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Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange
Technical Report Type 3

Health Care Claim: Institutional (837)

MAY 2006

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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**X223**.

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), repricer, 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.

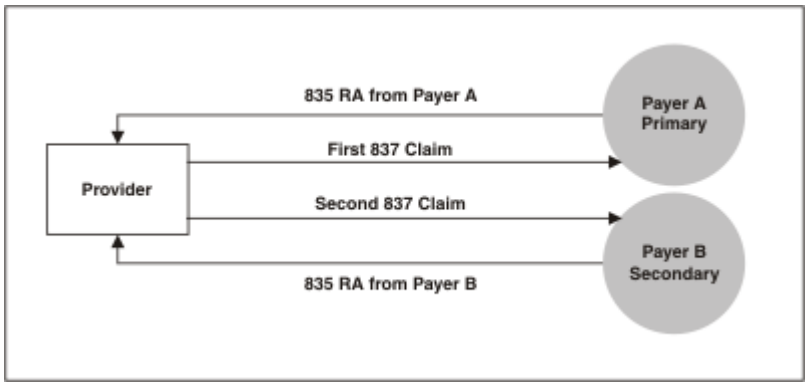
1.4.1.1 Coordination of Benefits Data Models -- Detail

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.

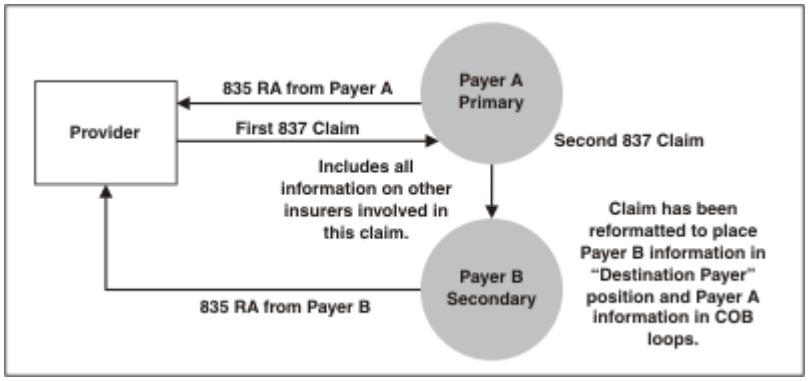
Step 3. If there are additional payers (not shown in Figure 1.1 - *Provider-to-Payer-to-Provider COB Model*), step 2 is repeated with the

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.

Institutional Claim 837 X223
(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*005010X223~ BHT*0019*00*0123*20050730*1023*CH~	**HEADER** ST*837*0002*005010X223~ 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~ ***SBR*S********CI~***
2010BA SUBSCRIBER NM1*IL*1*DOE*JOHN****MI*JD03398777~ REF*SY*033987777~	**2010BA SUBSCRIBER** ***NM1*IL*1*DOE*JANE****MI*JA7654321~*** ***REF*SY*765432111~***
2010BB PAYER NM1*PR*2*ABC INS*****PI*12345~ REF*G2*12345678~ REF*LU*678~	**2010BB PAYER** ***NM1*PR*2*XYZ INS GROUP*****PI*54698~*** ***REF*G2*XYZ3434343~*** ***REF*LU*455~***
2000C PATIENT HL LOOP HL*3*2*23*0~ PAT*19~	**2000C PATIENT HL LOOP** HL*3*2*23*0~ ***PAT*19~***
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**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**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*CO*97*100~
CO = Contractual obligations qualifier
97 = Adjustment reason - Payment is included in the allowance for the basic service/procedure
100 = Amount of adjustment

Bundling with COB -– 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:B1~** (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
1 = Service Units

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

SVD*PAYER ID*60*HC:C1~**
Payer ID
= ID of the payer who adjudicated this service line
60 = Payer amount paid
HC = HCPCS qualifier
C = Unbundled HCPCS 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

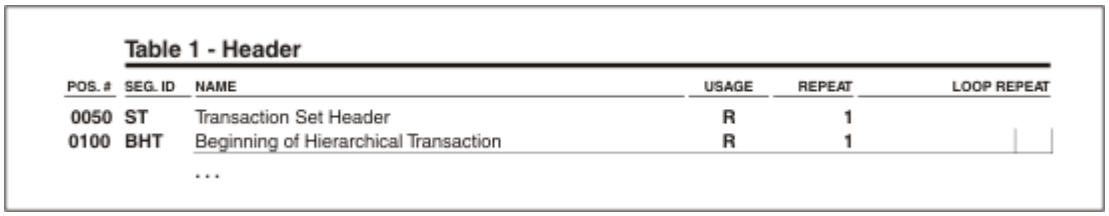


Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP 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 (005010X222), the Health Care Claim: Institutional (005010X223), the Health Care Claim: Dental (005010X224), and the health Care Service: Data Reporting (005010X225).

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

(Line 2 Adjustments) + (Line 2 Payment) = 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	

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

Each loop is assigned an industry specific name

R=Required
S=Situational

Segment repeats and loop repeats reflect actual usage

Position Numbers and Segment IDs retain their X12 values

Individual segments and entire loops are repeated

Figure 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:

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.

See section B.1.1.3.8 for a description of these values

Industry assigned Loop ID and Loop Name

Industry Loop Repeat

Industry Segment Repeat

Loop:	**2100B — PATIENT NAME Loop Repeat: 1**
Segment Repeat:	**1**
Industry usage → Usage:	**SITUATIONAL**
Situational Rule:	**Required when the patient is different from the insured. If not required by this implementation guide, do not send.**
TR3 Notes:	**1. Any necessary identification number must be provided in NM109.**
TR3 Example:	**NM1*QC*1*Shepard*Sam*A***34*452114586~**

Situational Rule

Industry Notes

Example

Figure 2.3. Segment Key — Implementation

DIAGRAM

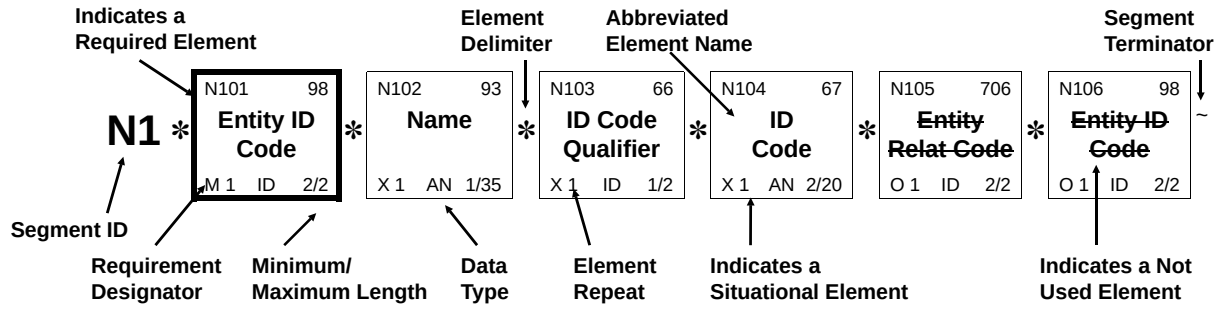


Figure 2.4. Segment Key — Diagram

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	**M 1**	
			Use the Primary Payer's adjudicated Medical Procedure Code.		
REQUIRED	**SVC01 - 1**		**235 Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**M**	**ID** **2/2**
			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.		
			CODE — DEFINITION		
			AD — **American Dental Association Codes** CODE SOURCE **135:** American Dental Association		
			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	**M 1**	**R** **1/18**
			SEMANTIC: SVC02 is the submitted service charge.		
			This value can not be negative.		
NOT USED	**SVC03**	**782**	**Monetary Amount**	**O 1**	**R** **1/18**
SITUATIONAL	**SVC04**	**234**	**Product/Service ID** Identifying number for a product or service	**O 1**	**AN** **1/48**
			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**		

Reference Designator

Composite Number

Industry Usage: See the following page for complete descriptions

Industry Note

Selected Code Values

See Appendix A for external code source reference

Data Element Number

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: Institutional

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	R	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	R	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	
			LOOP ID - 2300 CLAIM INFORMATION			**100**
143	1300	CLM	Claim Information	R	1	
149	1350	DTP	Discharge Hour	S	1	
150	1350	DTP	Statement Dates	R	1	
151	1350	DTP	Admission Date/Hour	S	1	
152	1350	DTP	Date - Repricer Received Date	S	1	
153	1400	CL1	Institutional Claim Code	R	1	
154	1550	PWK	Claim Supplemental Information	S	10	
158	1600	CN1	Contract Information	S	1	
160	1750	AMT	Patient Estimated Amount Due	S	1	
161	1800	REF	Service Authorization Exception Code	S	1	

163	1800	REF	Referral Number	S	1	
164	1800	REF	Prior Authorization	S	1	
166	1800	REF	Payer Claim Control Number	S	1	
167	1800	REF	Repriced Claim Number	S	1	
168	1800	REF	Adjusted Repriced Claim Number	S	1	
169	1800	REF	Investigational Device Exemption Number	S	5	
170	1800	REF	Claim Identifier For Transmission Intermediaries	S	1	
172	1800	REF	Auto Accident State	S	1	
173	1800	REF	Medical Record Number	S	1	
174	1800	REF	Demonstration Project Identifier	S	1	
175	1800	REF	Peer Review Organization (PRO) Approval Number	S	1	
176	1850	K3	File Information	S	10	
178	1900	NTE	Claim Note	S	10	
180	1900	NTE	Billing Note	S	1	
181	2200	CRC	EPSDT Referral	S	1	
184	2310	HI	Principal Diagnosis	R	1	
187	2310	HI	Admitting Diagnosis	S	1	
189	2310	HI	Patient's Reason For Visit	S	1	
193	2310	HI	External Cause of Injury	S	1	
218	2310	HI	Diagnosis Related Group (DRG) Information	S	1	
220	2310	HI	Other Diagnosis Information	S	2	
239	2310	HI	Principal Procedure Information	S	1	
242	2310	HI	Other Procedure Information	S	2	
258	2310	HI	Occurrence Span Information	S	2	
271	2310	HI	Occurrence Information	S	2	
284	2310	HI	Value Information	S	2	
294	2310	HI	Condition Information	S	2	
304	2310	HI	Treatment Code Information	S	2	
313	2410	HCP	Claim Pricing/Repricing Information	S	1	
			LOOP ID - 2310A ATTENDING PROVIDER NAME			**1**
319	2500	NM1	Attending Provider Name	S	1	
322	2550	PRV	Attending Provider Specialty Information	S	1	
324	2710	REF	Attending Provider Secondary Identification	S	4	
			LOOP ID - 2310B OPERATING PHYSICIAN NAME			**1**
326	2500	NM1	Operating Physician Name	S	1	
329	2710	REF	Operating Physician Secondary Identification	S	4	
			LOOP ID - 2310C OTHER OPERATING PHYSICIAN NAME			**1**
331	2500	NM1	Other Operating Physician Name	S	1	
334	2710	REF	Other Operating Physician Secondary Identification	S	4	
			LOOP ID - 2310D RENDERING PROVIDER NAME			**1**
336	2500	NM1	Rendering Provider Name	S	1	
339	2710	REF	Rendering Provider Secondary Identification	S	4	
			LOOP ID - 2310E SERVICE FACILITY LOCATION NAME			**1**
341	2500	NM1	Service Facility Location Name	S	1	
344	2650	N3	Service Facility Location Address	R	1	
345	2700	N4	Service Facility Location City, State, ZIP Code	R	1	
347	2710	REF	Service Facility Location Secondary Identification	S	3	
			LOOP ID - 2310F REFERRING PROVIDER NAME			**1**
349	2500	NM1	Referring Provider Name	S	1	
352	2710	REF	Referring Provider Secondary Identification	S	3	
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION			**10**
354	2900	SBR	Other Subscriber Information	S	1	
358	2950	CAS	Claim Level Adjustments	S	5	

364	3000	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
365	3000	AMT	Remaining Patient Liability	S	1	
366	3000	AMT	Coordination of Benefits (COB) Total Non-Covered Amount	S	1	
367	3100	OI	Other Insurance Coverage Information	R	1	
369	3150	MIA	Inpatient Adjudication Information	S	1	
374	3200	MOA	Outpatient Adjudication Information	S	1	
			LOOP ID - 2330A OTHER SUBSCRIBER NAME			**1**
377	3250	NM1	Other Subscriber Name	R	1	
380	3320	N3	Other Subscriber Address	S	1	
381	3400	N4	Other Subscriber City, State, ZIP Code	R	1	
383	3550	REF	Other Subscriber Secondary Identification	S	2	
			LOOP ID - 2330B OTHER PAYER NAME			**1**
384	3250	NM1	Other Payer Name	R	1	
386	3320	N3	Other Payer Address	S	1	
387	3400	N4	Other Payer City, State, ZIP Code	R	1	
389	3500	DTP	Claim Check or Remittance Date	S	1	
390	3550	REF	Other Payer Secondary Identifier	S	2	
392	3550	REF	Other Payer Prior Authorization Number	S	1	
393	3550	REF	Other Payer Referral Number	S	1	
394	3550	REF	Other Payer Claim Adjustment Indicator	S	1	
395	3550	REF	Other Payer Claim Control Number	S	1	
			LOOP ID - 2330C OTHER PAYER ATTENDING PROVIDER			**1**
396	3250	NM1	Other Payer Attending Provider	S	1	
398	3550	REF	Other Payer Attending Provider Secondary Identification	R	4	
			LOOP ID - 2330D OTHER PAYER OPERATING PHYSICIAN			**1**
400	3250	NM1	Other Payer Operating Physician	S	1	
402	3550	REF	Other Payer Operating Physician Secondary Identification	R	4	
			LOOP ID - 2330E OTHER PAYER OTHER OPERATING PHYSICIAN			**1**
404	3250	NM1	Other Payer Other Operating Physician	S	1	
406	3550	REF	Other Payer Other Operating Physician Secondary Identification	R	4	
			LOOP ID - 2330F OTHER PAYER SERVICE FACILITY LOCATION			**1**
408	3250	NM1	Other Payer Service Facility Location	S	1	
410	3550	REF	Other Payer Service Facility Location Secondary Identification	R	3	
			LOOP ID - 2330G OTHER PAYER RENDERING PROVIDER NAME			**1**
412	3250	NM1	Other Payer Rendering Provider Name	S	1	
414	3550	REF	Other Payer Rendering Provider Secondary Identification	R	4	
			LOOP ID - 2330H OTHER PAYER REFERRING PROVIDER			**1**
416	3250	NM1	Other Payer Referring Provider	S	1	
418	3550	REF	Other Payer Referring Provider Secondary Identification	R	3	
			LOOP ID - 2330I OTHER PAYER BILLING PROVIDER			**1**
420	3250	NM1	Other Payer Billing Provider	S	1	
422	3550	REF	Other Payer Billing Provider Secondary Identification	R	2	
			LOOP ID - 2400 SERVICE LINE NUMBER			**999**
423	3650	LX	Service Line Number	R	1	
424	3750	SV2	Institutional Service Line	R	1	
429	4200	PWK	Line Supplemental Information	S	10	

433	4550	DTP	Date - Service Date	S	1	
435	4700	REF	Line Item Control Number	S	1	
437	4700	REF	Repriced Line Item Reference Number	S	1	
438	4700	REF	Adjusted Repriced Line Item Reference Number	S	1	
439	4750	AMT	Service Tax Amount	S	1	
440	4750	AMT	Facility Tax Amount	S	1	
441	4850	NTE	Third Party Organization Notes	S	1	
442	4920	HCP	Line Pricing/Repricing Information	S	1	
			LOOP ID - 2410 DRUG IDENTIFICATION			**1**
449	4930	LIN	Drug Identification	S	1	
452	4940	CTP	Drug Quantity	R	1	
454	4950	REF	Prescription or Compound Drug Association Number	S	1	
			LOOP ID - 2420A OPERATING PHYSICIAN NAME			**1**
456	5000	NM1	Operating Physician Name	S	1	
459	5250	REF	Operating Physician Secondary Identification	S	20	
			LOOP ID - 2420B OTHER OPERATING PHYSICIAN NAME			**1**
461	5000	NM1	Other Operating Physician Name	S	1	
464	5250	REF	Other Operating Physician Secondary Identification	S	20	
			LOOP ID - 2420C RENDERING PROVIDER NAME			**1**
466	5000	NM1	Rendering Provider Name	S	1	
469	5250	REF	Rendering Provider Secondary Identification	S	20	
			LOOP ID - 2420D REFERRING PROVIDER NAME			**1**
471	5000	NM1	Referring Provider Name	S	1	
474	5250	REF	Referring Provider Secondary Identification	S	20	
			LOOP ID - 2430 LINE ADJUDICATION INFORMATION			**15**
476	5400	SVD	Line Adjudication Information	S	1	
480	5450	CAS	Line Adjustment	S	5	
486	5500	DTP	Line Check or Remittance Date	R	1	
487	5505	AMT	Remaining Patient Liability	S	1	
488	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

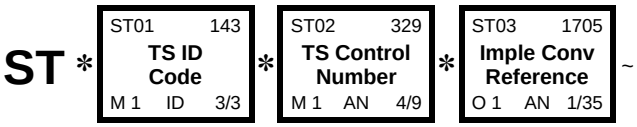
X12 Purpose: To indicate the start of a transaction set and to assign a control number

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **ST*837*987654*005010X223~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set **SEMANTIC:** The transaction set identifier (ST01) 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**	**M 1 ID 3/3**
REQUIRED	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **The Transaction Set Control Number in ST02 and SE02 must be identical. The number must be unique within a specific interchange (ISA-IEA), but can repeat in other interchanges.**	**M 1 AN 4/9**
REQUIRED	**ST03**	**1705**	**Implementation Convention Reference** Reference assigned to identify Implementation Convention **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.**	**O 1 AN 1/35**

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**

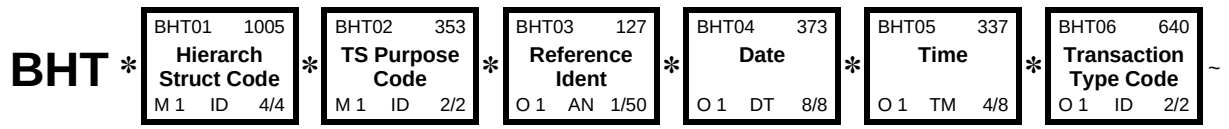
TR3 Notes:

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**
			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.	
			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. *NOTE:* 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**

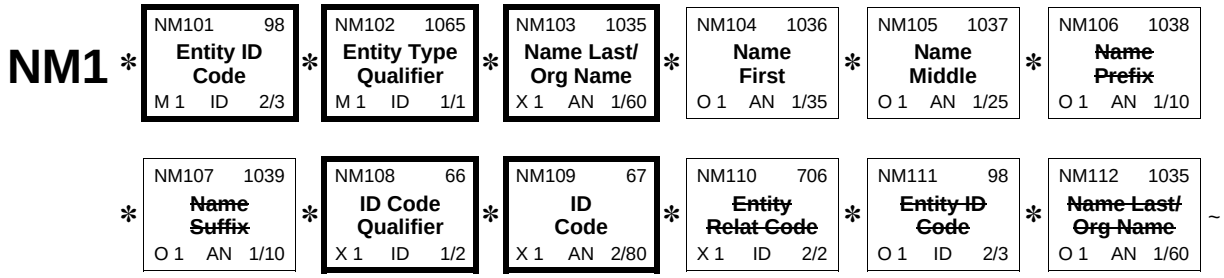
Usage: **REQUIRED**

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. CODE / DEFINITION **1** Person **2** Non-Person Entity	**M**	**1**	**ID**	**1/1**
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:** ***Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Submitter First Name**	**O**	**1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **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 CODE / DEFINITION **46** Electronic Transmitter Identification Number (ETIN) **Established by trading partner agreement**	**X**	**1**	**ID**	**1/2**
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**

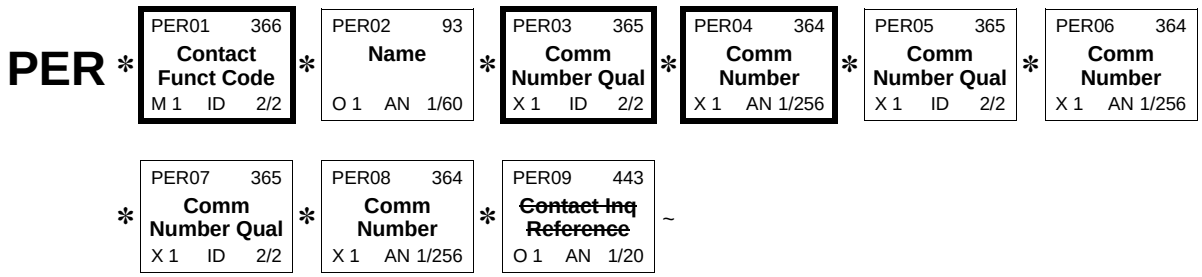
Usage: **REQUIRED**

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** Code identifying the major duty or responsibility of the person or group named	**M 1 ID 2/2**
			CODE: **IC** — DEFINITION: **Information Contact**	
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**
			SITUATIONAL RULE: ***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.***	
			IMPLEMENTATION NAME: **Submitter Contact Name**	
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number SYNTAX: P0304	**X 1 ID 2/2**
			CODE: **EM** — DEFINITION: **Electronic Mail**	
			CODE: **FX** — DEFINITION: **Facsimile**	
			CODE: **TE** — DEFINITION: **Telephone**	
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable SYNTAX: P0304	**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: ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***	
			CODE: **EM** — DEFINITION: **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:** ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***		**X 1**	**AN**	**1/256**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number **SYNTAX:** P0708 **SITUATIONAL RULE:** ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***		**X 1**	**ID**	**2/2**
			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:** ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***		**X 1**	**AN**	**1/256**
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.

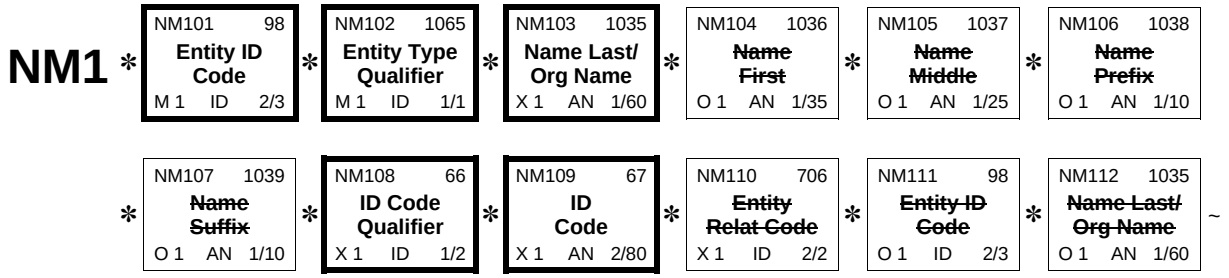
Loop: **1000B — RECEIVER NAME Loop Repeat: 1**

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

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: **Receiver 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**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 CODE / DEFINITION **46** **Electronic Transmitter Identification Number (ETIN)**	**X 1**	**ID**	**1/2**
REQUIRED	**NM109**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: **Receiver Primary 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

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.

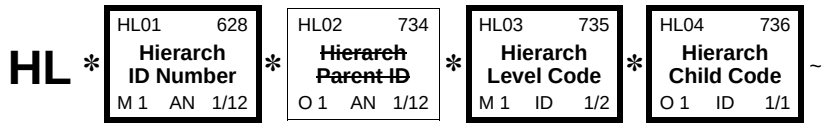
Loop: **2000A — BILLING PROVIDER HIERARCHICAL LEVEL** **Loop Repeat:** **>1**

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**

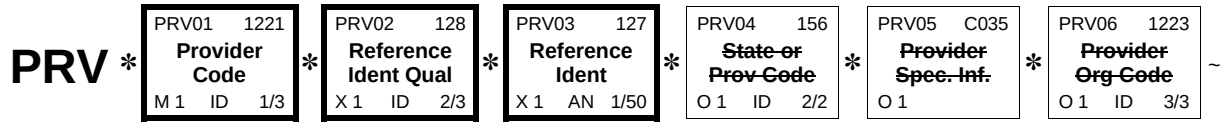
Segment Repeat: **1**

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 CODE / DEFINITION **BI** — **Billing**	**M 1 ID 1/3**
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification **SYNTAX:** P0203 CODE / DEFINITION **PXC** — **Health Care Provider Taxonomy Code** **CODE SOURCE 682:** Health Care Provider Taxonomy	**X 1 ID 2/3**
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**

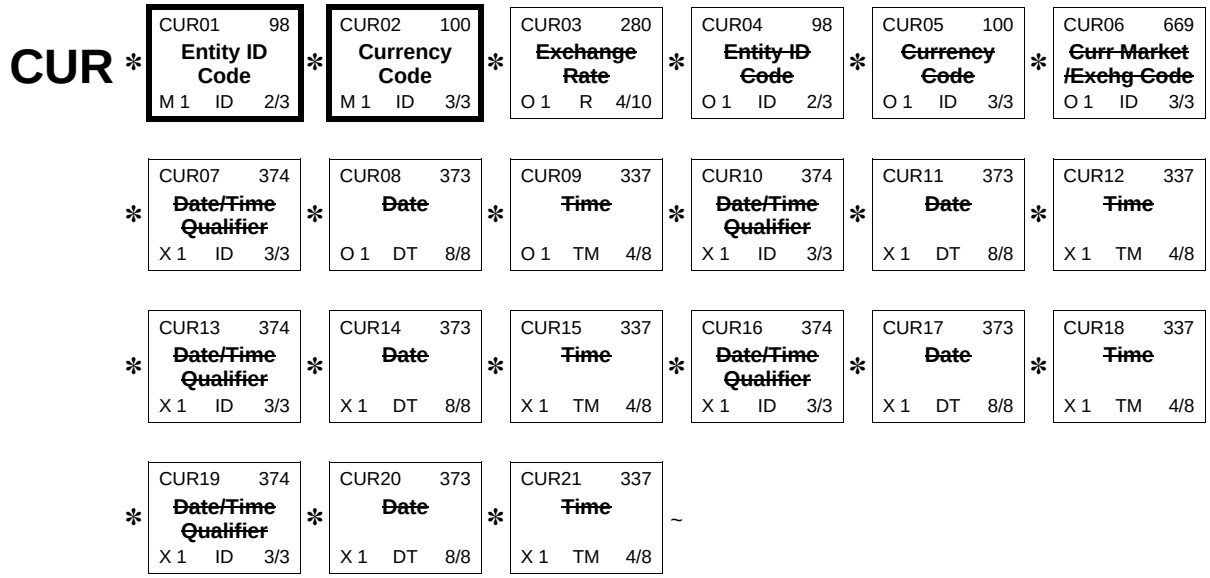
Usage: **SITUATIONAL**

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 **CODE** **DEFINITION** **85** **Billing Provider**	**M 1 ID 2/3**
REQUIRED	**CUR02**	**100**	**Currency Code** Code (Standard ISO) for country in whose currency the charges are specified **CODE SOURCE 5:** Countries, Currencies and Funds **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**

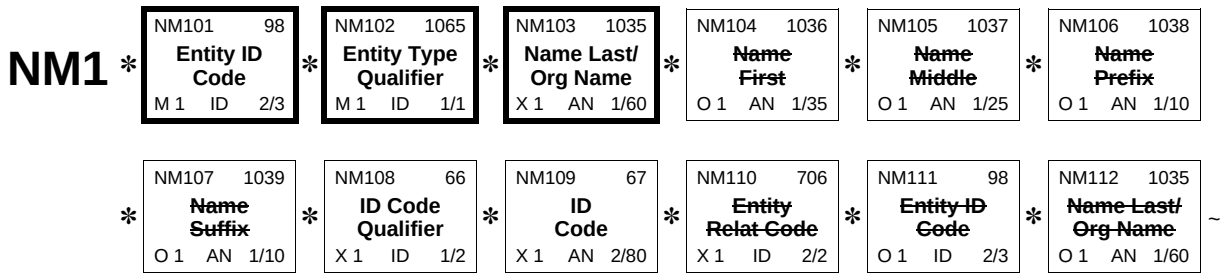
Usage: **REQUIRED**

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 CODE / DEFINITION **85** **Billing Provider**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **2** **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Billing Provider Organizational 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**

SITUATIONAL	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X 1**	**ID**	**1/2**
			CODE / **DEFINITION** **XX** — **Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **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**

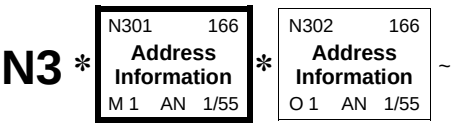
Usage: **REQUIRED**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***			
			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.

