TR3 Notes: 1. Non-destination (COB) payer's provider identification number(s).

2. See Crosswalking COB Data Elements section for more information on handling COB in the 837.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			0B	State License Number
			1G	Provider UPIN Number
				UPINs must be formatted as either X99999 or XXX999.
			G2	Provider Commercial Number
				This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Payer Referring Provider Identifier	X 1	AN	1/50
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1		

SEGMENT DETAIL

NM1 - OTHER PAYER BILLING PROVIDER**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 Set Notes:** 1. Segments NM1-N4 contain name and address information of the insurance carriers referenced in loop 2320.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2330I — OTHER PAYER BILLING PROVIDER **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated implementation of the HIPAA National Provider Identifier (NPI) rule when the provider in the corresponding Loop ID-2310 is sent and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

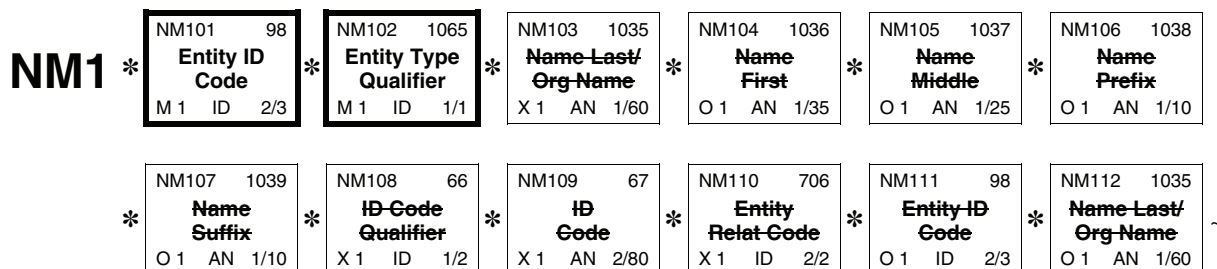
OR

Required after the mandated implementation of the NPI rule for providers who are not Health Care Providers when the provider is sent in the corresponding Loop ID-2310 and one or more additional payer-specific provider identification numbers are required by this non-destination payer (Loop ID-2330B) to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** NM1*85*2~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			CODE	DEFINITION		
			85	Billing Provider		
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			CODE	DEFINITION		
			2	Non-Person Entity		
NOT USED	NM103	1035	Name Last or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First	O 1	AN	1/35
NOT USED	NM105	1037	Name Middle	O 1	AN	1/25
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
NOT USED	NM107	1039	Name Suffix	O 1	AN	1/10
NOT USED	NM108	66	Identification Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60

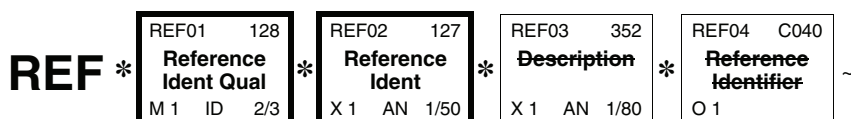
SEGMENT DETAIL

REF - OTHER PAYER BILLING PROVIDER
SECONDARY IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2330I — OTHER PAYER BILLING PROVIDER**Segment Repeat:** 2**Usage:** REQUIRED**TR3 Notes:** 1. See Crosswalking COB Data Elements section for more information on handling COB in the 837.**TR3 Example:** REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES						
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3				
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>G2</td><td>Provider Commercial Number This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.</td></tr></tbody></table>	CODE	DEFINITION	G2	Provider Commercial Number This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.			
CODE	DEFINITION									
G2	Provider Commercial Number This code designates a proprietary provider number for the non-destination payer identified in the Other Payer Name Loop ID-2330B for this iteration of Loop ID-2320. This is true regardless of whether that payer is Medicare, Medicaid, a Blue Cross Blue Shield plan, a commercial plan, or any other health plan.									
			LU Location Number							
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	X 1	AN	1/50				
			IMPLEMENTATION NAME: Other Payer Billing Provider Identifier							
NOT USED	REF03	352	Description	X 1	AN	1/80				
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1						

SEGMENT DETAIL

LX - SERVICE LINE NUMBER

X12 Segment Name: Transaction Set Line Number

X12 Purpose: To reference a line number in a transaction set

X12 Set Notes: 1. Loop 2400 contains Service Line information.

Loop: 2400 — SERVICE LINE NUMBER **Loop Repeat:** 999

Segment Repeat: 1

Usage: REQUIRED

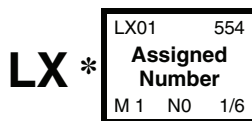
TR3 Notes: 1. The LX functions as a line counter.

2. The Service Line LX segment must begin with one and is incremented by one for each additional service line of a claim.

3. LX01 is used to indicate bundling in SVD06 in the Line Item Adjudication loop. See Section 1.4.1.2 for more information on bundling and unbundling.

TR3 Example: LX*1~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	LX01	554	Assigned Number Number assigned for differentiation within a transaction set	M 1	NO	1/6

SEGMENT DETAIL

SV2 - INSTITUTIONAL SERVICE LINE

X12 Segment Name: Institutional Service**X12 Purpose:** To specify the service line item detail for a health care institution**X12 Syntax:** 1. R0102

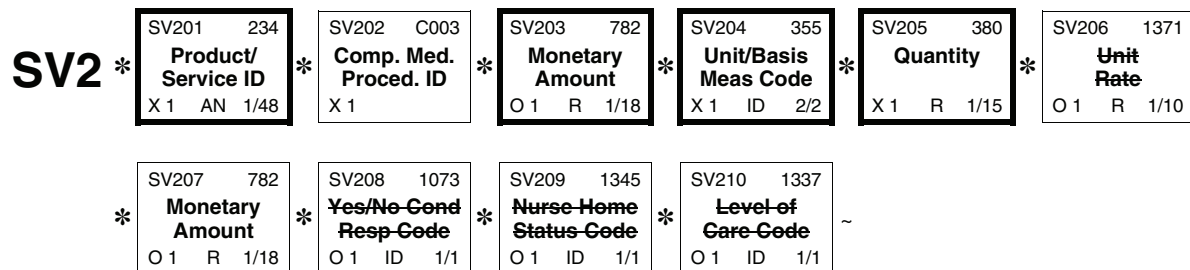
At least one of SV201 or SV202 is required.

2. P0405

If either SV204 or SV205 is present, then the other is required.

Loop: 2400 — SERVICE LINE NUMBER**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** SV2*0300*HC:81099*73.42*UN*1~**TR3 Example:** SV2*0120**1500*DA*5~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SV201	234	Product/Service ID Identifying number for a product or service SYNTAX: R0102 SEMANTIC: SV201 is the revenue code. IMPLEMENTATION NAME: Service Line Revenue Code See Code Source 132: National Uniform Billing Committee (NUBC) Codes.	X 1 AN 1/48

SITUATIONAL	SV202	C003	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		X 1
To identify a medical procedure by its standardized codes and applicable modifiers					
SITUATIONAL RULE: <i>Required for outpatient claims when an appropriate procedure code exists for this service line item.</i>					
OR					
<i>Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics only) or HIPPS code exists for this service line item.</i>					
<i>If not required by this implementation guide, do not send.</i>					
REQUIRED	SV202 - 1	235	Product/Service ID Qualifier	M ID	2/2
Code identifying the type/source of the descriptive number used in Product/Service ID (234)					
SEMANTIC: C003-01 qualifies C003-02 and C003-08.					
IMPLEMENTATION NAME: Product or Service ID Qualifier					
		CODE	DEFINITION		
		ER	Jurisdiction Specific Procedure and Supply Codes		
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.		
			CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes		
		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: Healthcare Common Procedure Coding System		
		HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code		
			CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities		

		IV	Home Infusion EDI Coalition (HIEC) Product/Service Code		
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Home Infusion EDI Coalition (HIEC) Product/Service Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.		
			CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List		
		WK	Advanced Billing Concepts (ABC) Codes		
			At the time of this writing, this code set has been approved by the Secretary of HHS as a pilot project allowed under HIPAA law. The qualifier may only be used in transactions covered under HIPAA; By parties registered in the pilot project and their trading partners, OR If a new rule names the Complementary, Alternative, or Holistic Procedure Codes as an allowable code set under HIPAA, OR For claims which are not covered under HIPAA.		
			CODE SOURCE 843: Advanced Billing Concepts (ABC) Codes		
REQUIRED	SV202 - 2	234	Product/Service ID	M AN 1/48	
			Identifying number for a product or service		
			SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.		
			IMPLEMENTATION NAME: Procedure Code		
SITUATIONAL	SV202 - 3	1339	Procedure Modifier	O AN 2/2	
			This identifies special circumstances related to the performance of the service, as defined by trading partners		
			SEMANTIC: C003-03 modifies the value in C003-02 and C003-08.		
			SITUATIONAL RULE: <i>Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.</i>		
SITUATIONAL	SV202 - 4	1339	Procedure Modifier	O AN 2/2	
			This identifies special circumstances related to the performance of the service, as defined by trading partners		
			SEMANTIC: C003-04 modifies the value in C003-02 and C003-08.		
			SITUATIONAL RULE: <i>Required when a second modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.</i>		

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	
			SEMANTIC: C003-05 modifies the value in C003-02 and C003-08.	
			SITUATIONAL RULE: <i>Required when a third modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.</i>	
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	
			SEMANTIC: C003-06 modifies the value in C003-02 and C003-08.	
			SITUATIONAL RULE: <i>Required when a fourth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.</i>	
SITUATIONAL	SV202 - 7	352	Description	O AN 1/80
			A free-form description to clarify the related data elements and their content	
			SEMANTIC: C003-07 is the description of the procedure identified in C003-02.	
			SITUATIONAL RULE: <i>Required when, in the judgment of the submitter, the Procedure Code does not definitively describe the service/product/supply and Loop ID-2410 is not used.</i>	
			OR <i>Required when SV202-2 is a non-specific Procedure Code. Non-specific codes may include in their descriptors terms such as: Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug, Generic; or Prescription Drug, Brand Name.</i>	
			<i>If not required by this implementation guide, do not send.</i>	
NOT USED	SV202 - 8	234	Product/Service ID	O AN 1/48
REQUIRED	SV203 782		Monetary Amount	O 1 R 1/18
			Monetary amount	
			SEMANTIC: SV203 is the submitted service line item amount.	
			IMPLEMENTATION NAME: Line Item Charge Amount	
			This is the total charge amount for this service line. The amount is inclusive of the provider's base charge and any applicable tax amounts reported within this line's AMT segments.	
			Zero "0" is an acceptable value for this element.	

REQUIRED	SV204	355	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken SYNTAX: P0405	X 1	ID	2/2						
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>DA</td><td>Days</td></tr><tr><td>UN</td><td>Unit</td></tr></table>	CODE	DEFINITION	DA	Days	UN	Unit			
CODE	DEFINITION											
DA	Days											
UN	Unit											
REQUIRED	SV205	380	Quantity Numeric value of quantity SYNTAX: P0405 IMPLEMENTATION NAME: Service Unit Count The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.	X 1	R	1/15						
NOT USED	SV206	1371	Unit Rate	O 1	R	1/10						
SITUATIONAL	SV207	782	Monetary Amount Monetary amount SEMANTIC: SV207 is a non-covered service amount. SITUATIONAL RULE: <i>Required if needed to report line specific non-covered charge amount. If not required this implementation guide, do not send.</i> IMPLEMENTATION NAME: Line Item Denied Charge or Non-Covered Charge Amount	O 1	R	1/18						
NOT USED	SV208	1073	Yes/No Condition or Response Code	O 1	ID	1/1						
NOT USED	SV209	1345	Nursing Home Residential Status Code	O 1	ID	1/1						
NOT USED	SV210	1337	Level of Care Code	O 1	ID	1/1						

SEGMENT DETAIL

PWK - LINE SUPPLEMENTAL INFORMATION**X12 Segment Name:** Paperwork**X12 Purpose:** To identify the type or transmission or both of paperwork or supporting information**X12 Syntax:** 1. P0506

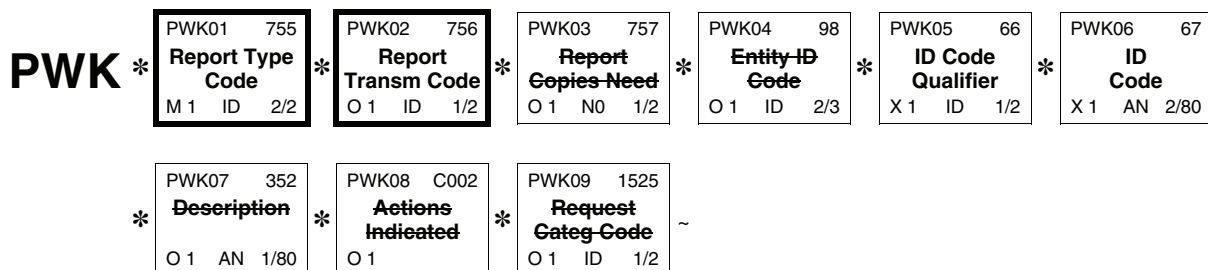
If either PWK05 or PWK06 is present, then the other is required.

Loop: 2400 — SERVICE LINE NUMBER**Segment Repeat:** 10**Usage:** SITUATIONAL

Situational Rule: Required when there is a paper attachment following this claim.
OR
Required when attachments are sent electronically (PWK02 = EL) but are transmitted in another functional group (for example, 275) rather than by paper. PWK06 is then used to identify the attached electronic documentation. The number in PWK06 is carried in the TRN of the electronic attachment.
OR
Required when the provider deems it necessary to identify additional information that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but the information is not being submitted with the claim. Use the value of "AA" in PWK02 to convey this specific use of the PWK segment.
If not required by this implementation guide, do not send.

TR3 Example: PWK*OZ*BM***AC*DMN0012~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/2
IMPLEMENTATION NAME: Attachment Report Type Code				
			CODE	DEFINITION
			03	Report Justifying Treatment Beyond Utilization Guidelines
			04	Drugs Administered
			05	Treatment Diagnosis
			06	Initial Assessment
			07	Functional Goals
			08	Plan of Treatment
			09	Progress Report
			10	Continued Treatment
			11	Chemical Analysis
			13	Certified Test Report
			15	Justification for Admission
			21	Recovery Plan
			A3	Allergies/Sensitivities Document
			A4	Autopsy Report
			AM	Ambulance Certification
			AS	Admission Summary
			B2	Prescription
			B3	Physician Order
			B4	Referral Form
			BR	Benchmark Testing Results
			BS	Baseline
			BT	Blanket Test Results
			CB	Chiropractic Justification
			CK	Consent Form(s)
			CT	Certification
			D2	Drug Profile Document
			DA	Dental Models
			DB	Durable Medical Equipment Prescription
			DG	Diagnostic Report
			DJ	Discharge Monitoring Report
			DS	Discharge Summary
			EB	Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor)
			HC	Health Certificate
			HR	Health Clinic Records
			I5	Immunization Record

IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

REQUIRED

PWK02

756

Report Transmission Code

O 1 ID 1/2

Code defining timing, transmission method or format by which reports are to be sent

IMPLEMENTATION NAME: Attachment Transmission Code

CODE	DEFINITION
AA	Available on Request at Provider Site
	This means that the additional information is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.
BM	By Mail
EL	Electronically Only
	Indicates that the attachment is being transmitted in a separate X12 functional group.
EM	E-Mail
FT	File Transfer
	Required when the actual attachment is maintained by an attachment warehouse or similar vendor.

			FX	By Fax			
NOT USED	PWK03	757	Report Copies Needed		O 1	N0	1/2
NOT USED	PWK04	98	Entity Identifier Code		O 1	ID	2/3
SITUATIONAL	PWK05	66	Identification Code Qualifier		X 1	ID	1/2
			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.				
			SITUATIONAL RULE: <i>Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.</i>				
			CODE	DEFINITION			
			AC	Attachment Control Number			
SITUATIONAL	PWK06	67	Identification Code		X 1	AN	2/80
			Code identifying a party or other code				
			SYNTAX: P0506				
			SITUATIONAL RULE: <i>Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.</i>				
			IMPLEMENTATION NAME: Attachment Control Number				
			PWK06 is used to identify the attached electronic documentation. The number in PWK06 is carried in the TRN of the electronic attachment.				
			For the purpose of this implementation, the maximum field length is 50.				
NOT USED	PWK07	352	Description		O 1	AN	1/80
NOT USED	PWK08	C002	ACTIONS INDICATED		O 1		
NOT USED	PWK09	1525	Request Category Code		O 1	ID	1/2

SEGMENT DETAIL

DTP - DATE - SERVICE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

Loop: 2400 — SERVICE LINE NUMBER

Segment Repeat: 1

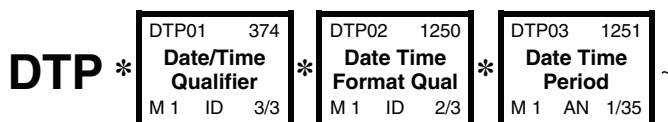
Usage: SITUATIONAL

Situational Rule: Required on outpatient service lines where a drug is not being billed and the Statement Covers Period is greater than one day.
OR
Required on service lines where a drug is being billed and the payer's adjudication is known to be impacted by the drug duration or the date the prescription was written.
If not required by this implementation guide, do not send.

- TR3 Notes:**
1. In cases where a drug is being billed on a service line, date range may be used to indicate drug duration for which the drug supply will be 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 (for example, 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.
 2. In cases where a drug is being billed on a service line, a single date may be used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

TR3 Example: DTP*472*D8*20060108~

DIAGRAM



ELEMENT DETAIL

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 1	ID	3/3						
IMPLEMENTATION NAME: Date Time Qualifier												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>472</td><td>Service</td></tr></table>							CODE	DEFINITION	472	Service		
CODE	DEFINITION											
472	Service											
REQUIRED	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	M 1	ID	2/3						
SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.												
RD8 is required only when the “To and From” dates are different. However, at the discretion of the submitter, RD8 can also be used when the “To and From” dates are the same.												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>D8</td><td>Date Expressed in Format CCYYMMDD</td></tr><tr><td>RD8</td><td>Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD</td></tr></table>							CODE	DEFINITION	D8	Date Expressed in Format CCYYMMDD	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
CODE	DEFINITION											
D8	Date Expressed in Format CCYYMMDD											
RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD											
REQUIRED	DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times	M 1	AN	1/35						
IMPLEMENTATION NAME: Service Date												

SEGMENT DETAIL

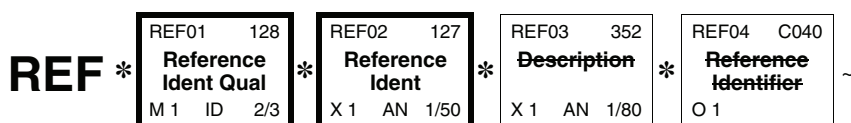
REF - LINE ITEM CONTROL NUMBER

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2400 — SERVICE LINE NUMBER**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the submitter needs a line item control number for subsequent communications to or from the payer. If not required by this implementation guide, do not send.**TR3 Notes:** 1. The line item control number must be unique within a patient control number (CLM01). Payers are required to return this number in the remittance advice transaction (835) if the provider sends it to them in the 837 and adjudication is based upon line item detail regardless of whether bundling or unbundling has occurred.2. Submitters are **STRONGLY** encouraged to routinely send a unique line item control number on all service lines, particularly if the submitter automatically posts their remittance advice. Submitting a unique line item control number allows the capability to automatically post by service line.**TR3 Example:** REF*6R*54321~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION		
			6R	Provider Control Number		

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Line Item Control Number The maximum number of characters to be supported for this field is '30'. A submitter may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any receiving system is '30'. Characters beyond 30 are not required to be stored nor returned by any 837-receiving system.	X 1	AN	1/50
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1		

SEGMENT DETAIL

REF - REPRICED LINE ITEM REFERENCE NUMBER

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2400 — SERVICE LINE NUMBER

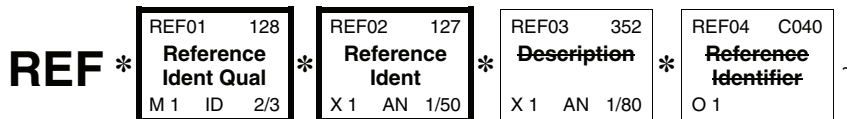
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when a repricing (pricing) organization needs to have an identifying number on the service line in their submission to their payer organization. This segment is not completed by providers. If not required by this implementation guide, do not send.

TR3 Example: REF*9B*444444~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			9B Repriced Line Item Reference Number	
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Repriced Line Item Reference Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

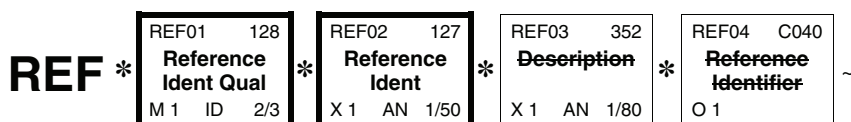
SEGMENT DETAIL

REF - ADJUSTED REPRICED LINE ITEM
REFERENCE NUMBER**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2400 — SERVICE LINE NUMBER**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when a repricing (pricing) organization needs to have an identifying number on an adjusted service line in their submission to their payer organization. This segment is not completed by providers. If not required by this implementation guide, do not send.**TR3 Example:** REF*9D*444444~

DIAGRAM



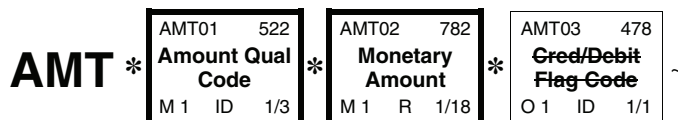
ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			9D Adjusted Repriced Line Item Reference Number	
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Adjusted Repriced Line Item Reference Number	X 1 AN 1/50
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

AMT - SERVICE TAX AMOUNT**X12 Segment Name:** Monetary Amount Information**X12 Purpose:** To indicate the total monetary amount**Loop:** 2400 — SERVICE LINE NUMBER**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when a service tax or surcharge applies to the service being reported in SV201 and the submitter is required to report that information to the receiver. If not required by this implementation guide, do not send.**TR3 Notes:** 1. When reporting the Service Tax Amount (AMT02), the amount reported in the Line Item Charge Amount (SV203) for this service line must include the amount reported in the Service Tax Amount.**TR3 Example:** AMT*GT*15~

DIAGRAM



ELEMENT DETAIL

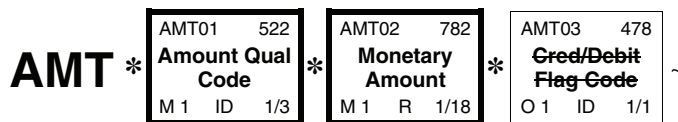
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3
			CODE	DEFINITION
			GT	Goods and Services Tax
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18
			IMPLEMENTATION NAME: Service Tax Amount	
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1

SEGMENT DETAIL

AMT - FACILITY TAX AMOUNT

X12 Segment Name: Monetary Amount Information**X12 Purpose:** To indicate the total monetary amount**Loop:** 2400 — SERVICE LINE NUMBER**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when a facility tax or surcharge applies to the service being reported in SV201 and the submitter is required to report that information to the receiver. If not required by this implementation guide, do not send.**TR3 Notes:** 1. When reporting the Facility Tax Amount (AMT02), the amount reported in the Line Item Charge Amount (SV203) for this service line must include the amount reported in the Facility Tax Amount.**TR3 Example:** AMT*N8*22~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3
			CODE DEFINITION	
			N8 Miscellaneous Taxes	
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18
			IMPLEMENTATION NAME: Facility Tax Amount	
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1

SEGMENT DETAIL

NTE - THIRD PARTY ORGANIZATION NOTES

X12 Segment Name: Note/Special Instruction

X12 Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction

X12 Comments: 1. The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processible. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.

Loop: 2400 — SERVICE LINE NUMBER

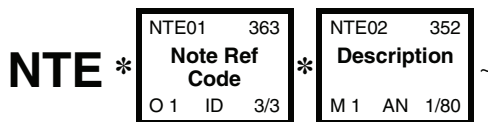
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when the TPO/repricer needs to forward additional information to the payer. This segment is not completed by providers. If not required by this implementation guide, do not send.

TR3 Example: NTE*TPO*state regulation 123 was applied during the pricing of this claim~

DIAGRAM



ELEMENT DETAIL

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 1 ID 3/3
			CODE	DEFINITION
			TPO	Third Party Organization Notes
REQUIRED	NTE02	352	Description A free-form description to clarify the related data elements and their content	M 1 AN 1/80
			IMPLEMENTATION NAME: Line Note Text	

SEGMENT DETAIL

**HCP - LINE PRICING/REPRICING
INFORMATION****X12 Segment Name:** Health Care Pricing**X12 Purpose:** To specify pricing or repricing information about a health care claim or line item**X12 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**

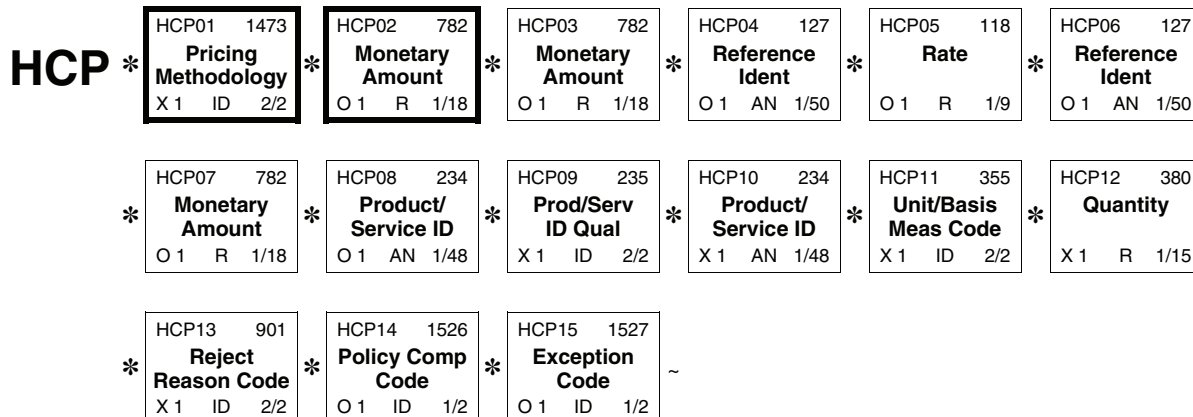
If either HCP11 or HCP12 is present, then the other is required.

Loop: 2400 — SERVICE LINE NUMBER**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.**TR3 Notes:** 1. This information is specific to the destination payer reported in Loop ID-2010BB.

2. For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.

TR3 Example: HCP*03*100*10*RPO12345~

DIAGRAM



ELEMENT DETAIL

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 SYNTAX: R0113 Specific code use is determined by Trading Partner Agreement due to the variances in contracting policies in the industry.	X 1	ID	2/2																																
			<table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>00</td><td>Zero Pricing (Not Covered Under Contract)</td></tr><tr><td>01</td><td>Priced as Billed at 100%</td></tr><tr><td>02</td><td>Priced at the Standard Fee Schedule</td></tr><tr><td>03</td><td>Priced at a Contractual Percentage</td></tr><tr><td>04</td><td>Bundled Pricing</td></tr><tr><td>05</td><td>Peer Review Pricing</td></tr><tr><td>06</td><td>Per Diem Pricing</td></tr><tr><td>07</td><td>Flat Rate Pricing</td></tr><tr><td>08</td><td>Combination Pricing</td></tr><tr><td>09</td><td>Maternity Pricing</td></tr><tr><td>10</td><td>Other Pricing</td></tr><tr><td>11</td><td>Lower of Cost</td></tr><tr><td>12</td><td>Ratio of Cost</td></tr><tr><td>13</td><td>Cost Reimbursed</td></tr><tr><td>14</td><td>Adjustment Pricing</td></tr></tbody></table>	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			
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13	Cost Reimbursed																																					
14	Adjustment Pricing																																					
REQUIRED	HCP02	782	Monetary Amount Monetary amount SEMANTIC: HCP02 is the allowed amount.	O 1	R	1/18																																
SITUATIONAL	HCP03	782	Monetary Amount Monetary amount SEMANTIC: HCP03 is the savings amount. SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i> This information is specific to the destination payer reported in Loop ID-2010BB.	O 1	R	1/18																																

SITUATIONAL	HCP04	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SEMANTIC: HCP04 is the repricing organization identification number.			
SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>			
This information is specific to the destination payer reported in Loop ID-2010BB.			
SITUATIONAL	HCP05	118	Rate O 1 R 1/9 Rate expressed in the standard monetary denomination for the currency specified
SEMANTIC: HCP05 is the pricing rate associated with per diem or flat rate repricing.			
SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>			
This information is specific to the destination payer reported in Loop ID-2010BB.			
SITUATIONAL	HCP06	127	Reference Identification O 1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
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.			
SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>			
This information is specific to the destination payer reported in Loop ID-2010BB.			
SITUATIONAL	HCP07	782	Monetary Amount O 1 R 1/18 Monetary amount
SEMANTIC: HCP07 is the approved DRG amount.			
SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>			
This information is specific to the destination payer reported in Loop ID-2010BB.			

SITUATIONAL	HCP08	234	Product/Service ID	O 1 AN 1/48

Identifying number for a product or service

SEMANTIC: HCP08 is the approved revenue code.

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

IMPLEMENTATION NAME: Product or Service ID

This information is specific to the destination payer reported in Loop ID-2010BB.

SITUATIONAL	HCP09	235	Product/Service ID Qualifier	X 1 ID 2/2

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

SYNTAX: P0910

SITUATIONAL RULE: *Required when HCP10 exists. If not required by this implementation guide, do not send.*

IMPLEMENTATION NAME: Product or Service ID Qualifier

CODE	DEFINITION
ER	Jurisdiction Specific Procedure and Supply Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Jurisdiction Specific Procedure and Supply Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes
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: Healthcare Common Procedure Coding System
HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

			IV	Home Infusion EDI Coalition (HIEC) Product/Service Code						
				This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Home Infusion EDI Coalition (HIEC) Product/Service Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.						
				CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List						
			WK	Advanced Billing Concepts (ABC) Codes						
				At the time of this writing, this code set has been approved by the Secretary of HHS as a pilot project allowed under HIPAA law. The qualifier may only be used in transactions covered under HIPAA; By parties registered in the pilot project and their trading partners, OR If a new rule names the Complementary, Alternative, or Holistic Procedure Codes as an allowable code set under HIPAA, OR For claims which are not covered under HIPAA.						
				CODE SOURCE 843: Advanced Billing Concepts (ABC) Codes						
SITUATIONAL	HCP10	234	Product/Service ID		X 1	AN	1/48			
				Identifying number for a product or service						
				SYNTAX: P0910						
				SEMANTIC: HCP10 is the approved procedure code.						
				SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>						
				IMPLEMENTATION NAME: Repriced Approved HCPCS Code						
				This information is specific to the destination payer reported in Loop ID-2010BB.						

SITUATIONAL **HCP11** **355** **Unit or Basis for Measurement Code** **X 1** **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

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

CODE	DEFINITION
DA	Days
UN	Unit

SITUATIONAL **HCP12** **380** **Quantity** **X 1** **R** **1/15**
Numeric value of quantity

SYNTAX: P1112

SEMANTIC: HCP12 is the approved service units or inpatient days.

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

This information is specific to the destination payer reported in Loop ID-2010BB.

The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.

SITUATIONAL **HCP13** **901** **Reject Reason Code** **X 1** **ID** **2/2**
Code assigned by issuer to identify reason for rejection

SYNTAX: R0113

SEMANTIC: HCP13 is the rejection message returned from the third party organization.

SITUATIONAL RULE: *Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.*

This information is specific to the destination payer reported in Loop ID-2010BB.

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 repricing

SITUATIONAL	HCP14	1526	Policy Compliance Code	O 1	ID	1/2														
			Code specifying policy compliance																	
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>																	
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SITUATIONAL	HCP15	1527	Exception Code	O 1	ID	1/2														
			Code specifying the exception reason for consideration of out-of-network health care services																	
			SEMANTIC: HCP15 is the exception reason generated by a third party organization.																	
			SITUATIONAL RULE: <i>Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.</i>																	
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5	State Mandates																			
6	Other																			

SEGMENT DETAIL

LIN - DRUG IDENTIFICATION**X12 Segment Name:** Item Identification**X12 Purpose:** To specify basic item identification data**X12 Set Notes:** 1. Loop 2410 contains compound drug components, quantities and prices.

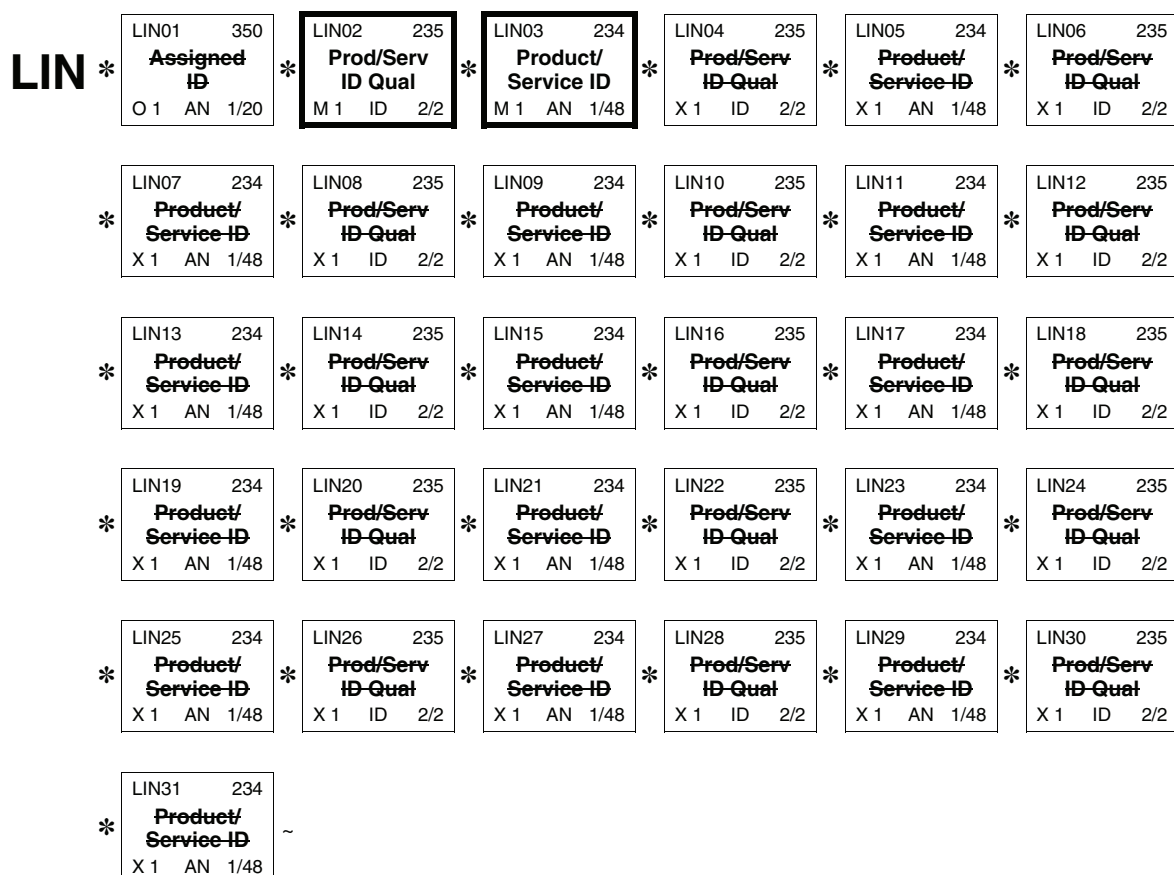
- X12 Syntax:**
1. **P0405**
If either LIN04 or LIN05 is present, then the other is required.
 2. **P0607**
If either LIN06 or LIN07 is present, then the other is required.
 3. **P0809**
If either LIN08 or LIN09 is present, then the other is required.
 4. **P1011**
If either LIN10 or LIN11 is present, then the other is required.
 5. **P1213**
If either LIN12 or LIN13 is present, then the other is required.
 6. **P1415**
If either LIN14 or LIN15 is present, then the other is required.
 7. **P1617**
If either LIN16 or LIN17 is present, then the other is required.
 8. **P1819**
If either LIN18 or LIN19 is present, then the other is required.
 9. **P2021**
If either LIN20 or LIN21 is present, then the other is required.
 10. **P2223**
If either LIN22 or LIN23 is present, then the other is required.
 11. **P2425**
If either LIN24 or LIN25 is present, then the other is required.
 12. **P2627**
If either LIN26 or LIN27 is present, then the other is required.
 13. **P2829**
If either LIN28 or LIN29 is present, then the other is required.
 14. **P3031**
If either LIN30 or LIN31 is present, then the other is required.

X12 Comments: 1. See the Data Dictionary for a complete list of IDs.**Loop:** 2410 — DRUG IDENTIFICATION **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required when government regulation mandates that prescribed drugs and biologics are reported with NDC numbers.
OR
Required when the provider or submitter chooses to report NDC numbers to enhance the claim reporting or adjudication processes.
If not required by this implementation guide, do not send.

TR3 Notes: 1. Drugs and biologics reported in this segment are a further specification of service(s) described in the SV2 segment of this Service Line Loop ID-2400.

TR3 Example: LIN**N4*01234567891~

DIAGRAM**ELEMENT DETAIL**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	LIN01	350	Assigned Identification	O 1 AN 1/20

REQUIRED	LIN02	235	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234) COMMENT: LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU. IMPLEMENTATION NAME: Product or Service ID Qualifier	M 1	ID	2/2
REQUIRED	LIN03	234	Product/Service ID Identifying number for a product or service IMPLEMENTATION NAME: National Drug Code	M 1	AN	1/48
NOT USED	LIN04	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN05	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN06	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN07	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN08	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN09	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN10	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN11	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN12	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN13	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN14	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN15	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN16	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN17	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN18	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN19	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN20	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN21	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN22	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN23	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN24	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN25	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN26	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN27	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN28	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN29	234	Product/Service ID	X 1	AN	1/48
NOT USED	LIN30	235	Product/Service ID Qualifier	X 1	ID	2/2
NOT USED	LIN31	234	Product/Service ID	X 1	AN	1/48

SEGMENT DETAIL

CTP - DRUG QUANTITY

X12 Segment Name: Pricing Information**X12 Purpose:** To specify pricing information**X12 Syntax:** 1. **P0405**

If either CTP04 or CTP05 is present, then the other is required.

2. **C0607**

If CTP06 is present, then CTP07 is required.

3. **C0902**

If CTP09 is present, then CTP02 is required.

4. **C1002**

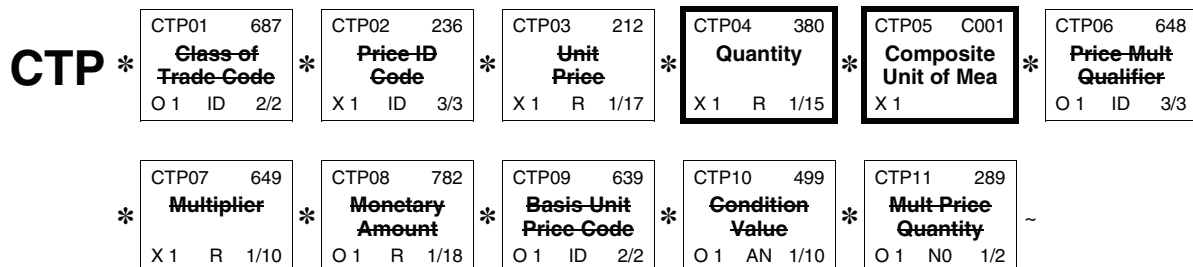
If CTP10 is present, then CTP02 is required.

5. **C1103**

If CTP11 is present, then CTP03 is required.

Loop: 2410 — DRUG IDENTIFICATION**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** CTP****2*UN~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
NOT USED	CTP01	687	Class of Trade Code	O 1 ID 2/2
NOT USED	CTP02	236	Price Identifier Code	X 1 ID 3/3
NOT USED	CTP03	212	Unit Price	X 1 R 1/17
REQUIRED	CTP04	380	Quantity Numeric value of quantity SYNTAX: P0405	X 1 R 1/15
IMPLEMENTATION NAME: National Drug Unit Count				

REQUIRED	CTP05	C001	COMPOSITE UNIT OF MEASURE	X 1		
			To identify a composite unit of measure			
			(See Figures Appendix for examples of use)			
REQUIRED	CTP05 - 1	355	Unit or Basis for Measurement Code	M	ID	2/2
			Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken			
			COMMENTS:			
			If C001-11 is not used, its value is to be interpreted as 1.			
			If C001-12 is not used, its value is to be interpreted as 1.			
			If C001-14 is not used, its value is to be interpreted as 1.			
			If C001-15 is not used, its value is to be interpreted as 1.			
			IMPLEMENTATION NAME: Code Qualifier			
			CODE	DEFINITION		
		F2	International Unit			
		GR	Gram			
		ME	Milligram			
		ML	Milliliter			
		UN	Unit			
NOT USED	CTP05 - 2	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 3	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 4	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 5	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 6	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 7	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 8	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 9	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 10	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 11	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 12	649	Multiplier	O	R	1/10
NOT USED	CTP05 - 13	355	Unit or Basis for Measurement Code	O	ID	2/2
NOT USED	CTP05 - 14	1018	Exponent	O	R	1/15
NOT USED	CTP05 - 15	649	Multiplier	O	R	1/10
NOT USED	CTP06	648	Price Multiplier Qualifier	O 1	ID	3/3
NOT USED	CTP07	649	Multiplier	X 1	R	1/10
NOT USED	CTP08	782	Monetary Amount	O 1	R	1/18
NOT USED	CTP09	639	Basis of Unit Price Code	O 1	ID	2/2
NOT USED	CTP10	499	Condition Value	O 1	AN	1/10
NOT USED	CTP11	289	Multiple Price Quantity	O 1	N0	1/2

SEGMENT DETAIL

REF - PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2410 — DRUG IDENTIFICATION**Segment Repeat:** 1**Usage:** SITUATIONAL

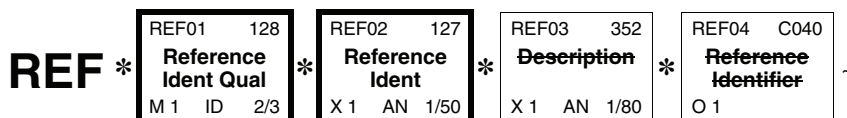
Situational Rule: Required when dispensing of the drug has been done with an assigned prescription number.
OR
Required when the provided medication involves the compounding of two or more drugs being reported and there is no prescription number.
If not required by this implementation guide, do not send.

TR3 Notes:

1. 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.
2. For cases where the drug is provided without a prescription (for example, from a physician's office), the value provided in this segment is a "link sequence number". The link sequence number is a provider assigned number that is unique to this claim. Its purpose is to enable the receiver to piece together the components of the compound.

TR3 Example: REF*XZ*123456~

DIAGRAM



ELEMENT DETAIL

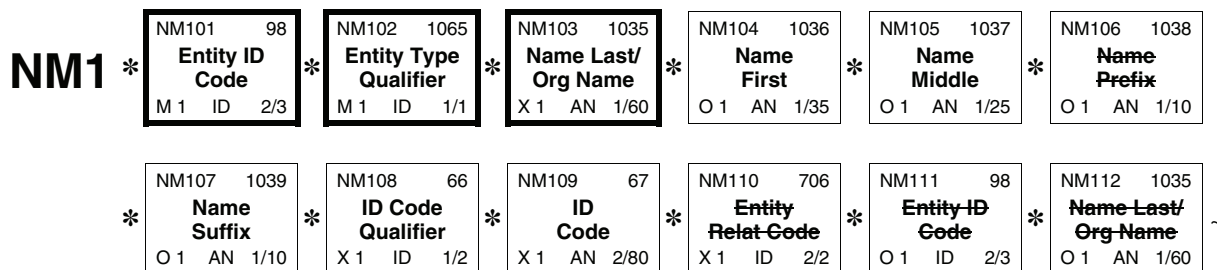
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			VY	Link Sequence Number
			XZ	Pharmacy Prescription Number

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203	X 1 AN 1/50
IMPLEMENTATION NAME: Prescription Number				
NOT USED	REF03	352	Description	X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1

SEGMENT DETAIL

NM1 - OPERATING PHYSICIAN NAME**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2420A — OPERATING PHYSICIAN NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when a surgical procedure code is listed on this claim.
AND
The Operating Physician for this line is different than the Operating Physician reported in Loop ID-2310B (claim level).
If not required by this implementation guide, do not send.**TR3 Notes:** 1. The Operating Physician is the individual with primary responsibility for performing the surgical procedure(s).**TR3 Example:** NM1*72*1*MEYERS*JANE****XX*1234567891~

DIAGRAM



ELEMENT DETAIL

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 1 ID 2/3
			CODE	DEFINITION
			72	Operating Physician
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1 ID 1/1
			CODE	DEFINITION
			1	Person
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1 AN 1/60
			IMPLEMENTATION NAME: Operating Physician Last Name	
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1 AN 1/35
			IMPLEMENTATION NAME: Operating Physician First Name	
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1 AN 1/25
			IMPLEMENTATION NAME: Operating Physician Middle Name or Initial	
NOT USED	NM106	1038	Name Prefix	O 1 AN 1/10
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1 AN 1/10
			IMPLEMENTATION NAME: Operating Physician Name Suffix	

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> OR <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> OR <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Operating Physician Primary Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - OPERATING PHYSICIAN SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information

X12 Purpose: To specify identifying information

X12 Syntax: 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2420A — OPERATING PHYSICIAN NAME

Segment Repeat: 20

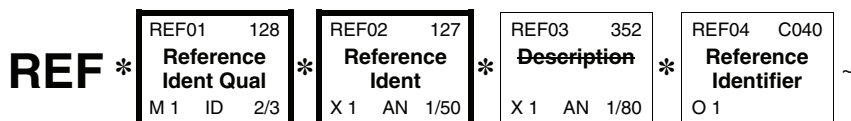
Usage: SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.
OR
Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.
If not required by this implementation guide, do not send.

TR3 Notes: 1. When it is necessary to report one or more non-destination payer Secondary Identifiers, the composite data element in REF04 is used to identify the payer who assigned this identifier.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION		
			0B	State License Number		
			1G	Provider UPIN Number		
			UPINs must be formatted as either X99999 or XXX999.			

			G2	Provider Commercial Number				
			This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.					
			LU	Location Number				
REQUIRED	REF02	127	Reference Identification	X 1	AN	1/50		
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier					
			SYNTAX: R0203					
			IMPLEMENTATION NAME: Operating Physician Secondary Identifier					
NOT USED	REF03	352	Description	X 1	AN	1/80		
SITUATIONAL	REF04	C040	REFERENCE IDENTIFIER	O 1				
			To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier					
			SYNTAX: P0304 If either C04003 or C04004 is present, then the other is required. P0506 If either C04005 or C04006 is present, then the other is required.					
			SITUATIONAL RULE: <i>Required when the identifier reported in REF02 of this segment is for a non-destination payer.</i>					
			Do not use this composite when the value reported in REF01 is either 0B or 1G.					
REQUIRED	REF04 - 1	128	Reference Identification Qualifier	M	ID	2/3		
			Code qualifying the Reference Identification					
			CODE	DEFINITION				
			2U	Payer Identification Number				
REQUIRED	REF04 - 2	127	Reference Identification	M	AN	1/50		
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier					
			IMPLEMENTATION NAME: Other Payer Primary Identifier					
			The payer identifier reported in this field must match the cooresponding payer identifier reported in Loop ID-2330B NM109.					
NOT USED	REF04 - 3	128	Reference Identification Qualifier	X	ID	2/3		
NOT USED	REF04 - 4	127	Reference Identification	X	AN	1/50		
NOT USED	REF04 - 5	128	Reference Identification Qualifier	X	ID	2/3		
NOT USED	REF04 - 6	127	Reference Identification	X	AN	1/50		

SEGMENT DETAIL

NM1 - OTHER OPERATING PHYSICIAN NAME

X12 Segment Name: Individual or Organizational Name

X12 Purpose: To supply the full name of an individual or organizational entity

X12 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.

X12 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.

3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2420B — OTHER OPERATING PHYSICIAN NAME **Loop Repeat:** 1

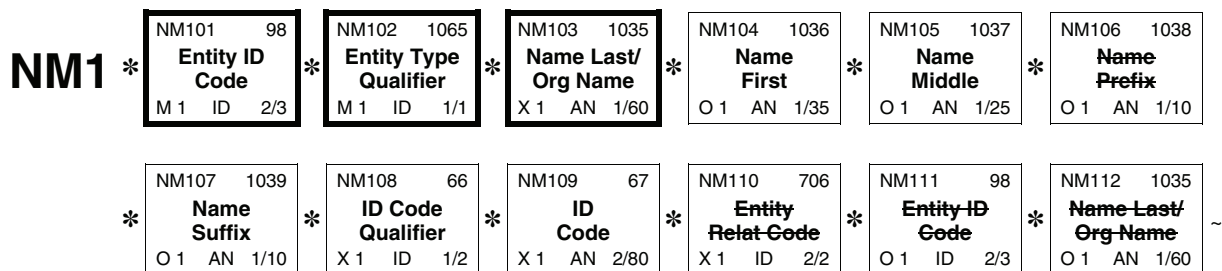
Segment Repeat: 1

Usage: SITUATIONAL

Situational Rule: Required when another Operating Physician is involved,
AND
The Other Operating Physician for this line is different than the Other Operating Physician reported in Loop ID-2310C (claim level).
If not required by this implementation guide, do not send.

TR3 Example: NM1*ZZ*1*JONES*JOHN***SR*XX*1234567891~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>ZZ</td><td>Mutually Defined ZZ is used to indicate Other Operating Physician.</td></tr></table>	CODE	DEFINITION	ZZ	Mutually Defined ZZ is used to indicate Other Operating Physician.			
CODE	DEFINITION									
ZZ	Mutually Defined ZZ is used to indicate Other Operating Physician.									
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr></table>	CODE	DEFINITION	1	Person			
CODE	DEFINITION									
1	Person									
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60				
			IMPLEMENTATION NAME: Other Operating Physician Last Name							
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1	AN	1/35				
			IMPLEMENTATION NAME: Other Operating Physician First Name							
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/25				
			IMPLEMENTATION NAME: Other Operating Physician Middle Name or Initial							
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/10				
			IMPLEMENTATION NAME: Other Operating Physician Name Suffix							

SITUATIONAL	NM108	66	Identification Code Qualifier	X 1	ID	1/2						
Code designating the system/method of code structure used for Identification Code (67)												
SYNTAX: P0809												
SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i>												
OR												
<i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i>												
OR												
<i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i>												
<i>If not required by this implementation guide, do not send.</i>												
<table><tr><td>CODE</td><td>DEFINITION</td></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier</td></tr><tr><td colspan="2">CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>							CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier	CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier	
CODE	DEFINITION											
XX	Centers for Medicare and Medicaid Services National Provider Identifier											
CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier												
SITUATIONAL	NM109	67	Identification Code	X 1	AN	2/80						
Code identifying a party or other code												
SYNTAX: P0809												
SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i>												
OR												
<i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i>												
OR												
<i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i>												
<i>If not required by this implementation guide, do not send.</i>												
IMPLEMENTATION NAME: Other Operating Physician Identifier												
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2						
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3						
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60						

SEGMENT DETAIL

REF - OTHER OPERATING PHYSICIAN
SECONDARY IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2420B — OTHER OPERATING PHYSICIAN NAME**Segment Repeat:** 20**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

OR

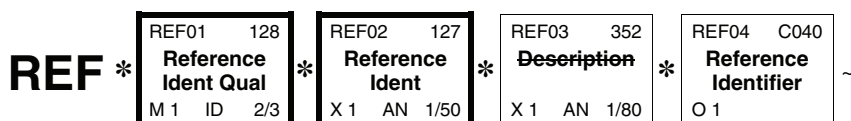
Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. When it is necessary to report one or more non-destination payer Secondary Identifiers, the composite data element in REF04 is used to identify the payer who assigned this identifier.

TR3 Example: REF*1G*A12345~

DIAGRAM



ELEMENT DETAIL

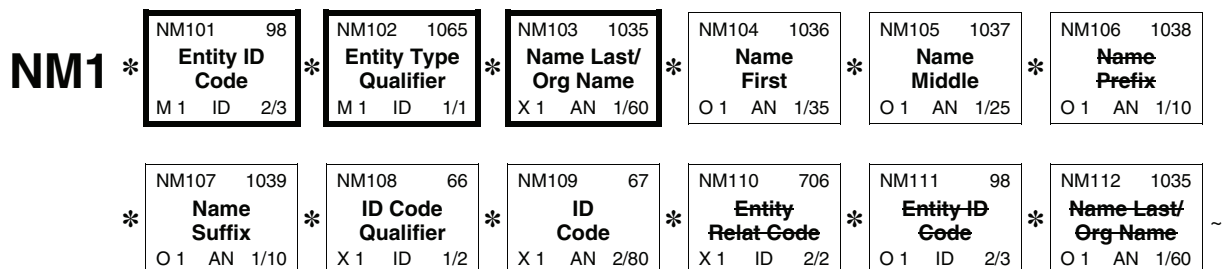
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			0B	State License Number
			1G	Provider UPIN Number
				UPINs must be formatted as either X99999 or XXX999.

			G2	Provider Commercial Number		
			This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.			
			LU	Location Number		
REQUIRED	REF02	127	Reference Identification	X 1	AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			SYNTAX: R0203			
			IMPLEMENTATION NAME: Other Provider Secondary Identifier			
NOT USED	REF03	352	Description	X 1	AN	1/80
SITUATIONAL	REF04	C040	REFERENCE IDENTIFIER	O 1		
			To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier			
			SYNTAX: P0304 If either C04003 or C04004 is present, then the other is required. P0506 If either C04005 or C04006 is present, then the other is required.			
			SITUATIONAL RULE: <i>Required when the identifier reported in REF02 of this segment is for a non-destination payer.</i>			
			Do not use this composite when the value reported in REF01 is either 0B or 1G.			
REQUIRED	REF04 - 1	128	Reference Identification Qualifier	M	ID	2/3
			Code qualifying the Reference Identification			
			CODE	DEFINITION		
			2U	Payer Identification Number		
REQUIRED	REF04 - 2	127	Reference Identification	M	AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			IMPLEMENTATION NAME: Other Payer Primary Identifier			
			The payer identifier reported in this field must match the cooresponding payer identifier reported in Loop ID-2330B NM109.			
NOT USED	REF04 - 3	128	Reference Identification Qualifier	X	ID	2/3
NOT USED	REF04 - 4	127	Reference Identification	X	AN	1/50
NOT USED	REF04 - 5	128	Reference Identification Qualifier	X	ID	2/3
NOT USED	REF04 - 6	127	Reference Identification	X	AN	1/50

SEGMENT DETAIL

NM1 - RENDERING PROVIDER NAME**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.**X12 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.
3. **C1203**
If NM112 is present, then NM103 is required.**Loop:** 2420C — RENDERING PROVIDER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when Rendering Provider is different than the Attending Provider reported in the 2310A loop of this claim.
AND
State or federal regulatory requirements call for a “combined claim”, that is, a claim that includes both facility and professional components (for example, a Medicaid clinic bill or Critical Access Hospital Claim.)
AND
The Rendering Provider for this line is different than the Rendering Provider reported in Loop ID 2310D (claim level).
If not required by this implementation guide, do not send.**TR3 Notes:** 1. The Rendering Provider is the health care professional who delivers or completes a particular medical service or non-surgical procedure.**TR3 Example:** NM1*82*1*DOE*JANE*C***XX*1234567804~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3
			CODE	DEFINITION		
			82	Rendering Provider		
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1
			CODE	DEFINITION		
			1	Person		
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60
			IMPLEMENTATION NAME: Rendering Provider Last Name			
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1	AN	1/35
			IMPLEMENTATION NAME: Rendering Provider First Name			
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/25
			IMPLEMENTATION NAME: Rendering Provider Middle Name or Initial			
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/10
			IMPLEMENTATION NAME: Rendering Provider Name Suffix			

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> <i>OR</i> <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> <i>OR</i> <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td> Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier </td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider is eligible to receive an NPI.</i> <i>OR</i> <i>Required for providers not in the United States or its territories on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI.</i> <i>OR</i> <i>Required for providers prior to the mandated NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Rendering Provider Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION**X12 Segment Name:** Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2420C — RENDERING PROVIDER NAME**Segment Repeat:** 20**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

OR

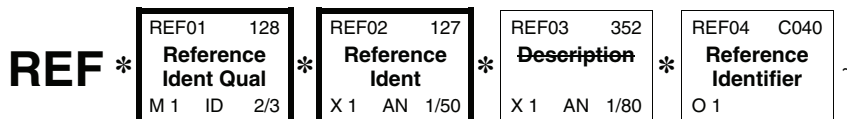
Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. When it is necessary to report one or more non-destination payer Secondary Identifiers, the composite data element in REF04 is used to identify the payer who assigned this identifier.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION		
			0B	State License Number		
			1G	Provider UPIN Number		
			UPINs must be formatted as either X99999 or XXX999.			

			G2	Provider Commercial Number		
			This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.			
			LU	Location Number		
REQUIRED	REF02	127	Reference Identification	X 1	AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			SYNTAX: R0203			
			IMPLEMENTATION NAME: Rendering Provider Secondary Identifier			
NOT USED	REF03	352	Description	X 1	AN	1/80
SITUATIONAL	REF04	C040	REFERENCE IDENTIFIER	O 1		
			To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier			
			SYNTAX: P0304 If either C04003 or C04004 is present, then the other is required. P0506 If either C04005 or C04006 is present, then the other is required.			
			SITUATIONAL RULE: <i>Required when the identifier reported in REF02 of this segment is for a non-destination payer.</i>			
			Do not use this composite when the value reported in REF01 is either 0B or 1G.			
REQUIRED	REF04 - 1	128	Reference Identification Qualifier	M	ID	2/3
			Code qualifying the Reference Identification			
			CODE	DEFINITION		
			2U	Payer Identification Number		
REQUIRED	REF04 - 2	127	Reference Identification	M	AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			IMPLEMENTATION NAME: Other Payer Primary Identifier			
			The payer identifier reported in this field must match the cooresponding payer identifier reported in Loop ID-2330B NM109.			
NOT USED	REF04 - 3	128	Reference Identification Qualifier	X	ID	2/3
NOT USED	REF04 - 4	127	Reference Identification	X	AN	1/50
NOT USED	REF04 - 5	128	Reference Identification Qualifier	X	ID	2/3
NOT USED	REF04 - 6	127	Reference Identification	X	AN	1/50

SEGMENT DETAIL

NM1 - REFERRING PROVIDER NAME**X12 Segment Name:** Individual or Organizational Name**X12 Purpose:** To supply the full name of an individual or organizational entity**X12 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.

X12 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.

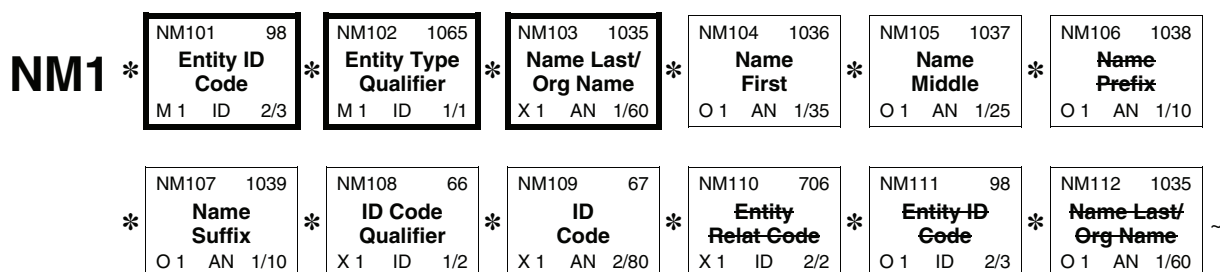
3. **C1203**
If NM112 is present, then NM103 is required.

Loop: 2420D — REFERRING PROVIDER NAME **Loop Repeat:** 1**Segment Repeat:** 1**Usage:** SITUATIONAL

Situational Rule: Required on an outpatient claim when the Referring Provider is different than the Attending Provider.
AND
The Referring Provider for this line is different than the Referring Provider reported in Loop ID 2310F (claim level).
If not required by this implementation guide, do not send.

TR3 Notes: 1. The Referring Provider is provider who sends the patient to another provider for services.**TR3 Example:** NM1*DN*1*SMITH*JANE*****XX*1234567890~

DIAGRAM



ELEMENT DETAIL

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 1	ID	2/3				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>DN</td><td>Referring Provider</td></tr></table>	CODE	DEFINITION	DN	Referring Provider			
CODE	DEFINITION									
DN	Referring Provider									
REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.	M 1	ID	1/1				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>1</td><td>Person</td></tr></table>	CODE	DEFINITION	1	Person			
CODE	DEFINITION									
1	Person									
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name SYNTAX: C1203	X 1	AN	1/60				
			IMPLEMENTATION NAME: Referring Provider Last Name							
SITUATIONAL	NM104	1036	Name First Individual first name SITUATIONAL RULE: <i>Required when the person has a first name. If not required by this implementation guide, do not send.</i>	O 1	AN	1/35				
			IMPLEMENTATION NAME: Referring Provider First Name							
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial SITUATIONAL RULE: <i>Required when the middle name or initial of the person is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/25				
			IMPLEMENTATION NAME: Referring Provider Middle Name or Initial							
NOT USED	NM106	1038	Name Prefix	O 1	AN	1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name SITUATIONAL RULE: <i>Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.</i>	O 1	AN	1/10				
			IMPLEMENTATION NAME: Referring Provider Name Suffix							

SITUATIONAL	NM108	66	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI and the NPI is available to the submitter.</i> <i>OR</i> <i>Required for providers prior to the mandated HIPAA NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	ID	1/2				
			<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>XX</td><td>Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier</td></tr></table>	CODE	DEFINITION	XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier			
CODE	DEFINITION									
XX	Centers for Medicare and Medicaid Services National Provider Identifier CODE SOURCE 537: Centers for Medicare & Medicaid Services National Provider Identifier									
SITUATIONAL	NM109	67	Identification Code Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: <i>Required for providers on or after the mandated HIPAA National Provider Identifier (NPI) implementation date when the provider has received an NPI and the NPI is available to the submitter.</i> <i>OR</i> <i>Required for providers prior to the mandated HIPAA NPI implementation date when the provider has received an NPI and the submitter has the capability to send it.</i> <i>If not required by this implementation guide, do not send.</i>	X 1	AN	2/80				
			IMPLEMENTATION NAME: Referring Provider Identifier							
NOT USED	NM110	706	Entity Relationship Code	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code	O 1	ID	2/3				
NOT USED	NM112	1035	Name Last or Organization Name	O 1	AN	1/60				

SEGMENT DETAIL

REF - REFERRING PROVIDER SECONDARY IDENTIFICATION

X12 Segment Name: Reference Information**X12 Purpose:** To specify identifying information**X12 Syntax:** 1. R0203

At least one of REF02 or REF03 is required.

Loop: 2420D — REFERRING PROVIDER NAME**Segment Repeat:** 20**Usage:** SITUATIONAL

Situational Rule: Required prior to the mandated HIPAA National Provider Identifier (NPI) implementation date when an identification number other than the NPI is necessary for the receiver to identify the provider.

OR

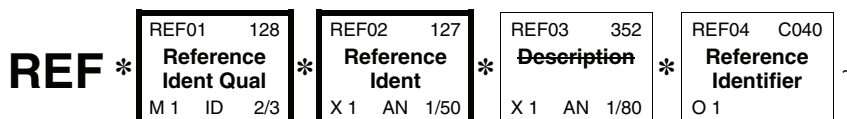
Required on or after the mandated NPI Implementation Date when NM109 in this loop is not used and an identification number other than the NPI is necessary for the receiver to identify the provider.

If not required by this implementation guide, do not send.