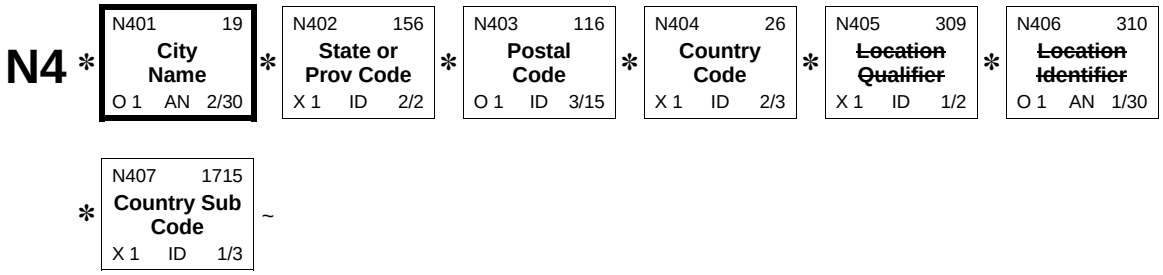
Loop: **2010AA — BILLING PROVIDER NAME**

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 **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**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

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

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Billing Provider State or Province Code**

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***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.***

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** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***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.***

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**

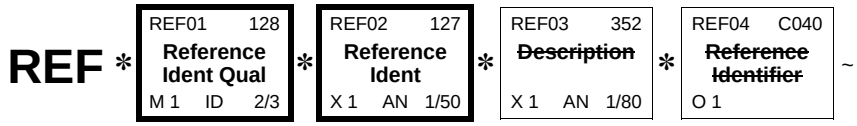
Segment Repeat: **1**

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: **EI** — DEFINITION: **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**

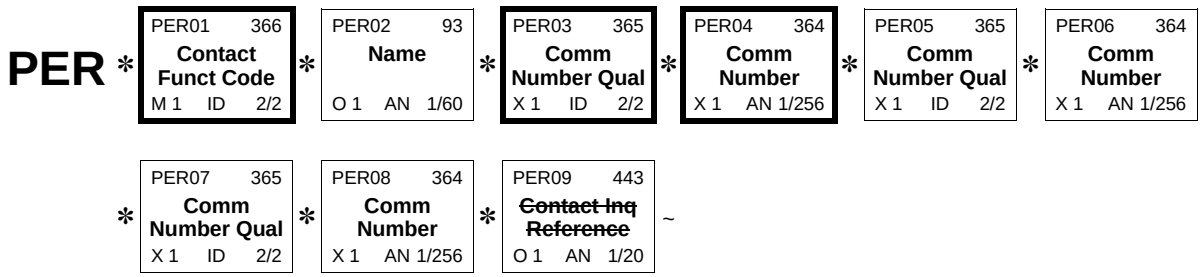
Situational Rule: **Required when this information is different than that contained in the Loop ID-1000A - Submitter PER segment. If not required by this implementation guide, do not send.**

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**

CODE	DEFINITION
IC	**Information Contact**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER02**	**93**	**Name** Free-form name	**O 1 AN 1/60**

SITUATIONAL RULE: ***Required in the first iteration of the Billing Provider Contact Information segment. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Billing Provider Contact Name**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1 ID 2/2**

SYNTAX: P0304

CODE	DEFINITION
EM	**Electronic Mail**
FX	**Facsimile**
TE	**Telephone**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable	**X 1 AN 1/256**

SYNTAX: P0304

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**PER05**	**365**	**Communication Number Qualifier** Code identifying the type of communication number	**X 1 ID 2/2**

SYNTAX: P0506

SITUATIONAL RULE: ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***

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:** ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***	**X 1**	**AN**	**1/256**
SITUATIONAL	**PER07**	**365**	**Communication Number Qualifier** Code identifying the type of communication number **SYNTAX:** P0708 **SITUATIONAL RULE:** ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***	**X 1**	**ID**	**2/2**
SITUATIONAL	**PER08**	**364**	**Communication Number** Complete communications number including country or area code when applicable **SYNTAX:** P0708 **SITUATIONAL RULE:** ***Required when this information is deemed necessary by the submitter. If not required by this implementation guide, do not send.***	**X 1**	**AN**	**1/256**
NOT USED	**PER09**	**443**	**Contact Inquiry Reference**	**O 1**	**AN**	**1/20**

CODE	DEFINITION
EM	**Electronic Mail**
EX	**Telephone Extension**
FX	**Facsimile**
TE	**Telephone**

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**

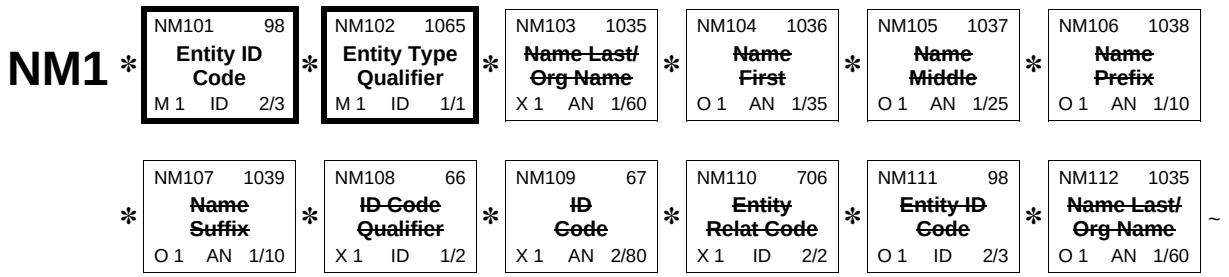
Usage: **SITUATIONAL**

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** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

CODE	DEFINITION
87	**Pay-to Provider**

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

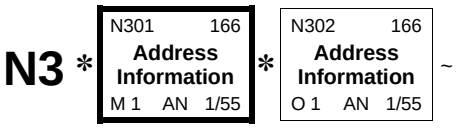
Loop: **2010AB — PAY-TO ADDRESS NAME**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***			
			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:

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.

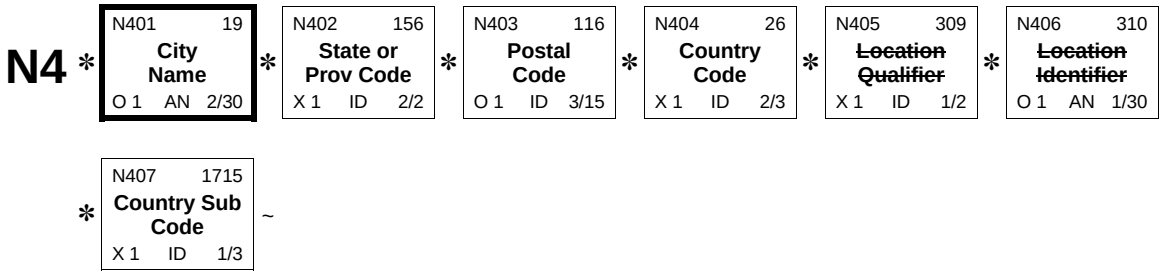
Loop: **2010AB — PAY-TO ADDRESS NAME**

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** O 1 AN 2/30 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 Address City Name**	

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

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

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Pay-to Address State Code**

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Pay-to Address Postal Zone or ZIP Code**

CODE SOURCE 51: ZIP Code
CODE SOURCE 932: Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***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.***

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

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**

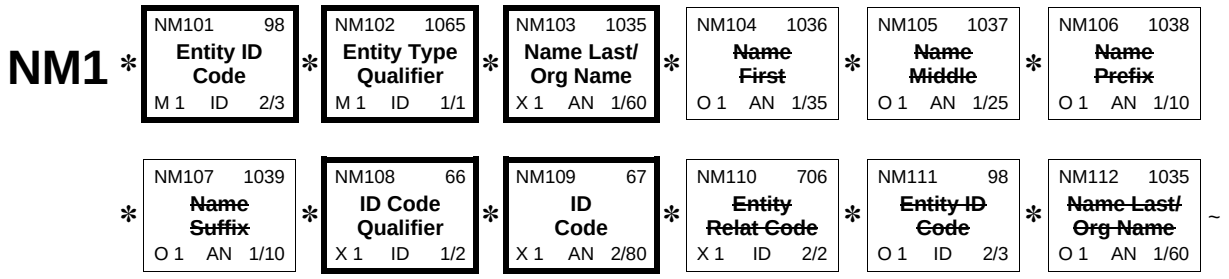
Situational Rule: **Required when willing trading partners agree to use this implementation for their subrogation payment requests.**

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** Code identifying an organizational entity, a physical location, property or an individual	**M 1 ID 2/3**

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**

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Pay-To Plan Organizational 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**
REQUIRED	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) **SYNTAX:** P0809 **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.**	**X 1**	**ID**	**1/2**

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 **IMPLEMENTATION NAME: Pay-To Plan Primary 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 - PAY-TO PLAN ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

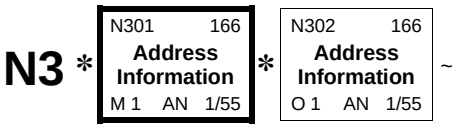
Loop: **2010AC — PAY-TO PLAN NAME**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***			
			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.

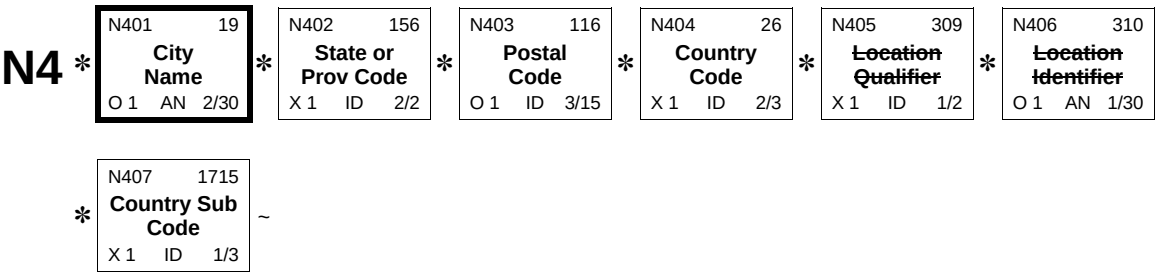
Loop: **2010AC — PAY-TO PLAN NAME**

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:** ***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.*** **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** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**
			SITUATIONAL RULE: ***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.***			
			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** Code identifying the country	**X 1**	**ID**	**2/3**
			SYNTAX: C0704			
			SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***			
			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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**
			SYNTAX: E0207, C0704			
			SITUATIONAL RULE: ***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.***			
			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**

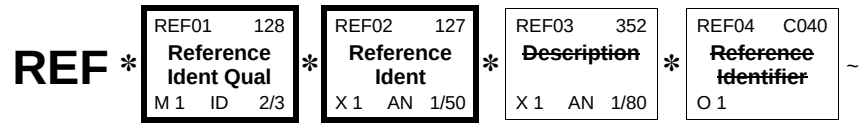
Segment Repeat: **1**

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: **2U** — DEFINITION: **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 SYNTAX: R0203 IMPLEMENTATION NAME: **Pay-to Plan 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

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.

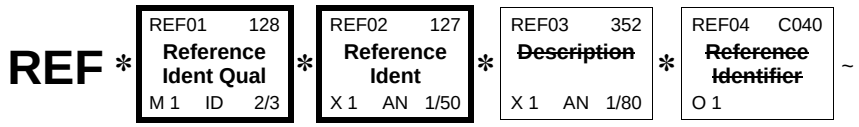
Loop: **2010AC — PAY-TO PLAN NAME**

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**
			CODE: **EI** — DEFINITION: **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**

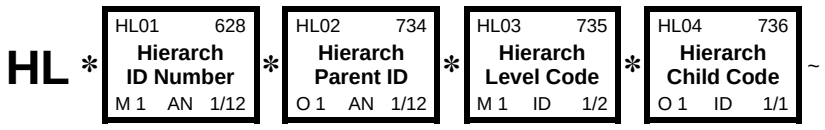
Usage: **REQUIRED**

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** **O 1 AN 1/12**

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.

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

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.

CODE	DEFINITION
22	**Subscriber**

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.

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.

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

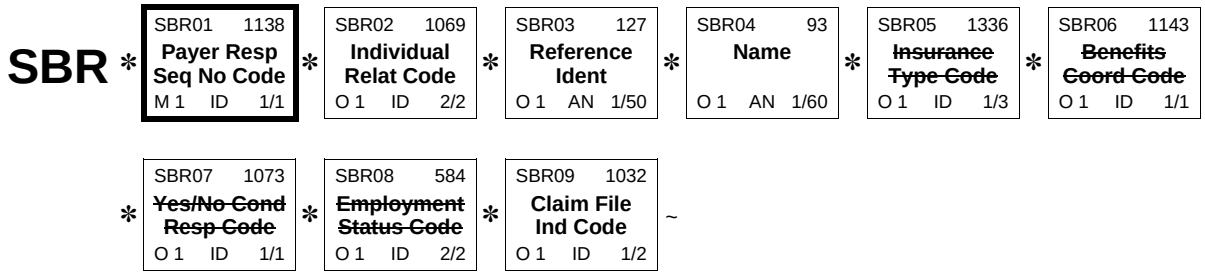
Loop: **2000B — SUBSCRIBER HIERARCHICAL LEVEL**

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** 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.		
SITUATIONAL	**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.				
			SITUATIONAL RULE: ***Required when the patient is the subscriber or is considered to be the subscriber. If not required by this implementation guide, do not send.***				
			CODE / **DEFINITION**				
			18 **Self**				
SITUATIONAL	**SBR03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**
			SEMANTIC: SBR03 is policy or group number.				
			SITUATIONAL RULE: ***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.***				
			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** Free-form name	**O**	**1**	**AN**	**1/60**
			SEMANTIC: SBR04 is plan name.				
			SITUATIONAL RULE: ***Required when SBR03 is not used and the group name is available. If not required by this implementation guide, do not send.***				
			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** Code identifying type of claim	**O**	**1**	**ID**	**1/2**
			SITUATIONAL RULE: ***Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.***				
			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**

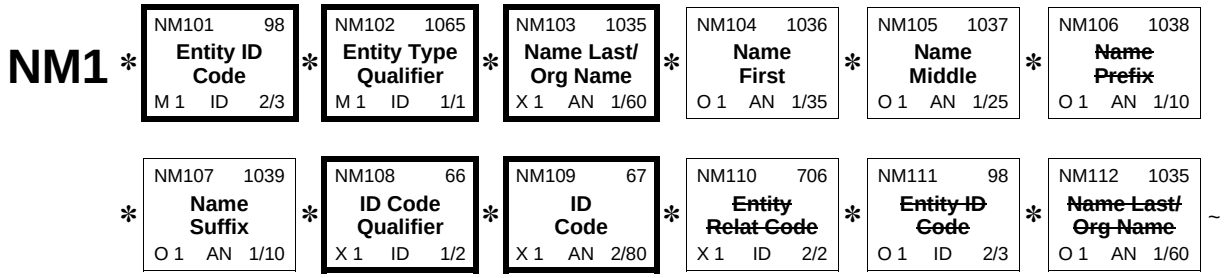
Usage: **REQUIRED**

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.	**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:** ***Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Subscriber First Name**	**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **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:** ***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.*** **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**
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**

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** Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: **Subscriber Primary 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 - SUBSCRIBER ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2010BA — SUBSCRIBER NAME**

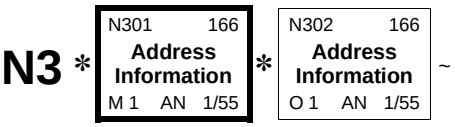
Segment Repeat: **1**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***	
			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.

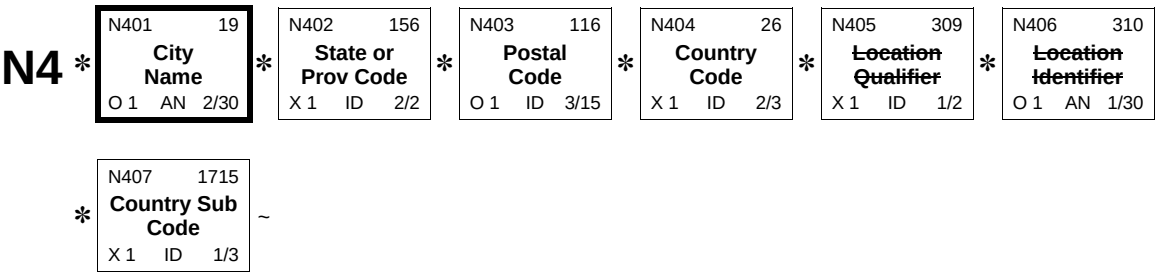
Loop: **2010BA — SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **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:** **Subscriber 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:** ***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.*** **IMPLEMENTATION NAME:** **Subscriber 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)	**O 1**	**ID**	**3/15**
			SITUATIONAL RULE: ***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.***			
			IMPLEMENTATION NAME: **Subscriber Postal Zone or ZIP Code**			
			CODE SOURCE **51:** ZIP Code CODE SOURCE **932:** Universal Postal Codes			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**
			SYNTAX: C0704			
			SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***			
			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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**
			SYNTAX: E0207, C0704			
			SITUATIONAL RULE: ***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.***			
			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. **P1011**
   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**

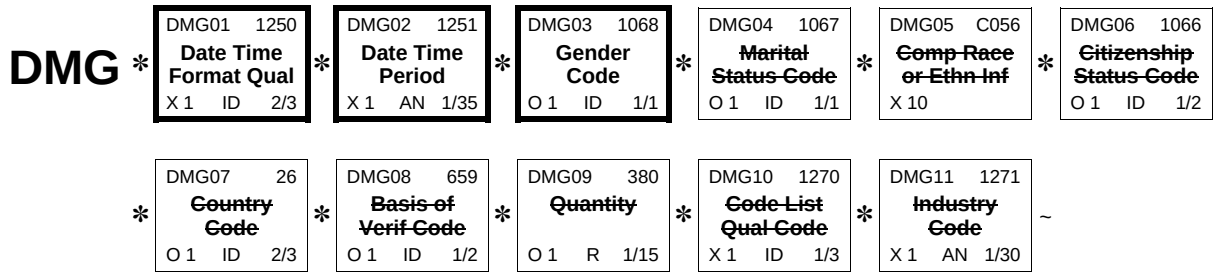
Segment Repeat: **1**

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 **CODE** / **DEFINITION** **D8** — **Date Expressed in Format CCYYMMDD**	**X 1 ID 2/3**
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. **IMPLEMENTATION NAME:** **Subscriber Birth Date**	**X 1 AN 1/35**

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**

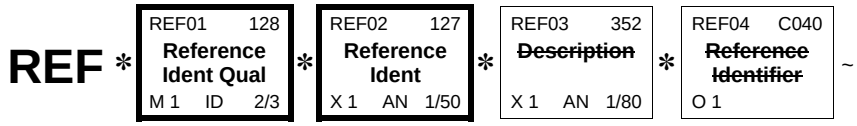
Segment Repeat: **1**

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: **SY** — DEFINITION: **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 **SYNTAX:** R0203 **IMPLEMENTATION NAME:** **Subscriber Supplemental 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 - 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**

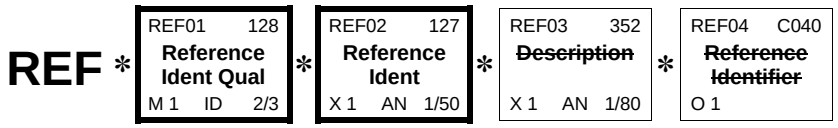
Situational Rule: **Required when the services included in this claim are to be considered as part of a property and casualty claim. If not required by this implementation guide, do not send.**

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 CODE: **Y4** DEFINITION: **Agency Claim Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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

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**

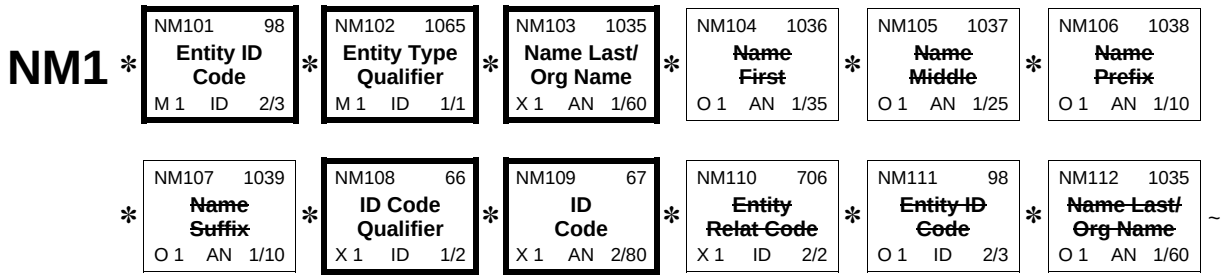
Segment Repeat: **1**

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**

CODE	DEFINITION
2	**Non-Person Entity**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Payer 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**
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 **IMPLEMENTATION NAME: Payer 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 - PAYER ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2010BB — PAYER NAME**

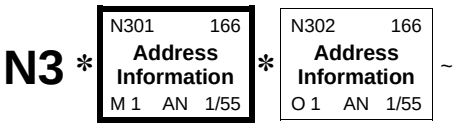
Segment Repeat: **1**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***	
			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.

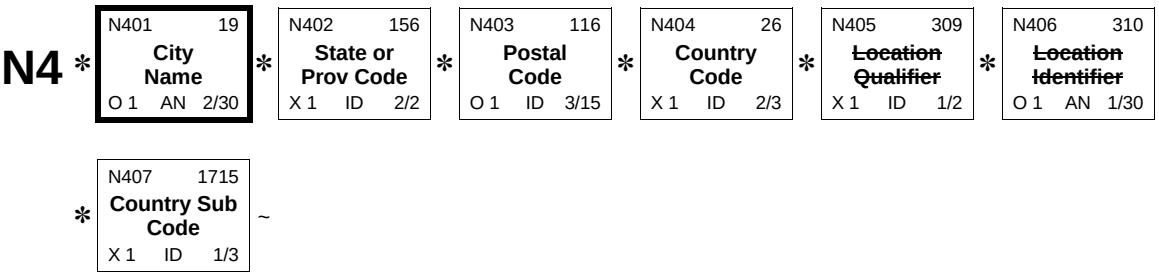
Loop: **2010BB — PAYER NAME**

Segment Repeat: **1**

Usage: **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: **Payer 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: ***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.*** 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)	**O 1**	**ID**	**3/15**
			SITUATIONAL RULE: ***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.***			
			IMPLEMENTATION NAME: **Payer Postal Zone or ZIP Code**			
			CODE SOURCE **51:** ZIP Code CODE SOURCE **932:** Universal Postal Codes			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**
			SYNTAX: C0704			
			SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***			
			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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**
			SYNTAX: E0207, C0704			
			SITUATIONAL RULE: ***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.***			
			CODE SOURCE **5:** Countries, Currencies and Funds			
			Use the country subdivision codes from Part 2 of ISO 3166.			

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**

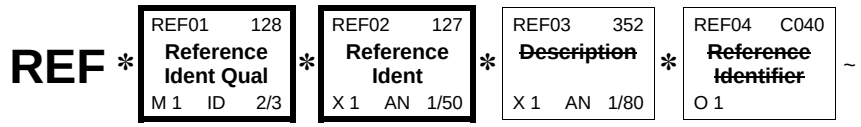
Segment Repeat: **3**

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**

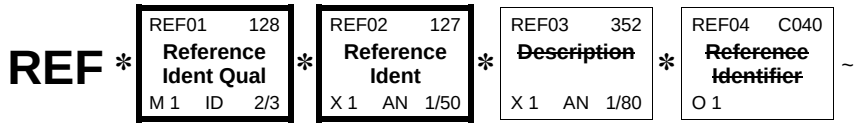
Segment Repeat: **1**

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**

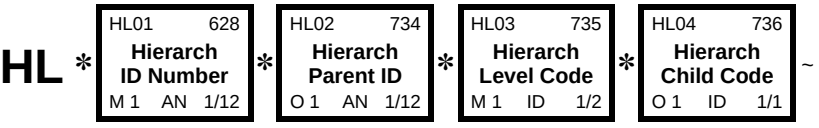
Situational Rule: **Required when the patient is a dependent of the subscriber identified in Loop ID-2000B and cannot be uniquely identified to the payer using the subscriber's identifier in the Subscriber Level. If not required by this implementation guide, do not send.**

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 **COMMENT:** HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	**M 1 AN 1/12**

REQUIRED **HL02** **734** **Hierarchical Parent ID Number** **O 1 AN 1/12**

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.