TR3 Notes: 1. When it is necessary to report one or more non-destination payer Secondary Identifiers, the composite data element in REF04 is used to identify the payer who assigned this identifier.

TR3 Example: REF*G2*12345~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1 ID 2/3
			CODE	DEFINITION
			0B	State License Number
			1G	Provider UPIN Number
				UPINs must be formatted as either X99999 or XXX999.

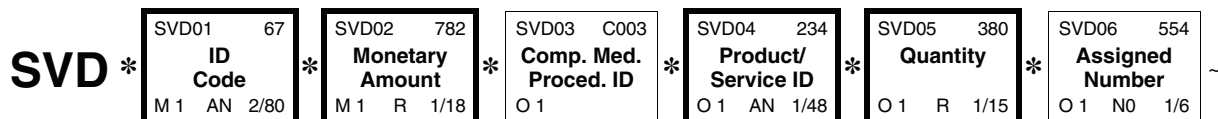
			G2	Provider Commercial Number		
			This code designates a proprietary provider number for the destination payer identified in the Payer Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including: Medicare, Medicaid, Blue Cross, etc.			
REQUIRED	REF02	127	Reference Identification		X 1 AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			SYNTAX: R0203			
			IMPLEMENTATION NAME: Referring Provider Secondary Identifier			
NOT USED	REF03	352	Description		X 1 AN	1/80
SITUATIONAL	REF04	C040	REFERENCE IDENTIFIER		O 1	
			To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier			
			SYNTAX: P0304 If either C04003 or C04004 is present, then the other is required. P0506 If either C04005 or C04006 is present, then the other is required.			
			SITUATIONAL RULE: Required when the identifier reported in REF02 of this segment is for a non-destination payer.			
			Do not use this composite when the value reported in REF01 is either 0B or 1G.			
REQUIRED	REF04 - 1	128	Reference Identification Qualifier		M ID	2/3
			Code qualifying the Reference Identification			
			CODE	DEFINITION		
			2U	Payer Identification Number		
REQUIRED	REF04 - 2	127	Reference Identification		M AN	1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			IMPLEMENTATION NAME: Other Payer Primary Identifier			
			The payer identifier reported in this field must match the cooresponding payer identifier reported in Loop ID-2330B NM109.			
NOT USED	REF04 - 3	128	Reference Identification Qualifier		X ID	2/3
NOT USED	REF04 - 4	127	Reference Identification		X AN	1/50
NOT USED	REF04 - 5	128	Reference Identification Qualifier		X ID	2/3
NOT USED	REF04 - 6	127	Reference Identification		X AN	1/50

SEGMENT DETAIL

SVD - LINE ADJUDICATION INFORMATION

X12 Segment Name: Service Line Adjudication**X12 Purpose:** To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers**X12 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.**Loop:** 2430 — LINE ADJUDICATION INFORMATION **Loop Repeat:** 15**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the claim has been previously adjudicated by payer identified in Loop ID-2330B and this service line has payments and/or adjustments applied to it. If not required by this implementation guide, do not send.**TR3 Notes:** 1. To show unbundled lines: If, in the original claim, line 3 is unbundled into (for example) 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.**TR3 Example:** SVD*11122333*50.5**0305*1~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SVD01	67	Identification Code Code identifying a party or other code SEMANTIC: SVD01 is the payer identification code. IMPLEMENTATION NAME: Other Payer Primary Identifier This identifier indicates the payer responsible for the reimbursement described in this iteration of the 2430 loop. The identifier indicates the Other Payer by matching the appropriate Other Payer Primary Identifier (Loop ID-2330B, element NM109).	M 1 AN 2/80

REQUIRED	SVD02	782	Monetary Amount	M 1 R 1/18

Monetary amount

SEMANTIC: SVD02 is the amount paid for this service line.

IMPLEMENTATION NAME: **Service Line Paid Amount**

Zero “0” is an acceptable value for this element.

SITUATIONAL	SVD03	C003	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	O 1

To identify a medical procedure by its standardized codes and applicable modifiers

SITUATIONAL RULE: ***Required when a line level procedure code other than a revenue code was returned on the 835 remittance advice (SVC01).***

If not required by this implementation guide, do not send.

This element contains the procedure code that was used to adjudicate this service line.

REQUIRED	SVD03 - 1	235	Product/Service ID Qualifier	M ID 2/2

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

SEMANTIC:

C003-01 qualifies C003-02 and C003-08.

IMPLEMENTATION NAME: **Product or Service ID Qualifier**

CODE	DEFINITION
ER	Jurisdiction Specific Procedure and Supply Codes CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes
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.
HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code CODE SOURCE 130: Healthcare Common Procedure Coding System
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Home Infusion EDI Coalition (HIEC) Product/Service Codes as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA. CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List

		WK	Advanced Billing Concepts (ABC) Codes			
			At the time of this writing, this code set has been approved by the Secretary of HHS as a pilot project allowed under HIPAA law. The qualifier may only be used in transactions covered under HIPAA; By parties registered in the pilot project and their trading partners, OR If a new rule names the Complementary, Alternative, or Holistic Procedure Codes as an allowable code set under HIPAA, OR For claims which are not covered under HIPAA.			
			CODE SOURCE 843: Advanced Billing Concepts (ABC) Codes			
REQUIRED	SVD03 - 2	234	Product/Service ID	M	AN	1/48
			Identifying number for a product or service			
			SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.			
			IMPLEMENTATION NAME: Procedure Code			
SITUATIONAL	SVD03 - 3	1339	Procedure Modifier	O	AN	2/2
			This identifies special circumstances related to the performance of the service, as defined by trading partners			
			SEMANTIC: C003-03 modifies the value in C003-02 and C003-08.			
			SITUATIONAL RULE: <i>Required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. This is the first procedure code modifier. If not required by this implementation guide, do not send.</i>			
SITUATIONAL	SVD03 - 4	1339	Procedure Modifier	O	AN	2/2
			This identifies special circumstances related to the performance of the service, as defined by trading partners			
			SEMANTIC: C003-04 modifies the value in C003-02 and C003-08.			
			SITUATIONAL RULE: <i>Required when a second modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.</i>			
SITUATIONAL	SVD03 - 5	1339	Procedure Modifier	O	AN	2/2
			This identifies special circumstances related to the performance of the service, as defined by trading partners			
			SEMANTIC: C003-05 modifies the value in C003-02 and C003-08.			
			SITUATIONAL RULE: <i>Required when a third modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.</i>			

SITUATIONAL	SVD03 - 6	1339	Procedure Modifier	O AN 2/2
This identifies special circumstances related to the performance of the service, as defined by trading partners				
SEMANTIC: C003-06 modifies the value in C003-02 and C003-08.				
SITUATIONAL RULE: <i>Required when a fourth modifier clarifies or improves the reporting accuracy of the associated procedure code. If not required by this implementation guide, do not send.</i>				
SITUATIONAL	SVD03 - 7	352	Description	O AN 1/80
A free-form description to clarify the related data elements and their content				
SEMANTIC: C003-07 is the description of the procedure identified in C003-02.				
SITUATIONAL RULE: <i>Required when SVC01-7 was returned in the 835 transaction. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Procedure Code Description				
NOT USED	SVD03 - 8	234	Product/Service ID	O AN 1/48
REQUIRED	SVD04 234	Product/Service ID	O 1 AN 1/48	
Identifying number for a product or service				
SEMANTIC: SVD04 is the revenue code.				
IMPLEMENTATION NAME: Service Line Revenue Code				
REQUIRED	SVD05 380	Quantity	O 1 R 1/15	
Numeric value of quantity				
SEMANTIC: SVD05 is the paid units of service.				
IMPLEMENTATION NAME: Paid Service Unit Count				
This is the number of paid units from the remittance advice. When paid units are not present on the remittance advice, use the original billed units.				
The maximum length for this field is 8 digits excluding the decimal. When a decimal is used, the maximum number of digits allowed to the right of the decimal is three.				
SITUATIONAL	SVD06 554	Assigned Number	O 1 N0 1/6	
Number assigned for differentiation within a transaction set				
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.				
SITUATIONAL RULE: <i>Required when payer bundled this service line. If not required by this implementation guide, do not send.</i>				
IMPLEMENTATION NAME: Bundled Line Number				

SEGMENT DETAIL

CAS - LINE ADJUSTMENT**X12 Segment Name:** Claims Adjustment**X12 Purpose:** To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

- X12 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.

X12 Comments: 1. Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

Loop: 2430 — LINE ADJUDICATION INFORMATION**Segment Repeat:** 5**Usage:** SITUATIONAL

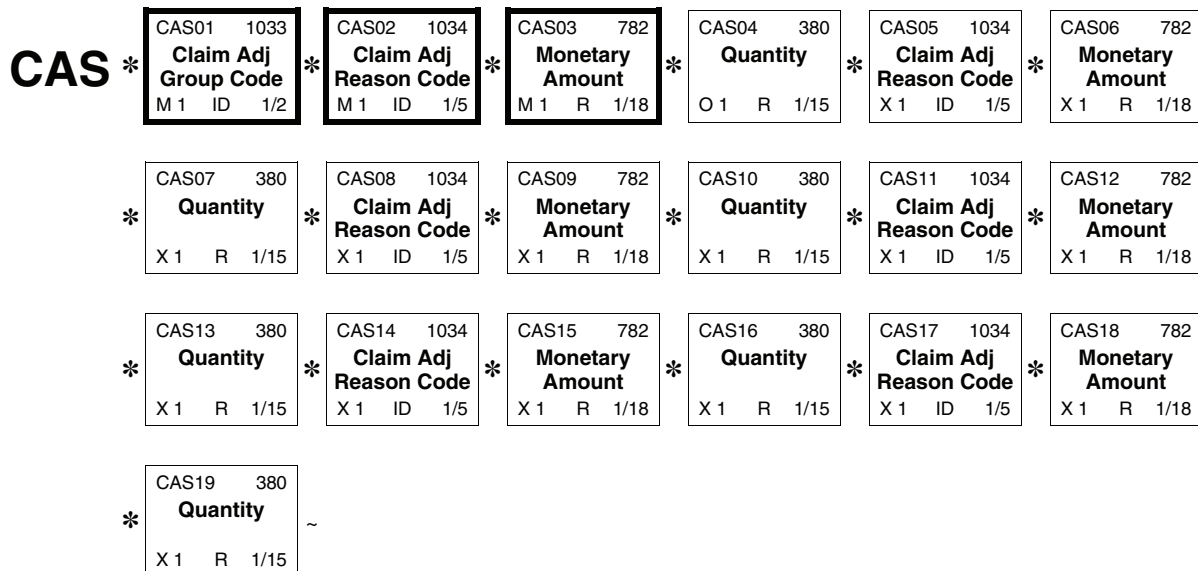
Situational Rule: Required when the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged. If not required by this implementation guide, do not send.

TR3 Notes: 1. A single CAS segment contains six repetitions of the “adjustment trio” composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first non-zero adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

TR3 Example: CAS*PR*1*7.93~

TR3 Example: CAS*OA*93*15.06~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES		
REQUIRED	CAS01	1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment	M 1	ID	1/2
			CODE	DEFINITION		
			CO	Contractual Obligations		
			CR	Correction and Reversals		
			OA	Other adjustments		
			PI	Payor Initiated Reductions		
			PR	Patient Responsibility		

REQUIRED	CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made	M 1	ID	1/5
IMPLEMENTATION NAME: Adjustment Reason Code						
CODE SOURCE 139: Claim Adjustment Reason Code						
REQUIRED	CAS03	782	Monetary Amount Monetary amount	M 1	R	1/18
SEMANTIC: CAS03 is the amount of adjustment.						
IMPLEMENTATION NAME: Adjustment Amount						
SITUATIONAL	CAS04	380	Quantity Numeric value of quantity	O 1	R	1/15
SEMANTIC: CAS04 is the units of service being adjusted.						
SITUATIONAL RULE: Required when the number of service units has been adjusted. If not required by this implementation guide, do not send.						
IMPLEMENTATION NAME: Adjustment Quantity						
SITUATIONAL	CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made	X 1	ID	1/5
SYNTAX: L050607, C0605, C0705						
SITUATIONAL RULE: Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this service line for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.						
IMPLEMENTATION NAME: Adjustment Reason Code						
CODE SOURCE 139: Claim Adjustment Reason Code						
See CODE SOURCE 139: Claim Adjustment Reason Code						
SITUATIONAL	CAS06	782	Monetary Amount Monetary amount	X 1	R	1/18
SYNTAX: L050607, C0605						
SEMANTIC: CAS06 is the amount of the adjustment.						
SITUATIONAL RULE: Required when CAS05 is present. If not required by this implementation guide, do not send.						
IMPLEMENTATION NAME: Adjustment Amount						
SITUATIONAL	CAS07	380	Quantity Numeric value of quantity	X 1	R	1/15
SYNTAX: L050607, C0705						
SEMANTIC: CAS07 is the units of service being adjusted.						
SITUATIONAL RULE: Required when CAS05 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.						
IMPLEMENTATION NAME: Adjustment Quantity						

SITUATIONAL	CAS08	1034	Claim Adjustment Reason Code X 1 ID 1/5 Code identifying the detailed reason the adjustment was made SYNTAX: L080910, C0908, C1008 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this service line for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CODE SOURCE 139: Claim Adjustment Reason Code
SITUATIONAL	CAS09	782	Monetary Amount X 1 R 1/18 Monetary amount SYNTAX: L080910, C0908 SEMANTIC: CAS09 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS08 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount
SITUATIONAL	CAS10	380	Quantity X 1 R 1/15 Numeric value of quantity SYNTAX: L080910, C1008 SEMANTIC: CAS10 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS08 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity
SITUATIONAL	CAS11	1034	Claim Adjustment Reason Code X 1 ID 1/5 Code identifying the detailed reason the adjustment was made SYNTAX: L111213, C1211, C1311 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this service line for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CODE SOURCE 139: Claim Adjustment Reason Code
SITUATIONAL	CAS12	782	Monetary Amount X 1 R 1/18 Monetary amount SYNTAX: L111213, C1211 SEMANTIC: CAS12 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS11 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount

SITUATIONAL	CAS13	380	Quantity Numeric value of quantity SYNTAX: L111213, C1311 SEMANTIC: CAS13 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS11 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity	X 1	R	1/15
SITUATIONAL	CAS14	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made SYNTAX: L141516, C1514, C1614 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this service line for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CODE SOURCE 139: Claim Adjustment Reason Code	X 1	ID	1/5
SITUATIONAL	CAS15	782	Monetary Amount Monetary amount SYNTAX: L141516, C1514 SEMANTIC: CAS15 is the amount of the adjustment. SITUATIONAL RULE: <i>Required when CAS14 is present. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Amount	X 1	R	1/18
SITUATIONAL	CAS16	380	Quantity Numeric value of quantity SYNTAX: L141516, C1614 SEMANTIC: CAS16 is the units of service being adjusted. SITUATIONAL RULE: <i>Required when CAS14 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Quantity	X 1	R	1/15
SITUATIONAL	CAS17	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was made SYNTAX: L171819, C1817, C1917 SITUATIONAL RULE: <i>Required when it is necessary to report an additional non-zero adjustment, beyond what has already been supplied, to this service line for the Claim Adjustment Group Code reported in CAS01. If not required by this implementation guide, do not send.</i> IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CODE SOURCE 139: Claim Adjustment Reason Code	X 1	ID	1/5

SITUATIONAL	CAS18	782	Monetary Amount	X 1	R	1/18

Monetary amount

SYNTAX: L171819, C1817

SEMANTIC: CAS18 is the amount of the adjustment.

SITUATIONAL RULE: *Required when CAS17 is present. If not required by this implementation guide, do not send.*

IMPLEMENTATION NAME: Adjustment Amount

SITUATIONAL	CAS19	380	Quantity	X 1	R	1/15

Numeric value of quantity

SYNTAX: L171819, C1917

SEMANTIC: CAS19 is the units of service being adjusted.

SITUATIONAL RULE: *Required when CAS17 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.*

IMPLEMENTATION NAME: Adjustment Quantity

SEGMENT DETAIL

DTP - LINE CHECK OR REMITTANCE DATE

X12 Segment Name: Date or Time or Period

X12 Purpose: To specify any or all of a date, a time, or a time period

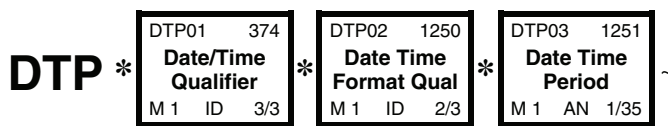
Loop: 2430 — LINE ADJUDICATION INFORMATION

Segment Repeat: 1

Usage: REQUIRED

TR3 Example: DTP*573*D8*20040203~

DIAGRAM



ELEMENT DETAIL

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 1 ID 3/3
IMPLEMENTATION NAME: Date Time Qualifier				
		CODE	DEFINITION	
		573	Date Claim Paid	
REQUIRED	DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format	M 1 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 1 AN 1/35
IMPLEMENTATION NAME: Adjudication or Payment Date				

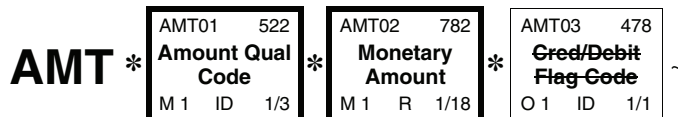
SEGMENT DETAIL

AMT - REMAINING PATIENT LIABILITY**X12 Segment Name:** Monetary Amount Information**X12 Purpose:** To indicate the total monetary amount**Loop:** 2430 — LINE ADJUDICATION INFORMATION**Segment Repeat:** 1**Usage:** SITUATIONAL**Situational Rule:** Required when the Other Payer referenced in SVD01 of this iteration of Loop ID-2430 has adjudicated this claim, provided line level information, and the provider has the ability to report line item information. If not required by this implementation guide, do not send.

- TR3 Notes:**
1. In the judgment of the provider, this is the remaining amount to be paid after adjudication by the Other Payer referenced in SVD01 of this iteration of Loop ID-2430.
 2. This segment is only used in provider submitted claims. It is not used in Payer-to-Payer Coordination of Benefits (COB).
 3. This segment is not used if the claim level (Loop ID-2320) Remaining Patient Liability AMT segment is used for this Other Payer.

TR3 Example: AMT*EAF*75~

DIAGRAM



ELEMENT DETAIL

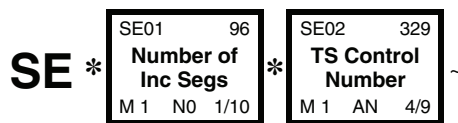
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	AMT01	522	Amount Qualifier Code Code to qualify amount	M 1 ID 1/3
			CODE DEFINITION	
			EAF Amount Owed	
REQUIRED	AMT02	782	Monetary Amount Monetary amount	M 1 R 1/18
			IMPLEMENTATION NAME: Remaining Patient Liability	
NOT USED	AMT03	478	Credit/Debit Flag Code	O 1 ID 1/1

SEGMENT DETAIL

SE - TRANSACTION SET TRAILER

X12 Segment Name: Transaction Set Trailer**X12 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)**X12 Comments:** 1. SE is the last segment of each transaction set.**Segment Repeat:** 1**Usage:** REQUIRED**TR3 Example:** SE*1230*987654~

DIAGRAM



ELEMENT DETAIL

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 1 NO 1/10
IMPLEMENTATION NAME: Transaction Segment Count				
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 1 AN 4/9
The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.				

3 Examples

- Please visit <http://www.wpc-edi.com/837> for additional or corrected examples.

3.1 Institutional

3.1.1 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.

PRIMARY 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
NPI: 9876540809
TIN: 567891234
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
PRINCIPAL DIAGNOSIS CODE: 366.9
SECONDARY DIAGNOSIS CODES:
401.9
794.31
NUMBER OF COVERED DAYS: 1
SERVICES:
INSTITUTIONAL SERVICES RENDERED:
REVENUE CODE: 0305 HCPCS Procedure Code: 85025 Unit: 1 Price \$13.39
REVENUE CODE: 0730 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: F
DOB: 12/11/1927
STATE TEACHERS ID#: 222004433
PAYER ID #: 1135

SEG#	LOOP SEGMENT/ELEMENT STRING
1	TRANSACTION SET HEADER ST*837*987654*005010X223A2~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0123*19960918*0932*CH~
3	1000A SUBMITTER NAME NM1 SUBMITTER NAME NM1*41*2*JONES HOSPITAL*****46*12345~

SEG#	LOOP SEGMENT/ELEMENT STRING
4	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JANE DOE*TE*900555555~
5	1000B RECEIVER NAME NM1 RECEIVER NAME NM1*40*2*MEDICARE*****46*00120~
6	2000A BILLING PROVIDER HL BILLING PROVIDER HIERARCHICAL LEVEL HL*1**20*1~
7	PRV BILLING PROVIDER SPECIALTY PRV*BI*PXC*203BA0200N~
8	2010AA BILLING PROVIDER NAME NM1 BILLING PROVIDER NAME INCLUDING NATIONAL PROVIDER ID NM1*85*2*JONES HOSPITAL*****XX*9876540809~
9	N3 BILLING PROVIDER ADDRESS N3*225 MAIN STREET BARKLEY BUILDING~
10	N4 BILLING PROVIDER LOCATION N4*CENTERVILLE*PA*17111~
11	REF BILLING PROVIDER TAX IDENTIFICATION NUMBER REF*EI*567891234~
12	2000B SUBSCRIBER HL LOOP HL SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*0~
13	SBR SUBSCRIBER INFORMATION SBR*P*18*****MB~
14	2010BA SUBSCRIBER NAME LOOP NM1 SUBSCRIBER NAME NM1*IL*1*DOE*JOHN*T***MI*030005074A~
15	N3 SUBSCRIBER ADDRESS N3*125 CITY AVENUE~

SEG#	LOOP SEGMENT/ELEMENT STRING
16	N4 SUBSCRIBER LOCATION N4*CENTERVILLE*PA*17111~
17	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19261111*M~
18	2010BB PAYER NAME LOOP NM1 PAYER NAME NM1*PR*2*MEDICARE B*****PI*00435~
19	REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*G2*330127~
20	2300 CLAIM INFORMATION CLM CLAIM LEVEL INFORMATION CLM*756048Q*89.93***14:A:1*Y*A*Y*Y~
21	DTP STATEMENT DATES DTP*434*D8*19960911~
22	CL1 INSTITUTIONAL CLAIM CODE CL1*3**01~
23	HI PRINCIPAL DIAGNOSIS CODES HI*BK:3669~
24	HI OTHER DIAGNOSIS INFORMATION HI*BF:4019*BF:79431~
25	HI OCCURRENCE INFORMATION HI*BH:A1:D8:19261111*BH:A2:D8:19911101*BH:B1:D8:19261111*BH:B2:D8:19870101~
26	HI VALUE INFORMATION HI*BE:A2:::15.31~
27	HI CONDITION INFORMATION HI*BG:09~
28	2310A ATTENDING PROVIDER NAME NM1 ATTENDING PROVIDER NM1*71*1*JONES*JOHN*J~

SEG#	LOOP SEGMENT/ELEMENT STRING
29	REF ATTENDING PROVIDER SECONDARY IDENTIFICATION REF*1G*B99937~
30	2320 OTHER SUBSCRIBER INFORMATION SBR OTHER SUBSCRIBER INFORMATION SBR*S*01*351630*STATE TEACHERS*****CI~
31	DMG OTHER SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19271211*F~
32	OI OTHER INSURANCE COVERAGE INFORMATION OI***Y***Y~
33	2330A OTHER SUBSCRIBER NAME NM1 OTHER SUBSCRIBER NAME NM1*IL*1*DOE*JANE*S***MI*222004433~
34	N3 - OTHER SUBSCRIBER ADDRESS N3*125 CITY AVENUE~
35	N4 - OTHER SUBSCRIBER CITY, STATE, ZIP CODE N4*CENTERVILLE*PA*17111~
36	2330B OTHER PAYER NAME NM1 OTHER PAYER NAME NM1*PR*2*STATE TEACHERS*****PI*1135~
37	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*1~
38	SV2 INSTITUTIONAL SERVICE SV2*0305*HC:85025*13.39*UN*1~
39	DTP DATE - SERVICE DATES DTP*472*D8*19960911~
40	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~

SEG#	LOOP SEGMENT/ELEMENT STRING
41	SV2 INSTITUTIONAL SERVICE SV2*0730*HC:93005*76.54*UN*3~
42	DTP DATE - SERVICE DATES DTP*472*D8*19960911~
43	TRAILER SE TRANSACTION SET TRAILER SE*43*987654~

Complete Data String:

ST*837*987654*005010X223A2~BHT*0019*00*0123*19960918*0932*CH
~NM1*41*2*JONES HOSPITAL*****46*12345~PER*IC*JANE DOE*TE*900
555555~NM1*40*2*MEDICARE*****46*00120~HL*1**20*1~PRV*BI*PXC
*203BA0200N~NM1*85*2*JONES HOSPITAL*****XX*9876540809~N3*225
MAIN STREET BARKLEY BUILDING~N4*CENTERVILLE*PA*17111~REF*EI
*567891234~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~REF*G2*33
0127~CLM*756048Q*89.93***14:A:1*Y*A*Y*Y~DTP*434*D8*19960911~
CL1*3**01~HI*BK:3669~HI*BF:4019*BF:79431~HI*BH:A1:D8:1926111
1*BH:A2:D8:19911101*BH:B1:D8:19261111*BH:B2:D8:19870101~HI*B
E:A2:::15.31~HI*BG:09~NM1*71*1*JONES*JOHN*J~REF*1G*B99937~SB
R*S*01*351630*STATE TEACHERS*****CI~DMG*D8*19271211*F~OI***Y
Y~NM1*IL*1*DOE*JANE*SMI*222004433~N3*125 CITY AVENUE~N
4*CENTERVILLE*PA*17111~NM1*PR*2*STATE TEACHERS*****PI*1135~L
X*1~SV2*0305*HC:85025*13.39*UN*1~DTP*472*D8*19960911~LX*2~SV
2*0730*HC:93005*76.54*UN*3~DTP*472*D8*19960911~SE*43*987654~

3.1.2 Business Scenario 2 - Two Claims for the Same Provider

For both claims the patient is the subscriber and the transaction is being directly submitted from the provider to the payer.

This example combines two claims for the same provider.

DESTINATION PAYER: TRICARE

PAYER ID: 99999
BILLING PROVIDER: Jones Hospital
BILLING PROVIDER ADDRESS: 225 MAIN STREET, ANYWHERE, PA, 17111
BILLING PROVIDER SPECIALTY: 282N00000X
BILLING PROVIDER EMPLOYER ID: 123456789
BILLING PROVIDER NPI: 1234567890
SUBMITTER ETIN: 12345
SUBMITTER CONTACT: Jane Doe
SUBMITTER CONTACT TELEPHONE: (111)222-3333

CLAIM #1:

SUBSCRIBER: John T. Doe
MEMBER ID: 030005074
SUBSCRIBER ADDRESS: 125 City Avenue, Anywhere, PA, 17111
DOB: November 11, 1968
SEX: M
PATIENT ACCOUNT #: 756048Q
CLAIM AMOUNT: 89.95
TYPE OF BILL: 131
CLAIM DATE: March 15, 2005
PRINCIPAL DIAGNOSIS: 366.9
OTHER DIAGNOSIS: 401.9, 794.31
ATTENDING PHYSICIAN: John J. Jones
ATTENDING PHYSICIAN NPI: 1122334455
UPIN: U12345
PROCEDURES:
Rev code: 0305 HCPCS: 85025 Billed Amt: 13.39 Units: 1.
Rev code: 0730 HCPCS: 93010 Billed Amt: 76.56 Units: 3.

CLAIM #2:

SUBSCRIBER: Joe Smith
MEMBER ID: 123405074
SUBSCRIBER ADDRESS: 5 Main Street, Anywhere, PA, 17111
DOB: December 12, 1962
SEX: M
PATIENT ACCOUNT #: 756049Q
CLAIM AMOUNT: 50.00
TYPE OF BILL: 131
CLAIM DATE: April 1, 2005
PRINCIPAL DIAGNOSIS: 300.00

ATTENDING PHYSICIAN: Judy J. Jones
NPI: 9999999999
PROVIDER SPECIALTY: 363LP0200N
PROCEDURES:
Rev code: 0300 HCPCS: 85087 Billed Amt: 50.00 Units: 1.

SEG#	LOOP SEGMENT/ELEMENT STRING
1	TRANSACTION SET HEADER ST*837*987654*005010X223A2~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0123*20050630*0932*CH~
3	1000A SUBMITTER NAME NM1 SUBMITTER NAME NM1*41*2*JONES HOSPITAL*****46*12345~
4	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*JANE DOE*TE*1112223333~
5	1000B RECEIVER NAME NM1 RECEIVER NAME NM1*40*2*TRICARE*****46*99999~
6	2000A BILLING PROVIDER HL BILLING PROVIDER HIERARCHICAL LEVEL HL*1**20*1~
7	PRV BILLING PROVIDER SPECIALTY PRV*BI*PXC*282N00000X~
8	2010AA BILLING PROVIDER NAME NM1 BILLING PROVIDER NAME INCLUDING NATIONAL PROVIDER ID NM1*85*2*JONES HOSPITAL*****XX*1234567890~
9	N3 BILLING PROVIDER ADDRESS N3*225 MAIN STREET~
10	N4 BILLING PROVIDER LOCATION N4*ANYWHERE*PA*17111~

SEG#	LOOP SEGMENT/ELEMENT STRING
11	REF BILLING PROVIDER TAX IDENTIFICATION NUMBER REF*EI*123456789~
12	2000B SUBSCRIBER HL LOOP HL SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*0~
13	SBR SUBSCRIBER INFORMATION SBR*P*18*****CH~
14	2010BA SUBSCRIBER NAME LOOP NM1 SUBSCRIBER NAME NM1*IL*1*DOE*JOHN*T***MI*030005074~
15	N3 SUBSCRIBER ADDRESS N3*125 CITY AVENUE~
16	N4 SUBSCRIBER LOCATION N4*CENTERVILLE*PA*17111~
17	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19681111*M~
18	2010BB PAYER NAME LOOP NM1 PAYER NAME NM1*PR*2*TRICARE*****PI*99999~
19	2300 CLAIM INFORMATION CLM CLAIM LEVEL INFORMATION CLM*756048Q*89.95***13:A:1*Y*C*Y*Y~
20	DTP STATEMENT DATES DTP*434*RD8*20050315-20050315~
21	CL1 INSTITUTIONAL CLAIM CODE CL1***01~
22	HI PRINCIPAL DIAGNOSIS CODES HI*BK:3669~

SEG#	LOOP SEGMENT/ELEMENT STRING
23	HI OTHER DIAGNOSIS INFORMATION HI*BF:4019*BF:79431~
24	2310A ATTENDING PROVIDER NAME NM1 ATTENDING PROVIDER NM1*71*1*JONES*JOHN*J***XX*1122334455~
25	REF ATTENDING PROVIDER SECONDARY IDENTIFICATION REF*1G*U12345~
26	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*1~
27	SV2 INSTITUTIONAL SERVICE SV2*0305*HC:85025*13.39*UN*1~
28	DTP DATE - SERVICE DATES DTP*472*D8*20050315~
29	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~
30	SV2 INSTITUTIONAL SERVICE SV2*0730*HC:93010*76.56*UN*3~
31	DTP DATE - SERVICE DATES DTP*472*D8*20050315~
32	2000B SUBSCRIBER HL LOOP HL SUBSCRIBER HIERARCHICAL LEVEL HL*3*1*22*0~
33	SBR SUBSCRIBER INFORMATION SBR*P*18*****CH~
34	2010BA SUBSCRIBER NAME LOOP NM1 SUBSCRIBER NAME NM1*IL*1*SMITH*JOE****MI*123405074~

SEG#	LOOP SEGMENT/ELEMENT STRING
35	N3 SUBSCRIBER ADDRESS N3*5 MAIN STREET~
36	N4 SUBSCRIBER LOCATION N4*ANYWHERE*PA*17111~
37	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19621210*M~
38	2010BB PAYER NAME LOOP NM1 PAYER NAME NM1*PR*2*TRICARE*****PI*99999~
39	2300 CLAIM INFORMATION CLM CLAIM LEVEL INFORMATION CLM*756049Q*50***13:A:1*Y*C*Y*Y~
40	DTP STATEMENT DATES DTP*434*RD8*20050401-20050401~
41	CL1 INSTITUTIONAL CLAIM CODE CL1***01~
42	HI PRINCIPAL DIAGNOSIS CODES HI*BK:30000~
43	2310A ATTENDING PROVIDER NAME NM1 ATTENDING PROVIDER NM1*71*1*JONES*JUDY*J***XX*999999999~
44	PRV - ATTENDING PROVIDER SPECIALTY INFORMATION PRV*AT*PXC*363LP0200N~
45	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*1~
46	SV2 INSTITUTIONAL SERVICE SV2*0300*HC:85087*50*UN*1~

SEG#	LOOP SEGMENT/ELEMENT STRING
47	DTP DATE - SERVICE DATES DTP*472*D8*20050401~
48	TRAILER SE TRANSACTION SET TRAILER SE*48*987654~

Complete Data String:

ST*837*987654*005010X223A2~BHT*0019*00*0123*20050630*0932*CH
~NM1*41*2*JONES HOSPITAL*****46*12345~PER*IC*JANE DOE*TE*111
2223333~NM1*40*2*TRICARE*****46*99999~HL*1**20*1~PRV*BI*PXC*
282N00000X~NM1*85*2*JONES HOSPITAL*****XX*1234567890~N3*225
MAIN STREET~N4*ANYWHERE*PA*17111~REF*EI*123456789~HL*2*1*22*
0~SBR*P*18*****CH~NM1*IL*1*DOE*JOHN*T***MI*030005074~N3*12
5 CITY AVENUE~N4*ANYWHERE*PA*17111~DMG*D8*19681111*M~NM1*PR*
2*TRICARE*****PI*99999~CLM*756048Q*89.95***13:A:1*Y*C*Y*Y~DT
P*434*RD8*20050315-20050315~CL1***01~HI*BK:3669~HI*BF:4019*B
F:79431~NM1*71*1*JONES*JOHN*J***XX*1122334455~REF*1G*U12345~
LX*1~SV2*0305*HC:85025*13.39*UN*1~DTP*472*D8*20050315~LX*2~S
V2*0730*HC:93010*76.56*UN*3~DTP*472*D8*20050315~HL*3*1*22*0~
SBR*P*18*****CH~NM1*IL*1*SMITH*JOE*****MI*123405074~N3*5 MA
IN STREET~N4*ANYWHERE*PA*17111~DMG*D8*19621210*M~NM1*PR*2*TR
ICARE*****PI*99999~CLM*756049Q*50***13:A:1*Y*C*Y*Y~DTP*434*R
D8*20050401-20050401~CL1***01~HI*BK:30000~NM1*71*1*JONES*JUD
Y*J***XX*9999999999~PRV*AT*PXC*363LP0200N~LX*1~SV2*0300*HC:8
5087*50*UN*1~DTP*472*D8*20050401~SE*48*987654~

3.1.3 Business Scenario 3 - PPO Repriced Claim

Repriced claim being transmitted from a Regional PPO (Preferred Provider Organization) to a commercial health insurance company. The patient is a child of the subscriber. In this situation, the hospital has sent the claim to a clearinghouse, which then forwarded the claim to the repricer; the claim has been repriced and is now being forwarded to the appropriate payer for payment.

SUBSCRIBER: Jenny Jones

ADDRESS: 4512 West Avenue, Evansville, AZ 863030000

SEX: F

DATE OF BIRTH: 07/31/1969

EMPLOYER: DESSERT COMPANY, INC.

GROUP NUMBER: 46522567AW

MEMBER ID: 345U8423H

PATIENT: Joy Jones

ADDRESS: 4512 West Avenue, Evansville, AZ 863030000

SEX: F

DATE OF BIRTH: 08/20/1998

PATIENT ACCOUNT NUMBER: 456DFH43

OTHER INSURANCE: Other Coverage Company

PAYER ID: 534524

OTHER INSURED NAME: George Jones

OTHER GROUP NAME: T&T Plumbing Company

OTHER INSURED DATE OF BIRTH: 01/22/1970

OTHER INSURED MEMBER ID: 56454566

SUBMITTER: Regional PPO Network

SUBMITTER ID: 123456789

TAX ID: 123456789

RECEIVER: Local Insurance Company

RECEIVER ID: 54334452

DESTINATION PAYER: Local Insurance Company

PAYER ID NUMBER: 7452723

BILLING PROVIDER: Good Health Hospital

ADDRESS: 592 North Elm Street, Edgewood, AZ 86001-5590

NATIONAL PROVIDER ID (NPI): 1257234346

TAX IDENTIFICATION NUMBER (TIN): 344-23-2321

ATTENDING PROVIDER: Simon Johnson

NATIONAL PROVIDER ID (NPI): 5544332211

TOTAL CLAIM CHARGES: \$237.5

TOTAL CLAIM REPRICED AMOUNT: \$182.88

TOTAL CLAIM SAVINGS AMOUNT: \$54.62

TIN FOR THE REPRICING ORGANIZATION: 332211445

SERVICE LINE 1 REPRICING INFORMATION:

TOTAL SERVICE LINE CHARGES: \$178.00
TOTAL REPRICED AMOUNT: \$137.06
SAVINGS AMOUNT: \$40.94
TIN FOR THE REPRICING ORGANIZATION: 332211445
DATE OF SERVICE: 07/06/05

SERVICE LINE 2 REPRICING INFORMATION:

TOTAL SERVICE LINE CHARGES: \$59.50
TOTAL REPRICED AMOUNT: \$45.82
SAVINGS AMOUNT: \$13.68
TIN FOR THE REPRICING ORGANIZATION: 332211445
DATE OF SERVICE: 07/06/05

SEG#	LOOP SEGMENT/ELEMENT STRING
1	TRANSACTION SET HEADER ST*837*1002*005010X223A2~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*1002*20050721*09460000*CH~
3	1000A SUBMITTER NAME NM1 SUBMITTER NAME NM1*41*2*REGIONAL PPO NETWORK*****46*123456789~
4	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*SUBMITTER CONTACT INFO*TE*8001231234~
5	1000B RECEIVER NAME NM1 RECEIVER NAME NM1*40*2*LOCAL INSURANCE COMPANY*****46*54334452~
6	2000A BILLING PROVIDER HL BILLING PROVIDER HIERARCHICAL LEVEL HL*1**20*1~
7	2010AA BILLING PROVIDER NAME NM1 BILLING PROVIDER NAME INCLUDING NATIONAL PROVIDER ID NM1*85*2*GOOD HEALTH HOSPITAL*****XX*1257234346~

SEG#	LOOP SEGMENT/ELEMENT STRING
8	N3 BILLING PROVIDER ADDRESS N3*592 NORTH ELM STREET~
9	N4 BILLING PROVIDER LOCATION N4*EDGEWOOD*AZ*860015590~
10	REF BILLING PROVIDER TAX IDENTIFICATION NUMBER REF*EI*344232321~
11	2000B SUBSCRIBER HL LOOP HL SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*1~
12	SBR SUBSCRIBER INFORMATION SBR*P**46522567AW*****CI~
13	2010BA SUBSCRIBER NAME LOOP NM1 SUBSCRIBER NAME NM1*IL*1*JONES*JENNY****MI*345U8423H~
14	N3 SUBSCRIBER ADDRESS N3*4512 WEST AVENUE~
15	N4 SUBSCRIBER LOCATION N4*EVANSVILLE*AZ*863030000~
16	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19690731*F~
17	2010BB PAYER NAME LOOP NM1 PAYER NAME NM1*PR*2*LOCAL INSURANCE COMPANY*****PI*7452723~
18	2000C PATIENT HL LOOP HL PATIENT HIERARCHICAL LEVEL HL*3*2*23*0~
19	PAT PATIENT INFORMATION PAT*19~

SEG#	LOOP SEGMENT/ELEMENT STRING
20	2010CA PATIENT NAME NM1 PATIENT NAME NM1*QC*1*JONES*JOY~
21	N3 PATIENT STREET ADDRESS N3*4512 WEST AVENUE~
22	N4 PATIENT LOCATION N4*EVANSVILLE*AZ*863030000~
23	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19980820*F~
24	2300 CLAIM INFORMATION CLM CLAIM LEVEL INFORMATION CLM*456DFH43*237.5***13>A>1*Y**Y*Y~
25	DTP STATEMENT DATES DTP*434*RD8*20050706-20050706~
26	DTP ADMISSION DATE/HOUR DTP*435*DT*200507060800~
27	CL1 INSTITUTIONAL CLAIM CODE CL1**2*01~
28	AMT PATIENT ESTIMATED AMOUNT DUE AMT*F3*237.5~
29	REF REPRICED CLAIM NUMBER REF*9A*09459034092~
30	REF CLEARING HOUSE CLAIM NUMBER (ASSIGNED BY THE CLEARING HOUSE WHEN TRANSMITTING TO THE REPRICER) REF*D9*04566877634343456~
31	HI HEALTH CARE PRINCIPAL DIAGNOSIS CODES HI*BK>38181~
32	HI OTHER DIAGNOSIS INFORMATION HI*BF>38900~

SEG#	LOOP SEGMENT/ELEMENT STRING
33	HI OCCURRENCE INFORMATION HI*BH>11>D8>20050706~
34	HCP HEALTH CARE PRICING - REPRICING INFORMATION HCP*03*182.88*54.62*123456789~
35	2310A ATTENDING PROVIDER NAME NM1 ATTENDING PROVIDER NM1*71*1*JOHNSON*SIMON***XX*5544332211~
36	2320 OTHER SUBSCRIBER INFORMATION SBR OTHER SUBSCRIBER INFORMATION SBR*S*19**T&T PLUMBING COMPANY*****CI~
37	DMG OTHER SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19700122*M~
38	OI OTHER INSURANCE COVERAGE INFORMATION OI***Y***Y~
39	2330A OTHER SUBSCRIBER NAME NM1 OTHER SUBSCRIBER NAME NM1*IL*1*JONES*GEORGE***MI*56454566~
40	2330B OTHER PAYER NAME NM1 OTHER PAYER NAME NM1*PR*2*OTHER COVERAGE COMPANY*****PI*534524~
41	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*1~
42	SV2 INSTITUTIONAL SERVICE SV2*0471*HC>92557*178*UN*1~
43	DTP DATE - SERVICE DATES DTP*472*D8*20050706~
44	HCP HEALTH CARE PRICING - REPRICING INFORMATION HCP*03*137.06*40.94~

SEG#	LOOP SEGMENT/ELEMENT STRING
45	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*2~
46	SV2 INSTITUTIONAL SERVICE SV2*0471*HC>92567*59.5*UN*1~
47	DTP DATE - SERVICE DATES DTP*472*D8*20050706~
48	HCP HEALTH CARE PRICING - REPRICING INFORMATION HCP*03*45.82*13.68~
49	TRAILER SE TRANSACTION SET TRAILER SE*49*1002~

Complete Data String:

ST*837*1002*005010X223A2~BHT*0019*00*1002*20050721*09460000*
CH~NM1*41*2*REGIONAL PPO NETWORK*****46*123456789~PER*IC*SUB
MITTER CONTACT INFO*TE*8001231234~NM1*40*2*LOCAL INSURANCE C
OMPANY*****46*54334452~HL*1**20*1~NM1*85*2*GOOD HEALTH HOSPI
TAL*****XX*1257234346~N3*592 NORTH ELM STREET~N4*EDGEWOOD*AZ
*860015590~REF*EI*344232321~HL*2*1*22*1~SBR*P**46522567AW***
CI~NM1*IL*1*JONES*JENNY**MI*345U8423H~N3*4512 WEST AVEN
UE~N4*EVANSVILLE*AZ*863030000~DMG*D8*19690731*F~NM1*PR*2*LOC
AL INSURANCE COMPANY*****PI*7452723~HL*3*2*23*0~PAT*19~NM1*Q
C*1*JONES*JOY~N3*4512 WEST AVENUE~N4*EVANSVILLE*AZ*863030000
~DMG*D8*19980820*F~CLM*456DFH43*237.5***13>A>1*Y**Y*Y~DTP*43
4*RD8*20050706-20050706~DTP*435*DT*200507060800~CL1**2*01~AM
T*F3*237.5~REF*9A*09459034092~REF*D9*04566877634343456~HI*BK
>38181~HI*BF>38900~HI*BH>11>D8>20050706~HCP*03*182.88*54.62*
123456789~NM1*71*1*JOHNSON*SIMON*****XX*5544332211~SBR*S*19**
T&TPLUMBING COMPANY*****CI~DMG*D8*19700122*M~OI***Y***Y~NM1*
IL*1*JONES*GEORGE*****MI*56454566~NM1*PR*2*OTHER COVERAGE COM
PANY*****PI*534524~LX*1~SV2*0471*HC>92557*178*UN*1~DTP*472*D
8*20050706~HCP*03*137.06*40.94~LX*2~SV2*0471*HC>92567*59.5*U
N*1~DTP*472*D8*20050706~HCP*03*45.82*13.68~SE*49*1002~

3.1.4 Business Scenario 4 - Out of Network Repriced Claim

An out of network claim is being transmitted from a Regional PPO (Preferred Provider Organization) to a commercial health insurance company. The patient and the subscriber are the same. In this situation, the hospital has sent the claim to a clearinghouse, which then forwarded the claim to the repricer; the claim has been determined to be out of network and is now being forwarded to the appropriate payer for payment.

PATIENT/SUBSCRIBER: JAMES A SMITH

ADDRESS: 934 North Street, Columbus, OH 432150000

SEX: M

DATE OF BIRTH: 10/15/1962

EMPLOYER: TREE TRIMMING SERVICE

GROUP NUMBER: 34561W

MEMBER ID: 34902390F

PATIENT CONTROL NUMBER: W392-49141

SUBMITTER: Regional PPO Network

SUBMITTER ID: 123456789

RECEIVER: Conservative Insurance

RECEIVER ID: 000110002

DESTINATION PAYER: Conservative Insurance

PAYER ID NUMBER: 00123

BILLING PROVIDER: LOCAL HOSPITAL

ADDRESS: 3423 Small Street, Columbus, OH 432150000

NATIONAL PROVIDER ID (NPI): 1122334455

TAX IDENTIFICATION NUMBER (TIN): 111-00-2222

RENDERING PROVIDER: Dawn Rivers

NATIONAL PROVIDER ID (NPI): 2244224455

REPRICING INFORMATION:

TOTAL CHARGES: \$14.84

TOTAL REPRICED AMOUNT: \$0

SAVINGS AMOUNT: \$0

TIN FOR THE REPRICING ORGANIZATION: 333001234

DATE OF SERVICE: 06/17/05

SEG#	LOOP SEGMENT/ELEMENT STRING
1	TRANSACTION SET HEADER ST*837*1024*005010X223A2~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*1024*20050711*1335*CH~
3	1000A SUBMITTER NAME NM1 SUBMITTER NAME NM1*41*2*REGIONAL PPO NETWORK*****46*123456789~
4	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*SUBMITTER CONTACT INFO*TE*8001231234~
5	1000B RECEIVER NAME NM1 RECEIVER NAME NM1*40*2*CONSERVATIVE INSURANCE*****46*000110002~
6	2000A BILLING PROVIDER HL BILLING PROVIDER HIERARCHICAL LEVEL HL*1*20*1~
7	2010AA BILLING PROVIDER NAME NM1 BILLING PROVIDER NAME INCLUDING NATIONAL PROVIDER ID NM1*85*2*LOCAL HOSPITAL*****XX*1122334455~
8	N3 BILLING PROVIDER ADDRESS N3*3423 SMALL STREET~
9	N4 BILLING PROVIDER LOCATION N4*COLUMBUS*OH*432150000~
10	REF BILLING PROVIDER TAX IDENTIFICATION NUMBER REF*EI*111002222~
11	2000B SUBSCRIBER HL LOOP HL SUBSCRIBER HIERARCHICAL LEVEL HL*2*1*22*0~

SEG#	LOOP SEGMENT/ELEMENT STRING
12	SBR SUBSCRIBER INFORMATION SBR*P*18*34561W*****CI~
13	2010BA SUBSCRIBER NAME LOOP NM1 SUBSCRIBER NAME NM1*IL*1*SMITH* JAMES*A***MI*34902390F~
14	N3 SUBSCRIBER ADDRESS N3*934 NORTH STREET~
15	N4 SUBSCRIBER LOCATION N4*COLUMBUS*OH*432150000~
16	DMG SUBSCRIBER DEMOGRAPHIC INFORMATION DMG*D8*19621015*M~
17	2010BB - PAYER NAME LOOP NM1 PAYER NAME NM1*PR*2*CONSERVATIVE INSURANCE*****PI*0012~
18	2300 CLAIM INFORMATION CLM CLAIM LEVEL INFORMATION CLM*W392-49141*14.84***13>A>1*Y**Y*Y~
19	DTP STATEMENT DATES DTP*434*RD8*20050617-20050617~
20	DTP ADMISSION DATE/HOUR DTP*435*DT*200506170800~
21	CL1 INSTITUTIONAL CLAIM CODE CL1**1*01~
22	AMT PATIENT ESTIMATED AMOUNT DUE AMT*F3*14.84~
23	REF REPRICED CLAIM NUMBER REF*9A*459804390823~

SEG#	LOOP SEGMENT/ELEMENT STRING
24	REF CLEARING HOUSE CLAIM NUMBER (ASSIGNED BY THE CLEARING HOUSE WHEN TRANSMITTING TO THE REPRICER) REF*D9*32423466233~
25	HI HEALTH CARE DIAGNOSIS CODES HI*BK>53081~
26	HCP HEALTH CARE PRICING - OUT OF NETWORK INFORMATION HCP*00*0**333001234*****T1~
27	2310A ATTENDING PROVIDER NAME NM1 ATTENDING PROVIDER NM1*71*1*RIVERS*DAWN****XX*2244224455~
28	2400 SERVICE LINE LX SERVICE LINE COUNTER LX*1~
29	SV2 INSTITUTIONAL SERVICE SV2*0301*HC>82270*14.84*UN*1~
30	DTP DATE - SERVICE DATES DTP*472*D8*20050617~
31	TRAILER SE TRANSACTION SET TRAILER SE*31*1024~

Complete Data String:

ST*837*1024*005010X223A2~BHT*0019*00*1024*20050711*1335*CH~NM1*41*2*REGIONAL PPO NETWORK*****46*123456789~PER*IC*SUBMITTER CONTACT INFO*TE*8001231234~NM1*40*2*CONSERVATIVE INSURANCE*****46*000110002~HL*1**20*1~NM1*85*2*LOCAL HOSPITAL*****XX*1122334455~N3*3423 SMALL STREET~N4*COLUMBUS*OH*432150000~REF*EI*111002222~HL*2*1*22*0~SBR*P*18*34561W*****CI~NM1*IL*1*SMITH*JAMES*A***MI*34902390F~N3*934 NORTH STREET~N4*COLUMBUS*OH*432150000~DMG*D8*19621015*M~NM1*PR*2*CONSERVATIVE INSURANCE*****PI*00123~CLM*W392-49141*14.84***13>A>1*Y**Y*Y~DTP*434*RD8*20050617-20050617~DTP*435*DT*200506170800~CL1**1*01~AMT*F3*14.84~REF*9A*459804390823~REF*D9*32423466233~HI*BK>5308

1~HCP*00*0**333001234*****T1~NM1*71*1*RIVERS*DAWN****XX*
 2244224455~LX*1~SV2*0301*HC>82270*14.84*UN*1~DTP*472*D8*2005
 0617~SE*31*1024~

3.2 Property and Casualty

Healthcare Bill to Property & Casualty Payer

The requirements for submitting of Healthcare bills to Property & Casualty payers are presented here.

837 Transaction Set

Healthcare bills can be submitted to a Property & Casualty (P&C) payer. Because coverage is triggered by a specific event, certain information is critical to the billing process.

P&C bills must include both the bill information as well as the information related to the event that caused the injury or illness. Information concerning the event is necessary to associate a bill with the P&C claim.

P & C insurance is governed by State Insurance Regulations, Departments of Labor, Worker's Compensation Boards, or other jurisdictionally defined entities, which often mandates compliance with Jurisdiction-specific procedures.

The Business Need: Provider to P&C Payer Bill Transmission

- The date of accident/occurrence/onset of symptoms (Date of Loss) is a critical piece of information and must always be transmitted in the "Date - Accident" DTP segment within Loop ID-2300 (Claim loop).

The Date of Loss is used to determine the eligibility of coverage.

- The unique identification number, referred to in P&C as a claim number, must be provided. The claim number is transmitted in the REF segment of Loop ID-2010BA if the patient is the subscriber or in the REF segment of Loop ID-2010CA if the patient is not the subscriber.

Without a date of loss on the bill and claim number, the bill will incomplete and may be rejected.

3.2.1 Business Scenario 1 - 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: 10/31/2005

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: RON MEXICO

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, NY, NY, 10032

PAYER ID: 999888777

BILLING PROVIDER/SENDER: HALL OF FAME MEMORIAL HOSPITAL

TIN: 737373737

NATIONAL PROVIDER IDENTIFIER: 2365259638

ADDRESS: 1 CANTON ROAD, BROKEN FIELD, CA, 99998

PAY-TO-PROVIDER: HALL OF FAME MEMORIAL HOSPITAL

ATTENDING 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 = 10/31/2005, 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.

SEG#	LOOP SEGMENT/ELEMENT STRING
1	HEADER ST TRANSACTION SET HEADER ST*837*557766*005010X223A2~
2	BHT BEGINNING OF HIERARCHICAL TRANSACTION BHT*0019*00*0324*20051111*1800*CH~
3	1000A SUBMITTER NM1 SUBMITTER NAME NM1*41*2*HALL OF FAME MEMORIAL HOSPITAL*****46*737373737~
4	PER SUBMITTER EDI CONTACT INFORMATION PER*IC*KATE CASEY*TE*7152569877~
5	1000B RECEIVER NM1 RECEIVER NAME NM1*40*2*HEISMAN INSURANCE COMPANY*****46*999888777~
6	2000A BILLING PROVIDER HL LOOP HL*1**20*1~
7	PRV BILLING PROVIDER SPECIALTY PRV*BI*PXC*203BA0200N~
8	NM1 BILLING PROVIDER NAME NM1*85*2*HALL OF FAME MEMORIAL HOSPITAL*****XX*2365259638~
9	N3 BILLING PROVIDER ADDRESS N3*1 CANTON ROAD~
10	N4 BILLING PROVIDER LOCATION N4*BROKEN FIELD*CA*99998~
11	REF BILLING PROVIDER SECONDARY IDENTIFICATION REF*EI*737373737~

SEG#	LOOP SEGMENT/ELEMENT STRING
12	2000B SUBSCRIBER HL LOOP HL*2*1*22*1~
13	SBR SUBSCRIBER INFORMATION SBR*P*****AM~
14	2010BA SUBSCRIBER NM1*IL*1*HOWLING*HAL****MI*B999777791G~
15	2010BB PAYER NM1*PR*2*HEISMAN INSURANCE COMPANY*****PI*999888777~
16	2000C PATIENT HL LOOP HL*3*2*23*0~
17	PAT PATIENT INFORMATION PAT*21~
18	NM1 PATIENT NAME NM1*QC*1*MEXICO*RON~
19	N3 PATIENT ADDRESS N3*32 BUFFALO RUN~
20	N4 PATIENT CITY/STATE/ZIP CODE N4*ROCKING HORSE*CA*99666~
21	DMG PATIENT DEMOGRAPHIC INFORMATION DMG*D8*19480601*M~
22	REF PROPERTY AND CASUALTY CLAIM NUMBER REF*Y4*32323232~
23	2300 CLAIM CLM*67236695521*545***13:A:1*Y*A*Y*Y~
24	DTP STATEMENT DATES DTP*434*RD8*20051031-20051101~
25	CL1 INSTITUTIONAL CLAIM CODE CL1*3*7*1~

SEG#	LOOP SEGMENT/ELEMENT STRING
26	REF AUTO ACCIDENT STATE REF*LU*CA~
27	HI PRINCIPLE DIAGNOIS HI*BK:8842~
28	HI PATIENT'S REASON FOR VISIT HI*PR:8842~
29	HI EXTERNAL CAUSE OF INJURY HI*BN:E9750*BN:E9860~
30	2310A ATTENDING PROVIDER NAME NM1 ATTENDING PROVIDER NAME NM1*71*1*LOMBARDO*VINCENT***XX*2533698543~
31	2400 SERVICE LINE NUMBER LX SERVICE LINE NUMBER LX*1~
32	SV2 INSTITUTIONAL SERVICE LINE SV2*0450*HC:98765*150*UN*1~
33	DTP DATE - SERVICE DATE DTP*472*D8*20051031~
34	LX SERVICE LINE NUMBER LX*2~
35	SV2 INSTITUTIONAL SERVICE LINE SV2*0360*HC:26591*75*UN*1~
36	DTP DATE - SERVICE DATE DTP*472*D8*20051031~
37	LX SERVICE LINE NUMBER LX*3~
38	SV2 INSTITUTIONAL SERVICE LINE SV2*0312*HC:86225*100*UN*2~

SEG#	LOOP SEGMENT/ELEMENT STRING
39	DTP DATE - SERVICE DATE DTP*472*D8*20051031~
40	LX SERVICE LINE NUMBER LX*4~
41	SV2 INSTITUTIONAL SERVICE LINE SV2*0360*HC:99283*220*UN*1~
42	DTP DATE - SERVICE DATE DTP*472*D8*20051031~
43	TRAILER SE - TRANSACTION SET TRAILER SE*43*557766~

Complete Data String:

ST*837*557766*005010X223A2~BHT*0019*00*0324*20051111*1800*CH
~NM1*41*2*HALL OF FAME MEMORIAL HOSPITAL*****46*737373737~PE
R*IC*kate casey*TE*7152569877~NM1*40*2*HEISMAN INSURANCE COM
PANY*****46*999888777~HL*1**20*1~PRV*BI*pxc*203BA0200N~NM1*8
5*2*HALL OF FAME MEMORIAL HOSPITAL*****XX*2365259638~N3*1 CA
NTON ROAD~N4*BROKEN FIELD*CA*99998~REF*EI*737373737~HL*2*1*2
2*1~SBR*P*****AM~NM1*IL*1*HOWLING*HAL*****MI*B999777791G~N
M1*PR*2*HEISMAN INSURANCE COMPANY*****PI*999888777~HL*3*2*23
*0~PAT*21~NM1*QC*1*MEXICO*RON~N3*32 BUFFALO RUN~N4*ROCKING H
ORSE*CA*99666~DMG*D8*19480601*M~REF*Y4*32323232~CLM*67236695
521*545***13:A:1*Y*A*Y*Y~DTP*434*RD8*20051031-20051101~CL1*3
*7*1~REF*LU*CA~HI*BK:8842~HI*PR:8842~HI*BN:E9750*BN:E9860~NM
1*71*1*LOMBARDO*VINCENT*****XX*2533698543~LX*1~SV2*0450*HC:98
765*150*UN*1~DTP*472*D8*20051031~LX*2~SV2*0360*HC:26591*75*U
N*1~DTP*472*D8*20051031~LX*3~SV2*0312*HC:86225*100*UN*2~DTP*
472*D8*20051031~LX*4~SV2*0360*HC:99283*220*UN*1~DTP*472*D8*2
0051031~SE*43*557766~

A External Code Sources

A.1 External Code Sources

5 Countries, Currencies and Funds

SIMPLE DATA ELEMENT/CODE REFERENCES

26, 100, 1715, 66/38, 235/CH, 955/SP

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
25 West 43rd Street, 4th Floor
New York, NY 10036

ABSTRACT

Part 1 (Country codes) of the ISO 3166 international standard establishes codes that represent the current names of countries, dependencies, and other areas of special geopolitical interest, on the basis of lists of country names obtained from the United Nations. Part 2 (Country subdivision codes) establishes a code that represents the names of the principal administrative divisions, or similar areas, of the countries, etc. included in Part 1. Part 3 (Codes for formerly used names of countries) establishes a code that represents non-current country names, i.e., the country names deleted from ISO 3166 since its first publication in 1974. Most currencies are those of the geopolitical entities that are listed in ISO 3166 Part 1, 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 Part 1, 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 Part 1. The range 950-998

is reserved for identification of funds and currencies not associated with a single entity listed in ISO 3166 Part 1.

22 States and Provinces

SIMPLE DATA ELEMENT/CODE REFERENCES

156, 66/SJ, 235/A5, 771/009

SOURCE

U.S. Postal Service or

Canada Post or
Bureau of Transportation Statistics

AVAILABLE FROM

The U.S. state codes may be obtained from:

U.S. Postal Service

National Information Data Center

P.O. Box 2977

Washington, DC 20013

www.usps.gov

The Canadian province codes may be obtained from:

<http://www.canadapost.ca>

The Mexican state codes may be obtained from:

www.bts.gov/ntda/tbscd/mex-states.html

ABSTRACT

Provides names, abbreviations, and two character codes for the states, provinces and sub-country divisions as defined by the appropriate government agency of the United States, Canada, and Mexico.

51 ZIP Code

SIMPLE DATA ELEMENT/CODE REFERENCES

116, 66/16, 309/PQ, 309/PR, 309/PS, 771/010

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 Domestic Mail Manual includes information on the use of the new 11-digit zip code.

130 Healthcare Common Procedure Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HC, 1270/BO, 1270/BP

SOURCE

Healthcare Common Procedure Coding System

AVAILABLE FROM

Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT

HCPCS is Centers for Medicare & Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

131 International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

SIMPLE DATA ELEMENT/CODE REFERENCES

128/ICD, 235/DX, 235/ID, 1270/BF, 1270/BJ, 1270/BK, 1270/BN, 1270/BQ, 1270/BR, 1270/DD, 1270/PR, 1270/SD, 1270/TD, 1270/AAU, 1270/AAV, 1270/AAX

SOURCE

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II and III

AVAILABLE FROM

Superintendent of Documents
U.S. Government Printing Office
P.O. Box 371954
Pittsburgh, PA 15250

ABSTRACT

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes I, II (diagnoses) and III (procedures) describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases and procedures.

132 National Uniform Billing Committee (NUBC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/NU, 235/RB, 1270/BE, 1270/BG, 1270/BH, 1270/BI, 1270/NUB

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

ABSTRACT

Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee.

139 Claim Adjustment Reason Code

SIMPLE DATA ELEMENT/CODE REFERENCES

1034

SOURCE

National Health Care Claim Payment/Advice Committee Bulletins

AVAILABLE FROM

Blue Cross and Blue Shield Association
Health Information Technology Department
225 N Michigan Avenue
Chicago, IL 60601-7680

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

1354, 1270/DR

SOURCE

Federal Register and Health Insurance Manual 15 (HIM 15)

AVAILABLE FROM

Superintendent 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 Point of Origin for Admission or Visit

SIMPLE DATA ELEMENT/CODE REFERENCES

1314

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

ABSTRACT

A variety of codes explaining who recommended admission to a medical facility.

231 Priority (Type) of Admission or Visit

SIMPLE DATA ELEMENT/CODE REFERENCES

1315

SOURCE

National Uniform Billing Data Element Specifications

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

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 Last Position

AVAILABLE FROM

National Uniform Billing Committee
American Hospital Association
One North Franklin

Chicago, IL 60606

ABSTRACT

A variety of codes explaining the frequency of different Types of Bills (for example, Replacement Claims).

236 Uniform Billing Claim Form Bill Type

SIMPLE DATA ELEMENT/CODE REFERENCES

1332/A

SOURCE

National Uniform Billing Data Element Specifications Facility Type Code

AVAILABLE FROM

National Uniform Billing Committee

American Hospital Association

One North Franklin

Chicago, IL 60606

ABSTRACT

A variety of codes describing the type of medical facility.

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

One North Franklin

Chicago, IL 60606

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, 235/N5, 235/N6, 1270/NDC

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

Centers for Medicare & Medicaid Services (CMS) Treatment Codes

AVAILABLE FROM

Centers for Medicare & Medicaid Services
Office of Financial Management Program Integrity Group C3-02-16
7500 Security Boulevard
Baltimore MD 21244-1850

ABSTRACT

Codes used to describe the treatments provided in a home health setting.