REQUIRED **HL03** **735** **Hierarchical Level Code** **M 1 ID 1/2**

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.

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** **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
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.

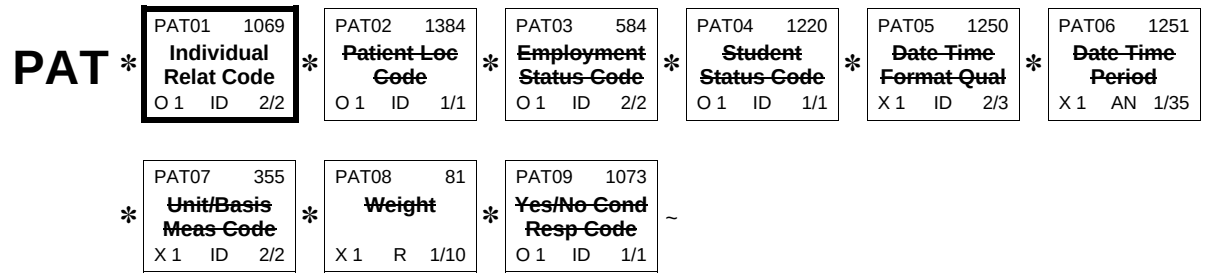
Loop: **2000C — PATIENT HIERARCHICAL LEVEL**

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** Code indicating the relationship between two individuals or entities	**O 1 ID 2/2**
			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.

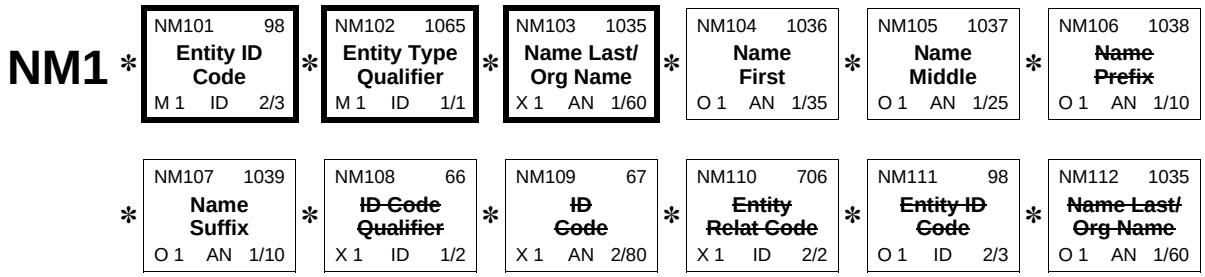
Loop: **2010CA — PATIENT NAME Loop Repeat: 1**

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: **QC** — DEFINITION: **Patient**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M 1 ID 1/1**
			CODE: **1** — DEFINITION: **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: ***Required when the person has a first name. If not required by this implementation guide, do not send.*** IMPLEMENTATION NAME: **Patient First Name**	**O 1**	**AN**	**1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: ***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.*** 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: ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** 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

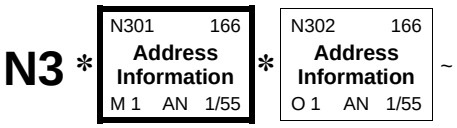
Loop: **2010CA — PATIENT NAME**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***	
			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.

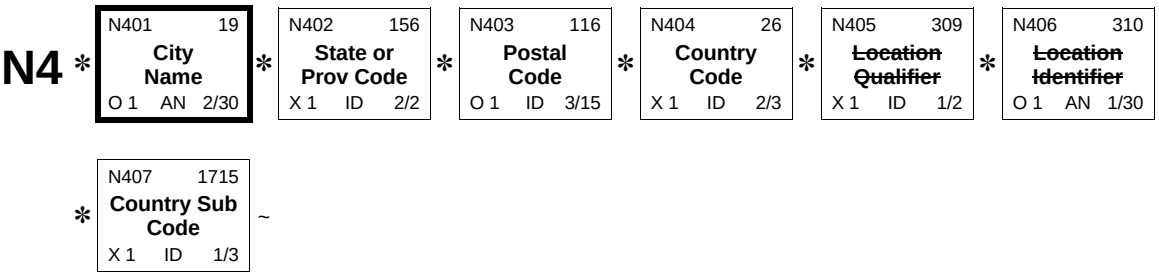
Loop: **2010CA — PATIENT NAME**

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:** ***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.*** **IMPLEMENTATION NAME:** **Patient 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)	**O 1**	**ID**	**3/15**
			SITUATIONAL RULE: ***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.***			
			IMPLEMENTATION NAME: **Patient Postal Zone or ZIP Code**			
			CODE SOURCE **51:** ZIP Code CODE SOURCE **932:** Universal Postal Codes			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**
			SYNTAX: C0704			
			SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***			
			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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**
			SYNTAX: E0207, C0704			
			SITUATIONAL RULE: ***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.***			
			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.

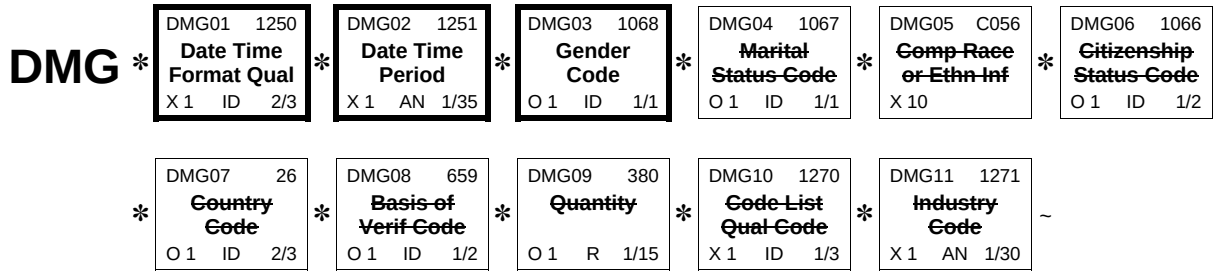
Loop: **2010CA — PATIENT NAME**

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 **CODE** / **DEFINITION** **D8** — **Date Expressed in Format CCYYMMDD**	**X 1 ID 2/3**
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. **IMPLEMENTATION NAME:** **Patient Birth Date**	**X 1 AN 1/35**

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**

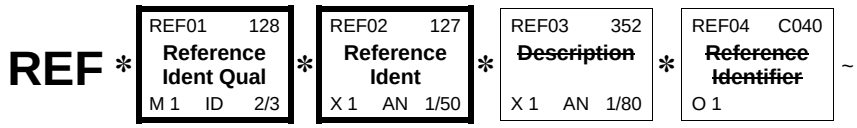
Situational Rule: **Required when the services included in this claim are to be considered as part of a property and casualty claim. If not required by this implementation guide, do not send.**

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 CODE / DEFINITION **Y4 — Agency Claim Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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

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**

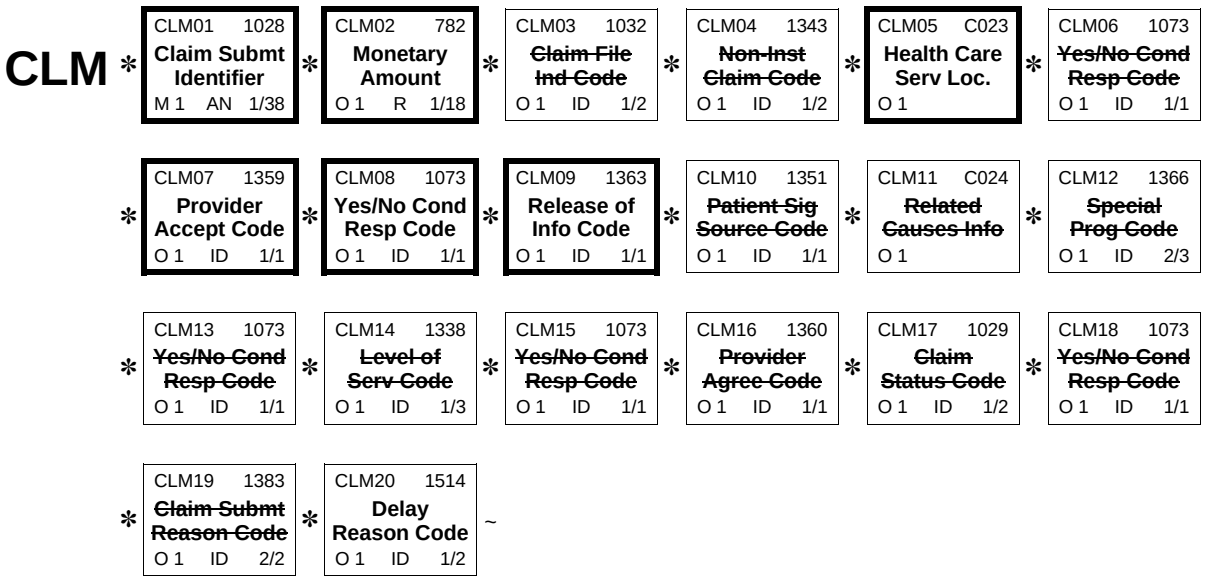
TR3 Notes:

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** **O 1** **R** **1/18**
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.

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** **O 1**
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

REQUIRED **CLM05 - 1** **1331** **Facility Code Value** **M** **AN** **1/2**
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**

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

SEMANTIC:
C023-02 qualifies C023-01 and C023-03.

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** **O** **ID** **1/1**
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

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** 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

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** Code indicating the reason why a request was delayed	O 1	ID	1/2

SITUATIONAL RULE: ***Required when the claim is submitted late (past contracted date of filing limitations). If not required by this implementation guide, do not send.***

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**

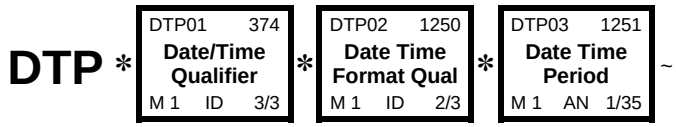
Segment Repeat: **1**

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 SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **TM** **Time Expressed in Format HHMM**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 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

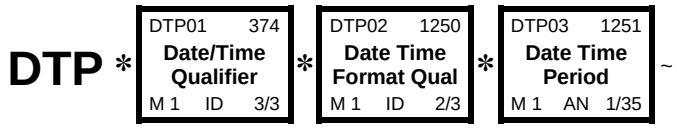
Loop: **2300 — CLAIM INFORMATION**

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: **434** — DEFINITION: **Statement**	
REQUIRED	**DTP02**	**1250**	**Date Time Period Format Qualifier** Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03.	**M 1 ID 2/3**
			CODE: **RD8** — DEFINITION: **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**

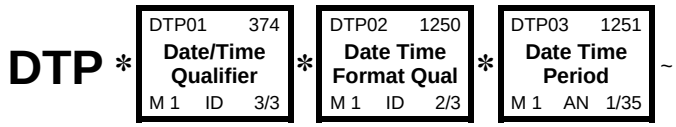
Segment Repeat: **1**

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 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.**	**M 1 ID 2/3**
			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**

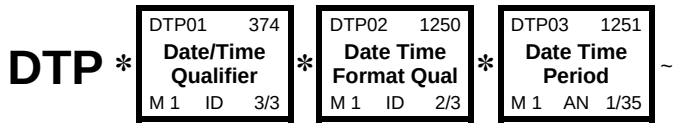
Segment Repeat: **1**

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 **SEMANTIC:** DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8 Date Expressed in Format CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 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

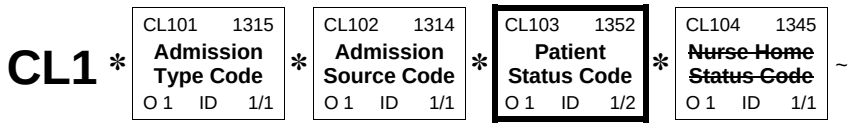
Loop: **2300 — CLAIM INFORMATION**

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **CL1*1*7*30~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**CL101**	**1315**	**Admission Type Code** Code indicating the priority of this admission	**O 1 ID 1/1**
			SITUATIONAL RULE: ***Required when patient is being admitted for inpatient services. If not required by this implementation guide, do not send.***	
			CODE SOURCE **231:** Admission Type Code	
SITUATIONAL	**CL102**	**1314**	**Admission Source Code** Code indicating the source of this admission	**O 1 ID 1/1**
			SITUATIONAL RULE: ***Required for all inpatient and outpatient services. If not required by this implementation guide, do not send.***	
			CODE SOURCE **230:** Admission Source Code	
REQUIRED	**CL103**	**1352**	**Patient Status Code** Code indicating patient status as of the “statement covers through date”	**O 1 ID 1/2**
			CODE SOURCE **239:** Patient Status Code	
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**

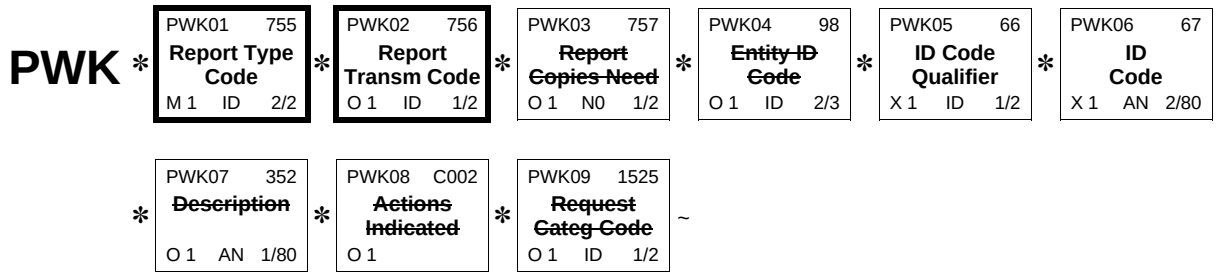
Segment Repeat: **10**

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**	**N0**	**1/2**
NOT USED	**PWK04**	**98**	**Entity Identifier Code**		**O 1**	**ID**	**2/3**
SITUATIONAL	**PWK05**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0506 COMMENT: PWK05 and PWK06 may be used to identify the addressee by a code number. SITUATIONAL RULE: ***Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.***		**X 1**	**ID**	**1/2**
			CODE	**DEFINITION**			
			AC	**Attachment Control Number**			
SITUATIONAL	**PWK06**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0506 SITUATIONAL RULE: ***Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.*** 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.**		**X 1**	**AN**	**2/80**
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**

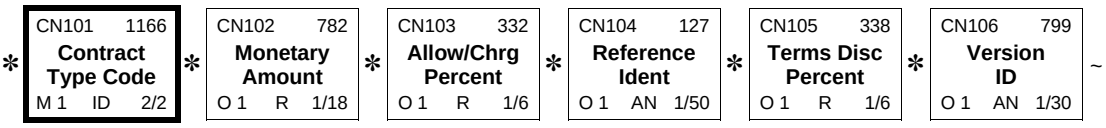
Situational Rule: **Required when the submitter is contractually obligated to supply this information on post-adjudicated claims. If not required by this implementation guide, do not send.**

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**

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

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
SITUATIONAL	**CN102**	**782**	**Monetary Amount** Monetary amount	**O 1 R 1/18**

SEMANTIC: CN102 is the contract amount.

SITUATIONAL RULE: ***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.***

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: ***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.***

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: ***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.***

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: ***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.***

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: ***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.***

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**

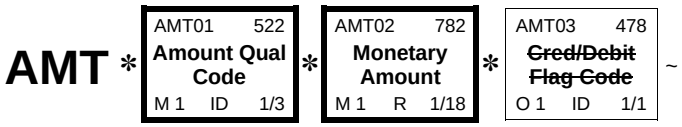
Segment Repeat: **1**

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** Code to qualify amount	**M 1 ID 1/3**
			CODE: **F3** — DEFINITION: **Patient Responsibility - Estimated**	
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount	**M 1 R 1/18**
			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**

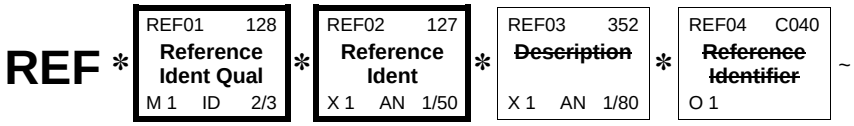
Segment Repeat: **1**

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**
			CODE: **4N** DEFINITION: **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 SYNTAX: R0203 IMPLEMENTATION NAME: **Service Authorization Exception Code**	**X 1 AN 1/50**

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**

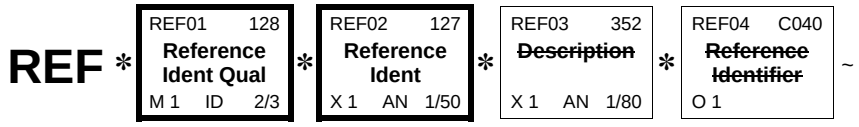
Usage: **SITUATIONAL**

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 CODE / DEFINITION **9F** **Referral Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Referral 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 - 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**

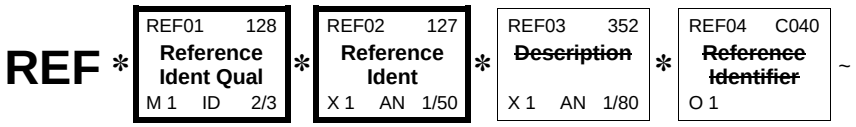
Situational Rule: **Required when an authorization number is assigned by the payer or UMO AND
the services on this claim were preauthorized.
If not required by this implementation guide, do not send.**

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 **IMPLEMENTATION NAME: Prior Authorization 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 - 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**

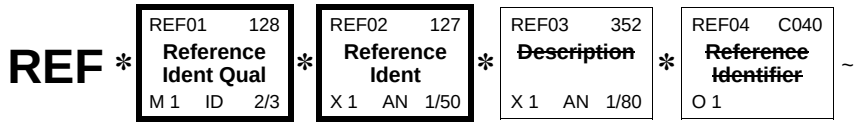
Usage: **SITUATIONAL**

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 CODE / DEFINITION **F8** **Original Reference Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Payer Claim Control 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 - 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**

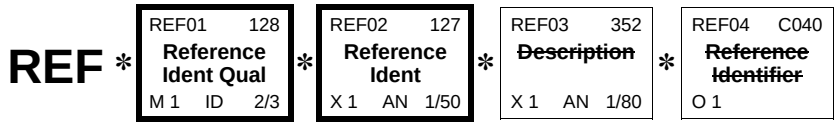
Usage: **SITUATIONAL**

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*RJ55555~**

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: **9A** DEFINITION: **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**

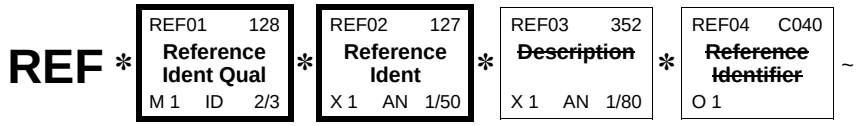
Usage: **SITUATIONAL**

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*RP44444444~**

DIAGRAM



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification CODE / DEFINITION **9C** **Adjusted Repriced Claim Reference Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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**

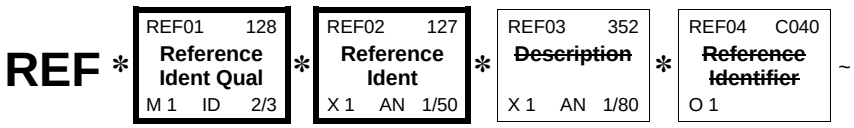
Segment Repeat: **5**

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 CODE / DEFINITION **LX** — **Qualified Products List**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Investigational Device Exemption 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 - 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**

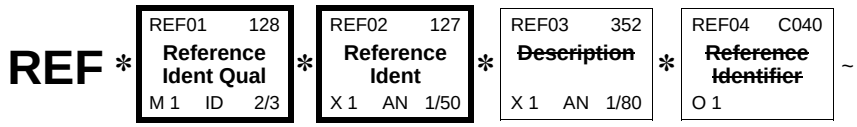
Usage: **SITUATIONAL**

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**

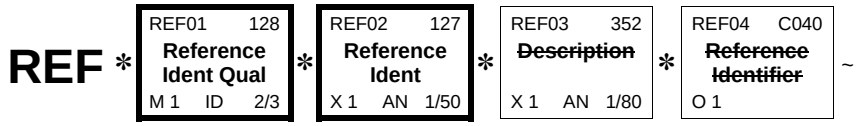
Segment Repeat: **1**

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 CODE / DEFINITION **LU** **Location Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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**

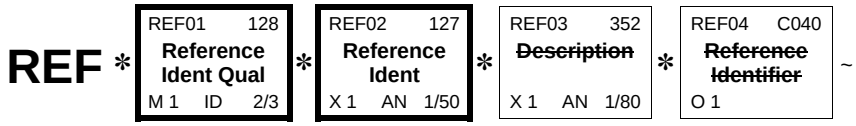
Segment Repeat: **1**

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 SYNTAX: R0203 IMPLEMENTATION NAME: **Medical Record 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 - 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**

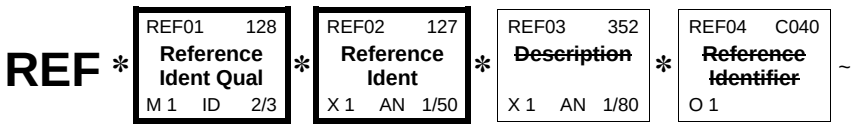
Segment Repeat: **1**

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 CODE / DEFINITION **P4** **Project Code**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Demonstration Project 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 - 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**

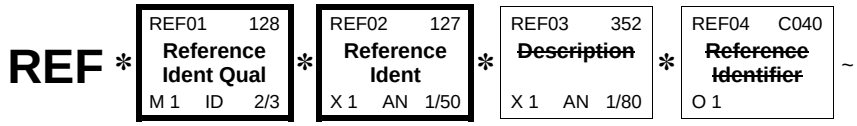
Segment Repeat: **1**

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 CODE / DEFINITION **G4** — **Peer Review Organization (PRO) Approval Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Peer Review Authorization 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

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.**

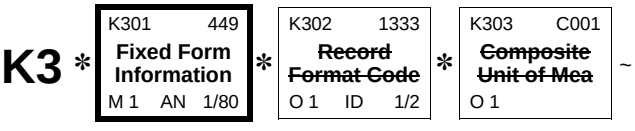
If not required by this implementation guide, do not send.

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 processable. 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**

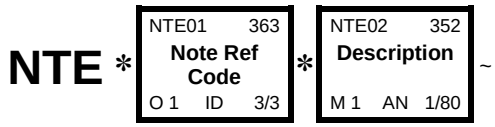
Usage: **SITUATIONAL**

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**

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** A free-form description to clarify the related data elements and their content		**M 1**	**AN**	**1/80**
			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 processable. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.

Loop: **2300 — CLAIM INFORMATION**

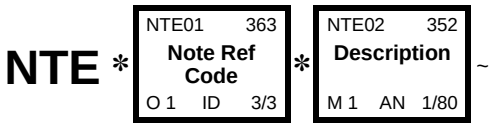
Segment Repeat: **1**

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: **ADD** — DEFINITION: **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**

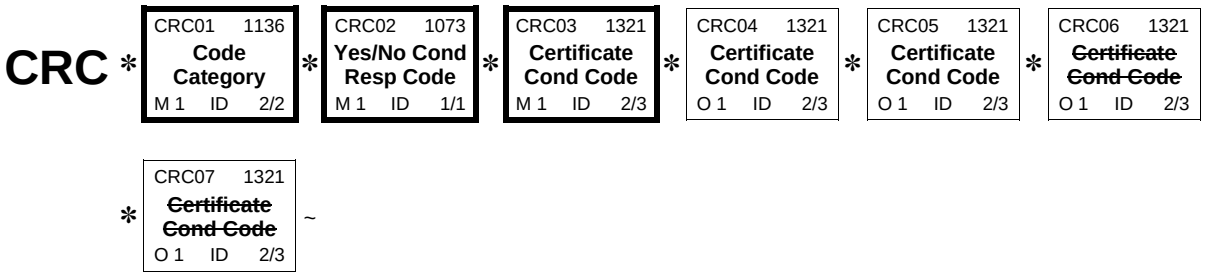
Segment Repeat: **1**

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. **IMPLEMENTATION NAME:** **Code Qualifier**	**M 1 ID 2/2**

CODE	DEFINITION
ZZ	**Mutually Defined**
	EPSDT Screening referral information.

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

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** **M 1 ID 2/3**
Code indicating a condition

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** **O 1 ID 2/3**
Code indicating a condition

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

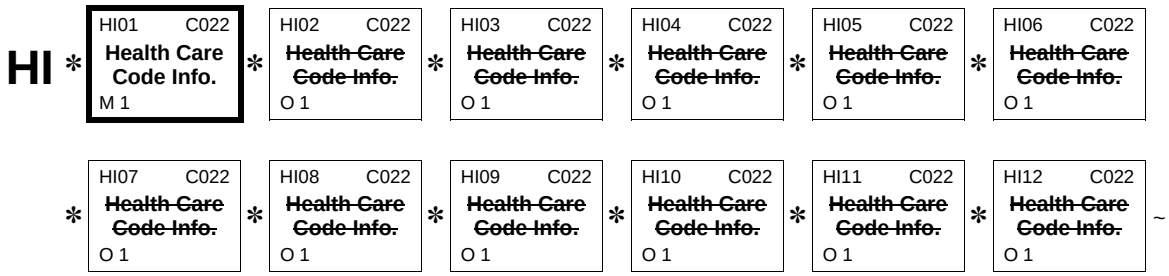
Usage: **REQUIRED**

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** 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.	**M 1**
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
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** 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: **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** 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	
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**

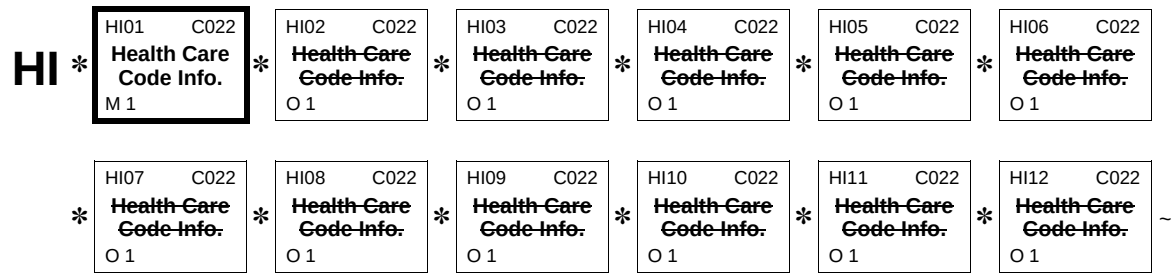
Situational Rule: **Required when claim involves an inpatient admission.**
If not required by this implementation guide, do not send.