411 Remittance Advice Remark Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

1270/HE

SOURCE

Centers for Medicare & Medicaid Services

OIS/BSOG/DDIS, Mail Stop N2-13-16
7500 Security Boulevard
Baltimore MD 21244

AVAILABLE FROM

Washington Publishing Company <http://www.wpc-edi.com>

ABSTRACT

Remittance Advice Remark Codes (RARC) are used to convey information about claim adjudication. It could provide general information or supplemental explanations to an adjustment already reported by a Claim Adjustment Reason Code.

513 Home Infusion EDI Coalition (HIEC) Product/Service Code List

SIMPLE DATA ELEMENT/CODE REFERENCES

235/IV, 1270/HO

SOURCE

Home Infusion EDI Coalition (HIEC) Coding System

AVAILABLE FROM

HIEC Chairperson
HIBCC (Health Industry Business Communications Council)
5110 North 40th Street
Suite 250
Phoenix, AZ 85018

ABSTRACT

This list contains codes identifying home infusion therapy products/services.

537 Centers for Medicare & Medicaid Services National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XX, 128/HPI

SOURCE

National Provider System

AVAILABLE FROM

Centers for Medicare & Medicaid Services
Office of Financial Management
Division of Provider/Supplier Enrollment
C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Centers for Medicare & Medicaid Services is developing the National Provider Identifier (NPI), which has been proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

540 Centers for Medicare and Medicaid Services PlanID

SIMPLE DATA ELEMENT/CODE REFERENCES

66/XV, 128/ABY

SOURCE

PlanID Database

AVAILABLE FROM

Centers for Medicare and Medicaid Services
Center of Beneficiary Services, Membership Operations Group
Division of Benefit Coordination
S1-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Centers for Medicare and Medicaid Services has joined with other payers to develop a unique national payer identification number. The Centers for Medicare and Medicaid Services is the authorizing agent for enumerating payers through the services of a PlanID Registrar. It may also be used by other payers on a voluntary basis.

576 Workers Compensation Specific Procedure and Supply Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/ER

SOURCE

IAIABC Jurisdiction Medical Bill Report Implementation Guide

AVAILABLE FROM

IAIABC EDI Implementation Manager
International Association of Industrial Accident Boards and Commissions
8643 Hauses - Suite 200
87th Parkway
Shawnee Mission, KS 66215

ABSTRACT

The IAIABC Jurisdiction Medical Bill Report Implementation Guide describes the requirements for submitting and the data contained within a jurisdiction medical report. The Implementation Guide includes: Reporting scenarios, data definitions, trading partner requirements tables, reference to industry codes, and IAIABC maintained code lists.

682 Health Care Provider Taxonomy

SIMPLE DATA ELEMENT/CODE REFERENCES

128/PXC, 1270/68

SOURCE

The National Uniform Claim Committee

AVAILABLE FROM

The National Uniform Claim Committee
c/o American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT

Codes defining the health care service provider type, classification, and area of specialization.

716 Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

SIMPLE DATA ELEMENT/CODE REFERENCES

235/HP

SOURCE

Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities

AVAILABLE FROM

Division of Institutional Claims Processing
Centers for Medicare and Medicaid Services
C4-10-07
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT

The Centers for Medicare and Medicaid services develops and publishes the HIPPS codes to establish a coding system for claims submission and claims payment under prospective payment systems. These codes represent the case mix classification groups that are used to determine payment rates under prospective payment systems. Case mix classification groups include, but may not be limited to , resource utilization groups (RUGs) for skilled nursing facilities, home health resource groups (HHRGs) for home health agencies, and case mix groups (CMGs) for inpatient rehabilitation facilities.

843 Advanced Billing Concepts (ABC) Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

235/WK, 1270/CAH

SOURCE

The CAM and Nursing Coding Manual

AVAILABLE FROM

Alternative Link
6121 Indian School Road NE
Suite 131
Albuquerque, NM 87110

ABSTRACT

The manual contains the Advanced Billing Concepts (ABC) codes, descriptive terms and identifiers for reporting complementary or alternative medicine, nursing, and other integrative health care procedures.

896 International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

SIMPLE DATA ELEMENT/CODE REFERENCES

128/PCS, 235/IP, 1270/BBQ, 1270/BBR

SOURCE

International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)

AVAILABLE FROM

CMM, HAPG, Division of Acute Care
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), describes the classification of inpatient procedures for statistical purposes and for the indexing of healthcare records by procedures.

897 International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

SIMPLE DATA ELEMENT/CODE REFERENCES

128/I10, 235/DC, 1270/ABF, 1270/ABJ, 1270/ABK, 1270/ABN, 1270/ABU, 1270/ABV, 1270/ADD, 1270/APR, 1270/ASD, 1270/ATD

SOURCE

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)

AVAILABLE FROM

OCD/Classifications and Public Health Data Standards
National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782

ABSTRACT

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), describes the classification of morbidity and mortality information for statistical purposes and for the indexing of healthcare records by diseases.

932 Universal Postal Codes

SIMPLE DATA ELEMENT/CODE REFERENCES

116

SOURCE

Universal Postal Union website

AVAILABLE FROM

International Bureau of the Universal Postal Union
POST*CODE
Case postale 13
3000 BERNE 15 Switzerland

ABSTRACT

The postcode is the fundamental, essential element of an address. A unique, universal identifier, it unambiguously identifies the addressee's locality and assists in the transmission and sorting of mail items. At present, 105 UPU member countries use postcodes as part of their addressing systems.

B Nomenclature

B.1 ASC X12 Nomenclature

B.1.1 Interchange and Application Control Structures

Appendix B is provided as a reference to the X12 syntax, usage, and related information. It is not a full statement of Interchange and Control Structure rules. The full X12 Interchange and Control Structures and other rules (X12.5, X12.6, X12.59, X12 dictionaries, other X12 standards and official documents) apply unless specifically modified in the detailed instructions of this implementation guide (see Section B.1.1.3.1.2 - *Decimal* for an example of such a modification).

B.1.1.1 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.

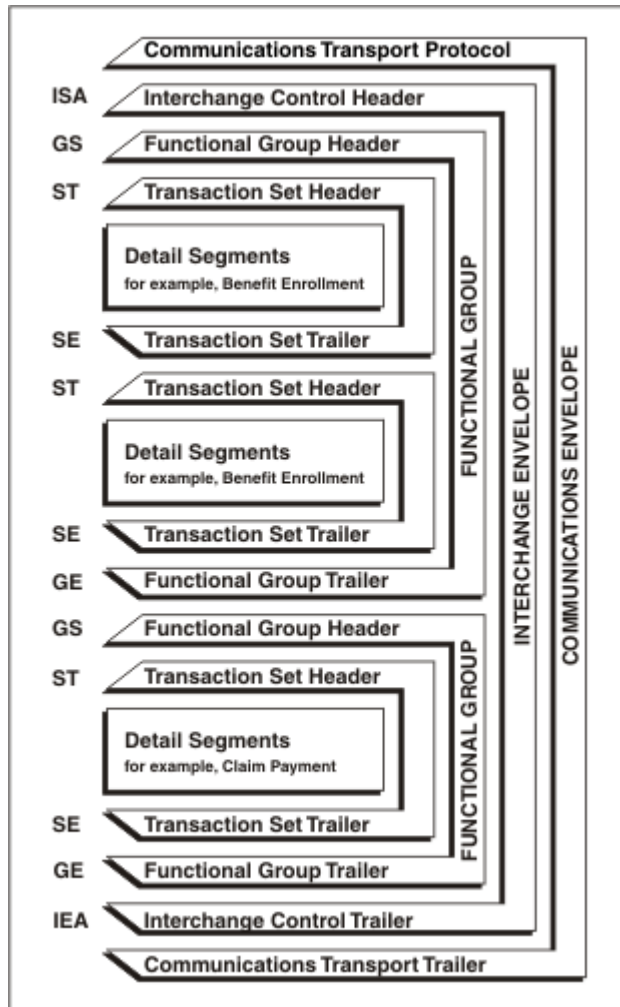
Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, 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.

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 B.1 - *Transmission Control Schematic*, illustrates this interchange control.

Figure B.1 - Transmission Control Schematic



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.

B.1.1.2 Application Control Structure Definitions and Concepts

B.1.1.2.1 Basic Structure

A data element corresponds to a data field in data processing terminology. 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.

B.1.1.2.2 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 Table B.1 - *Basic Character Set*, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

Table B.1 - *Basic Character Set*

A...Z	0...9	!	"	&	'	(	)	+	*
,	-	.	/	:	;	?	=	" " (space)	

B.1.1.2.3 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 Table B.2 - *Extended Character Set*.

Table B.2 - *Extended Character Set*

a...z	%	~	@	[	]	_	{	}
\		<	>	^	`	#	\$	

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.

For implementations compliant with this guide, either the entire extended character set must be acceptable, or the entire extended character set must not be used. In the absence of a specific trading partner agreement to the contrary, trading partners will assume that the extended character set is acceptable. Use of the extended character set allows the use of the "@" character in email addresses within the PER segment. Users should note that characters in the extended character set, as well as the basic character set, may be used as delimiters only when they do not occur in the data as stated in Section B.1.1.2.4.1 - *Base Control Set*.

B.1.1.2.4 Control Characters

Two control character groups are specified; they have restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In Table B.3 - *Base Control Set*, the column IA5 represents CCITT V.3 International Alphabet 5.

B.1.1.2.4.1 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:

Table B.3 - Base Control Set

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		

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.

B.1.1.2.4.2 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are shown in Table B.4 - *Extended Control Set*.

Table B.4 - 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

B.1.1.2.5 Delimiters

A delimiter is a character used to separate two data elements or component elements 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 can be considered in implementations compliant with this guide (see Appendix C, ISA Segment Note 1) to be a 105 byte fixed length record, followed by a segment terminator. The data element separator is byte number 4; the repetition separator is byte number

83; 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 Table B.5 - *Delimiters*, in all examples of EDI transmissions.

Table B.5 - Delimiters

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

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 will result in errors in translation. The existence of asterisks (*) within transmitted application data is a known issue that can affect translation software.

B.1.1.3 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

B.1.1.3.1 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 ordinal 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.

A simple data element within a segment may have an attribute indicating that it may occur once or a specific number of times more than once. The number of permitted repeats are defined as an attribute in the individual segment where the repeated data element occurs.

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 Table B.6 - *Data Element Types*, appear in this implementation guide.

Table B.6 - Data Element Types

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
TM	Time
B	Binary

The data element minimum and maximum lengths may be restricted in this implementation guide for a compliant implementation. Such restrictions may occur by virtue of the allowed qualifier for the data element or by specific instructions regarding length or format as stated in this implementation guide.

B.1.1.3.1.1 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 (+) must not be transmitted.

EXAMPLE

A transmitted value of 1234, when specified as numeric type N2, represents a value of 12.34.

Leading zeros must be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

B.1.1.3.1.2 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 must be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) must not be transmitted.

Leading zeros must be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point must 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.

While the ASC X12 standard supports usage of exponential notation, this guide prohibits that usage.

For implementation of this guide under the rules promulgated under the Health Insurance Portability and Accountability Act (HIPAA), decimal data elements in Data Element 782 (Monetary Amount) will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). Note the statement in the preceding paragraph that the decimal point and leading sign, if sent, are not part of the character count.

EXAMPLE

For implementations mandated under HIPAA rules:

- The following transmitted value represents the largest positive dollar amount that can be sent: 99999999.99
- The following transmitted value is the longest string of characters that can be sent representing whole dollars: 99999999
- The following transmitted value is the longest string of characters that can be sent representing negative dollars and cents: -99999999.99
- The following transmitted value is the longest string of characters that can be sent representing negative whole dollars: -99999999

B.1.1.3.1.3 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 must 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."

B.1.1.3.1.4 String

A string data element is a sequence of any characters from the basic or extended character sets. The string data element must contain at least one non-space character. The significant characters shall be left justified. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces must be suppressed unless they are necessary to satisfy a minimum length. The representation for this data element type is "AN."

B.1.1.3.1.5 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 the TA1 segment where the century is easily determined because of the nature of an interchange header.

B.1.1.3.1.6 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.

B.1.1.3.1.7 Binary

The binary data element is any sequence of octets ranging in value from binary 00000000 to binary 11111111. This data element type has no defined maximum length. Actual length is specified by the immediately preceding data element. Within the body of a transaction set (from ST to SE) implemented according to this technical report, the binary data element type is only used in the segments Binary Data Segment BIN, and Binary Data Structure BDS. Within those segments, Data Element 785 Binary Data is a string of octets which can assume any binary pattern from hexadecimal 00 to FF, and can be used to send text as well as coded data, including data from another application in its native format. The binary data type is also used in some control and security structures.

Not all transaction sets use the Binary Data Segment BIN or Binary Data Structure BDS.

B.1.1.3.2 Repeating Data Elements

Simple or composite data elements within a segment can be designated as repeating data elements. Repeating data elements are adjacent data elements that occur up to a number of times specified in the standard as number of repeats. The implementation guide may also specify the number of repeats of a repeating data element in a specific location in the transaction that are permitted in a compliant implementation. Adjacent occurrences of the same repeating simple data element or composite data structure in a segment shall be separated by a repetition separator.

B.1.1.3.3 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 in Section B.1.1.3.8 - *Reference Designator* and Section B.1.1.3.9 - *Condition Designator*.

A composite data structure within a segment may have an attribute indicating that it may occur once or a specific number of times more than once. The number of permitted repeats are defined as an attribute in the individual segment where the repeated composite data structure occurs.

B.1.1.3.4 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.

B.1.1.3.5 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 Section B.1.1.3.9 - *Condition Designator*.

B.1.1.3.6 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.

B.1.1.3.7 Comments

A segment comment provides additional information regarding the intended use of the segment.

B.1.1.3.8 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 prefixed with a hyphen and 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.

B.1.1.3.9 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 2.1 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.

Table B.7 - Condition Designator

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.

DESIGNATOR	DESCRIPTION	
	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.

B.1.1.3.10 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 must 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.

If a segment has no data in any data element within the segment (an "empty" segment), that segment must not be sent.

B.1.1.3.11 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.

B.1.1.3.11.1 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.

B.1.1.3.11.2 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.

B.1.1.3.11.3 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.

B.1.1.3.11.4 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.

B.1.1.3.12 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 B.1 - *Transmission Control Schematic*.

B.1.1.3.12.1 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.

B.1.1.3.12.2 Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

B.1.1.3.12.3 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."

B.1.1.3.12.4 Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

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.

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 consecutive occurrence of the loop. If the loop does not occur, the LS and LE segments are suppressed.

B.1.1.3.12.5 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.

B.1.1.3.12.6 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.

Table B.8 - Data Segment Requirement Designators

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.

B.1.1.3.12.7 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.

B.1.1.3.12.8 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."

B.1.1.3.13 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 B.1 - *Transmission Control Schematic*.

B.1.1.4 Envelopes and Control Structures**B.1.1.4.1 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 elements are identical. In most translation software products, if these elements 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. 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. GS08 indicates the version of the transaction sets contained within the ISA/IEA envelope. The versions are not required to be the same. An Interchange

Acknowledgment can be requested through data element ISA14. The interchange acknowledgment is 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. 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 discrepancy, in most commercial products, the interchange is suspended. The other data element in the IEA segment is IEA02 which is referenced above.

See Appendix C, EDI Control Directory, for a complete detailing of the interchange control header and trailer. The authors recommend that when two transactions with different X12 versions numbers are sent in one interchange control structure (multiple functional groups within one ISA/IEA envelope), the Interchange Control version used should be that of the most recent transaction version included in the envelope. For the transmission of HIPAA transactions with mixed versions, this would be a compliant enveloping structure.

B.1.1.4.2 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. 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. GS08, Version/Release/Industry Identifier Code is the version/release/sub-release of the transaction sets being transmitted in this functional group.

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 Appendix C, EDI Control Directory, for a complete detailing of the functional group header and trailer.

B.1.1.4.3 HL Structures

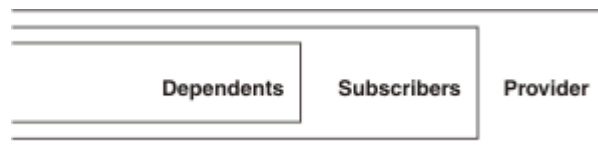
The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide.

For example, 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 usage, number of repeats, and whether that level has subordinate levels within a transaction set.

For implementations compliant with this guide, the repeats of the loops identified by the HL structure shall appear in the hierarchical order specified in BHT01, when those particular hierarchical levels exist. That is, an HL parent loop must be followed by the subordinate child loops, if any, prior to commencing a new HL parent loop at the same hierarchical level.

The following diagram, from transaction set 837, illustrates a typical hierarchy.



The two examples below illustrate this requirement:

Example 1 based on Implementation Guide 811X201:

INSURER

First STATE in transaction (child of INSURER)

First POLICY in transaction (child of first STATE)

First VEHICLE in transaction (child of first POLICY)

Second POLICY in transaction (child of first STATE)

Second VEHICLE in transaction (child of second POLICY)

Third VEHICLE in transaction (child of second POLICY)

Second STATE in transaction (child of INSURER)
Third POLICY in transaction (child of second STATE)
Fourth VEHICLE in transaction (child of third POLICY)

Example 2 based on Implementation Guide 837X141

First PROVIDER in transaction
 First SUBSCRIBER in transaction (child of first PROVIDER)
Second PROVIDER in transaction
 Second SUBSCRIBER in transaction (child of second PROVIDER)
 First DEPENDENT in transaction (child of second SUBSCRIBER)
 Second DEPENDENT in transaction (child of second SUBSCRIBER)
Third SUBSCRIBER in transaction (child of second PROVIDER)
Third PROVIDER in transaction
 Fourth SUBSCRIBER in transaction (child of third PROVIDER)
 Fifth SUBSCRIBER in transaction (child of third PROVIDER)
 Third DEPENDENT in transaction (child of fifth SUBSCRIBER)

B.1.1.5 Acknowledgments

B.1.1.5.1 Interchange Acknowledgment, TA1

The TA1 segment provides the capability for the interchange receiver to notify the sender that a valid envelope was received or that problems were encountered with the interchange control structure. The TA1 verifies the envelopes only. Transaction set-specific verification is accomplished through use of the Functional Acknowledgment Transaction Set, 997. See Section B.1.1.5.2 - *Functional Acknowledgment, 997*, for more details. The TA1 is unique in that it is a single segment transmitted without the GS/GE envelope structure. 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 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.

B.1.1.5.2 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. The 997 is used as a functional acknowledgment to a previously transmitted functional group.

The 997 is a transaction set and thus is encapsulated within the interchange control structure (envelopes) for transmission.

B.2 Object Descriptors

Object Descriptors (OD) provide a method to uniquely identify specific locations within an implementation guide. There is an OD assigned at every level of the X12N implementation:

1. Transaction Set
2. Loop
3. Segment
4. Composite Data Element
5. Component Data Element
6. Simple Data Element

ODs at the first four levels are coded using X12 identifiers separated by underbars:

Entity	Example
1. Transaction Set Identifier plus a unique 2 character value	837Q1
2. Above plus under bar plus Loop Identifier as assigned within an implementation guide	837Q1_2330C
3. Above plus under bar plus Segment Identifier	837Q1_2330C_NM1

Entity	Example
4. Above plus Reference Designator plus under bar plus Composite Identifier	837Q1_2400_SV101_C003

The fifth and sixth levels add a name derived from the "Industry Term" defined in the X12N Data Dictionary. The name is derived by removing the spaces.

Entity	Example
5. Number 4 above plus composite sequence plus under bar plus name	837Q1_2400_SV101_C00302_ProcedureCode
6. Number 3 above plus Reference Designator plus two under bars plus name	837Q1_2330C_NM109__OtherPayerPatientPrimaryIdentifier

Said in another way, ODs contain a coded component specifying a location in an implementation guide, a separator, and a name portion. For example:



Since ODs are unique across all X12N implementation guides, they can be used for a variety of purposes. For example, as a cross reference to older data transmission systems, like the National Standard Format for health care claims, or to form XML tags for newer data transmission systems.

C EDI Control Directory

C.1 Control Segments

- **ISA**
Interchange Control Header Segment
- **GS**
Functional Group Header Segment
- **GE**
Functional Group Trailer Segment
- **IEA**
Interchange Control Trailer Segment

SEGMENT DETAIL

ISA - INTERCHANGE CONTROL HEADER

X12 Segment Name: Interchange Control Header

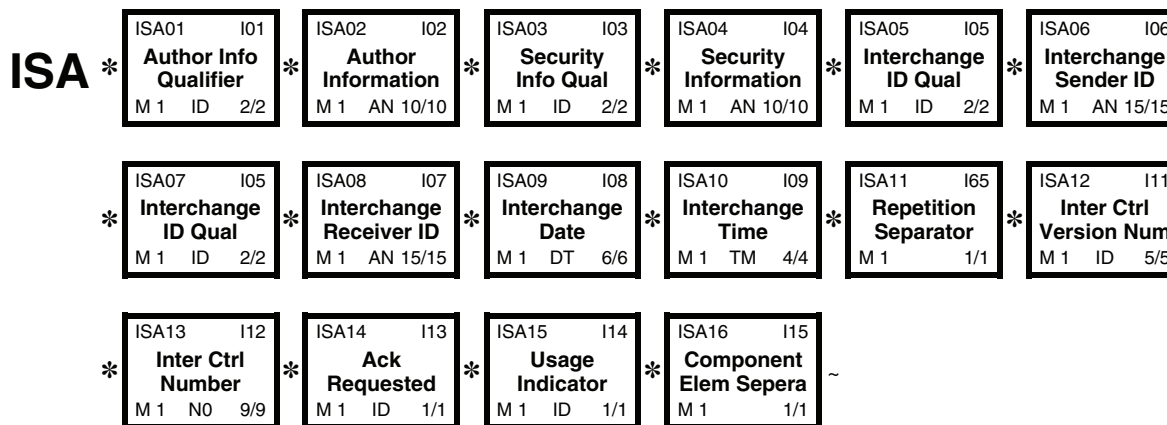
X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Usage: REQUIRED

- TR3 Notes:**
1. All positions within each of the data elements must be filled.
 2. For compliant implementations under this implementation guide, ISA13, the interchange Control Number, must be a positive unsigned number. Therefore, the ISA segment can be considered a fixed record length segment.
 3. The first element separator defines the element separator to be used through the entire interchange.
 4. The ISA segment terminator defines the segment terminator used throughout the entire interchange.
 5. Spaces in the example interchanges are represented by “.” for clarity.

TR3 Example: ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*030101*1253*^*00501*000000905*1*T*::~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	ISA01	I01	Authorization Information Qualifier Code identifying the type of information in the Authorization Information	M 1 ID 2/2
			CODE	DEFINITION
			00	No Authorization Information Present (No Meaningful Information in I02)
			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 1	AN	10/10																						
REQUIRED	ISA03	I03	Security Information Qualifier Code identifying the type of information in the Security Information	M 1	ID	2/2																						
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>00</td><td>No Security Information Present (No Meaningful Information in I04)</td></tr><tr><td>01</td><td>Password</td></tr></table>							CODE	DEFINITION	00	No Security Information Present (No Meaningful Information in I04)	01	Password																
CODE	DEFINITION																											
00	No Security Information Present (No Meaningful Information in I04)																											
01	Password																											
REQUIRED	ISA04	I04	Security Information 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)	M 1	AN	10/10																						
REQUIRED	ISA05	I05	Interchange ID Qualifier Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified	M 1	ID	2/2																						
This ID qualifies the Sender in ISA06.																												
<table><tr><th>CODE</th><th>DEFINITION</th></tr><tr><td>01</td><td>Duns (Dun & Bradstreet)</td></tr><tr><td>14</td><td>Duns Plus Suffix</td></tr><tr><td>20</td><td>Health Industry Number (HIN)</td></tr><tr><td></td><td>CODE SOURCE 121: Health Industry Number</td></tr><tr><td>27</td><td>Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)</td></tr><tr><td>28</td><td>Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)</td></tr><tr><td>29</td><td>Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)</td></tr><tr><td>30</td><td>U.S. Federal Tax Identification Number</td></tr><tr><td>33</td><td>National Association of Insurance Commissioners Company Code (NAIC)</td></tr><tr><td>ZZ</td><td>Mutually Defined</td></tr></table>							CODE	DEFINITION	01	Duns (Dun & Bradstreet)	14	Duns Plus Suffix	20	Health Industry Number (HIN)		CODE SOURCE 121: Health Industry 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
CODE	DEFINITION																											
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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 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	M 1	AN	15/15																						
REQUIRED	ISA07	I05	Interchange ID Qualifier Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified	M 1	ID	2/2																						

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 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 1	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 1	DT	6/6
				Date of the interchange			
				The date format is YYMMDD.			
REQUIRED	ISA10	I09		Interchange Time	M 1	TM	4/4
				Time of the interchange			
				The time format is HHMM.			
REQUIRED	ISA11	I65		Repetition Separator	M 1		1/1
				Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator			
REQUIRED	ISA12	I11		Interchange Control Version Number	M 1	ID	5/5
				Code specifying the version number of the interchange control segments			
				CODE	DEFINITION		
			00501	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003			
REQUIRED	ISA13	I12		Interchange Control Number	M 1	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.			
				Must be a positive unsigned number and must be identical to the value in IEA02.			
REQUIRED	ISA14	I13		Acknowledgment Requested	M 1	ID	1/1
				Code indicating sender's request for an interchange acknowledgment			
				See Section B.1.1.5.1 for interchange acknowledgment information.			
				CODE	DEFINITION		
			0	No Interchange Acknowledgment Requested			
			1	Interchange Acknowledgment Requested (TA1)			

REQUIRED	ISA15	I14	Interchange Usage Indicator		M 1	ID	1/1
			Code indicating 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		1/1
			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				

SEGMENT DETAIL

GS - FUNCTIONAL GROUP HEADER

X12 Segment Name: Functional Group Header

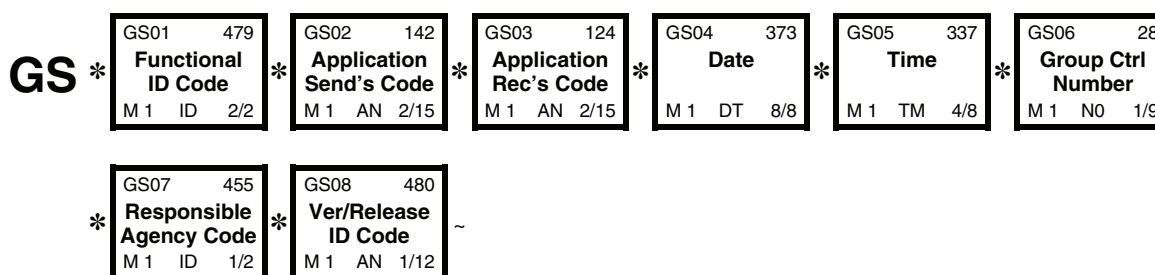
X12 Purpose: To indicate the beginning of a functional group and to provide control information

X12 Comments: 1. A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Usage: REQUIRED

TR3 Example: GS*XX*SENDER CODE*RECEIVER
CODE*19991231*0802*1*X*005010X223A2~

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	GS01	479	Functional Identifier Code Code identifying a group of application related transaction sets	M 1 ID 2/2
This is the 2-character Functional Identifier Code assigned to each transaction set by X12. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information.				
REQUIRED	GS02	142	Application Sender's Code Code identifying party sending transmission; codes agreed to by trading partners	M 1 AN 2/15
Use this code to identify the unit sending the information.				
REQUIRED	GS03	124	Application Receiver's Code Code identifying party receiving transmission; codes agreed to by trading partners	M 1 AN 2/15
Use this code to identify the unit receiving the information.				
REQUIRED	GS04	373	Date Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year	M 1 DT 8/8
SEMANTIC: GS04 is the group date.				
Use this date for the functional group creation date.				

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 1 TM 4/8				
REQUIRED	GS06	28	Group Control Number 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. For implementations compliant with this guide, GS06 must be unique within a single transmission (that is, within a single ISA to IEA enveloping structure). The authors recommend that GS06 be unique within all transmissions over a period of time to be determined by the sender.	M 1 NO 1/9				
REQUIRED	GS07	455	Responsible Agency Code Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480 <table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>X</td><td>Accredited Standards Committee X12</td></tr></tbody></table>	CODE	DEFINITION	X	Accredited Standards Committee X12	M 1 ID 1/2
CODE	DEFINITION							
X	Accredited Standards Committee X12							
REQUIRED	GS08	480	Version / Release / Industry Identifier Code 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 SOURCE 881: Version / Release / Industry Identifier Code This is the unique Version/Release/Industry Identifier Code assigned to an implementation by X12N. The specific code for a transaction set defined by this implementation guide is presented in section 1.2, Version Information. <table><thead><tr><th>CODE</th><th>DEFINITION</th></tr></thead><tbody><tr><td>005010X223A2</td><td>Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003</td></tr></tbody></table>	CODE	DEFINITION	005010X223A2	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003	M 1 AN 1/12
CODE	DEFINITION							
005010X223A2	Standards Approved for Publication by ASC X12 Procedures Review Board through October 2003							

SEGMENT DETAIL

GE - FUNCTIONAL GROUP TRAILER

X12 Segment Name: Functional Group Trailer

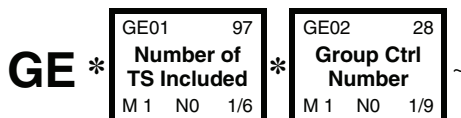
X12 Purpose: To indicate the end of a functional group and to provide control information

X12 Comments: 1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Usage: REQUIRED

TR3 Example: GE*1*1~

DIAGRAM



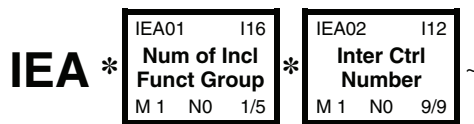
ELEMENT DETAIL

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 1 NO 1/6
REQUIRED	GE02	28	Group Control Number Assigned number originated and maintained by the sender	M 1 NO 1/9
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.				

SEGMENT DETAIL

IEA - INTERCHANGE CONTROL TRAILER**X12 Segment Name:** Interchange Control Trailer**X12 Purpose:** To define the end of an interchange of zero or more functional groups and interchange-related control segments**Usage:** **REQUIRED****TR3 Example:** IEA*1*000000905~

DIAGRAM



ELEMENT DETAIL

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 1	N0	1/5
REQUIRED	IEA02	I12	Interchange Control Number A control number assigned by the interchange sender	M 1	N0	9/9

D Change Summary

This Implementation Guide defines X12N implementation 005010X223A2 of the Health Care Claim: Institutional. It is based on version/release/subrelease 005010 of the ASC X12 standards. The previous X12N implementation of the Health Care Claim: Institutional was 004050X141, based on version/release/subrelease 004050 of the ASC X12 standards.

Implementation of 005010X223A2 contains significant changes and clarifications. It can only be used with other trading partners who have also implemented 005010X223A2. Below is a high-level description of the substantive changes from the previous version.

D.1 Global Changes

1. All Situational Rules throughout this implementation guide have changed to comply with ASC X12N implementation guide standards.
2. The guide contains many revisions to informational notes within the various loops, segments and data elements. The revisions add explanatory text.
3. Billing Provider as well as all 2310x and 2420x provider loops contain instruction on the use of the HIPAA National Provider Identifier (NPI) both prior to, and after, the nationally mandated implementation date for that identifier. In instances where a provider identifier is reported, the National Provider Identifier is reported in **NM109** data element with a **NM108** qualifier of **XX**. The EIN and SSN qualifiers have been removed from all provider related NM108 elements. Any secondary or proprietary identifiers are reported in the secondary identifier **REF** segments. For a more detailed explanation of NPI usage, see **Section 1.10** National Provider Identifier Usage within the HIPAA 837 Transaction.
4. The **G2** qualifier replaces program-specific codes such as **1A**, Blue Cross; **1B**, Blue Shield; **1C**, Medicare; **1D**, Medicaid; **1H**, Champus; etc. to designate a proprietary identifier in all Secondary Identification provider segments.
5. The following qualifiers have been revised to assign specific values in place of generic values:
 - The Provider Taxonomy Code has replaced the generic value of **ZZ** (Mutually Defined) with the specific value of **PXC** (Health Care Provider Taxonomy Code).
 - The qualifier for the HIPAA Individual Patient Identifier has replaced the generic value of **ZZ** (Mutually Defined) with the specific value of **II** (Standard Unique Health Identifier for each individual in the United States).
6. In order to report payer-specific provider identifiers, prior authorization, and referral numbers for non-destination payers at the service line level, data element **REF04** is used to indicate the payer associated with the identifier in **REF01** and **REF02**.

7. Requirements for address segments (**N3** and **N4**) have changed. The underlying code sets for country codes and sub-country codes, as well as for postal zones (ZIP Codes in the US) have been enhanced for greater international mailing uniformity.
8. References to “Insured” in notes and implementation names have changed to the more descriptive term “Subscriber”. See **Section 1.5**, Business Terminology and **Section 1.4.3.2.2.2**, Subscriber / Patient Hierarchical Level (**HL**) Segment for more information.
9. Changes have been made to support the HIPAA National Plan Identifier (National Plan ID). This identifier is accommodated in the following loops:
 - Pay-to Plan Name, Loop ID-2010AC
 - Payer Name, Loop ID-2010BB
 - Other Payer Name, Loop ID-2330B
10. All Aliases have been removed from the guide.
- 10.1 The guide ID has changed to 005010X223A2 (this guide) in several places in the Front Matter and in Section 3 Examples.

D.2 Detailed Transaction Changes

Front Matter

ASC X12N implementation guide standards for the content and organization of Front Matter sections have changed for this version. The items listed below are those where significant changes have occurred. This list does not include section numbering changes.

11. The explanation of COB reporting (Section 1.4.1) is enhanced and a cross-walk chart and examples are added to show how destination and non-destination payer related information is reported on primary and secondary claims. The COB section includes several new supplemental explanations:
 - COB claims generated from paper or proprietary remittance advices (Section 1.4.1.3).
 - Medicaid subrogation claims (Section 1.4.1.5).
12. A section is added to specify the balancing requirements for the 837 transaction (Section 1.4.4).
13. A section is added to explain allowed and approved amount reporting and calculations (Section 1.4.5).
14. Business Terminology (Section 1.5) is expanded to include new definitions of Bundling, Claim, Encounter, Inpatient, Outpatient, Pay-to-Plan Claims, and Unbundling. Other definitions were updated.
15. A section is added (Section 1.10) to describe the use of the National Provider Identifier (NPI) with the 837 transaction.

16. A section is added (Section 1.11) to explain the reporting of drug claims with the 837 transaction.
17. A section is added (Section 1.12) to address a number of additional 837 reporting instructions, including:
 - Individuals with one legal name,
 - Rejecting claims based on the inclusion of situational data,
 - Multiple REF segments with the same qualifier,
 - Provider Tax ID's,
 - Claim and line redundant information,
 - Inpatient and outpatient designation, and
 - Trading partner acknowledgments.

Transaction Header

18. The value of the Implementation Reference Number (**ST03**) has changed to 005010X223A2, which represents the guide ID for this implementation guide.
19. The Beginning of Hierarchical Transaction (**BHT**) segment includes examples for a claim and an encounter.

Loop ID-2000A

20. Beginning with the 5010 version, the Billing Provider must be a health care or atypical service provider (as described in **Section 1.10.1** Providers Who Are Not Eligible for Enumeration).
21. The Pay-to Provider loop has been renamed and is now called the Pay-to Address Name loop (Loop ID-2010AB). Its one and only purpose is to supply an alternate location to send reimbursement.
22. Due to the change in function of the Pay-to Address Name loop, the only permitted value for the Provider Code (PRV01) in the Billing Provider Specialty Information (**PRV**) segment is **BI** (Billing). The guide no longer supports value **PT** (Pay-To).
23. The situational Rule for the Billing Provider Taxonomy (**PRV**) segment has been expanded to enable non-individual taxonomies to be used.
24. The segment notes for the Foreign Currency Information (**CUR**) segment now include the instruction that all amounts reported in the transaction be of the currency named in the **CUR** segment. If there is no **CUR** segment, then all amounts will be in US dollars.

Loop ID-2010AA

25. The Billing Provider loop contains no payer-specific provider identifiers. When it is necessary to send a payer-specific provider identifier, it must be sent in either the Payer Name loop (Loop ID-2010BB) or the Other Payer Name loop (Loop ID-2330B).

26. The only provider identifiers allowed in the Billing Provider loop are:
 - the NPI
 - the provider's taxpayer id
27. The Billing Provider Name segment contains the NPI, which is Situational.
28. The Billing Provider Address must be a street address. Other types of mailing addresses for the Billing Provider (such as a Post Office Box or a Lock Box) must be sent in the Pay-To Address Name loop.
29. The Billing Provider Secondary Identification Number segment has been changed to be the Billing Provider Tax Identification segment.
30. The Billing Provider Tax Identification (**REF**) segment is required and contains the provider's taxpayer identifier to be used for 1099 reporting purposes.
31. The Claim Submitter Credit/Debit Card Information (**REF**) segment has been deleted.
32. The Billing Provider Contact Name (**PER02**) is Required in the first iteration of the Billing Provider Contact Information segment. If a second iteration of the segment is sent, **PER02** is Not Used.

Loop ID-2010AB

33. The Pay-To Address Name loop replaces the Pay-To Provider Name loop. Its sole purpose is to supply an alternate location to send reimbursement. There are no names and no identifiers in the Pay-To Address Name loop.
34. The Pay-To Provider Secondary Identification Number (**REF**) segment has been removed.

Loop ID-2010AC

35. The usage of the Pay-to Plan Name loop has expanded and is no longer limited to Medicaid subrogation.
36. The qualifier in **NM101** has been changed to no longer use the generic value **ZZ** (Mutually Defined) in favor of the more specific value **PE** (Payee).
37. The Pay-to Plan secondary **REF** segments have been "flattened". There are now two distinct segments, each with a repeat count of one. The segments are the Pay-to Plan Secondary Identification segment and the Pay-to Plan Tax Identification Number segment.

Loop ID-2000B

38. The Subscriber / Patient hierarchy has changed to follow the same principles used in other HIPAA transactions, such as Eligibility Request/Response and Claim Status Inquiry/Response. The basic principles are as follows:
 - If the patient has a unique identifier assigned by the destination payer in Loop ID-2010BB, then the patient is considered to be the subscriber and

is sent in the Subscriber loop (Loop ID-2000B) and the Patient Hierarchical Level (Loop ID-2000C) is not used.

- If the patient is different than the subscriber and the patient does not have a unique identifier, then the subscriber information is sent in Loop ID-2000B and the patient information is sent in Loop ID-2000C.

39. There are new values for the Payer Responsibility Sequence Number Code (**SBR01**). The new values support sequencing of up to 11 payers. The new values also include a value of U (Unknown) to be used in certain payer-to-payer COB situations.
40. The Situational Rule for the Subscriber Group Name (**SBR04**) has changed.
41. The list of valid values for the Claim Filing Indicator Code (**SBR09**) has changed.

Loop ID-2010BA

42. The Subscriber Primary Identifier and its qualifier (**NM108** and **NM109**) remain Situational (**NM108** and **NM109** were Required in 005010X223). The elements are still required when **NM102** of the Subscriber Name segment has a value of '1' (Person) but are not used when **NM102** has a value of '2' (Non-Person). **NM102** could indicate a Non-Person for Worker's Compensation claims.
43. The Situational Rule for the Subscriber Address segments (**N3** and **N4**) has changed.
- 43.1 The usage for the Subscriber City, State and ZIP Code (**N4**) segment remains Situational. (This **N4** segment had been Required in 005010X223.)
44. The Situational Rule for the Subscriber Demographic Information segment (**DMG**) has changed.
45. The Repeat Count for the Subscriber Secondary Identification (**REF**) segment has decreased to one. The only permitted value for the Subscriber Secondary Identification (**REF**) segment is the subscriber's Social Security Number (qualifier **SY**).

Loop ID-2010BB

46. By adding an informational note to the Payer Name segment, the usage of this segment and loop now explicitly supports designating a reprinter as the destination payer.
47. The element notes for the qualifier for the Payer Identifier (**NM108/NM109**) now contain specific instructions on when to use the HIPAA National Plan ID (value **XV**) vs. when to use the generic Payer Identifier (value **PI**).
- 47.1 The usage for the Payer City, State and ZIP Code (**N4**) segment remains Situational. (This **N4** segment had been Required in 005010X223.)
48. Loop ID-2010BB (Payer Name) now contains the Billing Provider Secondary Information (**REF**) segment. This new segment contains provider identifiers that were formerly sent in the Billing Provider loop.

Loop ID-2010BC

49. Loop ID-2010BC (Credit/Debit Card Holder Name) has been deleted.

Loop ID-2000C

50. The Situational Rule for the Patient Hierarchical Level has changed in support of the revised Subscriber / Patient hierarchy. The loop is required only when the patient is not the subscriber and the patient does not have a unique identifier assigned by the destination payer. In this case, the patient can only be identified when associated with the subscriber.

Loop ID-2010CA

51. The Patient Primary Identifier and associated qualifier (**NM108/NM109**) are now Not Used.
52. The Patient Secondary Identification (**REF**) segment has been deleted.
- 52.1 A new **REF** segment (Property and Casualty Patient Identifier) was added to the 2010CA (Patient Name) loop. The Property and Casualty Patient Identifier segment has a usage of Situational.

Loop ID-2300

53. The Total Claim Charge Amount (**CLM02**) now explicitly states that it must be the sum of the service line charge amounts (sum of the **SV203**'s.)
54. CLM07 has changed from Situational to Required.
55. The element note for the Provider Accept Assignment Code (**CLM07**) has changed to be more specific in its usage for Medicare claims and non-Medicare claims. Value **P** (Patient Refuses to Assign Benefits) has been removed.
56. A new value has been added to **CLM08**, the Benefits Assignment Certification Indicator. The new value is **W** (Not Applicable), which means that the patient has refused to assign benefits to the provider. In the previous version, **CLM07 = P** carried this message.
57. The usage of values in the Release of Information Code (**CLM09**) has been clarified to coincide with Privacy legislation.
58. This version has added a new date segment as the Repricer Received Date.
- 58.1 In the Institutional Claim Code (**CL1**) segment, the Admission Type Code (**CL101**) has been changed from Situational to Required. (This is a 005010X223A2 Errata change.)
59. Available values in the Attachment Report Type Code (**PWK01**) have been expanded.
60. The Attachment Transmission Code (**PWK02**) has added new value **FT** (File Transfer) to designate that the attachment is available from an attachment warehouse (vendor).

61. The Situational Rule for both **PWK05** and **PWK06** has changed to support **PWK02 = FT**.
62. The maximum field length for the Attachment Control Number (**PWK06**) is now 50 characters.
63. The Credit / Debit Card - Maximum Amount (**AMT**) segment has been removed.
64. The Situational Rule for the Service Authorization Exception Code (**REF**) segment has been clarified.
65. The segment notes for the Payer Claim Control Number (**REF**) segment have been clarified.
66. The Prior Authorization or Referral Number (**REF**) segment is now two distinct segments: the Referral Number segment; and the Prior Authorization segment. The qualifiers did not change.
67. The Repriced Claim Number (**REF**) and the Adjusted Repriced Claim Number (**REF**) segments have been added to the 2300 loop.
68. The Claim Identifier for Transmission Intermediaries is the new name for the Claim Identification Number for Clearinghouses and Other Transmission Intermediaries segment. The qualifier (**REF01 = D9**) did not change.
69. The Auto Accident State (**REF**) segment has been added.
70. The Situational Rule has been clarified for the File Information (**K3**) segment. Segment notes explain the process for applying for an exception to be allowed to use the segment.
71. In all diagnosis code related (**HI**) segments, an additional qualifier has been added to support ICD-10-CM Diagnosis Codes (if allowed under HIPAA).
72. The Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information (**HI**) segment has been split into separate HI segments for:
 - Principal Diagnosis;
 - Admitting Diagnosis;
 - Patient's Reason for Visit; and,
 - External Cause of Injury.
73. Up to three Patient Reason for Visit values may now be reported per claim.
74. Up to twelve External Cause of Injury values may now be reported per claim.
75. A Present on Admission (**POA**) indicator has been added to the Principal Diagnosis, External Cause of Injury, and Other Diagnosis Information (**HI**) segments.

- 76. The Situational Rule for the Principal Procedure Information (**HI**) segment has been revised so that a claim level procedure is only reported on inpatient claims. Further, the segment is only used when a procedure was performed.
- 77. The Situational Rule for the Other Procedure Information (**HI**) segment has been revised so that a other procedures are only reported on inpatient claims.
- 78. The qualifier for HCPCS procedure codes has been removed from allowable values in the Principal Procedure Information and Other Procedure Information (**HI**) segments.
- 79. The qualifier for Advanced Billing Concepts Codes has been added to the Principal Procedure Information (**HI**) segment.
- 80. The Situational Rule for the claim-level Claim Pricing / Repricing Information (**HCP**) segment has been clarified. The Situational Rules for the data elements within the segment have also been clarified.

Loop ID-2305

- 81. The Home Health Care Plan Information loop (**Loop ID-2305**) including the Home Health Care Plan Information (**CR7**) and Health Care Services Delivery (**HSD**) segments have been removed.

Loop ID-2310A

- 82. The Attending Physician Name (**NM1**) segment has been renamed to Attending Provider Name.
- 83. The Situational Rule for the claim-level Attending Provider loop has been clarified.
- 84. A TR3 Note has been added to the Attending Physician Name (**NM1**) segment to define this provider role.
- 85. The Attending Provider must be a person. (Loop ID-2310AINM102 must be a '1'.)
- 86. The only identifier allowed in the Attending Provider Name segment (**NM108** and **NM109**) is the National Provider Identifier (NPI). The identifier has a usage of Situational.
- 87. The segment repeat for the Attending Provider Secondary Identification (**REF**) segment has been reduced to 4.
- 88. The list of valid qualifiers for the Attending Provider Secondary Identifier (Loop ID-2310A | REF01) now contains only **0B** (State License Number), **1G** (Provider UPIN Number), **G2** (Provider Commercial Number), and **LU** (Location Number). The specific values such as **1B** (Blue Shield Provider Number), **1D** (Medicaid Provider Number) etc. have been removed. In their place, use **G2**.

Loop ID-2310B

89. The Situational Rule for the claim-level Operating Physician loop has been clarified.
90. The only identifier allowed in the Operating Physician Name segment (**NM108** and **NM109**) is the National Provider Identifier (NPI). The identifier has a usage of Situational.
91. The segment repeat for the Operating Physician Secondary Identification (**REF**) segment has been reduced to 4.
92. The list of valid qualifiers for the Operating Physician Secondary Identifier (Loop ID-2310A|REF01) now contains only **0B** (State License Number), **1G** (Provider UPIN Number), **G2** (Provider Commercial Number) and **LU** (Location Number). The specific values such as **1B** (Blue Shield Provider Number), **1D** (Medicaid Provider Number) etc. have been removed. In their place, use **G2**.

Loop ID-2310C through Loop ID-2310F

93. Other Provider Name loop (Loop ID-2310C in 004050X141) has been deleted. This deleted loop, along with the addition of several new provider loops, has resulted in the following 2310 loop changes.
- Other Provider Name is removed. Loop ID-2310C is redefined to Other Operating Physician Name.
 - New Loop ID-2310D for Rendering Provider Name is added.
 - Service Facility Name - Loop ID-2310E has loop name expanded to Service Facility Location Name.
 - New Loop ID-2310F for Referring Provider Name is added.

Loop ID-2310E

94. The Situational Rule for the claim-level Service Facility Location Name loop has been clarified.
95. The only identifier allowed in the Service Facility Location Name segment (**NM108** and **NM109**) is the National Provider Identifier (NPI). The identifier has a usage of Situational.
96. The Entity Identifier Code in the Service Facility Location Name segment must be '77'.
97. The Repeat Count for the Service Facility Location Secondary Identification segment is now three.
98. The list of valid qualifiers for the Service Facility Location Name Secondary Identifier (Loop ID-2310A | REF01) now contains only **0B** (State License Number), **G2** (Provider Commercial Number) and **LU** (Location Number). The specific values such as **1B** (Blue Shield Provider Number), **1D** (Medicaid Provider Number) etc. have been removed. In their place, use **G2**.

Loop ID-2320

- 99. There are new values for the Payer Responsibility Sequence Number Code (**SBR01**). The new values support sequencing of up to 11 payers.
- 100. The Situational Rule for the Subscriber Group Name (**SBR04**) has changed.
- 101. The list of valid values for the Claim Filing Indicator Code (**SBR09**) has changed.
- 102. The segment notes and Situational Rule for the Claim Adjustment (**CAS**) segment have been clarified.
- 103. The Situational Rules for the various elements in the **CAS** segment have been clarified.
- 104. The COB Total Allowed Amount (**AMT**) segment in Loop ID-2320 has been removed.
- 105. The Remaining Patient Liability (**AMT**) segment has been added to Loop ID-2320.
- 106. The COB Total Non-Covered Amount (**AMT**) segment has been added to Loop ID-2320.
- 107. The Other Insured Demographic Information (**DMG**) segment has been removed.
- 108. A new value has been added to **OI03** (Benefits Assignment Certification Indicator). The new value is **W** (Not Applicable), which means that the patient has refused to assign benefits to the provider.
- 109. The Situational Rule for the Inpatient Adjudication Information (**MIA**) segment has been clarified.
- 110. The Situational Rule for the Outpatient Adjudication Information (**MOA**) segment has been clarified.

Loop ID-2330A

- 111. The Situational Rule for the Other Subscriber has been clarified.
- 111.1 The usage for the Other Subscriber City, State and ZIP Code (**N4**) segment remains Situational. (This **N4** segment had been Required in 005010X223.)
- 112. The Repeat Count for the Subscriber Secondary Identification (**REF**) segment has decreased from three to two.
- 113. The only permitted value for the Subscriber Secondary Identification (**REF**) segment is the subscriber's Social Security Number (qualifier **SY**).

Loop ID-2330B

- 114.** The element notes for the Other Payer Primary Identifier (Loop ID-2330B | **NM108-NM109**) contain instructions for using the HIPAA National Plan ID, when issued.
- 114.1** The usage for the Other Payer City, State and ZIP Code (**N4**) segment remains Situational. (This **N4** segment had been Required in 005010X223.)
- 115.** The Claim Adjudication Date (**DTP**) segment has been renamed to Claim Check or Remittance Date segment.
- 116.** The Other Payer Secondary Identification and Reference Number (**REF**) segment and the Other Payer Prior Authorization or Referral Number (**REF**) segment have been split into the following separate segments:
- Other Payer Secondary Identifier;
 - Other Payer Prior Authorization Number;
 - Other Payer Referral Number; and,
 - Other Payer Claim Control Number.
- 117.** The Other Payer Claim Adjustment Indicator (**REF**) segment have been added.
- 118.** The Other Payer Patient Information loop (formerly Loop ID-2330C) has been removed. If the payer in Loop ID-2330B has assigned a unique identifier to the patient, then the patient must be sent in the Other Subscriber loop.

Loop ID-2330C through Loop ID-2330I

- 119.** The removal of the Other Payer Patient Information loop, and the addition of several new 2330 loops results in the following loop name changes. These changes are listed showing the 004050X141 Loop ID first followed by the Loop ID as named within this implementation.
- Other Payer Attending Provider - Loop ID-2330D moved to Loop ID-2330C.
 - Other Payer Operating Physician - Loop ID-2330E moved to Loop ID-2330D.
 - Other Payer Other Provider - Loop ID-2330F is removed.
 - Other Payer Service Facility Location - Loop ID-2330H is moved to Loop ID-2330F.
 - Other Payer Other Operating Physician - New Loop ID-2330E.
 - Other Payer Rendering Provider - New Loop ID-2330G.
 - Other Payer Referring Provider - New Loop ID-2330H.
 - Other Payer Billing Provider - New Loop ID-2330I.
- 120.** The Other Payer Patient Information loop (Loop ID-2330C) has been removed. All remaining 2330x loops have been renumbered.

- 121. Loop ID-2330F (Other Payer Billing Provider) has been added.
- 122. Loop ID-2330G (Other Payer Service Facility Location) has been added.
- 123. Loop ID-2330H (Other Payer Assistant Surgeon) has been added.

Loop ID-2400

- 123.1 In the Institutional Service Line (**SV2**) segment, the Situational Rule for the Composite Medical Procedure Identifier (**SV202**) is modified to reference “procedure code” instead of “HCPCS or HIPPS code”.
- 124. The Procedure Code Description (**SV202-7**) has been changed from Not Used to Situational.
- 125. The usage of the Line Item Charge Amount (**SV203**) has been clarified. The amount is inclusive of the provider’s base charge and any applicable tax amounts reported in the line’s tax amount (**AMT**) segments.
- 126. The maximum size of the Service Unit Count (**SV205**) is set at 8 digits.
- 127. The Unit Rate (**SV206**) is changed to Not Used.
- 128. Available values in the Attachment Report Type Code (**PWK01**) have been expanded.
- 129. The Attachment Transmission Code (**PWK02**) has added new value **FT** (File Transfer) to designate that the attachment is available from an attachment warehouse (vendor).
- 130. The Situational Rule for both **PWK05** and **PWK06** has changed to support **PWK02 = FT**.
- 131. The maximum field length for the Attachment Control Number (**PWK06**) is now 50 characters.
- 132. The name of the Service Line Date (**DTP**) segment has changed to Date - Service Date.
- 133. The usage notes for the Line Item Control Number (**REF**) segment have been clarified.
- 134. The Situational Rule and usage notes for the Service Tax Amount and Facility Tax Amount (**AMT**) segments have been clarified along with a reminder that the Line Item Charge Amount (**SV203**) must include amounts reported in the Service and Facility Tax Amounts.
- 135. Added Third Party Organization Notes (**NTE**) segment.
- 136. The usage of the Line Pricing/Repricing Information (**HCP**) segment has been clarified.
- 137. The listed values in Product or Service ID Qualifier (**HCP09**) have been modified to be in sync with the qualifiers listed in SV202-1.

Loop ID-2410

- 138. The usage of the Drug Quantity (**CTP**) segment has been changed from Situational to Required. Notes were deleted.
- 139. The name of the Prescription Number (**REF**) segment has been changed to Prescription or Compound Drug Association Number.
- 140. The Situational Rule and TR3 Notes of the Prescription or Compound Drug Association Number (**REF**) segment have been clarified.
- 141. Added the qualifier **VY** (Link Sequence Number) to the Prescription or Compound Drug Association Number (**REF**) segment.

Loop ID-2420A through Loop ID-2420D

- 142. Attending Physician Name loop (Loop ID-2420A in the 004050X141) and the Other Provider Name loop (Loop ID-2420C in the 004050X141) have been deleted. The removal of these loops, and the addition of several new 2420 loops results in the following loop name changes. These changes are listed showing the 004050X141 Loop ID first followed by the Loop ID as named within this implementation.
 - Attending Physician - Loop ID-2420A is removed.
 - Operating Physician - Loop ID-2420B moved to Loop ID-2420A.
 - Other Operating Physician - New Loop ID-2420B.
 - Other Provider - Loop ID-2420C is removed.
 - Rendering Provider - New Loop ID-2420C.
 - Referring Provider - New Loop ID-2420D.
- 143. The Secondary Identifier (**REF**) segments in the 2420 service line provider loops now allow identification of a specific payer (the destination payer named in Loop ID-2010BB or a specified payer from the Other Payer loop (Loop ID-2330B). If the identifier belongs to the destination payer, then composite **REF04** is not used. If the identifier belongs to a specific non-destination payer, then **REF04** indicates the specific non-destination payer.

Loop ID-2430

- 144. The Situational Rule and the usage notes for the Line Adjudication Information loop have been clarified.
- 145. Crosswalk references to specific elements in the ASC X12 835 Payment / Remittance Advice transaction have been removed.
- 146. SVD01 element note of the Line Adjudication Information (**SVD**) segment was clarified.
- 147. Since there is now a specific qualifier available, the generic qualifier **ZZ** for the Product or Service ID Qualifier (**SVD03-1**) has been replaced by the specific qualifier **ER** (Jurisdiction Specific Procedure and Supply Codes), as defined by Code Source 576.

- 148. Added element note to the Paid Service Unit Count SVD05 of the Line Adjudication Information (**SVD**) segment to indicate a maximum length of 8 digits excluding the decimal. When decimal used, maximum digits allowed to the right of decimal is three.
- 149. The usage notes for **SVD06** Bundled Line Number have been clarified.
- 150. The segment name for the **CAS** segment changed from Service Line Adjustment to the more descriptive Line Adjustment.
- 151. The segment name for the **DTP** segment changed from Service Adjudication Date to the more descriptive Line Check or Remittance Date.
- 152. The Remaining Patient Liability (**AMT**) segment has been added.

Section 2 Examples

- 153. All examples were revised to contain the new Guide ID (005010X223A2).

Appendix B Nomenclature

- 154. In section B.1.1.2.2., blank spaces in the Basic Character Set were replaced with a quote mark (") and apostrophe (').
- 155. In section B.1.1.2.3., two additional characters were added: a carat (^) and open single quote mark (').

Appendix C Control Segments

- 156. The listed value for element **GS08** was changed to contain the new Guide ID (005010X223A2).
- 157. The segment example for the Functional Group Header (**GS**) was changed to contain the new Guide ID (005010X223A2).

E Data Element Glossary

E.1 Data Element Name Index

This section contains an alphabetic listing of data elements used in this implementation guide. Consult the X12N Data Element Dictionary for a complete list of all X12N Data Elements. Data element names in normal type are generic ASC X12 names. Italic type indicates a health care industry defined name.

Name	Payment Date
Definition	Date of payment.
Transaction Set ID	277
Locator Key	D | 2200D | SPA12 | C001-2 | 1373 156
H=Header, D=Detail, S=Summary	
Loop ID	
Segment ID/Reference Designator	
Composite ID-Sequence	
Data Element Number	
Page Number	

Adjudication or Payment Date

Date of payment or denial determination by previous payer.

D | 2330B | DTP03 | - | 1251 391
D | 2430 | DTP03 | - | 1251 488

Adjusted Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify an adjusted claim.

D | 2300 | REF02 | - | 127 170

Adjusted Repriced Line Item Reference Number

Identification number of an adjusted repriced line item adjusted from an original amount.

D | 2400 | REF02 | - | 127 440

Adjustment Amount

Adjustment amount for the associated reason code.

D | 2320 | CAS03 | - | 1782 362
D | 2320 | CAS06 | - | 1782 362
D | 2320 | CAS09 | - | 1782 363
D | 2320 | CAS12 | - | 1782 364
D | 2320 | CAS15 | - | 1782 364
D | 2320 | CAS18 | - | 1782 365
D | 2430 | CAS03 | - | 1782 484
D | 2430 | CAS06 | - | 1782 484
D | 2430 | CAS09 | - | 1782 485
D | 2430 | CAS12 | - | 1782 485
D | 2430 | CAS15 | - | 1782 486
D | 2430 | CAS18 | - | 1782 487

Adjustment Quantity

Numeric quantity associated with the related reason code for coordination of benefits.

D | 2320 | CAS04 | - | 1380 362
D | 2320 | CAS07 | - | 1380 363
D | 2320 | CAS10 | - | 1380 363
D | 2320 | CAS13 | - | 1380 364
D | 2320 | CAS16 | - | 1380 364
D | 2320 | CAS19 | - | 1380 365
D | 2430 | CAS04 | - | 1380 484
D | 2430 | CAS07 | - | 1380 484
D | 2430 | CAS10 | - | 1380 485
D | 2430 | CAS13 | - | 1380 486
D | 2430 | CAS16 | - | 1380 486
D | 2430 | CAS19 | - | 1380 487

Adjustment Reason Code

Code that indicates the reason for the adjustment.

D | 2320 | CAS02 | - | 1034 362
D | 2320 | CAS05 | - | 1034 362
D | 2320 | CAS08 | - | 1034 363
D | 2320 | CAS11 | - | 1034 363
D | 2320 | CAS14 | - | 1034 364
D | 2320 | CAS17 | - | 1034 365
D | 2430 | CAS02 | - | 1034 484
D | 2430 | CAS05 | - | 1034 484
D | 2430 | CAS08 | - | 1034 485
D | 2430 | CAS11 | - | 1034 485
D | 2430 | CAS14 | - | 1034 486
D | 2430 | CAS17 | - | 1034 486

Admission Date and Hour

The date and time of the admission to the facility.

D | 2300 | DTP03 | - | 1251 153

Admission Source Code

Code indicating the source of this admission.
D | 2300 | CL102 | - | 1314 155

Admission Type Code

Code indicating the priority of this admission.
D | 2300 | CL101 | - | 1315 155

Admitting Diagnosis Code

The diagnosis code describing the patient's diagnosis at the time of admission.
D | 2300 | H101 | C022-2 | 1271 190

Amount Qualifier Code

Code to qualify amount.
D | 2300 | AMT01 | - | 522 162
D | 2320 | AMT01 | - | 522 366
D | 2320 | AMT01 | - | 522 367
D | 2320 | AMT01 | - | 522 368
D | 2400 | AMT01 | - | 522 441
D | 2400 | AMT01 | - | 522 442
D | 2430 | AMT01 | - | 522 489

Assigned Number

Number assigned for differentiation within a transaction set.
D | 2400 | LX01 | - | 554 425

Assignment or Plan Participation Code

An indication, used by a health plan, that the provider does or does not accept assignment of benefits.
D | 2300 | CLM07 | - | 1359 148

Attachment Control Number

Identification number of attachment related to the claim.
D | 2300 | PWK06 | - | 67 159
D | 2400 | PWK06 | - | 67 434

Attachment Report Type Code

Code to specify the type of attachment that is related to the claim.
D | 2300 | PWK01 | - | 755 157
D | 2400 | PWK01 | - | 755 432

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 | - | 756 158
D | 2400 | PWK02 | - | 756 433

Attending Provider First Name

First Name of the provider responsible for the care of the patient.
D | 2310A | NM104 | - | 1036 322

Attending Provider Last Name

Last Name of the provider responsible for the care of the patient.
D | 2310A | NM103 | - | 1035 322

Attending Provider Middle Name or Initial

Middle name or initial of the provider responsible for care of the patient.
D | 2310A | NM105 | - | 1037 322

Attending Provider Name Suffix

Suffix to the name of the provider responsible for the care of the patient.
D | 2310A | NM107 | - | 1039 322

Attending Provider Primary Identifier

Primary identifier for the provider responsible for the care of the patient.
D | 2310A | NM109 | - | 167 323

Attending Provider Secondary Identifier

Additional identifier for the provider responsible for the care of the patient.
D | 2310A | REF02 | - | 127 327

Auto Accident State or Province Code

State or Province where auto accident occurred.
D | 2300 | REF02 | - | 127 174

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 148
D | 2320 | OI03 | - | 1073 369

Billing Note Text

Free-form text providing additional information about the bill or claim being submitted.
D | 2300 | NTE02 | - | 352 182

Billing Provider Address Line

Address line of the billing provider or billing entity address.
D | 2010AA | N301 | - | 166 87
D | 2010AA | N302 | - | 166 87

Billing Provider City Name

City of the billing provider or billing entity
D | 2010AA | N401 | - | 19 88

Billing Provider Contact Name

Person at billing organization to contact regarding the billing transaction.

D | 2010AA | PER02 | - | 93 92

Billing Provider Identifier

Identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.

D | 2010AA | NM109 | - | 167 86

Billing Provider Organizational Name

Organization name of the entity billing for services.

D | 2010AA | NM103 | - | 1035 85

Billing Provider Postal Zone or ZIP Code

Postal zone code or ZIP code for the provider or billing entity billing for services.

D | 2010AA | N403 | - | 1116 89

Billing Provider Secondary Identifier

Secondary identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.

D | 2010BB | REF02 | - | 1127 130

Billing Provider State or Province Code

State or province for provider or billing entity billing for services.