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** 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.	**M 1**

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
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 SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: **Admitting Diagnosis Code**	**M**	**AN**	**1/30**
NOT USED	**HI01 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**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.**

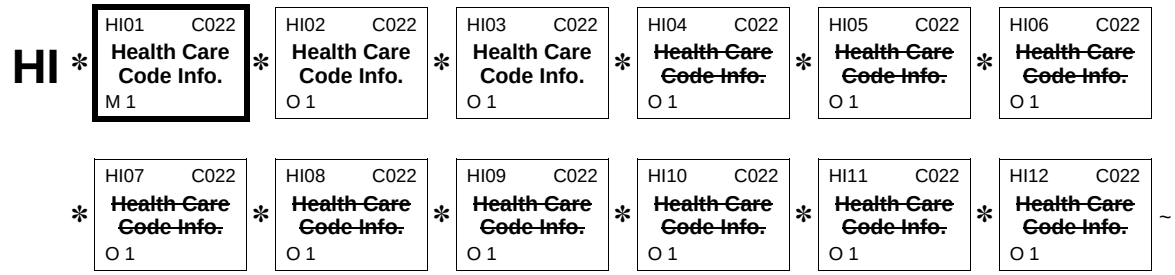
TR3 Notes:

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** 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.	**M 1**

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
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 **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: **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** **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	**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
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** 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	**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** 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 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**

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	**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: Patient Reason For Visit**	**M**	**AN**	**1/30**
NOT USED	**HI03 - 3**	**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI03 - 4**	**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI03 - 5**	**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI03 - 6**	**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI03 - 7**	**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**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.**

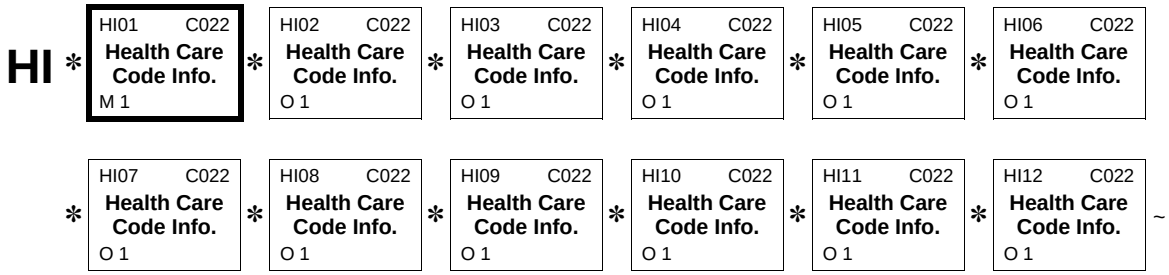
TR3 Notes:

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** 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.	**M 1**

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
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 **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: **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** **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
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** **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: **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.

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** **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
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 **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: **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** **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
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** **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: **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** **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
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 **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: **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** **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
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 **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: **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** **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
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** **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: **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** **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
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 **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: **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** **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
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 **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: 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** **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
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 **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: **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** **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
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 **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: **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**

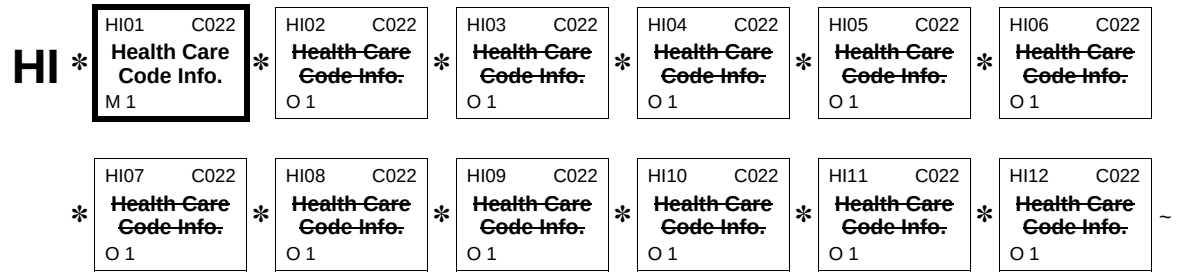
Segment Repeat: **1**

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** 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.	**M 1**
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
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 **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**	**M**	**AN**	**1/30**
NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**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.**

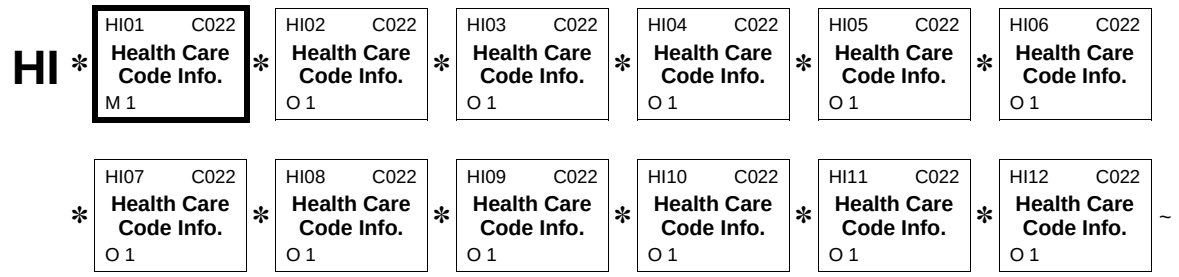
TR3 Notes:

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** 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.	**M 1**

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 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	HI03	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 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** **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 **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: **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** **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 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** 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	**HI05**	**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 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 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	HI07	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 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** **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 **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: **Other Diagnosis**

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 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** 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	**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 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** **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 **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: **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** **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 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 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

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.**

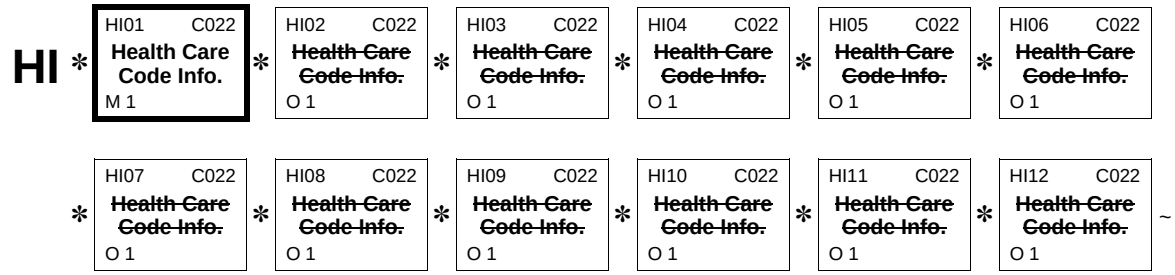
TR3 Notes:

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*BBR:0B110F5:D8:20050321~**

DIAGRAM



ELEMENT DETAIL

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

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
BBR	**International Classification of Diseases Clinical Modification (ICD-10-PCS) Principal 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)
BR	**International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure Codes**
	CODE SOURCE **131:** International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
CAH	**Advanced Billing Concepts (ABC) Codes**
	CODE SOURCE **843:** Advanced Billing Concepts (ABC) 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: **Principal Procedure 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.

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: **Principal 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**

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.**

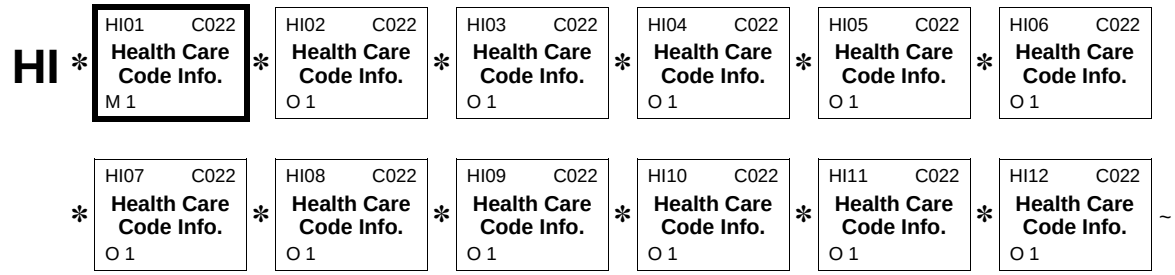
TR3 Notes:

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** 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.	**M 1**

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
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** **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 **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.

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: **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: ***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 **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.
	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 **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** **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 **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 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 **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
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 **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: **Procedure 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
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: ***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 **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
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 **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: ***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 **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
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 **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: **Procedure 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
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: **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: ***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 **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
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 **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.

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**

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	**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: ***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 **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**
	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 **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: ***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 **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
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** **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 **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.

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: **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: ***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 **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** **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	**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)

REQUIRED	**HI11 - 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 **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** 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	**HI12 - 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	**HI12 - 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	**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**

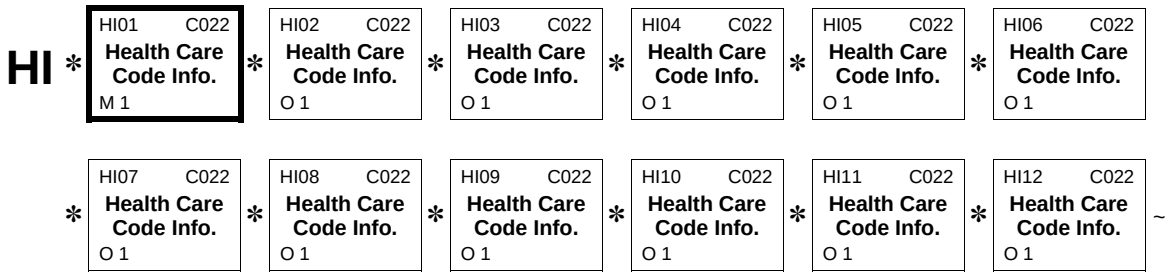
Segment Repeat: **2**

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** 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.	**M 1**
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
BI	**Occurrence Span** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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. **IMPLEMENTATION NAME:** **Occurrence Span Code**	**M AN 1/30**

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.

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

REQUIRED **HI01 - 4** **1251** **Date Time Period** **X AN 1/35**
Expression of a date, a time, or range of dates, times or dates and times

SYNTAX:
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 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 **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 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.

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.

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: ***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 **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.

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: ***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 **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
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.

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.

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.

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: ***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 **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
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.

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.

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.

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.

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: ***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 **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**

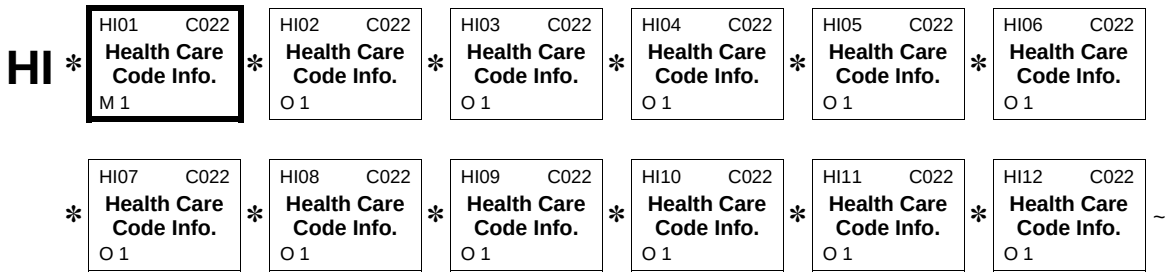
Segment Repeat: **2**

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** 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.	**M 1**
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 **BH** — **DEFINITION** **Occurrence** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. **IMPLEMENTATION NAME:** **Occurrence Code**	**M AN 1/30**

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.

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.

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: ***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 **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.

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.

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: ***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 **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.

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.

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: ***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 **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.

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.

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.

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.

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: ***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 **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.

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.

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** 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	**HI12 - 4**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times **SYNTAX:** P0304 **IMPLEMENTATION NAME: Occurrence Code Date**	**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 - 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**

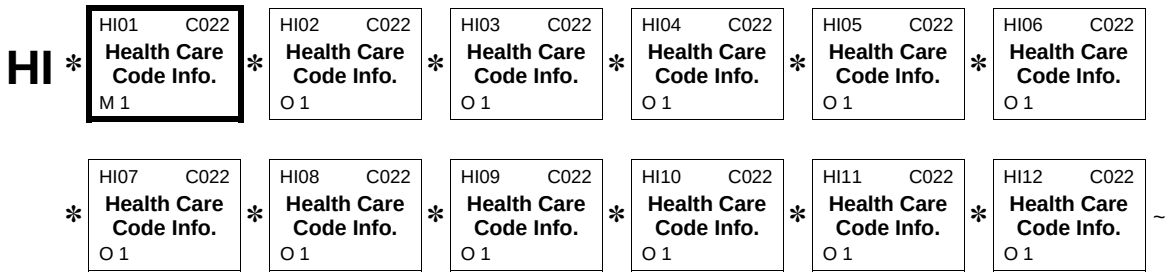
Segment Repeat: **2**

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** 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.	**M 1**
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** **BE** **Value** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. **IMPLEMENTATION NAME:** **Value Code**	**M AN 1/30**

NOT USED	HI01 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI01 - 4		1251	Date Time Period	X	AN	1/35
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 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	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
BE	Value

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

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

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: ***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	**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.

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: ***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 **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 **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. **IMPLEMENTATION NAME: Value Code**	**M**	**AN**	**1/30**
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 **IMPLEMENTATION NAME: Value Code 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** 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.***	**O**	**1**	
REQUIRED	**HI06 - 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. **CODE** **DEFINITION** **BE** **Value** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes	**M**	**ID**	**1/3**
REQUIRED	**HI06 - 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: Value Code**	**M**	**AN**	**1/30**
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 **IMPLEMENTATION NAME: Value Code 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 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 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
BE	**Value**

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

REQUIRED	HI07 - 2		1271	Industry Code Code indicating a code from a specific industry code list	M	AN	1/30

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 Monetary amount	O	R	1/18

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.

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 - 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
BE	**Value**

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

REQUIRED	**HI09 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				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** Monetary amount	**O**	**R**	**1/18**
				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** 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	**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**			
				BE **Value**			
				CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
REQUIRED	**HI10 - 2**		**1271**	**Industry Code** Code indicating a code from a specific industry code list	**M**	**AN**	**1/30**
				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** Monetary amount	**O**	**R**	**1/18**
				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 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
BE	**Value**

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

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

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 Monetary amount	O	R	1/18

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. **CODE** **DEFINITION** **BE** **Value** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes	**M**	**ID**	**1/3**
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. **IMPLEMENTATION NAME: Value Code**	**M**	**AN**	**1/30**
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 **IMPLEMENTATION NAME: Value Code 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 - 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**

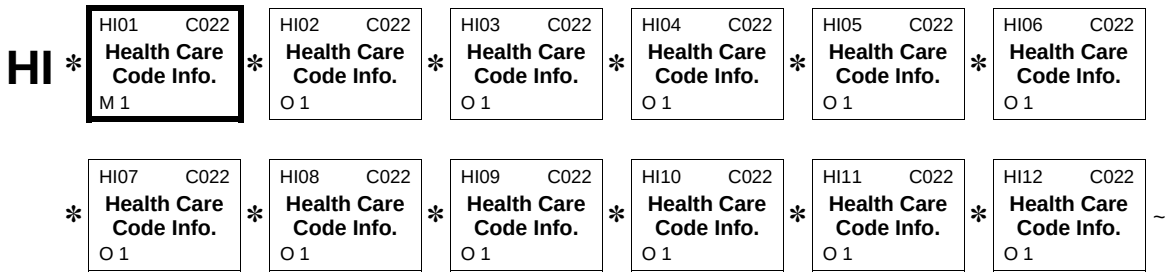
Segment Repeat: **2**

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** 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.	**M 1**
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** **BG** **Condition** **CODE SOURCE 132:** National Uniform Billing Committee (NUBC) Codes	
REQUIRED	**HI01 - 2**	**1271**	**Industry Code** Code indicating a code from a specific industry code list **SEMANTIC:** If C022-08 is used, then C022-02 represents the beginning value in a range of codes. **IMPLEMENTATION NAME:** **Condition Code**	**M AN 1/30**

NOT USED	HI01 - 3		1250	Date Time Period Format Qualifier	X	ID	2/3
NOT USED	HI01 - 4		1251	Date Time Period	X	AN	1/35
NOT USED	HI01 - 5		782	Monetary Amount	O	R	1/18
NOT USED	HI01 - 6		380	Quantity	O	R	1/15
NOT USED	HI01 - 7		799	Version Identifier	O	AN	1/30
NOT USED	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 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
BG	Condition

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

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

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: ***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 **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
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: ***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 **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	**Condition**

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: **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	**Condition**

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: **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.

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** **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 **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: **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** **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 **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
BG	**Condition**

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: **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 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
BG	Condition

CODE SOURCE **132:** National Uniform Billing Committee (NUBC) Codes

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

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: ***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 **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: ***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	**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. **IMPLEMENTATION NAME: Condition Code**	**M**	**AN**	**1/30**
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**

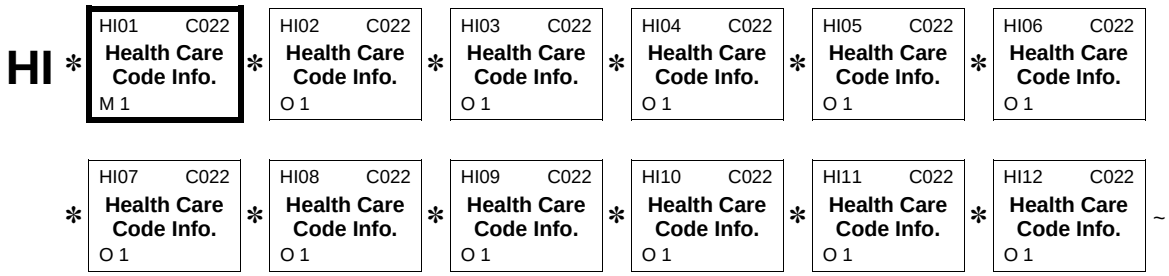
Segment Repeat: **2**

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** 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
TC	**Treatment Codes** **CODE SOURCE 359:** Treatment Codes

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. **IMPLEMENTATION NAME: Treatment Code**	**M**	**AN**	**1/30**
NOT USED	**HI01 - 3**		**1250**	**Date Time Period Format Qualifier**	**X**	**ID**	**2/3**
NOT USED	**HI01 - 4**		**1251**	**Date Time Period**	**X**	**AN**	**1/35**
NOT USED	**HI01 - 5**		**782**	**Monetary Amount**	**O**	**R**	**1/18**
NOT USED	**HI01 - 6**		**380**	**Quantity**	**O**	**R**	**1/15**
NOT USED	**HI01 - 7**		**799**	**Version Identifier**	**O**	**AN**	**1/30**
NOT USED	**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 **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.***	**O**	**1**	
REQUIRED	**HI02 - 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. **CODE** **DEFINITION** **TC** **Treatment Codes** **CODE SOURCE 359:** Treatment Codes	**M**	**ID**	**1/3**
REQUIRED	**HI02 - 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: Treatment Code**	**M**	**AN**	**1/30**
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 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	**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.

CODE	DEFINITION
TC	**Treatment Codes**

CODE SOURCE **359:** Treatment Codes

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

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: ***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	**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
TC	**Treatment Codes**

CODE SOURCE 359: Treatment Codes

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

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** 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	**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.

CODE	DEFINITION
TC	**Treatment Codes**

CODE SOURCE 359: Treatment Codes

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

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** 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	**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: 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** 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	**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.

CODE	DEFINITION
TC	**Treatment Codes**

CODE SOURCE 359: Treatment Codes

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

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** 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	**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: 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** 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	**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
TC	**Treatment Codes**

CODE SOURCE 359: Treatment Codes

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

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 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	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: **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**

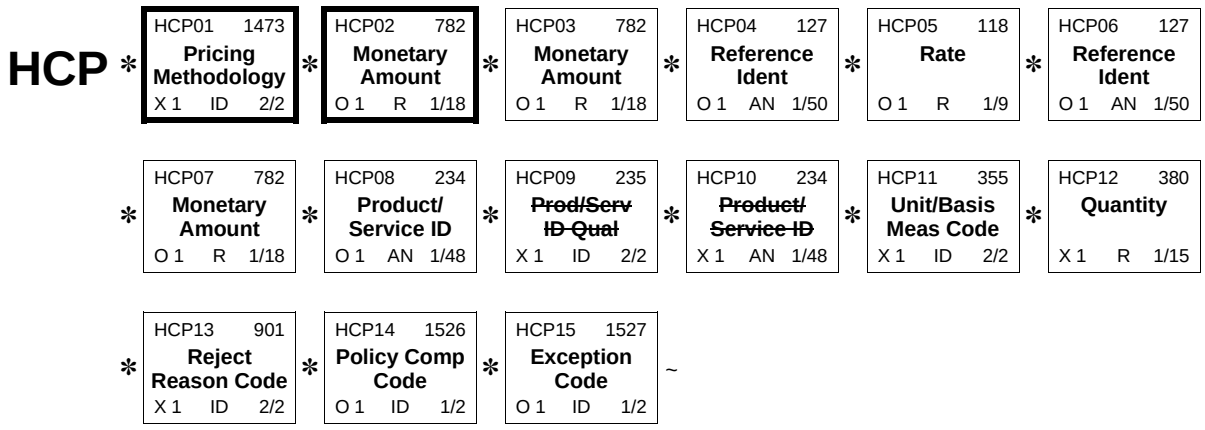
Situational Rule: **Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.**

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**
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: ***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: **Repriced Saving Amount** **This information is specific to the destination payer reported in Loop ID-2010BB.**	**O 1 R 1/18**

CODE	DEFINITION
00	**Zero Pricing (Not Covered Under Contract)**
01	**Priced as Billed at 100%**
02	**Priced at the Standard Fee Schedule**
03	**Priced at a Contractual Percentage**
04	**Bundled Pricing**
05	**Peer Review Pricing**
06	**Per Diem Pricing**
07	**Flat Rate Pricing**
08	**Combination Pricing**
09	**Maternity Pricing**
10	**Other Pricing**
11	**Lower of Cost**
12	**Ratio of Cost**
13	**Cost Reimbursed**
14	**Adjustment Pricing**

SITUATIONAL **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: ***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: **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: ***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: **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: ***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: **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: ***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: **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	**O 1**	**AN**	**1/48**

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: **Repriced Approved Revenue Code**

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

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	**X 1**	**ID**	**2/2**

SYNTAX: P1112

SITUATIONAL RULE: ***Required when HCP12 exists. If not required by this implementation guide, do not send.***

CODE	DEFINITION
DA	**Days**
UN	**Unit**

SITUATIONAL	**HCP12**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

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.***

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.

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**

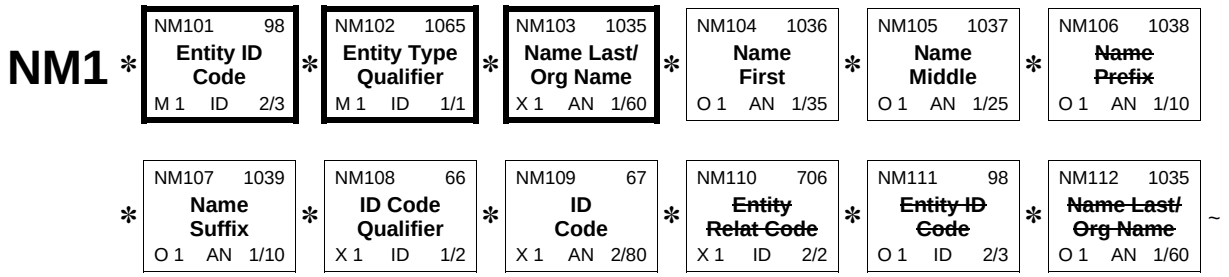
Usage: **SITUATIONAL**

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	**M 1**	**ID**	**1/1**

SEMANTIC: NM102 qualifies NM103.