D | 2010AA | N402 | - | 1156 89

Billing Provider Tax Identification Number

Tax identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.

D | 2010AA | REF02 | - | 1127 90

Bundled Line Number

Identification of line item bundled by payer in payment of benefits.

D | 2430 | SVD06 | - | 1554 481

Certification Condition Code Applies Indicator

Code indicating whether or not the condition codes apply to the patient or another entity.

D | 2300 | CRC02 | - | 11073 184

Claim Adjustment Group Code

Code identifying the general category of payment adjustment.

D | 2320 | CAS01 | - | 11033 362
D | 2430 | CAS01 | - | 11033 483

Claim DRG Amount

Total of Prospective Payment System operating and capital amounts for this claim.

D | 2320 | MIA04 | - | 1782 372

Claim Disproportionate Share Amount

Sum of operating capital disproportionate share amounts for this claim.

D | 2320 | MIA06 | - | 1782 372

Claim Filing Indicator Code

Code identifying type of claim or expected adjudication process.

D | 2000B | SBR09 | - | 11032 110
D | 2320 | SBR09 | - | 11032 358

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 | 11325 147

Claim Identifier

Identifies type of claims in this transaction.

H | - | BHT06 | - | 1640 69

Claim Indirect Teaching Amount

Total of operating and capital indirect teaching amounts for this claim.

D | 2320 | MIA18 | - | 1782 374

Claim MSP Pass-through Amount

Interim cost pass-through amount used to determine Medicare Secondary Payer liability.

D | 2320 | MIA07 | - | 1782 372

Claim Note Text

Narrative text providing additional information related to the claim.

D | 2300 | NTE02 | - | 1352 181

Claim PPS Capital Amount

Total Prospective Payment System (PPS) capital amount payable for this claim as output by PPS PRICER.

D | 2320 | MIA08 | - | 1782 372

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 | - | 1782 374

Claim Payment Remark Code

Code identifying the remark associated with the payment.

D | 2320 | MIA05 | - | 127 372
D | 2320 | MIA20 | - | 127 374
D | 2320 | MIA21 | - | 127 375
D | 2320 | MIA22 | - | 127 375
D | 2320 | MIA23 | - | 127 375
D | 2320 | MOA03 | - | 127 377
D | 2320 | MOA04 | - | 127 377
D | 2320 | MOA05 | - | 127 377
D | 2320 | MOA06 | - | 127 377
D | 2320 | MOA07 | - | 127 377

Code List Qualifier Code

Code identifying a specific industry code list.

D | 2300 | HI01 | C022-1 | 1270 186
D | 2300 | HI01 | C022-1 | 1270 190
D | 2300 | HI01 | C022-1 | 1270 192
D | 2300 | HI02 | C022-1 | 1270 193
D | 2300 | HI03 | C022-1 | 1270 194
D | 2300 | HI01 | C022-1 | 1270 196
D | 2300 | HI02 | C022-1 | 1270 198
D | 2300 | HI03 | C022-1 | 1270 200
D | 2300 | HI04 | C022-1 | 1270 202
D | 2300 | HI05 | C022-1 | 1270 204
D | 2300 | HI06 | C022-1 | 1270 206
D | 2300 | HI07 | C022-1 | 1270 208
D | 2300 | HI08 | C022-1 | 1270 210
D | 2300 | HI09 | C022-1 | 1270 212
D | 2300 | HI10 | C022-1 | 1270 214
D | 2300 | HI11 | C022-1 | 1270 216
D | 2300 | HI12 | C022-1 | 1270 218
D | 2300 | HI01 | C022-1 | 1270 220
D | 2300 | HI01 | C022-1 | 1270 223
D | 2300 | HI02 | C022-1 | 1270 224
D | 2300 | HI03 | C022-1 | 1270 226
D | 2300 | HI04 | C022-1 | 1270 227
D | 2300 | HI05 | C022-1 | 1270 229
D | 2300 | HI06 | C022-1 | 1270 230
D | 2300 | HI07 | C022-1 | 1270 232
D | 2300 | HI08 | C022-1 | 1270 233
D | 2300 | HI09 | C022-1 | 1270 235
D | 2300 | HI10 | C022-1 | 1270 236
D | 2300 | HI11 | C022-1 | 1270 238
D | 2300 | HI12 | C022-1 | 1270 239
D | 2300 | HI01 | C022-1 | 1270 242
D | 2300 | HI01 | C022-1 | 1270 245
D | 2300 | HI02 | C022-1 | 1270 246
D | 2300 | HI03 | C022-1 | 1270 247
D | 2300 | HI04 | C022-1 | 1270 248
D | 2300 | HI05 | C022-1 | 1270 250
D | 2300 | HI06 | C022-1 | 1270 251
D | 2300 | HI07 | C022-1 | 1270 252
D | 2300 | HI08 | C022-1 | 1270 253
D | 2300 | HI09 | C022-1 | 1270 255
D | 2300 | HI10 | C022-1 | 1270 256
D | 2300 | HI11 | C022-1 | 1270 257
D | 2300 | HI12 | C022-1 | 1270 258
D | 2300 | HI01 | C022-1 | 1270 260
D | 2300 | HI02 | C022-1 | 1270 261
D | 2300 | HI03 | C022-1 | 1270 262
D | 2300 | HI04 | C022-1 | 1270 263

D | 2300 | HI05 | C022-1 | 1270 264
D | 2300 | HI06 | C022-1 | 1270 265
D | 2300 | HI07 | C022-1 | 1270 266
D | 2300 | HI08 | C022-1 | 1270 267
D | 2300 | HI09 | C022-1 | 1270 268
D | 2300 | HI10 | C022-1 | 1270 269
D | 2300 | HI11 | C022-1 | 1270 270
D | 2300 | HI12 | C022-1 | 1270 271
D | 2300 | HI01 | C022-1 | 1270 273
D | 2300 | HI02 | C022-1 | 1270 274
D | 2300 | HI03 | C022-1 | 1270 275
D | 2300 | HI04 | C022-1 | 1270 276
D | 2300 | HI05 | C022-1 | 1270 277
D | 2300 | HI06 | C022-1 | 1270 278
D | 2300 | HI07 | C022-1 | 1270 279
D | 2300 | HI08 | C022-1 | 1270 280
D | 2300 | HI09 | C022-1 | 1270 281
D | 2300 | HI10 | C022-1 | 1270 282
D | 2300 | HI11 | C022-1 | 1270 283
D | 2300 | HI12 | C022-1 | 1270 284
D | 2300 | HI01 | C022-1 | 1270 286
D | 2300 | HI02 | C022-1 | 1270 287
D | 2300 | HI03 | C022-1 | 1270 288
D | 2300 | HI04 | C022-1 | 1270 289
D | 2300 | HI05 | C022-1 | 1270 289
D | 2300 | HI06 | C022-1 | 1270 290
D | 2300 | HI07 | C022-1 | 1270 291
D | 2300 | HI08 | C022-1 | 1270 292
D | 2300 | HI09 | C022-1 | 1270 292
D | 2300 | HI10 | C022-1 | 1270 293
D | 2300 | HI11 | C022-1 | 1270 294
D | 2300 | HI12 | C022-1 | 1270 295
D | 2300 | HI01 | C022-1 | 1270 296
D | 2300 | HI02 | C022-1 | 1270 297
D | 2300 | HI03 | C022-1 | 1270 298
D | 2300 | HI04 | C022-1 | 1270 299
D | 2300 | HI05 | C022-1 | 1270 299
D | 2300 | HI06 | C022-1 | 1270 300
D | 2300 | HI07 | C022-1 | 1270 301
D | 2300 | HI08 | C022-1 | 1270 302
D | 2300 | HI09 | C022-1 | 1270 302
D | 2300 | HI10 | C022-1 | 1270 303
D | 2300 | HI11 | C022-1 | 1270 304
D | 2300 | HI12 | C022-1 | 1270 305
D | 2300 | HI01 | C022-1 | 1270 306
D | 2300 | HI02 | C022-1 | 1270 307
D | 2300 | HI03 | C022-1 | 1270 308
D | 2300 | HI04 | C022-1 | 1270 309
D | 2300 | HI05 | C022-1 | 1270 309
D | 2300 | HI06 | C022-1 | 1270 310
D | 2300 | HI07 | C022-1 | 1270 311
D | 2300 | HI08 | C022-1 | 1270 311
D | 2300 | HI09 | C022-1 | 1270 312
D | 2300 | HI10 | C022-1 | 1270 313
D | 2300 | HI11 | C022-1 | 1270 313
D | 2300 | HI12 | C022-1 | 1270 314

Code Qualifier

Code identifying the type of unit or measurement.

D | 2300 | CRC01 | - | 1136 183
D | 2410 | CTP05 | C001-1 | 1355 455

Communication Number

Complete communications number including country or area code when applicable

H | 1000A | PER04 | - | 1364 74
H | 1000A | PER06 | - | 1364 75
H | 1000A | PER08 | - | 1364 75
D | 2010AA | PER04 | - | 1364 92
D | 2010AA | PER06 | - | 1364 93

D | 2010AA | PER08 | - | 364 93

**Communication Number
Qualifier**

Code identifying the type of communication number.

H | 1000A | PER03 | - | 365 74
H | 1000A | PER05 | - | 365 74
H | 1000A | PER07 | - | 365 75
D | 2010AA | PER03 | - | 365 92
D | 2010AA | PER05 | - | 365 92
D | 2010AA | PER07 | - | 365 93

Condition Code

Code(s) used to identify condition(s) relating to this bill or relating to the patient.

D | 2300 | HI01 | C022-2 | 1271 296
D | 2300 | HI02 | C022-2 | 1271 297
D | 2300 | HI03 | C022-2 | 1271 298
D | 2300 | HI04 | C022-2 | 1271 299
D | 2300 | HI05 | C022-2 | 1271 299
D | 2300 | HI06 | C022-2 | 1271 300
D | 2300 | HI07 | C022-2 | 1271 301
D | 2300 | HI08 | C022-2 | 1271 302
D | 2300 | HI09 | C022-2 | 1271 302
D | 2300 | HI10 | C022-2 | 1271 303
D | 2300 | HI11 | C022-2 | 1271 304
D | 2300 | HI12 | C022-2 | 1271 305

Condition Indicator

Code indicating a condition

D | 2300 | CRC03 | - | 1321 184
D | 2300 | CRC04 | - | 1321 184
D | 2300 | CRC05 | - | 1321 185

Contact Function Code

Code identifying the major duty or responsibility of the person or group named.

H | 1000A | PER01 | - | 366 74
D | 2010AA | PER01 | - | 366 92

Contract Amount

Fixed monetary amount pertaining to the contract

D | 2300 | CN102 | - | 1782 160

Contract Code

Code identifying the specific contract, established by the payer.

D | 2300 | CN104 | - | 1127 161

Contract Percentage

Percent of charges payable under the contract

D | 2300 | CN103 | - | 1332 161

Contract Type Code

Code identifying a contract type

D | 2300 | CN101 | - | 1166 160

Contract Version Identifier

Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.

D | 2300 | CN106 | - | 1799 161

Cost Report Day Count

The number of days that may be claimed as Medicare patient days on a cost report.

D | 2320 | MIA15 | - | 1380 374

Country Code

Code indicating the geographic location.

D | 2010AA | N404 | - | 126 89
D | 2010AB | N404 | - | 126 98
D | 2010AC | N404 | - | 126 103
D | 2010BA | N404 | - | 126 117
D | 2010BB | N404 | - | 126 126
D | 2010CA | N404 | - | 126 139
D | 2310E | N404 | - | 126 348
D | 2330A | N404 | - | 126 384
D | 2330B | N404 | - | 126 390

Country Subdivision Code

Code identifying the country subdivision.

D | 2010AA | N407 | - | 1715 89
D | 2010AB | N407 | - | 1715 98
D | 2010AC | N407 | - | 1715 103
D | 2010BA | N407 | - | 1715 117
D | 2010BB | N407 | - | 1715 126
D | 2010CA | N407 | - | 1715 139
D | 2310E | N407 | - | 1715 348
D | 2330A | N407 | - | 1715 384
D | 2330B | N407 | - | 1715 390

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 | - | 1380 371

Currency Code

Code for country in whose currency the charges are specified.

D | 2000A | CUR02 | - | 1100 82

**Date Time Period Format
Qualifier**

Code indicating the date format, time format, or date and time format.

D | 2010BA | DMG01 | - | 1250 118
D | 2010CA | DMG01 | - | 1250 140
D | 2300 | DTP02 | - | 1250 151
D | 2300 | DTP02 | - | 1250 152
D | 2300 | DTP02 | - | 1250 153
D | 2300 | DTP02 | - | 1250 154
D | 2300 | HI01 | C022-3 | 1250 242
D | 2300 | HI01 | C022-3 | 1250 245
D | 2300 | HI02 | C022-3 | 1250 246
D | 2300 | HI03 | C022-3 | 1250 248
D | 2300 | HI04 | C022-3 | 1250 249
D | 2300 | HI05 | C022-3 | 1250 250
D | 2300 | HI06 | C022-3 | 1250 251

D	|	2300	|	HI07	|	C022-3	|	1250	.....	253
D	|	2300	|	HI08	|	C022-3	|	1250	.....	254
D	|	2300	|	HI09	|	C022-3	|	1250	.....	255
D	|	2300	|	HI10	|	C022-3	|	1250	.....	256
D	|	2300	|	HI11	|	C022-3	|	1250	.....	258
D	|	2300	|	HI12	|	C022-3	|	1250	.....	259
D	|	2300	|	HI01	|	C022-3	|	1250	.....	261
D	|	2300	|	HI02	|	C022-3	|	1250	.....	262
D	|	2300	|	HI03	|	C022-3	|	1250	.....	263
D	|	2300	|	HI04	|	C022-3	|	1250	.....	264
D	|	2300	|	HI05	|	C022-3	|	1250	.....	265
D	|	2300	|	HI06	|	C022-3	|	1250	.....	266
D	|	2300	|	HI07	|	C022-3	|	1250	.....	267
D	|	2300	|	HI08	|	C022-3	|	1250	.....	268
D	|	2300	|	HI09	|	C022-3	|	1250	.....	269
D	|	2300	|	HI10	|	C022-3	|	1250	.....	270
D	|	2300	|	HI11	|	C022-3	|	1250	.....	271
D	|	2300	|	HI12	|	C022-3	|	1250	.....	272
D	|	2300	|	HI01	|	C022-3	|	1250	.....	274
D	|	2300	|	HI02	|	C022-3	|	1250	.....	275
D	|	2300	|	HI03	|	C022-3	|	1250	.....	276
D	|	2300	|	HI04	|	C022-3	|	1250	.....	277
D	|	2300	|	HI05	|	C022-3	|	1250	.....	278
D	|	2300	|	HI06	|	C022-3	|	1250	.....	279
D	|	2300	|	HI07	|	C022-3	|	1250	.....	280
D	|	2300	|	HI08	|	C022-3	|	1250	.....	281
D	|	2300	|	HI09	|	C022-3	|	1250	.....	282
D	|	2300	|	HI10	|	C022-3	|	1250	.....	283
D	|	2300	|	HI11	|	C022-3	|	1250	.....	284
D	|	2300	|	HI12	|	C022-3	|	1250	.....	285
D	|	2330B	|	DTP02	|	-	|	1250	.....	391
D	|	2400	|	DTP02	|	-	|	1250	.....	436
D	|	2430	|	DTP02	|	-	|	1250	.....	488

Date Time Qualifier

Code specifying the type of date or time or both date and time.

D	|	2300	|	DTP01	|	-	|	374	.....	151
D	|	2300	|	DTP01	|	-	|	374	.....	152
D	|	2300	|	DTP01	|	-	|	374	.....	153
D	|	2300	|	DTP01	|	-	|	374	.....	154
D	|	2330B	|	DTP01	|	-	|	374	.....	391
D	|	2400	|	DTP01	|	-	|	374	.....	436
D	|	2430	|	DTP01	|	-	|	374	.....	488

Delay Reason Code

Code indicating the reason why a request was delayed.

D	|	2300	|	CLM20	|	-	|	1514		149

Demonstration Project Identifier

Identification number for a Medicare demonstration project.

D	|	2300	|	REF02	|	-	|	127		176

Description

A free-form description to clarify the related data elements and their content.

D	|	2400	|	SV202	|	C003-7	|	352		429

**Diagnosis Related Group
(DRG) Code**

Diagnosis related group for this claim.

D	|	2300	|	HI01	|	C022-2	|	1271		221

Discharge Time

Time the patient was discharged from the inpatient care.

D	|	2300	|	DTP03	|	-	|	1251		151

**End Stage Renal Disease
Payment Amount**

Amount of payment under End Stage Renal Disease benefit.

D	|	2320	|	MOA08	|	-	|	1782		378

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual.

H	|	1000A	|	NM101	|	-	|	198	.....	71
H	|	1000B	|	NM101	|	-	|	198	.....	76
D	|	2000A	|	CUR01	|	-	|	198	.....	82
D	|	2010AA	|	NM101	|	-	|	198	.....	85
D	|	2010AB	|	NM101	|	-	|	198	.....	94
D	|	2010AC	|	NM101	|	-	|	198	.....	99
D	|	2010BA	|	NM101	|	-	|	198	.....	112
D	|	2010BB	|	NM101	|	-	|	198	.....	122
D	|	2010CA	|	NM101	|	-	|	198	.....	135
D	|	2310A	|	NM101	|	-	|	198	.....	321
D	|	2310B	|	NM101	|	-	|	198	.....	329
D	|	2310C	|	NM101	|	-	|	198	.....	334
D	|	2310D	|	NM101	|	-	|	198	.....	339
D	|	2310E	|	NM101	|	-	|	198	.....	344
D	|	2310F	|	NM101	|	-	|	198	.....	352
D	|	2330A	|	NM101	|	-	|	198	.....	380
D	|	2330B	|	NM101	|	-	|	198	.....	386
D	|	2330C	|	NM101	|	-	|	198	.....	399
D	|	2330C	|	NM101	|	-	|	198	.....	399
D	|	2330D	|	NM101	|	-	|	198	.....	403
D	|	2330E	|	NM101	|	-	|	198	.....	407
D	|	2330F	|	NM101	|	-	|	198	.....	411
D	|	2330G	|	NM101	|	-	|	198	.....	415
D	|	2330H	|	NM101	|	-	|	198	.....	419
D	|	2330I	|	NM101	|	-	|	198	.....	423
D	|	2420A	|	NM101	|	-	|	198	.....	459
D	|	2420B	|	NM101	|	-	|	198	.....	464
D	|	2420C	|	NM101	|	-	|	198	.....	469
D	|	2420D	|	NM101	|	-	|	198	.....	474

Entity Type Qualifier

Code qualifying the type of entity.

H	|	1000A	|	NM102	|	-	|	1065	.....	72
H	|	1000B	|	NM102	|	-	|	1065	.....	76
D	|	2010AA	|	NM102	|	-	|	1065	.....	85
D	|	2010AB	|	NM102	|	-	|	1065	.....	95
D	|	2010AC	|	NM102	|	-	|	1065	.....	100
D	|	2010BA	|	NM102	|	-	|	1065	.....	113
D	|	2010BB	|	NM102	|	-	|	1065	.....	123
D	|	2010CA	|	NM102	|	-	|	1065	.....	135
D	|	2310A	|	NM102	|	-	|	1065	.....	322
D	|	2310B	|	NM102	|	-	|	1065	.....	329
D	|	2310C	|	NM102	|	-	|	1065	.....	334
D	|	2310D	|	NM102	|	-	|	1065	.....	339
D	|	2310E	|	NM102	|	-	|	1065	.....	344
D	|	2310F	|	NM102	|	-	|	1065	.....	352
D	|	2330A	|	NM102	|	-	|	1065	.....	380
D	|	2330B	|	NM102	|	-	|	1065	.....	386
D	|	2330C	|	NM102	|	-	|	1065	.....	399
D	|	2330C	|	NM102	|	-	|	1065	.....	399
D	|	2330D	|	NM102	|	-	|	1065	.....	403
D	|	2330E	|	NM102	|	-	|	1065	.....	407
D	|	2330F	|	NM102	|	-	|	1065	.....	411
D	|	2330G	|	NM102	|	-	|	1065	.....	415

D | 2330H | NM102 | - | 1065	419
D | 2330I | NM102 | - | 1065	423
D | 2420A | NM102 | - | 1065	459
D | 2420B | NM102 | - | 1065	464
D | 2420C | NM102 | - | 1065	469
D | 2420D | NM102 | - | 1065	474

Exception Code

Exception code generated by the Third Party Organization.

D | 2300 | HCP15 | - | 1527	320
D | 2400 | HCP15 | - | 1527	450

External Cause of Injury Code

Code identifying the cause of the injury.

D | 2300 | HI01 | C022-2 | 1271	196
D | 2300 | HI02 | C022-2 | 1271	198
D | 2300 | HI03 | C022-2 | 1271	200
D | 2300 | HI04 | C022-2 | 1271	202
D | 2300 | HI05 | C022-2 | 1271	204
D | 2300 | HI06 | C022-2 | 1271	206
D | 2300 | HI07 | C022-2 | 1271	208
D | 2300 | HI08 | C022-2 | 1271	210
D | 2300 | HI09 | C022-2 | 1271	212
D | 2300 | HI10 | C022-2 | 1271	214
D | 2300 | HI11 | C022-2 | 1271	216
D | 2300 | HI12 | C022-2 | 1271	218

Facility Code Qualifier

Code identifying the type of facility referenced.

D | 2300 | CLM05 | C023-2 | 1332	147

Facility Tax Amount

The amount of facility tax or surcharge applicable to the reported service.

D | 2400 | AMT02 | - | 1782	442

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	147

Fixed Format Information

Data in fixed format agreed upon by sender and receiver

D | 2300 | K301 | - | 1449	179

HCPCS Payable Amount

Amount due under Medicare HCPCS system.

D | 2320 | MOA02 | - | 1782	377

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described.

D | 2000A | HL04 | - | 1736	79
D | 2000B | HL04 | - | 1736	108
D | 2000C | HL04 | - | 1736	132

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

D | 2000A | HL01 | - | 1628	78
D | 2000B | HL01 | - | 1628	107
D | 2000C | HL01 | - | 1628	131

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

D | 2000A | HL03 | - | 1735	78
D | 2000B | HL03 | - | 1735	108
D | 2000C | HL03 | - | 1735	132

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 | - | 1734	108
D | 2000C | HL02 | - | 1734	132

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	68

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67).

H | 1000A | NM108 | - | 166	72
H | 1000B | NM108 | - | 166	77
D | 2010AA | NM108 | - | 166	86
D | 2010AC | NM108 | - | 166	100
D | 2010BA | NM108 | - | 166	113
D | 2010BB | NM108 | - | 166	123
D | 2300 | PWK05 | - | 166	159
D | 2310A | NM108 | - | 166	323
D | 2310B | NM108 | - | 166	330
D | 2310C | NM108 | - | 166	335
D | 2310D | NM108 | - | 166	340
D | 2310E | NM108 | - | 166	344
D | 2310F | NM108 | - | 166	353
D | 2330A | NM108 | - | 166	381
D | 2330B | NM108 | - | 166	387
D | 2400 | PWK05 | - | 166	434
D | 2420A | NM108 | - | 166	460
D | 2420B | NM108 | - | 166	465
D | 2420C | NM108 | - | 166	470
D | 2420D | NM108 | - | 166	475

Individual Relationship Code

Code indicating the relationship between two individuals or entities.

D | 2000B | SBR02 | - | 1069	110
D | 2000C | PAT01 | - | 1069	133
D | 2320 | SBR02 | - | 1069	357

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 | 2320 | SBR03 | - | 127 358

Investigational Device Exemption Identifier

Number or reference identifying exemption assigned to an investigational device referenced in the claim.

D | 2300 | REF02 | - | 127 171

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 | - | 166 346

D | 2310E | N302 | - | 166 346

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 | - | 19 347

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 344

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 | - | 116 348

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 | - | 167 344

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 | - | 127 350

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 | - | 156 348

Lifetime Psychiatric Days Count

Number of lifetime psychiatric days used for this claim.

D | 2320 | MIA03 | - | 1380 372

Line Item Charge Amount

Charges related to this service.

D | 2400 | SV203 | - | 1782 429

Line Item Control Number

Identifier assigned by the submitter/provider to this line item.

D | 2400 | REF02 | - | 127 438

Line Item Denied Charge or Non-Covered Charge Amount

Line item charges denied or not covered.

D | 2400 | SV207 | - | 1782 430

Line Note Text

Narrative text providing additional information related to the service line.

D | 2400 | NTE02 | - | 1352 443

Medical Record Number

A unique number assigned to patient by the provider to assist in retrieval of medical records.

D | 2300 | REF02 | - | 127 175

Monetary Amount

Monetary amount.

D | 2400 | HCP02 | - | 1782 445

D | 2400 | HCP03 | - | 1782 445

D | 2400 | HCP07 | - | 1782 446

National Drug Code

The national drug identification number assigned by the Federal Drug Administration (FDA).

D | 2410 | LIN03 | - | 1234 453

National Drug Unit Count

The dispensing quantity, based upon the unit of measure as defined by the National Drug Code.

D | 2410 | CTP04 | - | 1380 454

Non-Covered Charge Amount

Charges pertaining to the related revenue center code that the primary payer will not cover.

D |	2320	|	AMT02	|	-	|	782		368

Non-Payable Professional Component Billed Amount

Amount of non-payable charges included in the bill related to professional services.

D |	2320	|	MIA19	|	-	|	782	.....	374
D |	2320	|	MOA09	|	-	|	782	.....	378

Note Reference Code

Code identifying the functional area or purpose for which the note applies.

D |	2300	|	NTE01	|	-	|	363	.....	180
D |	2300	|	NTE01	|	-	|	363	.....	182
D |	2400	|	NTE01	|	-	|	363	.....	443

Occurrence Code

A code defining a significant event relating to this bill that may affect payer processing.

D |	2300	|	HI01	|	C022-2	|	1271	.....	273
D |	2300	|	HI02	|	C022-2	|	1271	.....	274
D |	2300	|	HI03	|	C022-2	|	1271	.....	275
D |	2300	|	HI04	|	C022-2	|	1271	.....	276
D |	2300	|	HI05	|	C022-2	|	1271	.....	277
D |	2300	|	HI06	|	C022-2	|	1271	.....	278
D |	2300	|	HI07	|	C022-2	|	1271	.....	279
D |	2300	|	HI08	|	C022-2	|	1271	.....	280
D |	2300	|	HI09	|	C022-2	|	1271	.....	281
D |	2300	|	HI10	|	C022-2	|	1271	.....	282
D |	2300	|	HI11	|	C022-2	|	1271	.....	283
D |	2300	|	HI12	|	C022-2	|	1271	.....	284

Occurrence Code Date

Date associated with the Occurrence Code reported in this composite element.

D |	2300	|	HI01	|	C022-4	|	1251	.....	274
D |	2300	|	HI02	|	C022-4	|	1251	.....	275
D |	2300	|	HI03	|	C022-4	|	1251	.....	276
D |	2300	|	HI04	|	C022-4	|	1251	.....	277
D |	2300	|	HI05	|	C022-4	|	1251	.....	278
D |	2300	|	HI06	|	C022-4	|	1251	.....	279
D |	2300	|	HI07	|	C022-4	|	1251	.....	280
D |	2300	|	HI08	|	C022-4	|	1251	.....	281
D |	2300	|	HI09	|	C022-4	|	1251	.....	282
D |	2300	|	HI10	|	C022-4	|	1251	.....	283
D |	2300	|	HI11	|	C022-4	|	1251	.....	284
D |	2300	|	HI12	|	C022-4	|	1251	.....	285

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	.....	260
D |	2300	|	HI02	|	C022-2	|	1271	.....	261
D |	2300	|	HI03	|	C022-2	|	1271	.....	262
D |	2300	|	HI04	|	C022-2	|	1271	.....	263
D |	2300	|	HI05	|	C022-2	|	1271	.....	264
D |	2300	|	HI06	|	C022-2	|	1271	.....	265
D |	2300	|	HI07	|	C022-2	|	1271	.....	266
D |	2300	|	HI08	|	C022-2	|	1271	.....	267
D |	2300	|	HI09	|	C022-2	|	1271	.....	268
D |	2300	|	HI10	|	C022-2	|	1271	.....	269

D |	2300	|	HI11	|	C022-2	|	1271	.....	270
D |	2300	|	HI12	|	C022-2	|	1271	.....	271

Occurrence Span Code Date

Date associated with the Occurrence Span

Code reported in this composite element.

D |	2300	|	HI01	|	C022-4	|	1251	.....	261
D |	2300	|	HI02	|	C022-4	|	1251	.....	262
D |	2300	|	HI03	|	C022-4	|	1251	.....	263
D |	2300	|	HI04	|	C022-4	|	1251	.....	264
D |	2300	|	HI05	|	C022-4	|	1251	.....	265
D |	2300	|	HI06	|	C022-4	|	1251	.....	266
D |	2300	|	HI07	|	C022-4	|	1251	.....	267
D |	2300	|	HI08	|	C022-4	|	1251	.....	268
D |	2300	|	HI09	|	C022-4	|	1251	.....	269
D |	2300	|	HI10	|	C022-4	|	1251	.....	270
D |	2300	|	HI11	|	C022-4	|	1251	.....	271
D |	2300	|	HI12	|	C022-4	|	1251	.....	272

Old Capital Amount

The amount for old capital for this claim.

D |	2320	|	MIA12	|	-	|	782		373

Operating Physician First Name

First name of the physician performing the principle procedure.

D |	2310B	|	NM104	|	-	|	1036	.....	329
D |	2420A	|	NM104	|	-	|	1036	.....	459

Operating Physician Last Name

Last name of the physician performing the principle procedure.

D |	2310B	|	NM103	|	-	|	1035	.....	329
D |	2420A	|	NM103	|	-	|	1035	.....	459

Operating Physician Middle Name or Initial

Middle name or initial of the physician performing the principal procedure.

D |	2310B	|	NM105	|	-	|	1037	.....	329
D |	2420A	|	NM105	|	-	|	1037	.....	459

Operating Physician Name Suffix

Suffix to the name of the physician performing the principal procedure.

D |	2310B	|	NM107	|	-	|	1039	.....	329
D |	2420A	|	NM107	|	-	|	1039	.....	459

Operating Physician Primary Identifier

Primary identifier of the physician performing the principle procedure.

D |	2310B	|	NM109	|	-	|	167	.....	330
D |	2420A	|	NM109	|	-	|	167	.....	460

**Operating Physician
Secondary Identifier**

Additional identifier for the physician performing the principal procedure.

D | 2310B | REF02 | - | 127 332
D | 2420A | REF02 | - | 127 462

**Originator Application
Transaction Identifier**

An identification number that identifies a transaction within the originator's applications system.

H | | BHT03 | - | 127 69

Other Diagnosis

Other diagnosis for this claim.

D | 2300 | HI01 | C022-2 | 1271 223
D | 2300 | HI02 | C022-2 | 1271 224
D | 2300 | HI03 | C022-2 | 1271 226
D | 2300 | HI04 | C022-2 | 1271 227
D | 2300 | HI05 | C022-2 | 1271 229
D | 2300 | HI06 | C022-2 | 1271 230
D | 2300 | HI07 | C022-2 | 1271 232
D | 2300 | HI08 | C022-2 | 1271 233
D | 2300 | HI09 | C022-2 | 1271 235
D | 2300 | HI10 | C022-2 | 1271 236
D | 2300 | HI11 | C022-2 | 1271 238
D | 2300 | HI12 | C022-2 | 1271 239

**Other Insured Additional
Identifier**

Number providing additional identification of the other insured.

D | 2330A | REF02 | - | 127 385

Other Insured Address Line

Address line of the additional insured individual's mailing address.

D | 2330A | N301 | - | 166 382
D | 2330A | N302 | - | 166 382

Other Insured City Name

The city name of the additional insured individual.

D | 2330A | N401 | - | 119 383

Other Insured First Name

The first name of the additional insured individual.

D | 2330A | NM104 | - | 1036 380

Other Insured Group Name

Name of the group or plan through which the insurance is provided to the other insured.

D | 2320 | SBR04 | - | 193 358

Other Insured Identifier

An identification number, assigned by the third party payer, to identify the additional insured individual.

D | 2330A | NM109 | - | 167 381

Other Insured Last Name

The last name of the additional insured individual.

D | 2330A | NM103 | - | 1035 380

Other Insured Middle Name

The middle name of the additional insured individual.

D | 2330A | NM105 | - | 1037 380

Other Insured Name Suffix

The suffix to the name of the additional insured individual.

D | 2330A | NM107 | - | 1039 380

**Other Insured Postal Zone or
ZIP Code**

The Postal ZIP code of the additional insured individual's mailing address.

D | 2330A | N403 | - | 116 384

Other Insured State Code

The state code of the additional insured individual's mailing address.

D | 2330A | N402 | - | 156 384

**Other Operating Physician
First Name**

First Name of the individual performing a secondary surgical procedure or assisting the Operating Physician.

D | 2310C | NM104 | - | 1036 334
D | 2420B | NM104 | - | 1036 464

**Other Operating Physician
Identifier**

National identifier for the individual performing a secondary surgical procedure or assisting the Operating Physician.

D | 2310C | NM109 | - | 167 335
D | 2420B | NM109 | - | 167 465

**Other Operating Physician Last
Name**

Last Name of the individual performing a secondary surgical procedure or assisting the Operating Physician.

D | 2310C | NM103 | - | 1035 334
D | 2420B | NM103 | - | 1035 464

**Other Operating Physician
Middle Name or Initial**

Middle name or initial of the individual performing a secondary surgical procedure or assisting the Operating Physician.

D | 2310C | NM105 | - | 1037 334
D | 2420B | NM105 | - | 1037 464

**Other Operating Physician
Name Suffix**

Suffix to the name of the individual performing a secondary surgical procedure or assisting the Operating Physician.

D | 2310C | NM107 | - | 1039 334
D | 2420B | NM107 | - | 1039 464

Other Payer Address Line

Address line of the other payer's mailing address.

D | 2330B | N301 | - | 166 388
D | 2330B | N302 | - | 166 388

**Other Payer Attending Provider
Secondary Identifier**

The non-destination (COB) payer's attending provider identification.

D | 2330C | REF02 | - | 127 401

**Other Payer Billing Provider
Identifier**

The non-destination (COB) payer's identifier for the provider or organization in whose name the bill is submitted and to whom payment should be made.

D | 2330I | REF02 | - | 127 424

Other Payer City Name

The city name of the other payer's mailing address.

D | 2330B | N401 | - | 19 389

**Other Payer Claim Adjustment
Indicator**

Indicates the other payer has made a previous claim adjustment to this claim.

D | 2330B | REF02 | - | 127 396

**Other Payer Last or
Organization Name**

The name of the other payer organization.

D | 2330B | NM103 | - | 1035 387

**Other Payer Operating Provider
Secondary Identifier**

The non-destination (COB) payer's operating provider identification.

D | 2330D | REF02 | - | 127 405

**Other Payer Other Operating
Physician Secondary Identifier**

The non-destination (COB) payer's identifier for the individual performing a secondary surgical procedure or assisting the Operating Physician.

D | 2330E | REF02 | - | 127 409

**Other Payer Postal Zone or ZIP
Code**

The ZIP code of the other payer's mailing address.

D | 2330B | N403 | - | 116 390

Other Payer Primary Identifier

An identification number for the other payer.

D | 2330B | NM109 | - | 167 387
D | 2420A | REF04 | C040-2 | 127 462
D | 2420B | REF04 | C040-2 | 127 467
D | 2420C | REF04 | C040-2 | 127 472
D | 2420D | REF04 | C040-2 | 127 477
D | 2430 | SVD01 | - | 167 478

**Other Payer Prior Authorization
Number**

The non-destination (COB) payer's prior authorization number.

D | 2330B | REF02 | - | 127 394

**Other Payer Prior Authorization
or Referral Number**

The non-destination (COB) payer's prior authorization or referral number.

D | 2330B | REF02 | - | 127 395

**Other Payer Referring Provider
Identifier**

The non-destination (COB) payer's referring provider identifier.

D | 2330H | REF02 | - | 127 421

**Other Payer Rendering
Provider Secondary Identifier**

The non-destination (COB) payer's rendering provider identifier.

D | 2330G | REF02 | - | 127 417

**Other Payer Secondary
Identifier**

Additional identifier for the other payer organization

D | 2330B | REF02 | - | 127 393

**Other Payer Service Facility
Location Identifier**

The non-destination (COB) payer's service facility location identifier.

D | 2330F | REF02 | - | 127 412

Other Payer State Code

The state or province code of the other payer's mailing address.

D | 2330B | N402 | - | 156 390

Other Payer's Claim Control Number

A number assigned by the other payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN).

D | 2330B | REF02 | - | 127 397

Other Provider Secondary Identifier

Additional identification number of the other provider as defined by the payer organization.

D | 2310C | REF02 | - | 127 337

D | 2420B | REF02 | - | 127 467

PPS-Capital DSH DRG Amount

PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.

D | 2320 | MIA11 | - | 1782 373

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 | - | 1782 375

PPS-Capital FSP DRG Amount

PPS-capital federal portion for this claim as output by PPS-PRICER.

D | 2320 | MIA09 | - | 1782 373

PPS-Capital HSP DRG Amount

Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.

D | 2320 | MIA10 | - | 1782 373

PPS-Capital IME amount

PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.

D | 2320 | MIA13 | - | 1782 373

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 | - | 1782 374

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 | - | 1782 373

Paid Service Unit Count

Units of service paid by the payer for coordination of benefits.

D | 2430 | SVD05 | - | 1380 481

Patient Address Line

Address line of the street mailing address of the patient.

D | 2010CA | N301 | - | 166 137

D | 2010CA | N302 | - | 166 137

Patient Birth Date

Date of birth of the patient.

D | 2010CA | DMG02 | - | 1251 140

Patient City Name

The city name of the patient.

D | 2010CA | N401 | - | 19 138

Patient Control Number

Patient's unique alpha-numeric identification number for this claim assigned by the provider to facilitate retrieval of individual case records and posting of payment.

D | 2300 | CLM01 | - | 1028 146

Patient First Name

The first name of the individual to whom the services were provided.

D | 2010CA | NM104 | - | 1036 136

Patient Gender Code

A code indicating the sex of the patient.

D | 2010CA | DMG03 | - | 1068 141

Patient Last Name

The last name of the individual to whom the services were provided.

D | 2010CA | NM103 | - | 1035 136

Patient Middle Name or Initial

The middle name or initial of the individual to whom the services were provided.

D | 2010CA | NM105 | - | 1037 136

Patient Name Suffix

Suffix to the name of the individual to whom the services were provided.

D | 2010CA | NM107 | - | 1039 136

Patient Postal Zone or ZIP Code

The ZIP Code of the patient.

D | 2010CA | N403 | - | 116..... 139

Patient Reason For Visit

The diagnosis code describing the patient's reason for visit at the time of outpatient registration.

D | 2300 | HI01 | C022-2 | 1271 192

D | 2300 | HI02 | C022-2 | 1271 193

D | 2300 | HI03 | C022-2 | 1271 194

Patient Responsibility Amount

The amount determined to be the patient's responsibility for payment.

D | 2300 | AMT02 | - | 1782 162

Patient State Code

The State Postal Code of the patient.

D | 2010CA | N402 | - | 156 138

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 155

Pay-To Address Line

Address line of the provider to receive payment.

D | 2010AB | N301 | - | 166 96

D | 2010AB | N302 | - | 166 96

Pay-To Plan Address Line

Street address of the Pay-To Plan.

D | 2010AC | N301 | - | 166 101

D | 2010AC | N302 | - | 166 101

Pay-To Plan City Name

City name of the Pay-To Plan.

D | 2010AC | N401 | - | 119 102

Pay-To Plan Organizational Name

Organization name of the health plan that is seeking reimbursement (Pay-To Plan).

D | 2010AC | NM103 | - | 1035 100

Pay-To Plan Postal Zone or ZIP Code

Postal zone or ZIP code of the Pay-To Plan.

D | 2010AC | N403 | - | 116 103

Pay-To Plan Primary Identifier

Identification number for the Pay-To Plan.

D | 2010AC | NM109 | - | 167 100

Pay-To Plan State or Province Code

State or province code of the Pay-to Plan.

D | 2010AC | N402 | - | 156 102

Pay-To Plan Tax Identification Number

Tax identification number of the plan to whom payment should be made.

D | 2010AC | REF02 | - | 127 106

Pay-to Address City Name

City name of the entity to receive payment.

D | 2010AB | N401 | - | 119 97

Pay-to Address Postal Zone or ZIP Code

Postal code of the entity to receive payment (for example, ZIP code).

D | 2010AB | N403 | - | 116 98

Pay-to Address State Code

State or sub-country code of the entity to receive payment.

D | 2010AB | N402 | - | 156 98

Pay-to Plan Secondary Identifier

Additional identifier for the Pay-To Plan.

D | 2010AC | REF02 | - | 127 104

Payer Additional Identifier

Additional identifier for the payer.

D | 2010BB | REF02 | - | 127 128

Payer Address Line

Address line of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N301 | - | 166 124

D | 2010BB | N302 | - | 166 124

Payer City Name

The City Name of the Payer's claim mailing address for this particular payer ID and claim office.

D | 2010BB | N401 | - | 119 125

Payer Claim Control Number

A number assigned by the payer to identify a claim. The number is usually referred to as an Internal Control Number (ICN), Claim Control Number (CCN) or a Document Control Number (DCN).

D | 2300 | REF02 | - | 127 168

Payer Identifier

Number identifying the payer organization.

D | 2010BB | NM109 | - | 167 123

Payer Name

Name identifying the payer organization.

D | 2010BB | NM103 | - | 1035 123

Payer Paid Amount

The amount paid by the payer on this claim.

D | 2320 | AMT02 | - | 1782 366

Payer Postal Zone or ZIP Code

The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N403 | - | 1116 126

Payer Responsibility Sequence**Number Code**

Code identifying the insurance carrier's level of responsibility for a payment of a claim

D | 2000B | SBR01 | - | 1138 109

D | 2320 | SBR01 | - | 1138 357

Payer State Code

State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.

D | 2010BB | N402 | - | 1156 126

Peer Review Authorization**Number**

Authorization number provided by a review organization after review completed.

D | 2300 | REF02 | - | 1127 177

Policy Compliance Code

The code that specifies policy compliance.

D | 2300 | HCP14 | - | 11526 319

D | 2400 | HCP14 | - | 11526 450

Prescription Number

The unique identification number assigned by the pharmacy or supplier to the prescription.

D | 2410 | REF02 | - | 1127 457

Present on Admission Indicator

Code which provides an indication as to whether the diagnosis was present at the time of admission.

D | 2300 | HI01 | C022-9 | 1073 187

D | 2300 | HI01 | C022-9 | 1073 197

D | 2300 | HI02 | C022-9 | 1073 199

D | 2300 | HI03 | C022-9 | 1073 201

D | 2300 | HI04 | C022-9 | 1073 203

D | 2300 | HI05 | C022-9 | 1073 205

D | 2300 | HI06 | C022-9 | 1073 207

D | 2300 | HI07 | C022-9 | 1073 209

D | 2300 | HI08 | C022-9 | 1073 211

D | 2300 | HI09 | C022-9 | 1073 213

D | 2300 | HI10 | C022-9 | 1073 215

D | 2300 | HI11 | C022-9 | 1073 217

D | 2300 | HI12 | C022-9 | 1073 219

D | 2300 | HI01 | C022-9 | 1073 223

D | 2300 | HI02 | C022-9 | 1073 225

D | 2300 | HI03 | C022-9 | 1073 226

D | 2300 | HI04 | C022-9 | 1073 228

D | 2300 | HI05 | C022-9 | 1073 229

D | 2300 | HI06 | C022-9 | 1073 231

D | 2300 | HI07 | C022-9 | 1073 232

D | 2300 | HI08 | C022-9 | 1073 234

D | 2300 | HI09 | C022-9 | 1073 235

D | 2300 | HI10 | C022-9 | 1073 237

D | 2300 | HI11 | C022-9 | 1073 238

D | 2300 | HI12 | C022-9 | 1073 240

Pricing Methodology

Pricing methodology at which the claim or line item has been priced or repriced.

D | 2300 | HCP01 | - | 1473 316

D | 2400 | HCP01 | - | 1473 445

Principal Diagnosis Code

The diagnosis code describing the condition established, after study, to be chiefly responsible for occasioning the admission of the patient for care.

D | 2300 | HI01 | C022-2 | 1271 187

Principal Procedure Code

Code identifying the principal procedure, product or service.

D | 2300 | HI01 | C022-2 | 1271 242

Principal Procedure Date

Date on which the Principal Procedure was performed.

D | 2300 | HI01 | C022-4 | 1251 242

Prior Authorization Number

A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization.

D | 2300 | REF02 | - | 1127 167

Procedure Code

Code identifying the procedure, product or service.

D | 2300 | HI01 | C022-2 | 1271 245

D | 2300 | HI02 | C022-2 | 1271 246

D | 2300 | HI03 | C022-2 | 1271 247

D | 2300 | HI04 | C022-2 | 1271 249

D | 2300 | HI05 | C022-2 | 1271 250

D | 2300 | HI06 | C022-2 | 1271 251

D | 2300 | HI07 | C022-2 | 1271 252

D | 2300 | HI08 | C022-2 | 1271 254

D | 2300 | HI09 | C022-2 | 1271 255

D | 2300 | HI10 | C022-2 | 1271 256

D | 2300 | HI11 | C022-2 | 1271 257

D | 2300 | HI12 | C022-2 | 1271 259

D	|	2400	|	SV202	|	C003-2	|	234	.....	428
D	|	2430	|	SVD03	|	C003-2	|	234	.....	480

Procedure Code Description

Description clarifying the Product/Service
Procedure Code and related data elements.

D	|	2430	|	SVD03	|	C003-7	|	352		481

Procedure Date

Date when the health care procedure was
performed.

D	|	2300	|	HI01	|	C022-4	|	1251	.....	245
D	|	2300	|	HI02	|	C022-4	|	1251	.....	247
D	|	2300	|	HI03	|	C022-4	|	1251	.....	248
D	|	2300	|	HI04	|	C022-4	|	1251	.....	249
D	|	2300	|	HI05	|	C022-4	|	1251	.....	250
D	|	2300	|	HI06	|	C022-4	|	1251	.....	252
D	|	2300	|	HI07	|	C022-4	|	1251	.....	253
D	|	2300	|	HI08	|	C022-4	|	1251	.....	254
D	|	2300	|	HI09	|	C022-4	|	1251	.....	255
D	|	2300	|	HI10	|	C022-4	|	1251	.....	257
D	|	2300	|	HI11	|	C022-4	|	1251	.....	258
D	|	2300	|	HI12	|	C022-4	|	1251	.....	259

Procedure Modifier

This identifies special circumstances related to
the performance of the service.

D	|	2400	|	SV202	|	C003-3	|	1339	.....	428
D	|	2400	|	SV202	|	C003-4	|	1339	.....	428
D	|	2400	|	SV202	|	C003-5	|	1339	.....	429
D	|	2400	|	SV202	|	C003-6	|	1339	.....	429
D	|	2430	|	SVD03	|	C003-3	|	1339	.....	480
D	|	2430	|	SVD03	|	C003-4	|	1339	.....	480
D	|	2430	|	SVD03	|	C003-5	|	1339	.....	480
D	|	2430	|	SVD03	|	C003-6	|	1339	.....	481

Product or Service ID

Identifying number for a product or service.

D	|	2400	|	HCP08	|	-	|	234		447

Product or Service ID Qualifier

Code identifying the type/source of the
descriptive number used in Product/Service ID
(234).

D	|	2400	|	SV202	|	C003-1	|	235	.....	427
D	|	2400	|	HCP09	|	-	|	235	.....	447
D	|	2410	|	LIN02	|	-	|	235	.....	453
D	|	2430	|	SVD03	|	C003-1	|	235	.....	479

**Property Casualty Claim
Number**

Identification number for property casualty claim
associated with the services identified on the bill.

D	|	2010BA	|	REF02	|	-	|	127	.....	121
D	|	2010CA	|	REF02	|	-	|	127	.....	142

**Property and Casualty Patient
Identifier**

Identification number of the patient on a
Property and Casualty claim.

D	|	2010CA	|	REF02	|	-	|	127		143

Provider Code

Code identifying the type of provider.

D	|	2000A	|	PRV01	|	-	|	1221	.....	80
D	|	2310A	|	PRV01	|	-	|	1221	.....	324

Provider Taxonomy Code

Code designating the provider type,
classification, and specialization.

D	|	2000A	|	PRV03	|	-	|	127	.....	80
D	|	2310A	|	PRV03	|	-	|	127	.....	324

Quantity

Numeric value of quantity.

D	|	2400	|	HCP12	|	-	|	1380		449

Rate

Rate expressed in the standard monetary
denomination for the currency specified.

D	|	2400	|	HCP05	|	-	|	118		446

Receiver Name

Name of organization receiving the transaction.

H	|	1000B	|	NM103	|	-	|	1035		77

Receiver Primary Identifier

Primary identification number for the receiver of
the transaction.

H	|	1000B	|	NM109	|	-	|	167		77

Reference Identification

The identification value assigned by the sender
for this particular transaction.

D	|	2400	|	HCP04	|	-	|	127	.....	446
D	|	2400	|	HCP06	|	-	|	127	.....	446

**Reference Identification
Qualifier**

Code qualifying the reference identification.

D	|	2000A	|	PRV02	|	-	|	128	.....	80
D	|	2010AA	|	REF01	|	-	|	128	.....	90
D	|	2010AC	|	REF01	|	-	|	128	.....	104
D	|	2010AC	|	REF01	|	-	|	128	.....	106
D	|	2010BA	|	REF01	|	-	|	128	.....	120
D	|	2010BA	|	REF01	|	-	|	128	.....	121
D	|	2010BB	|	REF01	|	-	|	128	.....	127
D	|	2010BB	|	REF01	|	-	|	128	.....	129
D	|	2010CA	|	REF01	|	-	|	128	.....	142
D	|	2010CA	|	REF01	|	-	|	128	.....	143
D	|	2300	|	REF01	|	-	|	128	.....	163
D	|	2300	|	REF01	|	-	|	128	.....	165
D	|	2300	|	REF01	|	-	|	128	.....	166
D	|	2300	|	REF01	|	-	|	128	.....	168
D	|	2300	|	REF01	|	-	|	128	.....	169
D	|	2300	|	REF01	|	-	|	128	.....	170
D	|	2300	|	REF01	|	-	|	128	.....	171
D	|	2300	|	REF01	|	-	|	128	.....	172
D	|	2300	|	REF01	|	-	|	128	.....	174
D	|	2300	|	REF01	|	-	|	128	.....	175
D	|	2300	|	REF01	|	-	|	128	.....	176
D	|	2300	|	REF01	|	-	|	128	.....	177
D	|	2310A	|	PRV02	|	-	|	128	.....	324
D	|	2310A	|	REF01	|	-	|	128	.....	326

D	|	2310B	|	REF01	|	-	|	128	.....	331
D	|	2310C	|	REF01	|	-	|	128	.....	336
D	|	2310D	|	REF01	|	-	|	128	.....	341
D	|	2310E	|	REF01	|	-	|	128	.....	349
D	|	2310F	|	REF01	|	-	|	128	.....	354
D	|	2330A	|	REF01	|	-	|	128	.....	385
D	|	2330B	|	REF01	|	-	|	128	.....	392
D	|	2330B	|	REF01	|	-	|	128	.....	394
D	|	2330B	|	REF01	|	-	|	128	.....	395
D	|	2330B	|	REF01	|	-	|	128	.....	396
D	|	2330B	|	REF01	|	-	|	128	.....	397
D	|	2330C	|	REF01	|	-	|	128	.....	400
D	|	2330C	|	REF01	|	-	|	128	.....	400
D	|	2330D	|	REF01	|	-	|	128	.....	404
D	|	2330E	|	REF01	|	-	|	128	.....	408
D	|	2330F	|	REF01	|	-	|	128	.....	412
D	|	2330G	|	REF01	|	-	|	128	.....	416
D	|	2330H	|	REF01	|	-	|	128	.....	420
D	|	2330I	|	REF01	|	-	|	128	.....	424
D	|	2400	|	REF01	|	-	|	128	.....	437
D	|	2400	|	REF01	|	-	|	128	.....	439
D	|	2400	|	REF01	|	-	|	128	.....	440
D	|	2410	|	REF01	|	-	|	128	.....	456
D	|	2420A	|	REF01	|	-	|	128	.....	461
D	|	2420A	|	REF04	|	C040-1	|	128	.....	462
D	|	2420B	|	REF01	|	-	|	128	.....	466
D	|	2420B	|	REF04	|	C040-1	|	128	.....	467
D	|	2420C	|	REF01	|	-	|	128	.....	471
D	|	2420C	|	REF04	|	C040-1	|	128	.....	472
D	|	2420D	|	REF01	|	-	|	128	.....	476
D	|	2420D	|	REF04	|	C040-1	|	128	.....	477

Referral Number

Referral authorization number.

D	|	2300	|	REF02	|	-	|	127		165

Referring Provider First Name

The first name of provider who referred the patient to the provider of service on this claim.

D	|	2310F	|	NM104	|	-	|	1036	.....	352
D	|	2420D	|	NM104	|	-	|	1036	.....	474

Referring Provider Identifier

The identification number for the referring physician.

D	|	2310F	|	NM109	|	-	|	167	.....	353
D	|	2420D	|	NM109	|	-	|	167	.....	475

Referring Provider Last Name

The Last Name of Provider who referred the patient to the provider of service on this claim.

D	|	2310F	|	NM103	|	-	|	1035	.....	352
D	|	2420D	|	NM103	|	-	|	1035	.....	474

Referring Provider Middle Name or Initial

Middle name or initial of the provider who is referring patient for care.

D	|	2310F	|	NM105	|	-	|	1037	.....	352
D	|	2420D	|	NM105	|	-	|	1037	.....	474

Referring Provider Name Suffix

Suffix to the name of the provider referring the patient for care.

D	|	2310F	|	NM107	|	-	|	1039	.....	352
D	|	2420D	|	NM107	|	-	|	1039	.....	474

Referring Provider Secondary Identifier

Additional identification number for the provider referring the patient for service.

D	|	2310F	|	REF02	|	-	|	127	.....	355
D	|	2420D	|	REF02	|	-	|	127	.....	477

Reimbursement Rate

Rate used when payment is based upon a percentage of applicable charges.

D	|	2320	|	MOA01	|	-	|	1954		376

Reject Reason Code

Code assigned by issuer to identify reason for rejection.

D	|	2300	|	HCP13	|	-	|	1901	.....	319
D	|	2400	|	HCP13	|	-	|	1901	.....	449

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	.....	149
D	|	2320	|	OI06	|	-	|	1363	.....	370

Remaining Patient Liability

In the judgement of the provider, the amount that remained to be paid after adjudication by this Other Payer.

D	|	2320	|	AMT02	|	-	|	1782	.....	367
D	|	2430	|	AMT02	|	-	|	1782	.....	489

Rendering Provider First Name

The first name of the provider who performed the service.

D	|	2310D	|	NM104	|	-	|	1036	.....	339
D	|	2420C	|	NM104	|	-	|	1036	.....	469

Rendering Provider Identifier

The identifier assigned by the Payor to the provider who performed the service.

D	|	2310D	|	NM109	|	-	|	167	.....	340
D	|	2420C	|	NM109	|	-	|	167	.....	470

Rendering Provider Last Name

The last name of the provider who performed the service.

D	|	2310D	|	NM103	|	-	|	1035	.....	339
D	|	2420C	|	NM103	|	-	|	1035	.....	469

**Rendering Provider Middle
Name or Initial**

Middle name or initial of the provider who has provided the services to the patient.

D | 2310D | NM105 | - | 1037 339
D | 2420C | NM105 | - | 1037 469

Rendering Provider Name Suffix

Name suffix of the provider who has provided the services to the patient.

D | 2310D | NM107 | - | 1039 339
D | 2420C | NM107 | - | 1039 469

**Rendering Provider Secondary
Identifier**

Additional identifier for the provider providing care to the patient.

D | 2310D | REF02 | - | 127 342
D | 2420C | REF02 | - | 127 472

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 | - | 1782 316

Repriced Approved Amount

The amount allowed by the repricer for the claim or service line net of adjustments.

D | 2300 | HCP07 | - | 1782 317

Repriced Approved DRG Code

The Diagnosis Related Group approved by the repricer for payment for this claim

D | 2300 | HCP06 | - | 127 317

**Repriced Approved HCPCS
Code**

The HCPCS code that describes the services as approved by the repricer.

D | 2400 | HCP10 | - | 1234 448

**Repriced Approved Revenue
Code**

UB92 revenue code approved by the repricer for payment on the claim.

D | 2300 | HCP08 | - | 1234 318

**Repriced Approved Service
Unit Count**

Number of service units approved by pricing or repricing entity.

D | 2300 | HCP12 | - | 1380 318

**Repriced Claim Reference
Number**

Identification number, assigned by a repricing organization, to identify the claim.

D | 2300 | REF02 | - | 127 169

**Repriced Line Item Reference
Number**

Identification number of a line item repriced by a third party or prior payer.

D | 2400 | REF02 | - | 127 439

Repriced Saving Amount

The amount of savings related to Third Party Organization claims.

D | 2300 | HCP03 | - | 1782 316

Repricer Received Date

Date the claim was received by the repricer organization.

D | 2300 | DTP03 | - | 1251 154

**Repricing Organization
Identifier**

Reference or identification number of the repricing organization.

D | 2300 | HCP04 | - | 127 317

**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 | - | 118 317

**Service Authorization
Exception Code**

Code identifying the service authorization exception.

D | 2300 | REF02 | - | 127 163

Service Date

Date of service, such as the start date of the service, the end date of the service, or the single day date of the service.

D | 2400 | DTP03 | - | 1251 436

Service Line Paid Amount

Amount paid by the indicated payer for a service line

D | 2430 | SVD02 | - | 1782 479

Service Line Revenue Code

UB92 Revenue Code pertaining to the service line.

D | 2400 | SV201 | - | 1234 426

D | 2430 | SVD04 | - | 1234 481

Service Tax Amount

The amount of service tax or surcharge applicable to the reported service.

D | 2400 | AMT02 | - | 782 441

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 | - | 380 430

Statement From and To Date

The date of the start or end of the period covered on the claim.

D | 2300 | DTP03 | - | 1251 152

Submitter Contact Name

Name of the person at the submitter organization to whom inquiries about the transaction should be directed.

H | 1000A | PER02 | - | 193 74

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 72

Submitter Identifier

Code or number identifying the entity submitting the claim.

H | 1000A | NM109 | - | 167 72

Submitter Last or Organization Name

The last name or the organizational name of the entity submitting the transaction

H | 1000A | NM103 | - | 1035 72

Submitter Middle Name or Initial

The middle name or initial of the person submitting the transaction.

H | 1000A | NM105 | - | 1037 72

Subscriber Address Line

Address line of the current mailing address of the insured individual or subscriber to the coverage.

D | 2010BA | N301 | - | 166 115

D | 2010BA | N302 | - | 166 115

Subscriber Birth Date

The date of birth of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG02 | - | 1251 118

Subscriber City Name

The City Name of the insured individual or subscriber to the coverage.

D | 2010BA | N401 | - | 119 116

Subscriber First Name

The first name of the insured individual or subscriber to the coverage.

D | 2010BA | NM104 | - | 1036 113

Subscriber Gender Code

Code indicating the sex of the subscriber to the indicated coverage or policy.

D | 2010BA | DMG03 | - | 1068 119

Subscriber Group Name

Name of the group through which the coverage is provided to the subscriber.

D | 2000B | SBR04 | - | 193 110

Subscriber Group or Policy Number

The identifier assigned by the health plan or administrator to identify the group through which the coverage is provided to the subscriber.

D | 2000B | SBR03 | - | 127 110

Subscriber Last Name

The surname of the insured individual or subscriber to the coverage.

D | 2010BA | NM103 | - | 1035 113

Subscriber Middle Name or Initial

The middle name or initial of the subscriber to the indicated coverage or policy.

D | 2010BA | NM105 | - | 1037 113

Subscriber Name Suffix

Suffix of the insured individual or subscriber to the coverage.

D | 2010BA | NM107 | - | 1039 113

Subscriber Postal Zone or ZIP Code

The ZIP Code of the insured individual or subscriber to the coverage.

D | 2010BA | N403 | - | 116 117

Subscriber Primary Identifier

Primary identification number of the subscriber to the coverage.

D | 2010BA | NM109 | - | 167 114

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage.

D | 2010BA | N402 | - | 156 117

Subscriber Supplemental Identifier

Identifies another or additional distinguishing code number associated with the subscriber.

D | 2010BA | REF02 | - | 127 120

Terms Discount Percentage

Discount percentage available to the payer for payment within a specific time period.

D | 2300 | CN105 | - | 138 161

Total Claim Charge Amount

The sum of all charges included within this claim.

D | 2300 | CLM02 | - | 1782 147

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

D | | SE01 | - | 196 490

Transaction Set Control Number

The unique identification number within a transaction set.

H | | ST02 | - | 1329 67

D | | SE02 | - | 1329 490

Transaction Set Creation Date

Identifies the date the submitter created the transaction.

H | | BHT04 | - | 1373 69

Transaction Set Creation Time

Time file is created for transmission.

H | | BHT05 | - | 1337 69

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H | | ST01 | - | 1143 67

Transaction Set Purpose Code

Code identifying purpose of transaction set.

H | | BHT02 | - | 1353 68

Treatment Code

Codes describing the treatment ordered by the physician.

D | 2300 | HI01 | C022-2 | 1271 307

D | 2300 | HI02 | C022-2 | 1271 307

D | 2300 | HI03 | C022-2 | 1271 308
D | 2300 | HI04 | C022-2 | 1271 309
D | 2300 | HI05 | C022-2 | 1271 309
D | 2300 | HI06 | C022-2 | 1271 310
D | 2300 | HI07 | C022-2 | 1271 311
D | 2300 | HI08 | C022-2 | 1271 311
D | 2300 | HI09 | C022-2 | 1271 312
D | 2300 | HI10 | C022-2 | 1271 313
D | 2300 | HI11 | C022-2 | 1271 313
D | 2300 | HI12 | C022-2 | 1271 314

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 | 2300 | HCP11 | - | 1355 318

D | 2400 | SV204 | - | 1355 430

D | 2400 | HCP11 | - | 1355 449

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 | - | 1127 173

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 286

D | 2300 | HI02 | C022-2 | 1271 287

D | 2300 | HI03 | C022-2 | 1271 288

D | 2300 | HI04 | C022-2 | 1271 289

D | 2300 | HI05 | C022-2 | 1271 290

D | 2300 | HI06 | C022-2 | 1271 290

D | 2300 | HI07 | C022-2 | 1271 291

D | 2300 | HI08 | C022-2 | 1271 292

D | 2300 | HI09 | C022-2 | 1271 293

D | 2300 | HI10 | C022-2 | 1271 293

D | 2300 | HI11 | C022-2 | 1271 294

D | 2300 | HI12 | C022-2 | 1271 295

Value Code Amount

Amount associated with the value code reported in this composite element.

D | 2300 | HI01 | C022-5 | 1782 287

D | 2300 | HI02 | C022-5 | 1782 287

D | 2300 | HI03 | C022-5 | 1782 288

D | 2300 | HI04 | C022-5 | 1782 289

D | 2300 | HI05 | C022-5 | 1782 290

D | 2300 | HI06 | C022-5 | 1782 290

D | 2300 | HI07 | C022-5 | 1782 291

D | 2300 | HI08 | C022-5 | 1782 292

D | 2300 | HI09 | C022-5 | 1782 293

D | 2300 | HI10 | C022-5 | 1782 293

D | 2300 | HI11 | C022-5 | 1782 294

D | 2300 | HI12 | C022-5 | 1782 295

Version, Release, or Industry Identifier

Code indicating the version, release, sub-release and industry identification of the EDI standard being used.

H | | ST03 | - | 1705 **67**