CODE	DEFINITION
1	**Person**

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**X 1**	**AN**	**1/60**

SYNTAX: C1203

IMPLEMENTATION NAME: **Attending Provider Last Name**

SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name	**O 1**	**AN**	**1/35**

SITUATIONAL RULE: ***Required when the person has a first name. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Attending Provider First Name**

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

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Attending 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	**O 1**	**AN**	**1/10**

SITUATIONAL RULE: ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Attending 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:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X 1**	**ID**	**1/2**
			CODE / **DEFINITION** **XX** — **Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Attending Provider Primary 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

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**

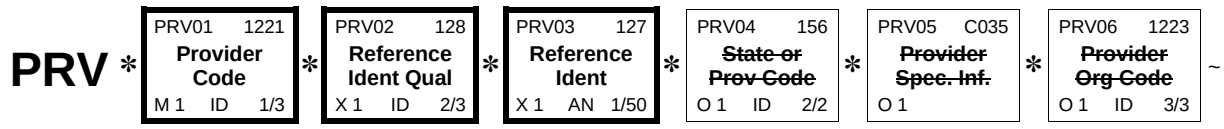
Segment Repeat: **1**

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 CODE: **AT** DEFINITION: **Attending**	**M 1 ID 1/3**
REQUIRED	**PRV02**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification SYNTAX: P0203 CODE: **PXC** DEFINITION: **Health Care Provider Taxonomy Code** CODE SOURCE **682:** Health Care Provider Taxonomy	**X 1 ID 2/3**
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

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**

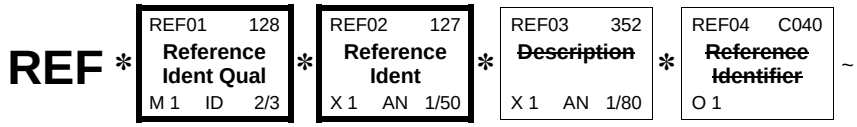
Segment Repeat: **4**

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**

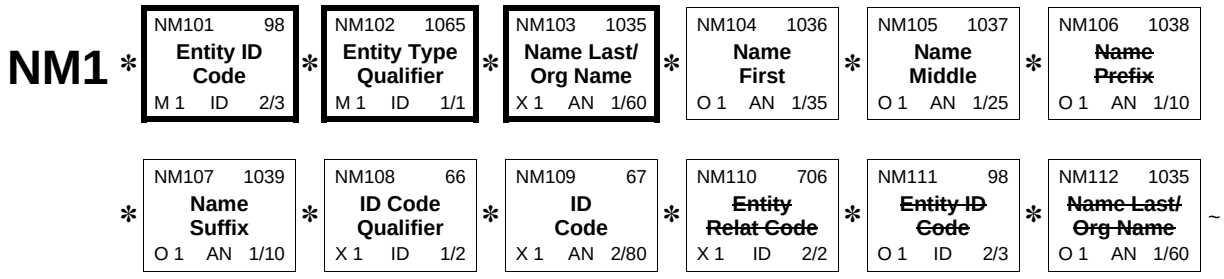
Situational Rule: **Required when a surgical procedure code is listed on this claim. If not required by this implementation guide, do not send.**

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 CODE: **72** DEFINITION: **Operating Physician**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE: **1** DEFINITION: **Person**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Operating Physician Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Operating Physician First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME: 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:** ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: 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)	**X 1**	**ID**	**1/2**

SYNTAX: P0809

SITUATIONAL RULE: ***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.***
OR
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.
OR
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.
If not required by this implementation guide, do not send.

CODE	DEFINITION
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X 1**	**AN**	**2/80**

SYNTAX: P0809

SITUATIONAL RULE: ***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.***
OR
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.
OR
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.
If not required by this implementation guide, do not send.

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**

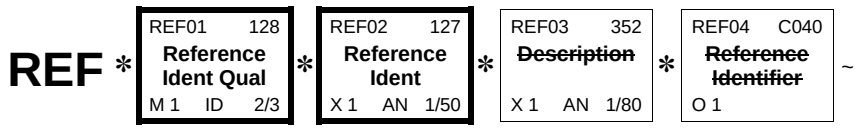
Segment Repeat: **4**

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**

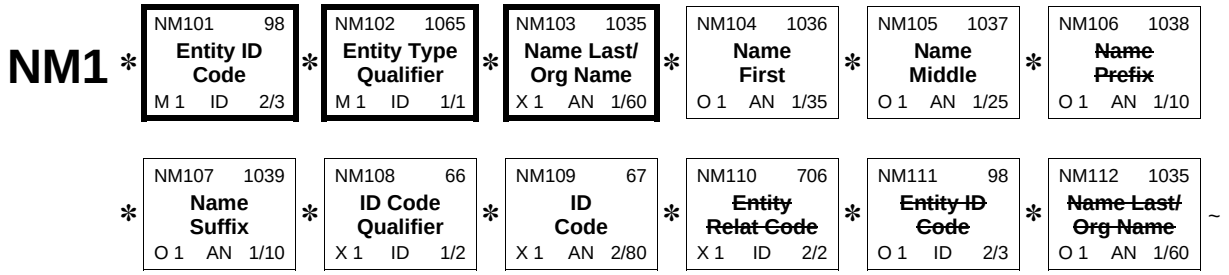
Situational Rule: **Required when another Operating Physician is involved. If not required by the implementation guide, do not send.**

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**
			CODE: **ZZ** DEFINITION: **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**
			CODE: **1** DEFINITION: **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	**O 1 AN 1/35**
			SITUATIONAL RULE: ***Required when the person has a first name. If not required by this implementation guide, do not send.***	
			IMPLEMENTATION NAME: **Other Operating Physician First Name**	
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O 1 AN 1/25**
			SITUATIONAL RULE: ***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.***	
			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	**O 1 AN 1/10**
			SITUATIONAL RULE: ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.***	
			IMPLEMENTATION NAME: **Other 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:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X 1**	**ID**	**1/2**

CODE	DEFINITION
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Other Operating Physician 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

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**

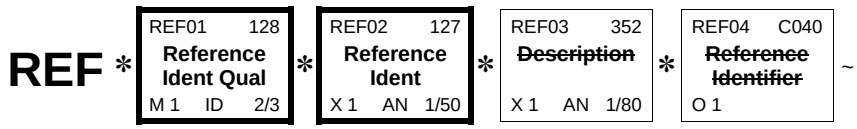
Segment Repeat: **4**

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**

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**

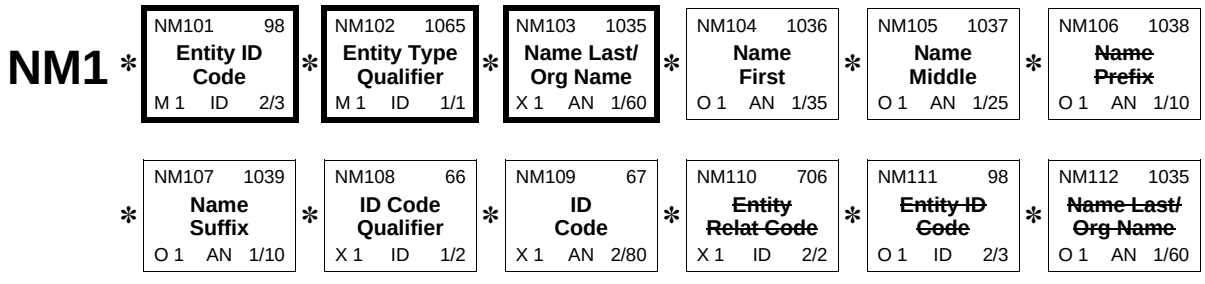
Usage: **SITUATIONAL**

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 CODE: **82** DEFINITION: **Rendering Provider**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE: **1** DEFINITION: **Person**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Rendering Provider Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Rendering Provider First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME: Rendering 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:** ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Rendering Provider 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:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X 1**	**ID**	**1/2**
			CODE / **DEFINITION** **XX** — **Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Rendering 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

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**

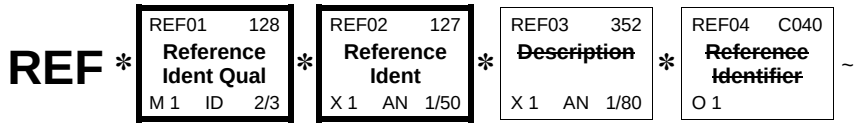
Segment Repeat: **4**

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**

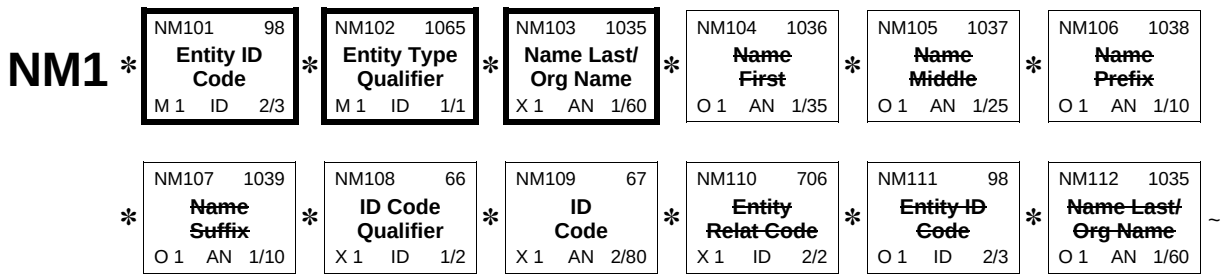
Situational Rule: **Required when the location of health care service is different than that carried in Loop ID-2010AA (Billing Provider).**
If not required by this implementation guide, do not send.

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 CODE: **77** — DEFINITION: **Service Location**	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: **2** — DEFINITION: **Non-Person Entity**	M 1 ID 1/1
REQUIRED	NM103	1035	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: **Laboratory or Facility 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
SITUATIONAL	NM108	66	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SYNTAX: P0809 SITUATIONAL RULE: ***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.*** CODE: **XX** — DEFINITION: **Centers for Medicare and Medicaid Services National Provider Identifier** CODE SOURCE **537:** Centers for Medicare and Medicaid Services National Provider Identifier	X 1 ID 1/2
SITUATIONAL	NM109	67	**Identification Code** Code identifying a party or other code SYNTAX: P0809 SITUATIONAL RULE: ***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.*** IMPLEMENTATION NAME: **Laboratory or Facility Primary 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 - 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**

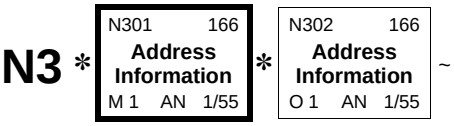
Usage: **REQUIRED**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***			
			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:

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.

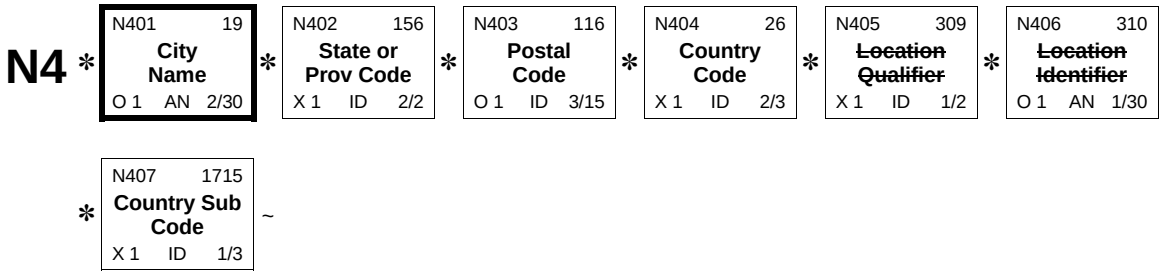
Loop: **2310E — SERVICE FACILITY LOCATION NAME**

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 **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**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

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

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Laboratory or Facility State or Province Code**

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***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.***

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.

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***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.***

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

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**

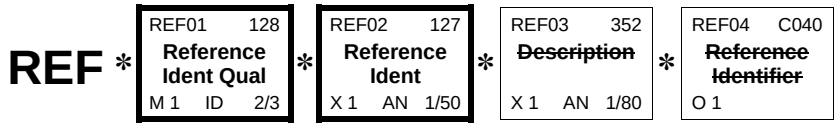
Segment Repeat: **3**

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 **IMPLEMENTATION NAME: Laboratory or Facility 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 - 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:

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: **2310F — REFERRING PROVIDER NAME Loop Repeat: 1**

Segment Repeat: **2**

Usage: **SITUATIONAL**

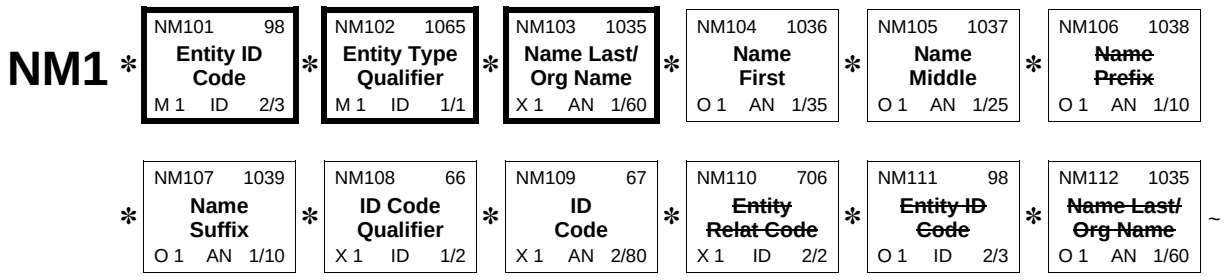
Situational Rule: **Required on an outpatient claim when the Referring Provider is different than the Attending Provider. If not required by this implementation guide, do not send.**

TR3 Notes:

1. **The Referring Provider is provider who sends the patient to another provider for services.**
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*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 CODE / DEFINITION **DN** — **Referring Provider**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** — **Person**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Referring Provider Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Referring Provider First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME: Referring 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:** ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Referring Provider 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:** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X**	**1**	**ID**	**1/2**

CODE	DEFINITION
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Referring 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

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**

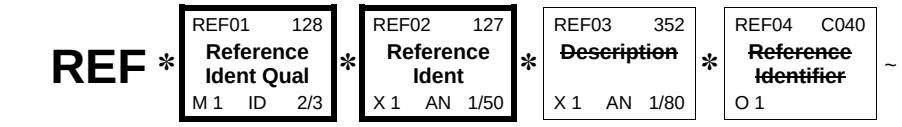
Usage: **SITUATIONAL**

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**

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** 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**		**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

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**

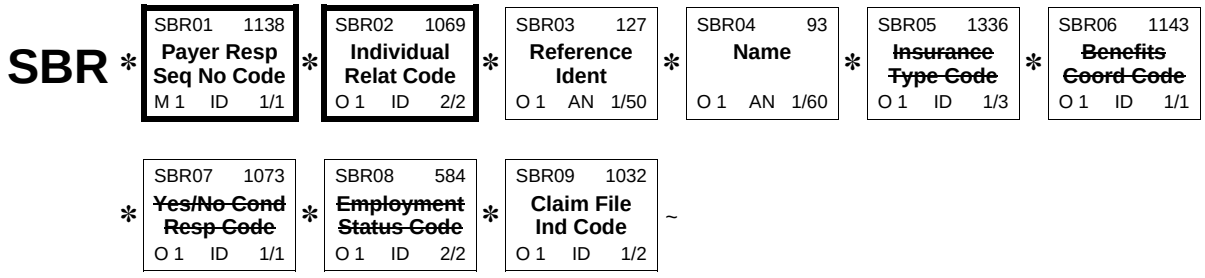
Usage: **SITUATIONAL**

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	**O 1**	**AN**	**1/50**

SEMANTIC: SBR03 is policy or group number.

SITUATIONAL RULE: ***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 implemetation guide, do not send.***

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.

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

SEMANTIC: SBR04 is plan name.

SITUATIONAL RULE: ***Required when SBR03 is not used and the group name is available. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Other Insured 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** Code identifying type of claim	**O 1**	**ID**	**1/2**

SITUATIONAL RULE: ***Required prior to mandated use of the HIPAA National Plan ID. If not required by this implementation guide, do not send.***

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.**

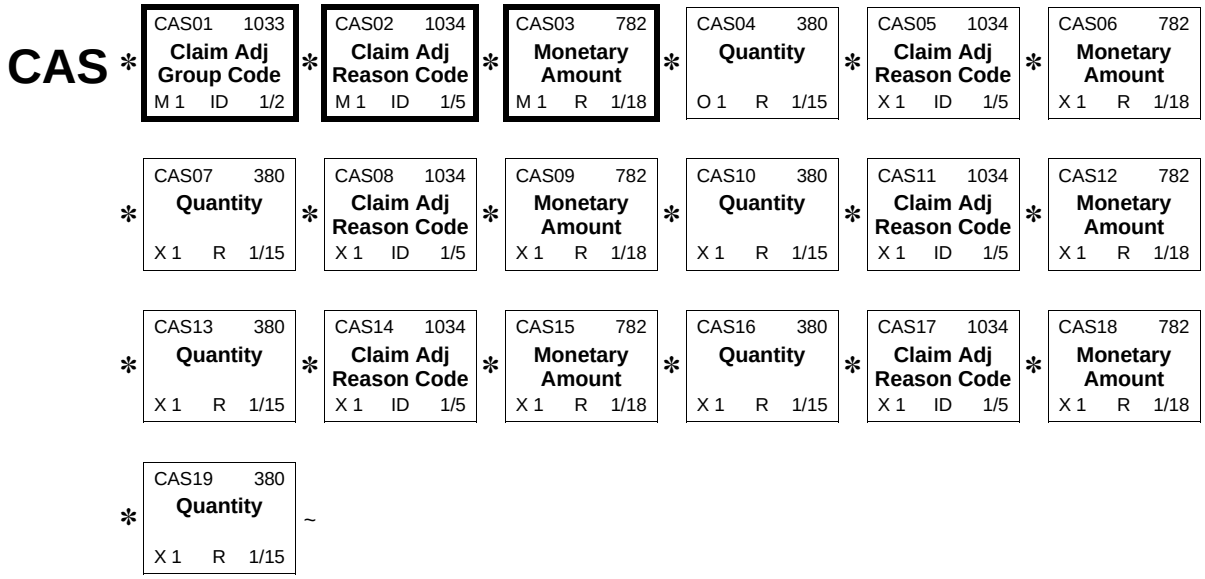
TR3 Notes:

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**

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 IMPLEMENTATION NAME: **Adjustment Reason Code** CODE SOURCE **139:** Claim Adjustment Reason Code **See CODE SOURCE 139: Claim Adjustment Reason Code**	**M 1 ID 1/5**
REQUIRED	**CAS03**	**782**	**Monetary Amount** Monetary amount SEMANTIC: CAS03 is the amount of adjustment. IMPLEMENTATION NAME: **Adjustment Amount**	**M 1 R 1/18**
SITUATIONAL	**CAS04**	**380**	**Quantity** Numeric value of quantity 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**	**O 1 R 1/15**
SITUATIONAL	**CAS05**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made 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 claim 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	**X 1 ID 1/5**
SITUATIONAL	**CAS06**	**782**	**Monetary Amount** Monetary amount 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**	**X 1 R 1/18**

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** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L080910, C0908, C1008

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Adjustment Reason Code**

CODE SOURCE 139: Claim Adjustment Reason Code

SITUATIONAL	**CAS09**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

SYNTAX: L080910, C0908

SEMANTIC: CAS09 is the amount of the adjustment.

SITUATIONAL RULE: ***Required when CAS08 is present. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Adjustment Amount**

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

SYNTAX: L080910, C1008

SEMANTIC: CAS10 is the units of service being adjusted.

SITUATIONAL RULE: ***Required when CAS08 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	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L111213, C1211, C1311

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Adjustment Reason Code**

CODE SOURCE 139: Claim Adjustment Reason Code

SITUATIONAL	**CAS12**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

SYNTAX: L111213, C1211

SEMANTIC: CAS12 is the amount of the adjustment.

SITUATIONAL RULE: ***Required when CAS11 is present. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Adjustment Amount**

SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

SYNTAX: L111213, C1311

SEMANTIC: CAS13 is the units of service being adjusted.

SITUATIONAL RULE: ***Required when CAS11 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	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L141516, C1514, C1614

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Adjustment Reason Code**

CODE SOURCE 139: Claim Adjustment Reason Code

SITUATIONAL	**CAS15**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

SYNTAX: L141516, C1514

SEMANTIC: CAS15 is the amount of the adjustment.

SITUATIONAL RULE: ***Required when CAS14 is present. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Adjustment Amount**

SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

SYNTAX: L141516, C1614

SEMANTIC: CAS16 is the units of service being adjusted.

SITUATIONAL RULE: ***Required when CAS14 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	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L171819, C1817, C1917

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Adjustment Reason Code**

CODE SOURCE 139: Claim Adjustment Reason Code

SITUATIONAL	**CAS18**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

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** Numeric value of quantity	**X 1**	**R**	**1/15**

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

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**

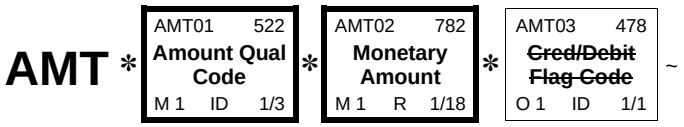
Segment Repeat: **1**

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 CODE: **D** — DEFINITION: **Payor Amount Paid**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount 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.**	**M 1 R 1/18**
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**

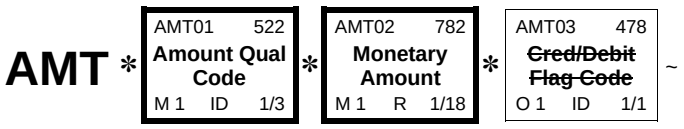
Situational Rule: **Required when the Other Payer identified in Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this claim and provided claim level information only.**
OR
Required when the Other Payer identified in Loop ID-2330B (of this iteration of Loop ID-2320) has adjudicated this 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 CODE / DEFINITION **EAF** **Amount Owed**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Remaining Patient Liability**	**M 1 R 1/18**
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**

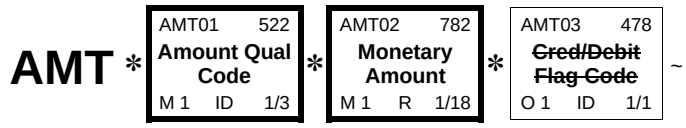
Situational Rule: **Required when the destination payer's cost avoidance policy allows providers to bypass claim submission to the otherwise prior payer identified in Loop ID-2330B. If not required by this implementation guide, do not send.**

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 CODE / DEFINITION **A8 — Noncovered Charges - Actual**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Non-Covered Charge Amount**	**M 1 R 1/18**
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**

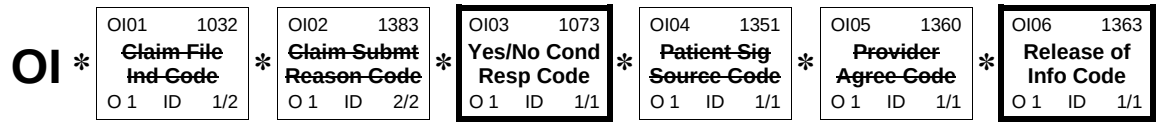
Usage: **REQUIRED**

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** **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

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**

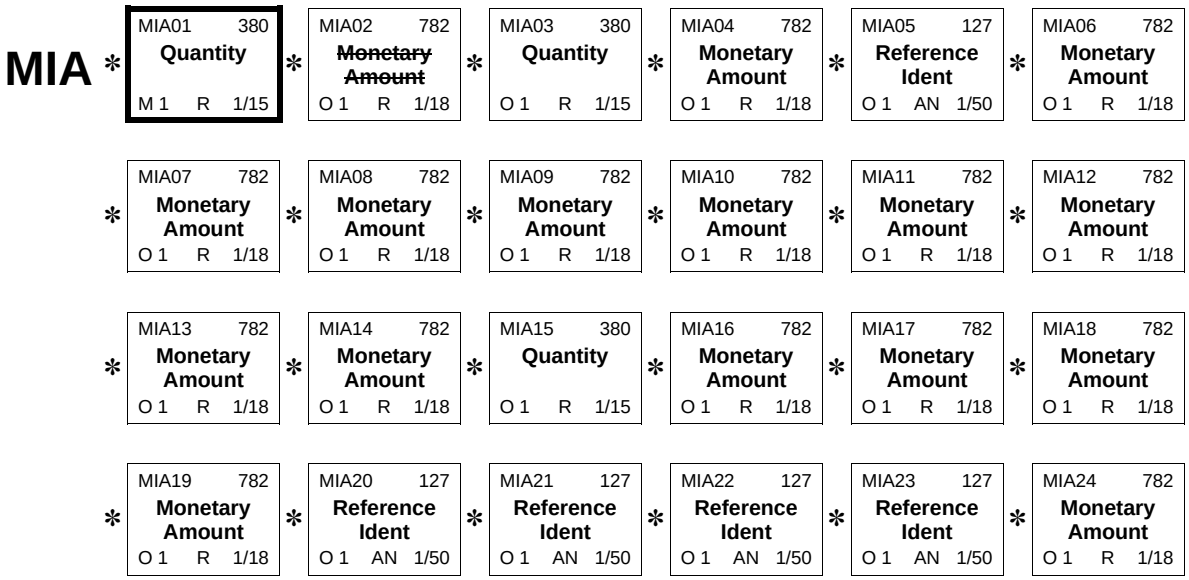
Segment Repeat: **1**

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	**O 1**	**R**		**1/15**

SEMANTIC: MIA03 is the lifetime psychiatric days.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Lifetime Psychiatric Days Count**

SITUATIONAL	**MIA04**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA04 is the Diagnosis Related Group (DRG) amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim DRG Amount**

SITUATIONAL	**MIA05**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O 1**	**AN**		**1/50**

SEMANTIC: MIA05 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MIA06**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA06 is the disproportionate share amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Disproportionate Share Amount**

SITUATIONAL	**MIA07**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA07 is the Medicare Secondary Payer (MSP) pass-through amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim MSP Pass-through Amount**

SITUATIONAL	**MIA08**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA08 is the total Prospective Payment System (PPS) capital amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim PPS Capital Amount**

SITUATIONAL	**MIA09**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**	**1/18**

SEMANTIC: MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **PPS-Capital FSP DRG Amount**

SITUATIONAL	**MIA10**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**	**1/18**

SEMANTIC: MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **PPS-Capital HSP DRG Amount**

SITUATIONAL	**MIA11**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**	**1/18**

SEMANTIC: MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **PPS-Capital DSH DRG Amount**

SITUATIONAL	**MIA12**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**	**1/18**

SEMANTIC: MIA12 is the old capital amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Old Capital Amount**

SITUATIONAL	**MIA13**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**	**1/18**

SEMANTIC: MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **PPS-Capital IME amount**

SITUATIONAL	**MIA14**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**	**1/18**

SEMANTIC: MIA14 is hospital specific Diagnosis Related Group (DRG) Amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **PPS-Operating Hospital Specific DRG Amount**

SITUATIONAL	**MIA15**	**380**	**Quantity** Numeric value of quantity	**O 1**	**R**		**1/15**

SEMANTIC: MIA15 is the cost report days.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Cost Report Day Count**

SITUATIONAL	**MIA16**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA16 is the federal specific Diagnosis Related Group (DRG) amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **PPS-Operating Federal Specific DRG Amount**

SITUATIONAL	**MIA17**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim PPS Capital Outlier Amount**

SITUATIONAL	**MIA18**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA18 is the indirect teaching amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Indirect Teaching Amount**

SITUATIONAL	**MIA19**	**782**	**Monetary Amount** Monetary amount	**O 1**	**R**		**1/18**

SEMANTIC: MIA19 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**

SITUATIONAL	**MIA20**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O 1**	**AN**		**1/50**

SEMANTIC: MIA20 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MIA21**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MIA21 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MIA22**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MIA22 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MIA23**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MIA23 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MIA24**	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R**	**1/18**

SEMANTIC: MIA24 is the capital exception amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

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**

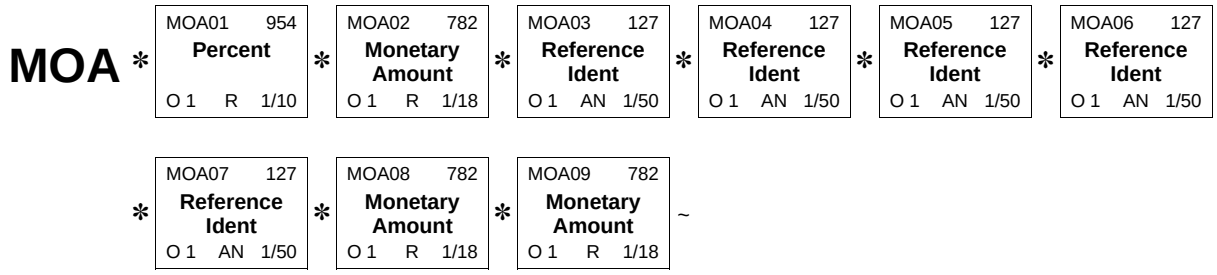
Segment Repeat: **1**

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:** ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Reimbursement Rate**	**O 1 R 1/10**

SITUATIONAL	**MOA02**	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R**	**1/18**

SEMANTIC: MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **HCPCS Payable Amount**

SITUATIONAL	**MOA03**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MOA03 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MOA04**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MOA04 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MOA05**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MOA05 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MOA06**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MOA06 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MOA07**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**	**1**	**AN**	**1/50**

SEMANTIC: MOA07 is the Claim Payment Remark Code. See Code Source 411.

SITUATIONAL RULE: ***Required when returned in the remittance advice. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Claim Payment Remark Code**

SITUATIONAL	**MOA08**	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R**	**1/18**

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** Monetary amount	**O**	**1**	**R**	**1/18**

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:

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: **2330A — OTHER SUBSCRIBER NAME Loop Repeat: 1**

Segment Repeat: **1**

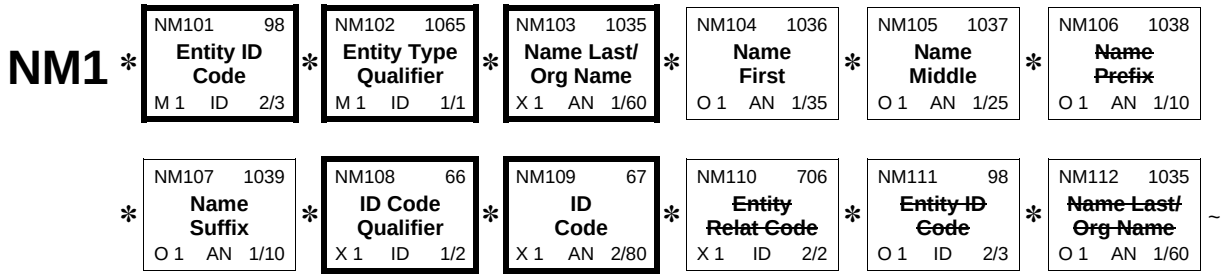
Usage: **REQUIRED**

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**
			CODE / DEFINITION **IL** — **Insured or Subscriber**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** — **Person** **2** — **Non-Person Entity**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Other Insured Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when NM102 = 1 (person) and the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Other Insured First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME: Other Insured Middle Name**	**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:** ***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.*** **IMPLEMENTATION NAME: Other Insured 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**

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** Code identifying a party or other code **SYNTAX:** P0809 **IMPLEMENTATION NAME:** **Other Insured 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 - OTHER SUBSCRIBER ADDRESS

X12 Segment Name: Party Location

X12 Purpose: To specify the location of the named party

Loop: **2330A — OTHER SUBSCRIBER NAME**

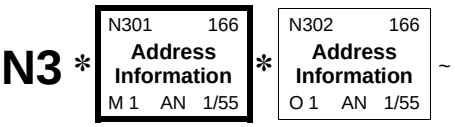
Segment Repeat: **1**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***	
			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.

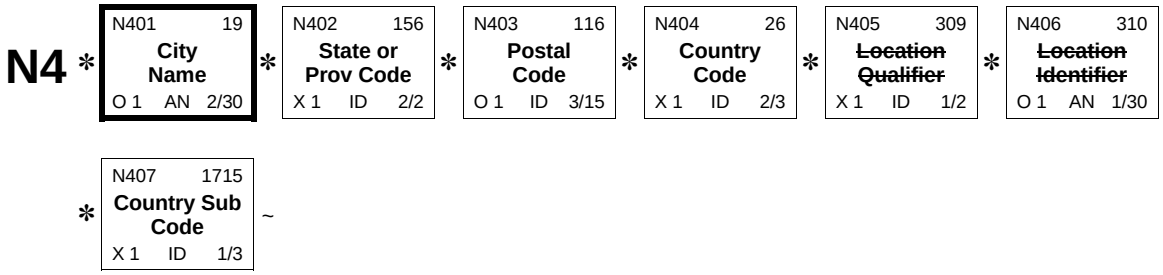
Loop: **2330A — OTHER SUBSCRIBER NAME**

Segment Repeat: **1**

Usage: **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:** **Other Insured City Name**	**O 1 AN 2/30**

SITUATIONAL	**N402**	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency	**X 1**	**ID**	**2/2**

SYNTAX: E0207

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

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Other Insured State Code**

CODE SOURCE 22: States and Provinces

SITUATIONAL	**N403**	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	**O 1**	**ID**	**3/15**

SITUATIONAL RULE: ***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.***

IMPLEMENTATION NAME: **Other Insured Postal Zone or ZIP Code**

CODE SOURCE 51: ZIP Code
CODE SOURCE 932: Universal Postal Codes

SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**

SYNTAX: C0704

SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***

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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**

SYNTAX: E0207, C0704

SITUATIONAL RULE: ***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.***

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

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**

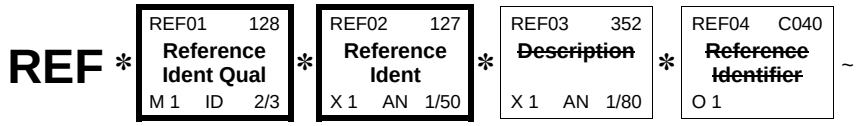
Segment Repeat: **2**

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: **SY** — DEFINITION: **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 SYNTAX: R0203 IMPLEMENTATION NAME: **Other Insured 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

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**

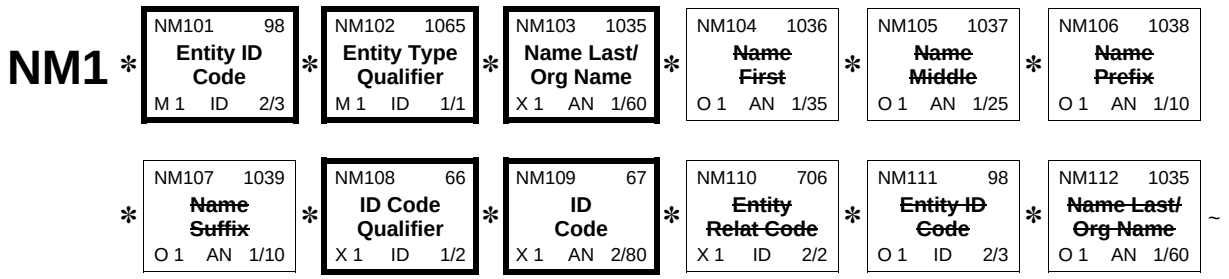
Segment Repeat: **1**

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**
			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**
			CODE / DEFINITION **2** — **Non-Person Entity**	

REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name SYNTAX: C1203 IMPLEMENTATION NAME: **Other Payer 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**
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 IMPLEMENTATION NAME: **Other Payer Primary Identifier**	**X 1**	**AN**	**2/80**

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**

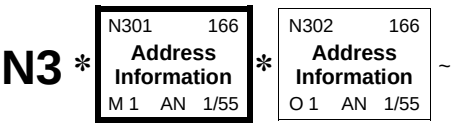
Segment Repeat: **1**

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: ***Required when there is a second address line. If not required by this implementation guide, do not send.***	
			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.

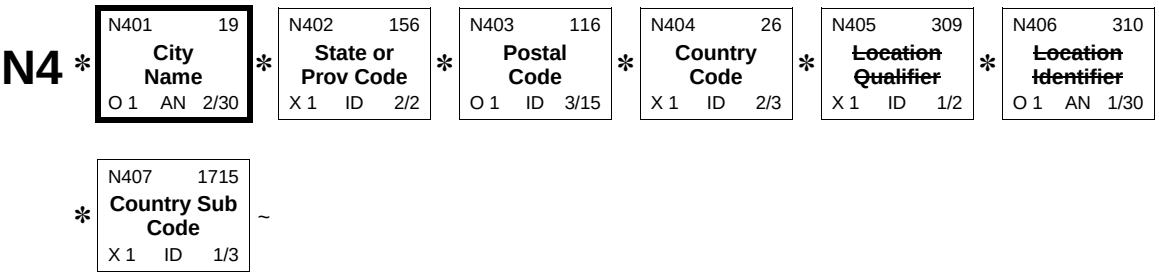
Loop: **2330B — OTHER PAYER NAME**

Segment Repeat: **1**

Usage: **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: **Other Payer 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: ***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.*** 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)	**O 1**	**ID**	**3/15**
			SITUATIONAL RULE: ***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.***			
			IMPLEMENTATION NAME: **Other Payer Postal Zone or ZIP Code**			
			CODE SOURCE **51:** ZIP Code CODE SOURCE **932:** Universal Postal Codes			
SITUATIONAL	**N404**	**26**	**Country Code** Code identifying the country	**X 1**	**ID**	**2/3**
			SYNTAX: C0704			
			SITUATIONAL RULE: ***Required when the address is outside the United States of America. If not required by this implementation guide, do not send.***			
			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** Code identifying the country subdivision	**X 1**	**ID**	**1/3**
			SYNTAX: E0207, C0704			
			SITUATIONAL RULE: ***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.***			
			CODE SOURCE **5:** Countries, Currencies and Funds			
			Use the country subdivision codes from Part 2 of ISO 3166.			

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**

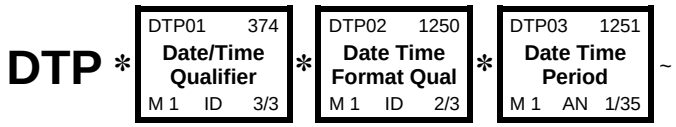
Segment Repeat: **1**

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 SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** **Date Expressed in Format CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 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**

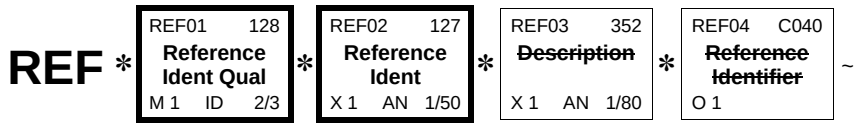
Segment Repeat: **2**

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**

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 **IMPLEMENTATION NAME: Other Payer 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

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**

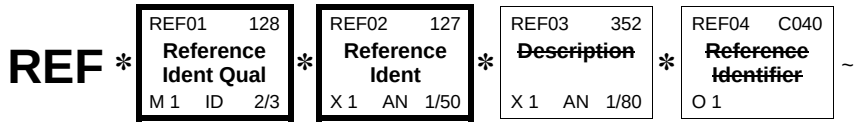
Segment Repeat: **1**

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 CODE / DEFINITION **G1 — Prior Authorization Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Other Payer Prior Authorization 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 - 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**

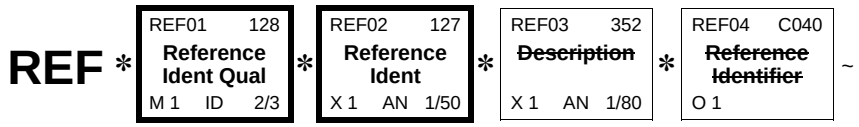
Segment Repeat: **1**

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 CODE: **9F** — DEFINITION: **Referral Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: **Other Payer Prior Authorization or Referral 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 - 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**

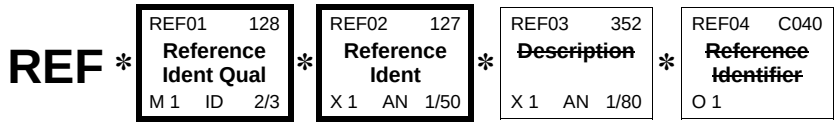
Segment Repeat: **1**

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 CODE / DEFINITION **T4** **Signal Code**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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**

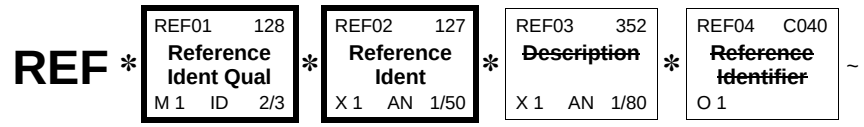
Segment Repeat: **1**

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: **F8** — DEFINITION: **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 SYNTAX: R0203 IMPLEMENTATION NAME: **Other Payer's Claim Control 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

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**

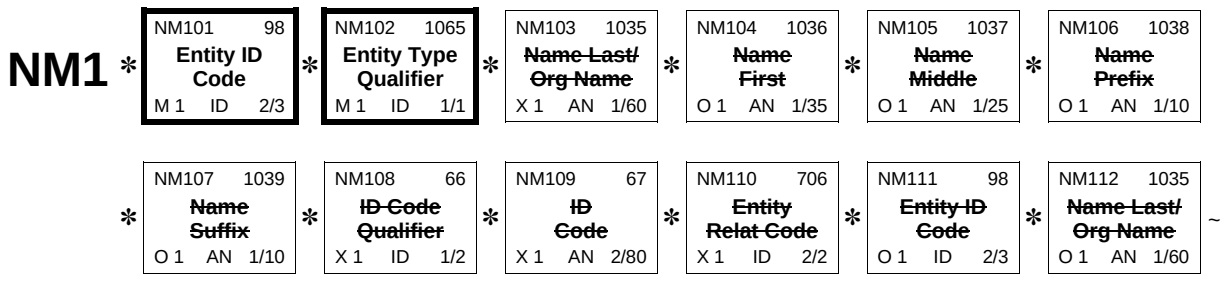
Usage: **SITUATIONAL**

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 CODE: 71 — DEFINITION: Attending Physician	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M 1 ID 1/1
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**

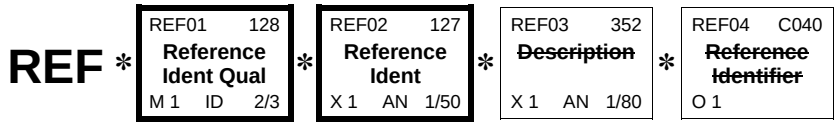
Segment Repeat: **4**

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**

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**

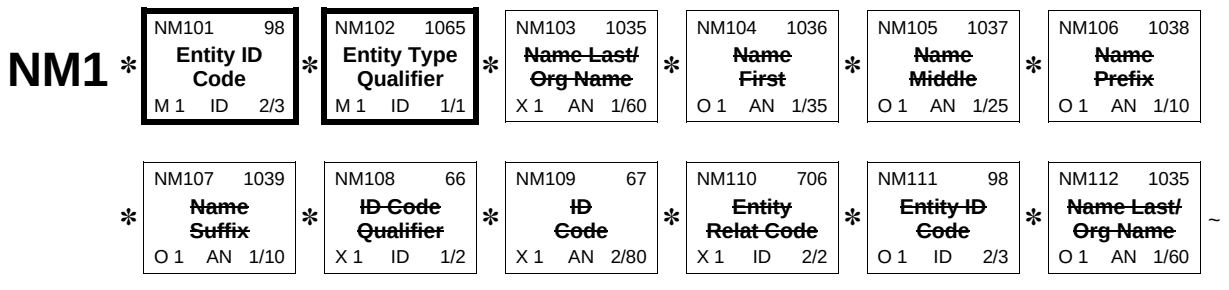
Usage: **SITUATIONAL**

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 CODE: 72 — DEFINITION: Operating Physician	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M 1 ID 1/1
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**

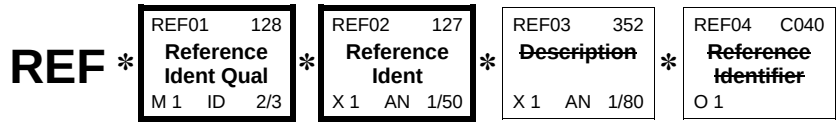
Segment Repeat: **4**

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**

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**

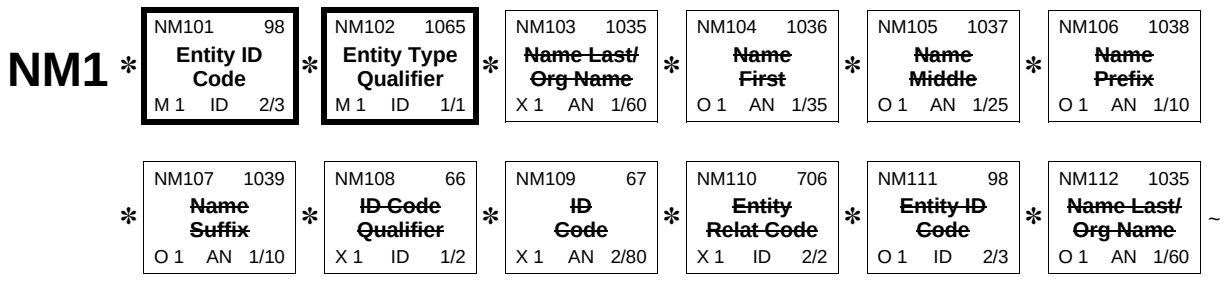
Usage: **SITUATIONAL**

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
			CODE: ZZ — DEFINITION: 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
			CODE: 1 — DEFINITION: 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**

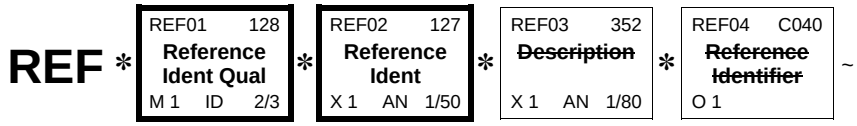
Usage: **REQUIRED**

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**

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 Other 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 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**

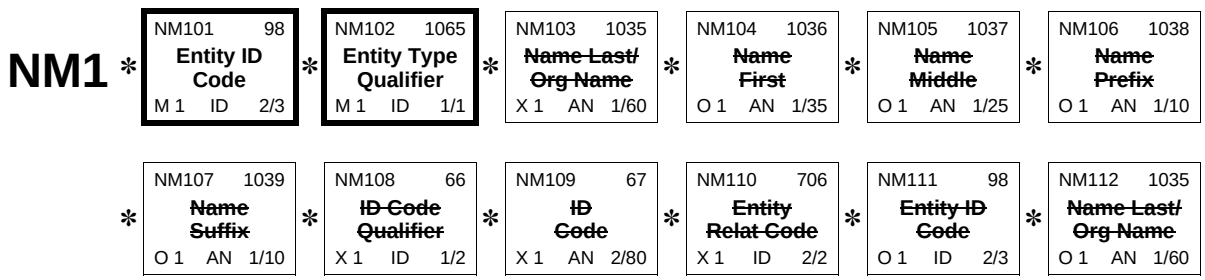
Usage: **SITUATIONAL**

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 CODE / DEFINITION 77 / Service Location	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE / DEFINITION 2 / Non-Person Entity	M 1 ID 1/1
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**

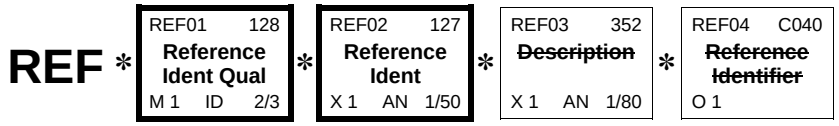
Usage: **REQUIRED**

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**

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
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**

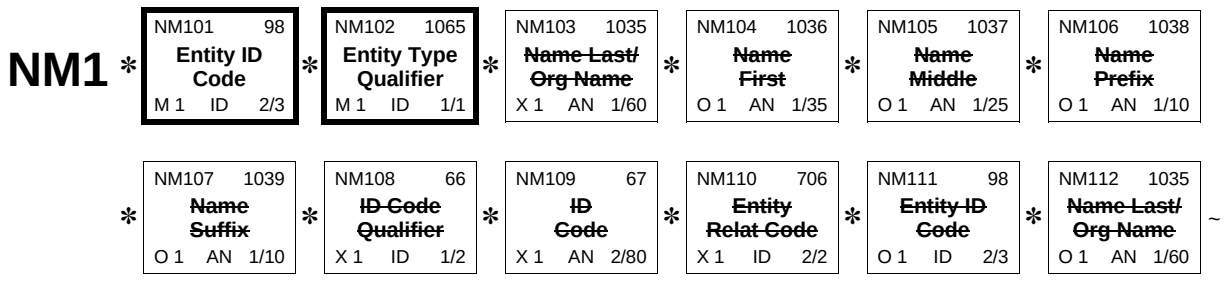
Usage: **SITUATIONAL**

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 CODE — DEFINITION 82 — Rendering Provider	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE — DEFINITION 1 — Person	M 1 ID 1/1
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**

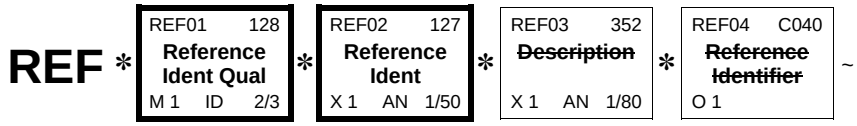
Usage: **REQUIRED**

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**

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**

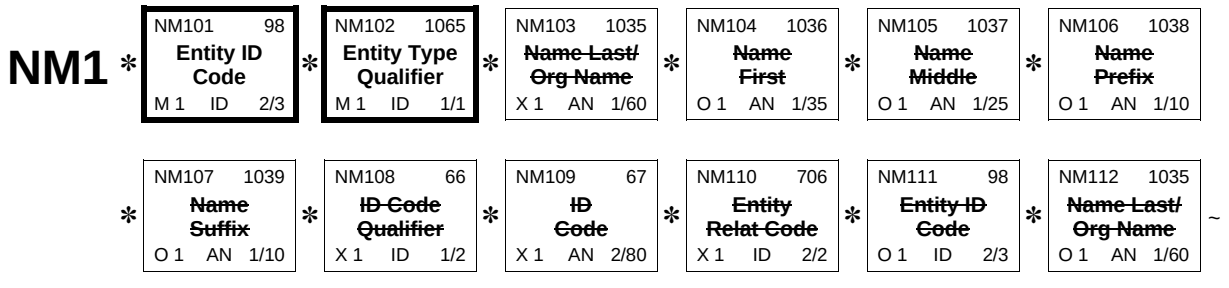
Usage: **SITUATIONAL**

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 CODE: DN — DEFINITION: Referring Provider	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE: 1 — DEFINITION: Person	M 1 ID 1/1
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**

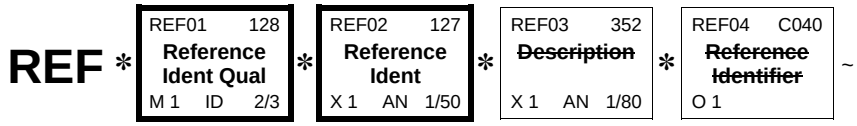
Usage: **REQUIRED**

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**

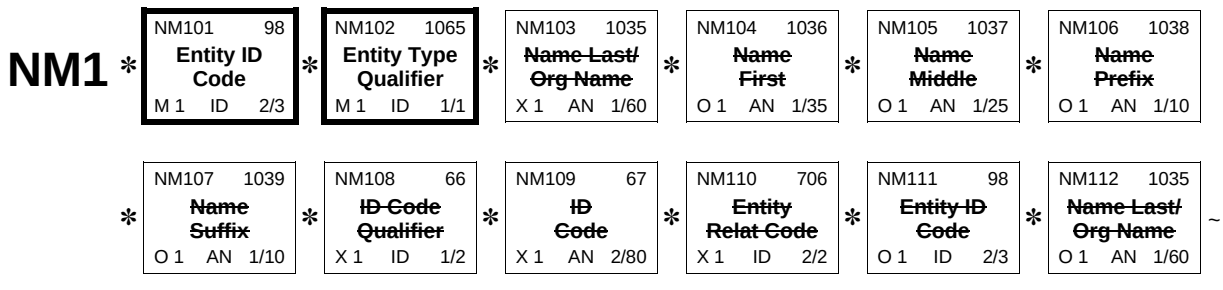
Usage: **SITUATIONAL**

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 CODE — DEFINITION 85 — Billing Provider	M 1 ID 2/3
REQUIRED	NM102	1065	**Entity Type Qualifier** Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE — DEFINITION 2 — Non-Person Entity	M 1 ID 1/1
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**

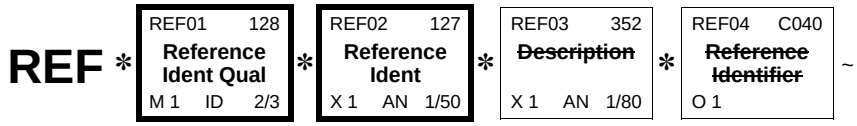
Segment Repeat: **2**

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**
			CODE: **G2** — DEFINITION: **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 Billing 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

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**

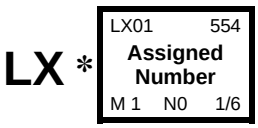
Segment Repeat: **1**

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**	**N0**	**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**

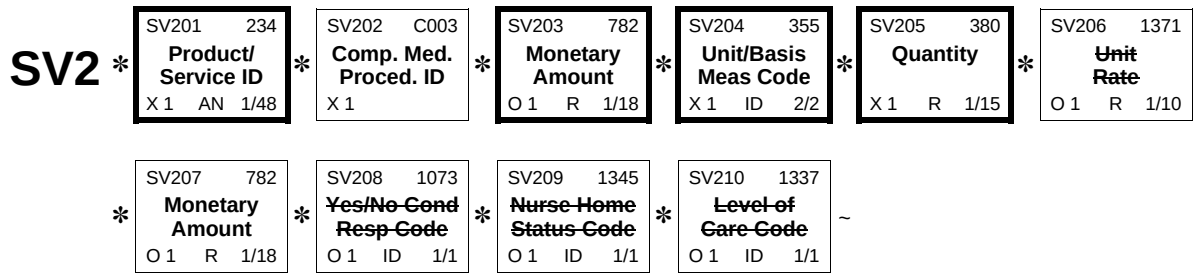
Segment Repeat: **1**

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: ***Required for outpatient claims when an appropriate HCPCS or HIPPS code exists for this service line item.***
OR
Required for inpatient claims when an appropriate HCPCS (drugs and/or biologics only) or HIPPS code exists for this service line item.
If not required by this implementation guide, do not send.

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 Procedural 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: ***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.***

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: ***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.***

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: ***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.***

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: ***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.***

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: ***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.***
OR
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.
If not required by this implementation guide, do not send.

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**

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:** ***Required if needed to report line specific non-covered charge amount. If not required this implementation guide, do not send.*** **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**

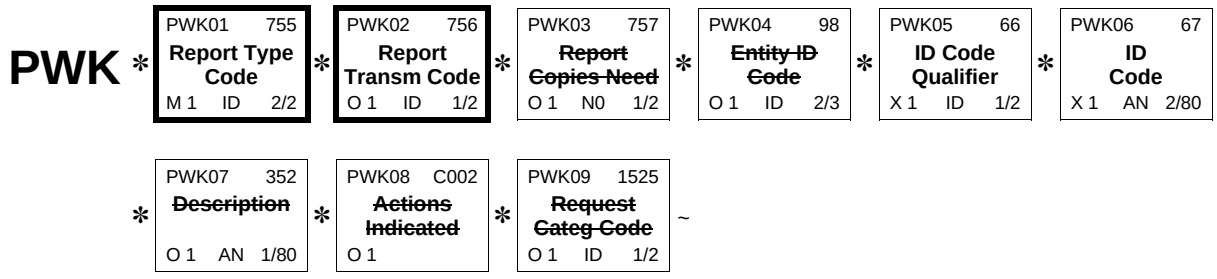
Segment Repeat: **10**

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** 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: ***Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.***		**X 1**	**ID**	**1/2**
			CODE	**DEFINITION**			
			AC	**Attachment Control Number**			
SITUATIONAL	**PWK06**	**67**	**Identification Code** Code identifying a party or other code SYNTAX: P0506 SITUATIONAL RULE: ***Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.*** 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.**		**X 1**	**AN**	**2/80**
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.

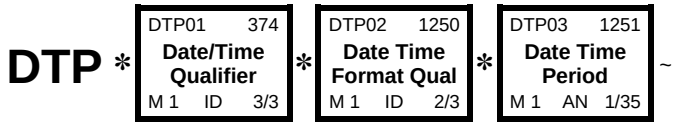
TR3 Notes:

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**	
			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.	
			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**

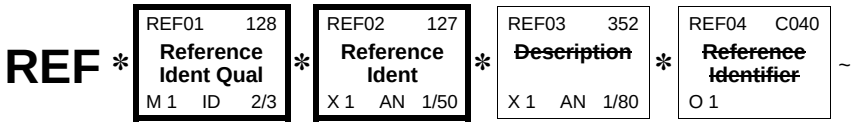
Situational Rule: **Required when the submitter needs a line item control number for subsequent communications to or from the payer. If not required by this implementation guide, do not send.**

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**

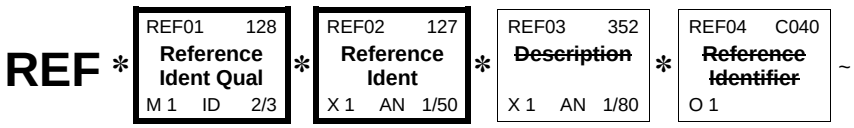
Segment Repeat: **1**

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 CODE: **9B** DEFINITION: **Repriced Line Item Reference Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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**

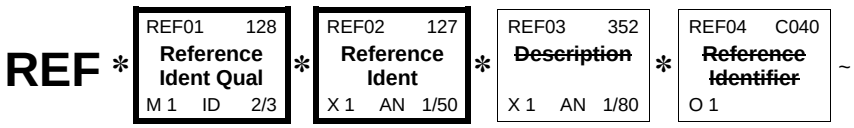
Segment Repeat: **1**

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 CODE: **9D** — DEFINITION: **Adjusted Repriced Line Item Reference Number**	**M 1 ID 2/3**
REQUIRED	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier 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**

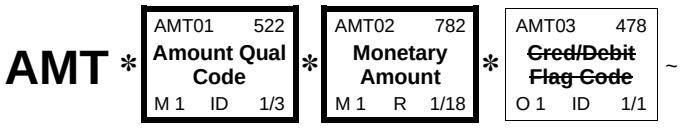
Situational Rule: **Required when a service tax or surcharge applies to the service being reported in SV201 and the submitter is required to report that information to the receiver. If not required by this implementation guide, do not send.**

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**

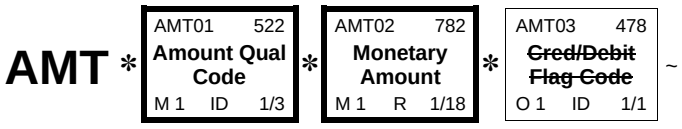
Situational Rule: **Required when a facility tax or surcharge applies to the service being reported in SV201 and the submitter is required to report that information to the receiver. If not required by this implementation guide, do not send.**

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 processable. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.

Loop: **2400 — SERVICE LINE NUMBER**

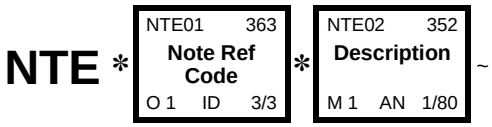
Segment Repeat: **1**

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: **TPO** — DEFINITION: **Third Party Organization Notes**	
REQUIRED	**NTE02**	**352**	**Description** A free-form description to clarify the related data elements and their content IMPLEMENTATION NAME: **Line Note Text**	**M 1 AN 1/80**

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**

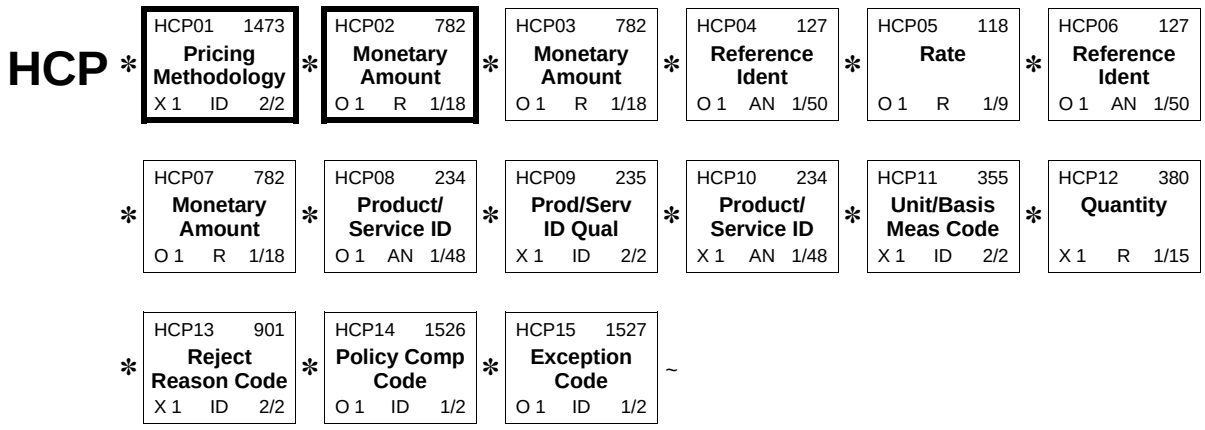
Situational Rule: **Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.**

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**
			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	
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:** ***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.**	**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: ***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.

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: ***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.

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: ***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.

SITUATIONAL **HCP07** **782** **Monetary Amount** **O 1 R 1/18**
Monetary amount

SEMANTIC: HCP07 is the approved DRG amount.

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.

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.**
HC	CODE SOURCE **576:** Workers Compensation Specific Procedure and Supply Codes **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	CODE SOURCE **130:** Healthcare Common Procedural Coding System **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** Identifying number for a product or service SYNTAX: P0910 SEMANTIC: HCP10 is the approved procedure 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: **Repriced Approved HCPCS Code** **This information is specific to the destination payer reported in Loop ID-2010BB.**	**X**	**1**	**AN**	**1/48**

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 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

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**

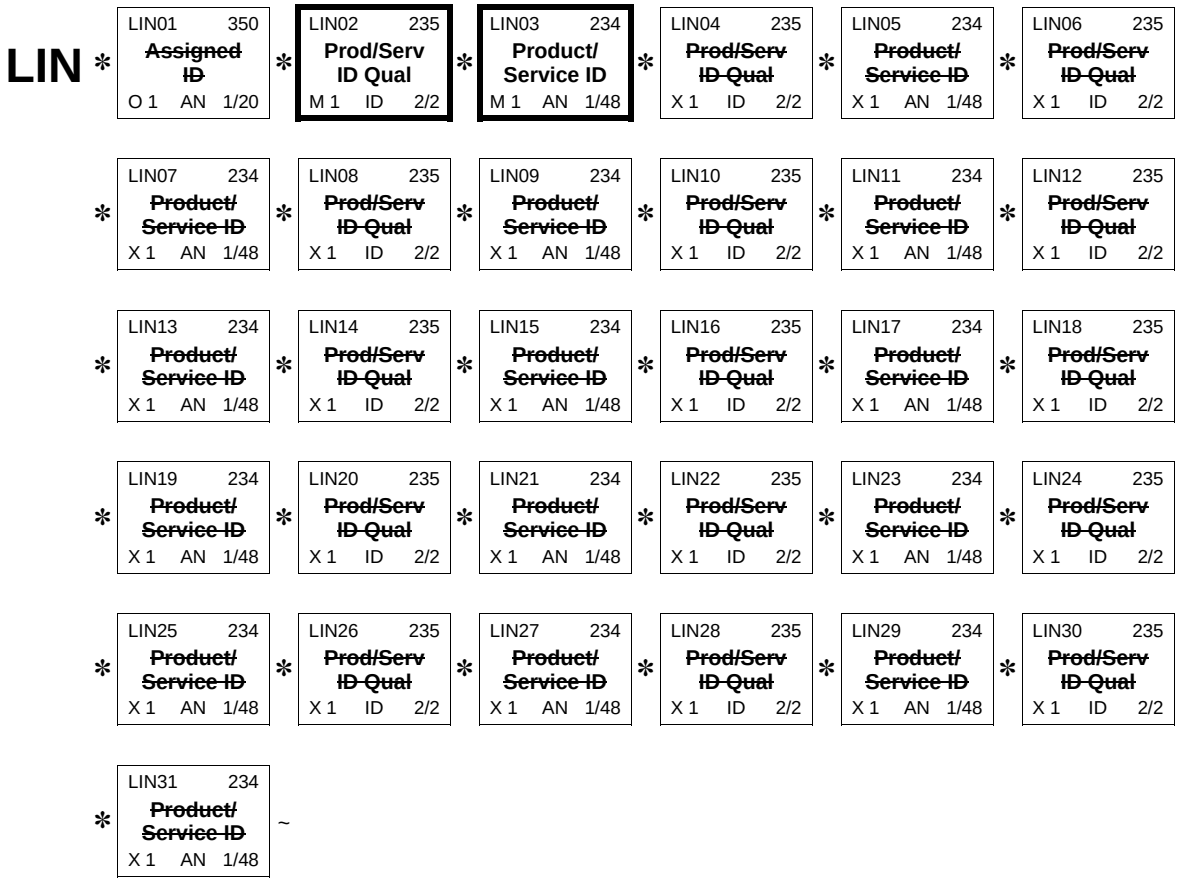
Usage: **SITUATIONAL**

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** CODE / DEFINITION **N4** — **National Drug Code in 5-4-2 Format** CODE SOURCE **240:** National Drug Code by Format	**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.

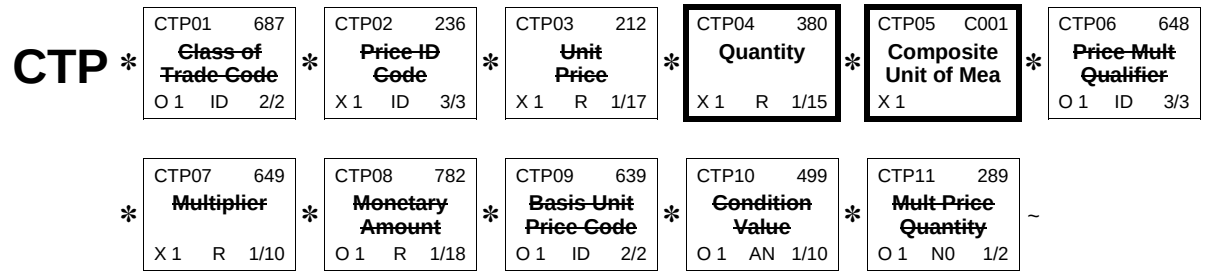
Loop: **2410 — DRUG IDENTIFICATION**

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 IMPLEMENTATION NAME: National Drug Unit Count	X 1 R 1/15

REQUIRED	**CTP05**	**C001**	**COMPOSITE UNIT OF MEASURE** To identify a composite unit of measure		**X 1**		
REQUIRED	**CTP05 - 1**		**355**	**Unit or Basis for Measurement Code** Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken **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**	**M**	**ID**	**2/2**
			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.

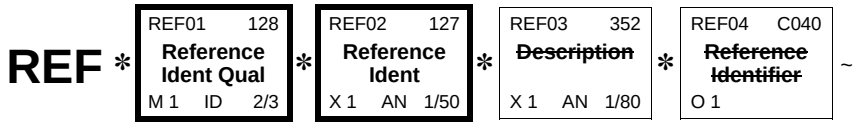
TR3 Notes:

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 **IMPLEMENTATION NAME: Prescription 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

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**

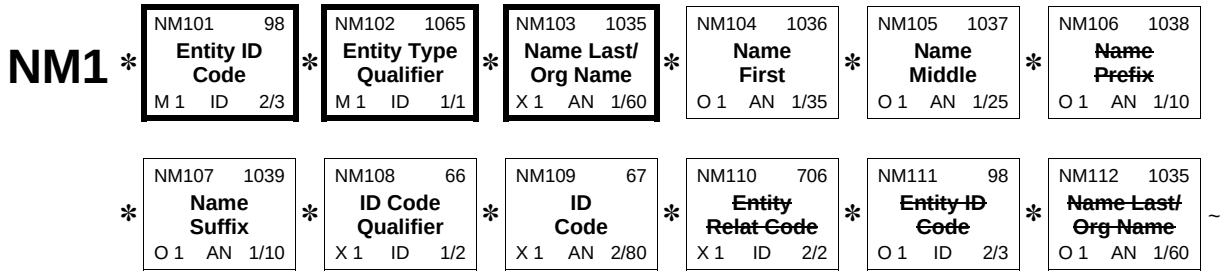
Situational Rule: **Required when a surgical procedure code is listed on this claim.
AND
The Operating Physician for this line is different than the Operating Physician reported in Loop ID-2310B (claim level).
If not required by this implementation guide, do not send.**

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: **72** DEFINITION: **Operating Physician**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103.	**M 1 ID 1/1**
			CODE: **1** DEFINITION: **Person**	
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Operating Physician Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Operating Physician First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME: 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:** ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: 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:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X 1**	**ID**	**1/2**
			CODE / **DEFINITION** **XX** — **Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Operating Physician Primary 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

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**

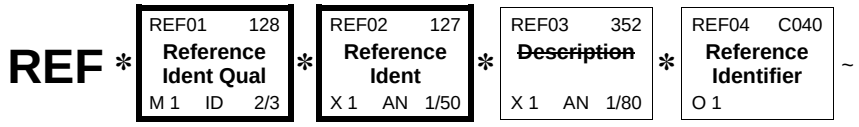
Usage: **SITUATIONAL**

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** 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**
SITUATIONAL	**REF04**	**C040**	**REFERENCE IDENTIFIER** 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.***		**O 1**		
			Do not use this composite when the value reported in REF01 is either 0B or 1G.				
REQUIRED	**REF04 - 1**		**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE	DEFINITION			
			2U	**Payer Identification Number**			
REQUIRED	**REF04 - 2**		**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier IMPLEMENTATION NAME: **Other Payer Primary Identifier**	**M**	**AN**	**1/50**
				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**

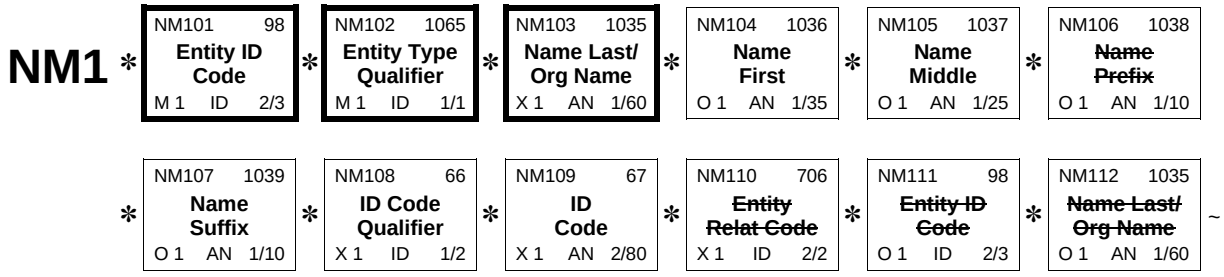
Segment Repeat: **1**

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**
			CODE: **ZZ** DEFINITION: **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**
			CODE: **1** DEFINITION: **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	**O 1 AN 1/35**
			SITUATIONAL RULE: ***Required when the person has a first name. If not required by this implementation guide, do not send.***	
			IMPLEMENTATION NAME: **Other Operating Physician First Name**	
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial	**O 1 AN 1/25**
			SITUATIONAL RULE: ***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.***	
			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	**O 1 AN 1/10**
			SITUATIONAL RULE: ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.***	
			IMPLEMENTATION NAME: **Other Operating Physician Name Suffix**	

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

SYNTAX: P0809

SITUATIONAL RULE: ***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.***
OR
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.
OR
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.
If not required by this implementation guide, do not send.

CODE	DEFINITION
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X 1**	**AN**	**2/80**

SYNTAX: P0809

SITUATIONAL RULE: ***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.***
OR
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.
OR
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.
If not required by this implementation guide, do not send.

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**

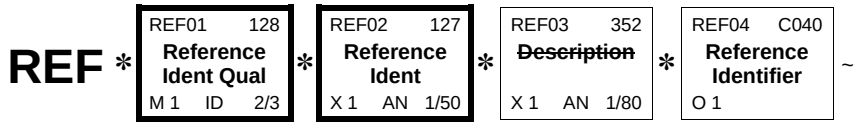
Usage: **SITUATIONAL**

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** 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**	
SITUATIONAL	**REF04**	**C040**	**REFERENCE IDENTIFIER** 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.***		**O 1**			
			Do not use this composite when the value reported in REF01 is either 0B or 1G.					
REQUIRED	**REF04 - 1**		**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**	
			CODE	DEFINITION				
			2U	**Payer Identification Number**				
REQUIRED	**REF04 - 2**		**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**M**	**AN**	**1/50**	
				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**

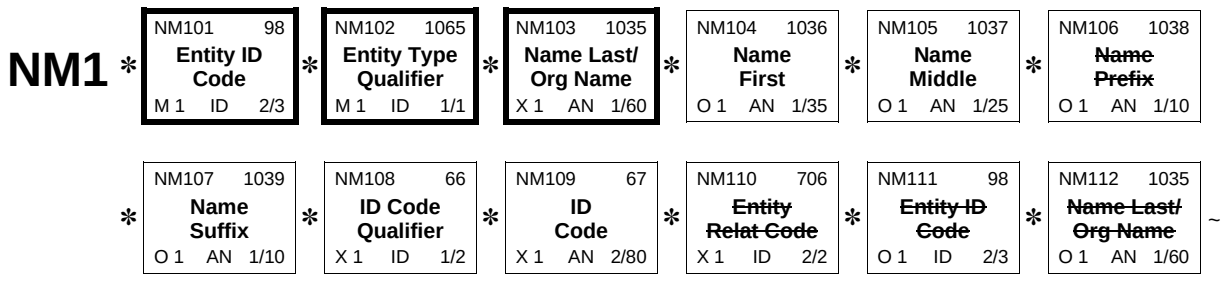
Situational Rule: **Required when Rendering Provider is different than the Attending Provider reported in the 2310A loop of this claim.**
AND
State or federal regulatory requirements call for a "combined claim", that is, a claim that includes both facility and professional components (for example, a 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: **82** — DEFINITION: **Rendering Provider**	
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE: **1** — DEFINITION: **Person**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME:** **Rendering Provider Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Rendering Provider First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME:** **Rendering 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:** ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME:** **Rendering Provider 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:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.***	**X 1**	**ID**	**1/2**
			CODE / **DEFINITION** **XX** — **Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier			
SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code **SYNTAX:** P0809 **SITUATIONAL RULE:** ***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.*** ***OR*** ***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.*** ***OR*** ***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.*** ***If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Rendering 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

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**

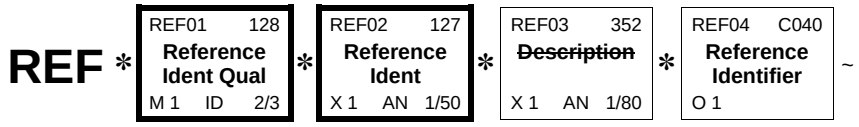
Usage: **SITUATIONAL**

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** 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**
SITUATIONAL	**REF04**	**C040**	**REFERENCE IDENTIFIER** 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.***		**O 1**		
			Do not use this composite when the value reported in REF01 is either 0B or 1G.				
REQUIRED	**REF04 - 1**		**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**	**2/3**
			CODE	DEFINITION			
			2U	**Payer Identification Number**			
REQUIRED	**REF04 - 2**		**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier IMPLEMENTATION NAME: **Other Payer Primary Identifier**	**M**	**AN**	**1/50**
				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**

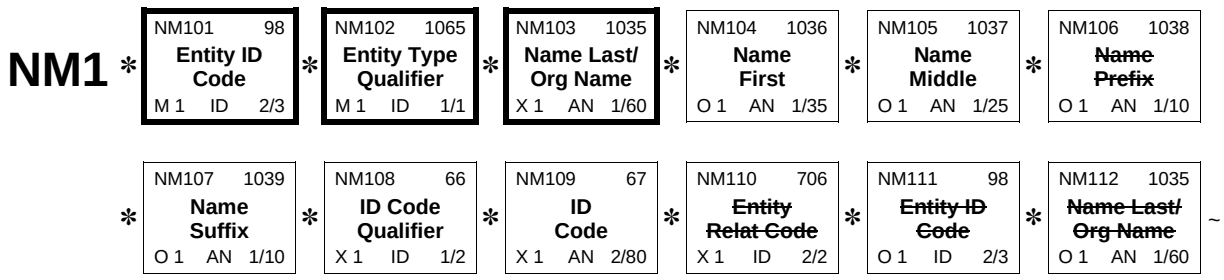
Situational Rule: **Required on an outpatient claim when the Referring Provider is different than the Attending Provider.**
AND
The Referring Provider for this line is different than the Referring Provider reported in Loop ID 2310F (claim level).
If not required by this implementation guide, do not send.

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 CODE / DEFINITION **DN** — **Referring Provider**	**M 1 ID 2/3**
REQUIRED	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity **SEMANTIC:** NM102 qualifies NM103. CODE / DEFINITION **1** — **Person**	**M 1 ID 1/1**
REQUIRED	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name **SYNTAX:** C1203 **IMPLEMENTATION NAME: Referring Provider Last Name**	**X 1 AN 1/60**
SITUATIONAL	**NM104**	**1036**	**Name First** Individual first name **SITUATIONAL RULE:** ***Required when the person has a first name. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Referring Provider First Name**	**O 1 AN 1/35**
SITUATIONAL	**NM105**	**1037**	**Name Middle** Individual middle name or initial **SITUATIONAL RULE:** ***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.*** **IMPLEMENTATION NAME: Referring 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:** ***Required when the name suffix is needed to identify the individual. If not required by this implementation guide, do not send.*** **IMPLEMENTATION NAME: Referring Provider 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)	**X 1**	**ID**	**1/2**

SYNTAX: P0809

SITUATIONAL RULE: ***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.***
OR
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.
If not required by this implementation guide, do not send.

CODE	DEFINITION
XX	**Centers for Medicare and Medicaid Services National Provider Identifier** **CODE SOURCE 537:** Centers for Medicare and Medicaid Services National Provider Identifier

SITUATIONAL	**NM109**	**67**	**Identification Code** Code identifying a party or other code	**X 1**	**AN**	**2/80**

SYNTAX: P0809

SITUATIONAL RULE: ***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.***
OR
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.
If not required by this implementation guide, do not send.

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**

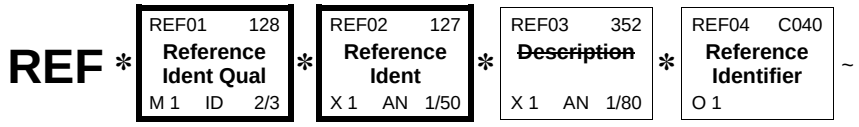
Usage: **SITUATIONAL**

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** 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**		**X**	**1**	**AN**	**1/50**
NOT USED	**REF03**	**352**	**Description**		**X**	**1**	**AN**	**1/80**
SITUATIONAL	**REF04**	**C040**	**REFERENCE IDENTIFIER** 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.**		**O**	**1**		
REQUIRED	**REF04 - 1**		**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**ID**		**2/3**
			CODE	**DEFINITION**				
			2U	**Payer Identification Number**				
REQUIRED	**REF04 - 2**		**127**	**Reference Identification** 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.**	**M**	**AN**		**1/50**
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**

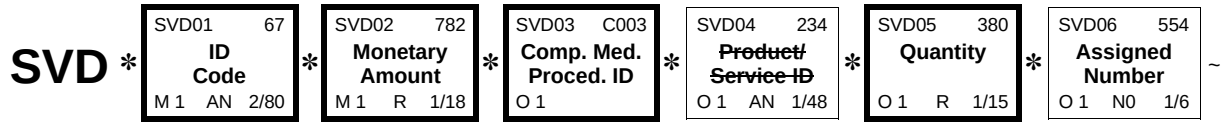
Usage: **SITUATIONAL**

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*43*55*HC:84550**3~**

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.

REQUIRED **SVD03** **C003** **COMPOSITE MEDICAL PROCEDURE IDENTIFIER** **O 1**
To identify a medical procedure by its standardized codes and applicable modifiers

This element contains the procedure code that was used to pay this service line.

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.
	CODE SOURCE 130: Healthcare Common Procedural 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	**SVD03 - 2**	**234**	**Product/Service ID** 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**	**M**	**AN**	**1/48**
SITUATIONAL	**SVD03 - 3**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-03 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***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.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 4**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-04 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***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.***	**O**	**AN**	**2/2**
SITUATIONAL	**SVD03 - 5**	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SEMANTIC: C003-05 modifies the value in C003-02 and C003-08. SITUATIONAL RULE: ***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.***	**O**	**AN**	**2/2**

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: ***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.***

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: ***Required when SVC01-7 was returned in the 835 transaction. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Procedure Code Description**

NOT USED **SVD03 - 8** **234** **Product/Service ID** **O AN 1/48**

NOT USED **SVD04** **234** **Product/Service ID** **O 1 AN 1/48**

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: ***Required when payer bundled this service line. If not required by this implementation guide, do not send.***

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.**

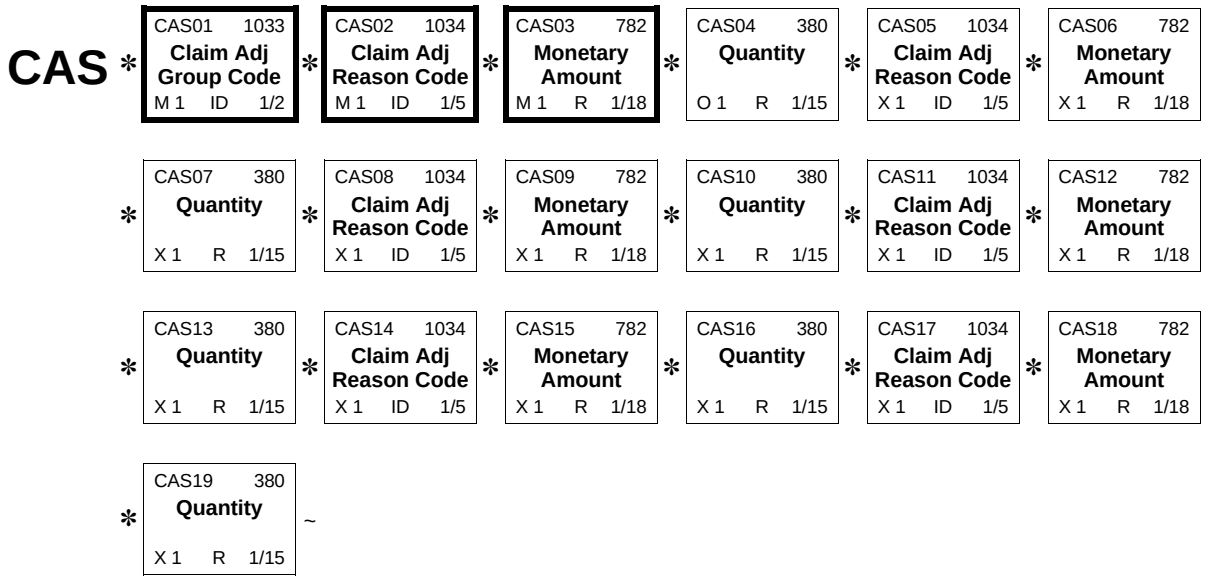
TR3 Notes:

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**	**M 1 ID 1/2**

Code identifying the general category of payment adjustment

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** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L080910, C0908, C1008

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	**CAS09**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

SYNTAX: L080910, C0908

SEMANTIC: CAS09 is the amount of the adjustment.

SITUATIONAL RULE: ***Required when CAS08 is present. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Adjustment Amount**

SITUATIONAL	**CAS10**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

SYNTAX: L080910, C1008

SEMANTIC: CAS10 is the units of service being adjusted.

SITUATIONAL RULE: ***Required when CAS08 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	**CAS11**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L111213, C1211, C1311

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	**CAS12**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

SYNTAX: L111213, C1211

SEMANTIC: CAS12 is the amount of the adjustment.

SITUATIONAL RULE: ***Required when CAS11 is present. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Adjustment Amount**

SITUATIONAL	**CAS13**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

SYNTAX: L111213, C1311

SEMANTIC: CAS13 is the units of service being adjusted.

SITUATIONAL RULE: ***Required when CAS11 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	**CAS14**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L141516, C1514, C1614

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	**CAS15**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

SYNTAX: L141516, C1514

SEMANTIC: CAS15 is the amount of the adjustment.

SITUATIONAL RULE: ***Required when CAS14 is present. If not required by this implementation guide, do not send.***

IMPLEMENTATION NAME: **Adjustment Amount**

SITUATIONAL	**CAS16**	**380**	**Quantity** Numeric value of quantity	**X 1**	**R**	**1/15**

SYNTAX: L141516, C1614

SEMANTIC: CAS16 is the units of service being adjusted.

SITUATIONAL RULE: ***Required when CAS14 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	**CAS17**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X 1**	**ID**	**1/5**

SYNTAX: L171819, C1817, C1917

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	**CAS18**	**782**	**Monetary Amount** Monetary amount	**X 1**	**R**	**1/18**

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** Numeric value of quantity	**X 1**	**R**	**1/15**

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

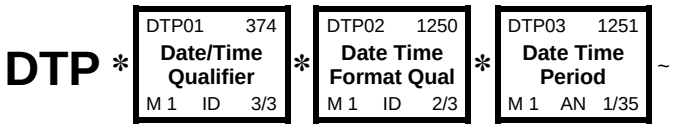
Loop: **2430 — LINE ADJUDICATION INFORMATION**

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 SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE / DEFINITION **D8** **Date Expressed in Format CCYYMMDD**	**M 1 ID 2/3**
REQUIRED	**DTP03**	**1251**	**Date Time Period** Expression of a date, a time, or range of dates, times or dates and times	**M 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**

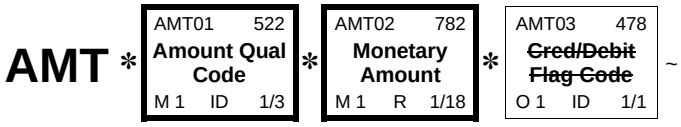
Situational Rule: **Required when the Other Payer referenced in SVD01 of this iteration of Loop ID-2430 has adjudicated this claim, provided line level information, and the provider has the ability to report line item information. If not required by this implementation guide, do not send.**

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 CODE / DEFINITION **EAF** — **Amount Owed**	**M 1 ID 1/3**
REQUIRED	**AMT02**	**782**	**Monetary Amount** Monetary amount IMPLEMENTATION NAME: **Remaining Patient Liability**	**M 1 R 1/18**
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)

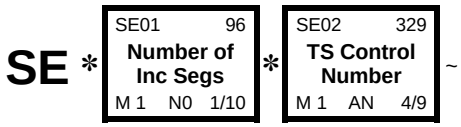
X12 Comments: **1.** SE is the last segment of each transaction set.

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 IMPLEMENTATION NAME: **Transaction Segment Count**	**M 1 N0 1/10**
REQUIRED	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set **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.**	**M 1 AN 4/9**

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*005010X223~**
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*9005555555~**
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*005010X223~BHT*0019*00*0123*19960918*0932*CH~N
M1*41*2*JONES HOSPITAL*****46*12345~PER*IC*JANE DOE*TE*90055
55555~NM1*40*2*MEDICARE*****46*00120~HL*1**20*1~PRV*BI*PXC*2
03BA0200N~NM1*85*2*JONES HOSPITAL*****XX*9876540809~N3*225 M
AIN STREET BARKLEY BUILDING~N4*CENTERVILLE*PA*17111~REF*EI*5
67891234~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~DM
G*D8*19261111*M~NM1*PR*2*MEDICARE B*****PI*00435~REF*G2*3301
27~CLM*756048Q*89.93***14:A:1*Y*A*Y*Y~DTP*434*D8*19960911~CL
1*3**01~HI*BK:3669~HI*BF:4019*BF:79431~HI*BH:A1:D8:19261111*
BH:A2:D8:19911101*BH:B1:D8:19261111*BH:B2:D8:19870101~HI*BE:
A2:::15.31~HI*BG:09~NM1*71*1*JONES*JOHN*J~REF*1G*B99937~SBR*
S*01*351630*STATE TEACHERS*****CI~DMG*D8*19271211*F~OI***Y**
*Y~NM1*IL*1*DOE*JANE*S***MI*222004433~N3*125 CITY AVENUE~N4*
CENTERVILLE*PA*17111~NM1*PR*2*STATE TEACHERS*****PI*1135~LX*
1~SV2*0305*HC:85025*13.39*UN*1~DTP*472*D8*19960911~LX*2~SV2*
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*005010X223~**
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*9999999999~**
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*005010X223~BHT*0019*00*0123*20050630*0932*CH~N
M1*41*2*JONES HOSPITAL*****46*12345~PER*IC*JANE DOE*TE*11122
23333~NM1*40*2*TRICARE*****46*99999~HL*1**20*1~PRV*BI*PXC*28
2N00000X~NM1*85*2*JONES HOSPITAL*****XX*1234567890~N3*225 MA
IN 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*125
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~DTP*
434*RD8*20050315-20050315~CL1***01~HI*BK:3669~HI*BF:4019*BF:
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~SV2
*0730*HC:93010*76.56*UN*3~DTP*472*D8*20050315~HL*3*1*22*0~SB
R*P*18*******CH~NM1*IL*1*SMITH*JOE****MI*123405074~N3*5 MAIN
 STREET~N4*ANYWHERE*PA*17111~DMG*D8*19621210*M~NM1*PR*2*TRIC
ARE*****PI*99999~CLM*756049Q*50***13:A:1*Y*C*Y*Y~DTP*434*RD8
*20050401-20050401~CL1***01~HI*BK:30000~NM1*71*1*JONES*JUDY*
J***XX*9999999999~PRV*AT*PXC*363LP0200N~LX*1~SV2*0300*HC:850
87*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*005010X223~**
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~**
8	N3 BILLING PROVIDER ADDRESS **N3*592 NORTH ELM STREET~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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~**
20	**2010CA PATIENT NAME** NM1 PATIENT NAME **NM1*QC*1*JONES*JOY~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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~**
33	HI OCCURRENCE INFORMATION **HI*BH>11>D8>20050706~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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~**
45	**2400 SERVICE LINE** LX SERVICE LINE COUNTER **LX*2~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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*005010X223~BHT*0019*00*1002*20050721*09460000*CH
~NM1*41*2*REGIONAL PPO NETWORK*****46*123456789~PER*IC*SUBMI
TTER CONTACT INFO*TE*8001231234~NM1*40*2*LOCAL INSURANCE COM
PANY*****46*54334452~HL*1**20*1~NM1*85*2*GOOD HEALTH HOSPITA
L*****XX*1257234346~N3*592 NORTH ELM STREET~N4*EDGEWOOD*AZ*8
60015590~REF*EI*344232321~HL*2*1*22*1~SBR*P**46522567AW*****
*CI~NM1*IL*1*JONES*JENNY****MI*345U8423H~N3*4512 WEST AVENUE
~N4*EVANSVILLE*AZ*863030000~DMG*D8*19690731*F~NM1*PR*2*LOCAL
INSURANCE COMPANY*****PI*7452723~HL*3*2*23*0~PAT*19~NM1*QC*1
*JONES*JOY~N3*4512 WEST AVENUE~N4*EVANSVILLE*AZ*863030000~DM
G*D8*19980820*F~CLM*456DFH43*237.5***13>A>1*Y**Y*Y~DTP*434*R
D8*20050706-20050706~DTP*435*DT*200507060800~CL1**2*01~AMT*F
3*237.5~REF*9A*09459034092~REF*D9*04566877634343456~HI*BK>38
181~HI*BF>38900~HI*BH>11>D8>20050706~HCP*03*182.88*54.62*123
456789~NM1*71*1*JOHNSON*SIMON****XX*5544332211~SBR*S*19**T&T
PLUMBING COMPANY*****CI~DMG*D8*19700122*M~OI***Y***Y~NM1*IL*
1*JONES*GEORGE****MI*56454566~NM1*PR*2*OTHER COVERAGE COMPAN
Y*****PI*534524~LX*1~SV2*0471*HC>92557*178*UN*1~DTP*472*D8*2
0050706~HCP*03*137.06*40.94~LX*2~SV2*0471*HC>92567*59.5*UN*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*005010X223~**
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~**
12	SBR SUBSCRIBER INFORMATION **SBR*P*18*34561W******CI~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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~**
24	REF CLEARING HOUSE CLAIM NUMBER (ASSIGNED BY THE CLEARING HOUSE WHEN TRANSMITTING TO THE REPRICER) **REF*D9*32423466233~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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*005010X223~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*11
22334455~N3*3423 SMALL STREET~N4*COLUMBUS*OH*432150000~REF*E
I*111002222~HL*2*1*22*0~SBR*P*18*34561W******CI~NM1*IL*1*SMI
TH*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*R
D8*20050617-20050617~DTP*435*DT*200506170800~CL1**1*01~AMT*F
3*14.84~REF*9A*459804390823~REF*D9*32423466233~HI*BK>53081~H
CP*00*0**333001234********T1~NM1*71*1*RIVERS*DAWN****XX*224
4224455~LX*1~SV2*0301*HC>82270*14.84*UN*1~DTP*472*D8*2005061
7~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*005010X223~**
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~**
12	**2000B SUBSCRIBER HL LOOP** **HL*2*1*22*1~**
13	SBR SUBSCRIBER INFORMATION **SBR*P********AM~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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~**
26	REF AUTO ACCIDENT STATE **REF*LU*CA~**
27	HI PRINCIPLE DIAGNOIS **HI*BK:8842~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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~**
39	DTP DATE - SERVICE DATE **DTP*472*D8*20051031~**
40	LX SERVICE LINE NUMBER **LX*4~**

SEG #	LOOP SEGMENT/ELEMENT STRING
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*005010X223~BHT*0019*00*0324*20051111*1800*CH~N
M1*41*2*HALL OF FAME MEMORIAL HOSPITAL*****46*737373737~PER*
IC*kate casey*TE*7152569877~NM1*40*2*HEISMAN INSURANCE COMPA
NY*****46*999888777~HL*1**20*1~PRV*BI*pxc*203BA0200N~NM1*85*
2*HALL OF FAME MEMORIAL HOSPITAL*****XX*2365259638~N3*1 CANT
ON ROAD~N4*BROKEN FIELD*CA*99998~REF*EI*737373737~HL*2*1*22*
1~SBR*P********AM~NM1*IL*1*HOWLING*HAL****MI*B999777791G~NM1
*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 HOR
SE*CA*99666~DMG*D8*19480601*M~REF*Y4*32323232~CLM*6723669552
1*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~NM1*
71*1*LOMBARDO*VINCENT****XX*2533698543~LX*1~SV2*0450*HC:9876
5*150*UN*1~DTP*472*D8*20051031~LX*2~SV2*0360*HC:26591*75*UN*
1~DTP*472*D8*20051031~LX*3~SV2*0312*HC:86225*100*UN*2~DTP*47
2*D8*20051031~LX*4~SV2*0360*HC:99283*220*UN*1~DTP*472*D8*200
51031~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 Domestics Mail Manual includes information on the use of the new 11-digit zip code.

130 Healthcare Common Procedural Coding System

SIMPLE DATA ELEMENT/CODE REFERENCES
235/HC, 1270/BO, 1270/BP

SOURCE
Healthcare Common Procedural Coding System

AVAILABLE FROM
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

ABSTRACT
HCPCS is Centers for Medicare & Medicaid Service's (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/Blue Shield Association
Interplan Teleprocessing Services Division
676 N. St. Clair Street
Chicago, IL 60611

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 Admission Source Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1314

SOURCE
National Uniform Billing Data Element Specifications

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

ABSTRACT
A variety of codes explaining who recommended admission to a medical facility.

231 Admission Type Code

SIMPLE DATA ELEMENT/CODE REFERENCES
1315

SOURCE
National Uniform Billing Data Element Specifications

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
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 Position 3

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
One North Franklin

Chicago, IL 60606

ABSTRACT
A variety of codes explaining the frequency of the bill submission.

236 Uniform Billing Claim Form Bill Type

SIMPLE DATA ELEMENT/CODE REFERENCES
1332/A

SOURCE
National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM
National Uniform Billing Committee
American Hospital Association
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
Health Care Financing Administration Treatment Codes

AVAILABLE FROM
Centers for Medicare and Medicaid Services Office of Financial Management
Program Integrity Group
C3-02-16
7500 Security Blvd.
Baltimore, MD 21244-1850

ABSTRACT
Codes used to describe the treatments provided in a home health setting.

411 Remittance Advice Remark Codes

SIMPLE DATA ELEMENT/CODE REFERENCES
1270/HE

SOURCE
Centers for Medicare and 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 and Medicaid Services National Provider Identifier

SIMPLE DATA ELEMENT/CODE REFERENCES
66/XX, 128/HPI

SOURCE
National Provider System

AVAILABLE FROM
Centers for Medicare and 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 and 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
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 and 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

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 Classicication 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

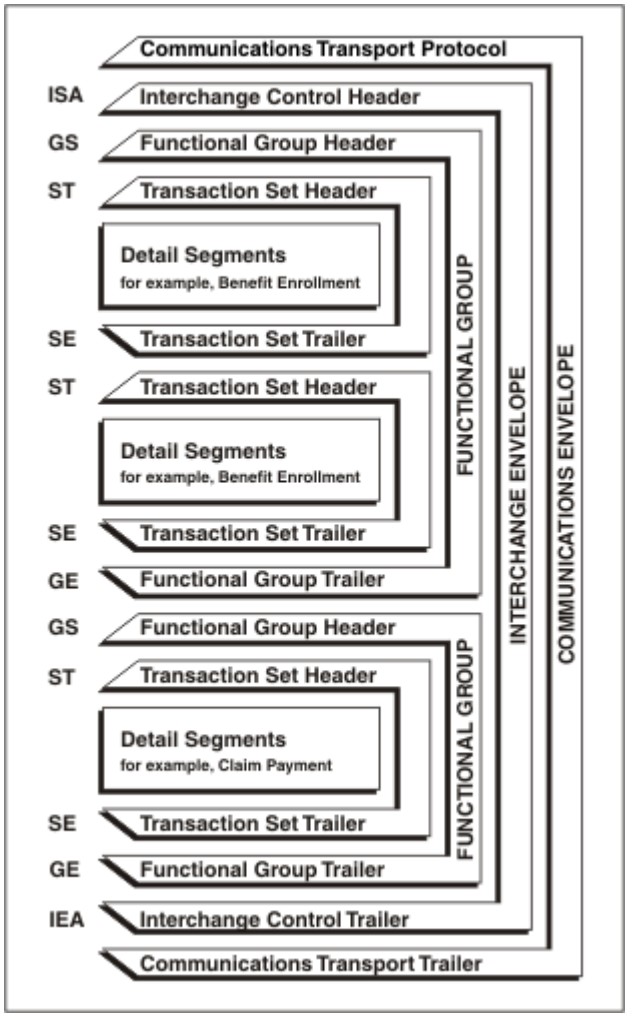
The transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a transaction set. For instance, a group of benefit enrollments sent from a sponsor to a payer is considered a transaction 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 ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The

distinction between simple and component data elements is strictly a matter of context because a data element can be used in either capacity.

Data elements are assigned a unique reference number. Each data element has a name, description, type, minimum length, and maximum length. For ID type data elements, this guide provides the applicable ASC X12 code values and their descriptions or references where the valid code list can be obtained.

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 acknowlegement 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 inter-change 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

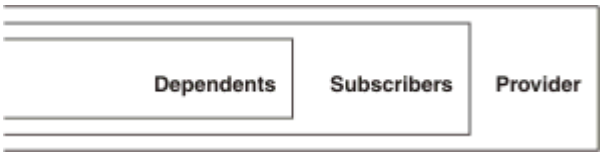
The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide.

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
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

Segment Repeat: **1**

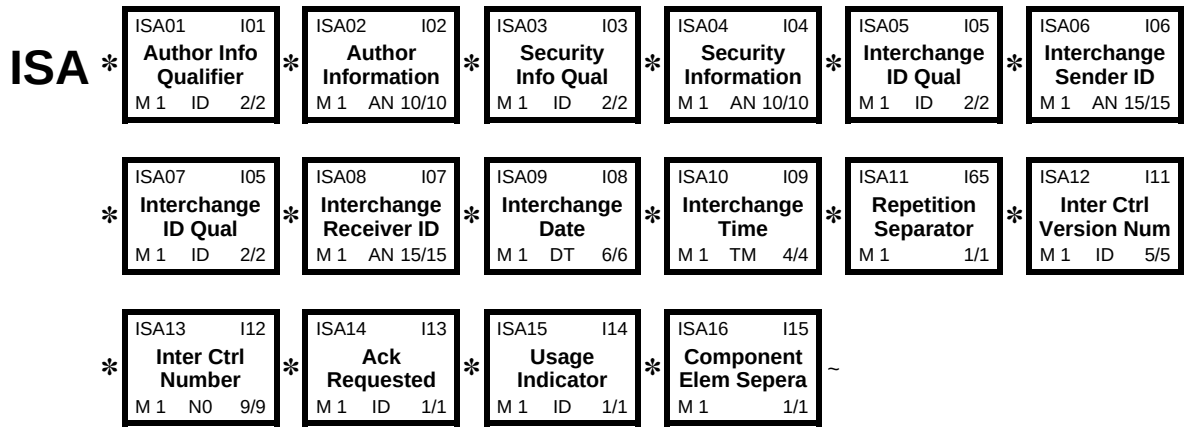
Usage: **REQUIRED**

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
			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.	
			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	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** **M 1 ID 2/2**
Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified

This ID qualifies the Receiver in ISA08.

CODE	DEFINITION
01	**Duns (Dun & Bradstreet)**
14	**Duns Plus Suffix**
20	**Health Industry Number (HIN)** CODE SOURCE **121:** Health Industry 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

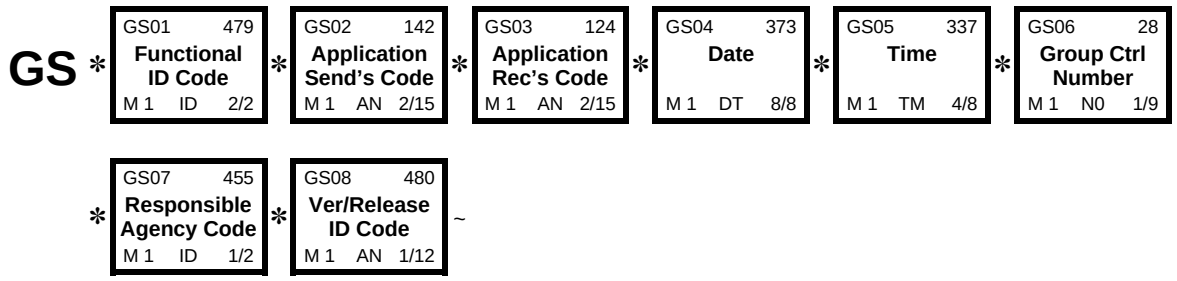
X12 Comments: **1.** A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Segment Repeat: **1**

Usage: **REQUIRED**

TR3 Example: **GS*XX*SENDER CODE*RECEIVER CODE*19991231*0802*1*X*005010X223~**

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 **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.**	**M 1 ID 2/2**
REQUIRED	**GS02**	**142**	**Application Sender's Code** Code identifying party sending transmission; codes agreed to by trading partners **Use this code to identify the unit sending the information.**	**M 1 AN 2/15**
REQUIRED	**GS03**	**124**	**Application Receiver's Code** Code identifying party receiving transmission; codes agreed to by trading partners **Use this code to identify the unit receiving the information.**	**M 1 AN 2/15**
REQUIRED	**GS04**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year **SEMANTIC:** GS04 is the group date. **Use this date for the functional group creation date.**	**M 1 DT 8/8**

REQUIRED **GS05** **337** **Time** **M 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: GS05 is the group time.

Use this time for the creation time. The recommended format is HHMM.

REQUIRED **GS06** **28** **Group Control Number** **M 1 N0 1/9**

Assigned number originated and maintained by the sender

SEMANTIC: The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

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.

REQUIRED **GS07** **455** **Responsible Agency Code** **M 1 ID 1/2**

Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480

CODE	DEFINITION
X	**Accredited Standards Committee X12**

REQUIRED **GS08** **480** **Version / Release / Industry Identifier Code** **M 1 AN 1/12**

Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed

CODE 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.

CODE	DEFINITION
005010X223	**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

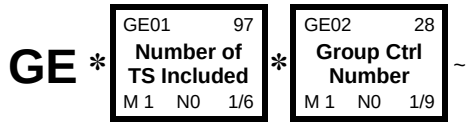
X12 Comments:
1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Segment Repeat: **1**

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 N0 1/6**
REQUIRED	**GE02**	**28**	**Group Control Number** Assigned number originated and maintained by the sender **SEMANTIC:** The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.	**M 1 N0 1/9**

SEGMENT DETAIL

IEA - INTERCHANGE CONTROL TRAILER

X12 Segment Name: Interchange Control Trailer

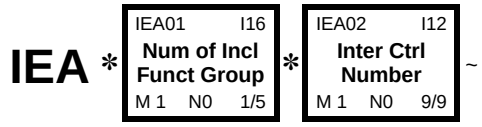
X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments

Segment Repeat: **1**

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 005010X223 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 005010X223 contains significant changes and clarifications. It can only be used with other trading partners who have also implemented 005010X223. 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.

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 crosswalk 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 005010X223, 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**) are now required.

43. The Situational Rule for the Subscriber Address segments (**N3** and **N4**) has changed.

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 repricer 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**).

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.

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.

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 Indicator has been added to the Other Diagnosis Information (**HI**) segment.

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-2310A|NM102 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.

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.

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

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.

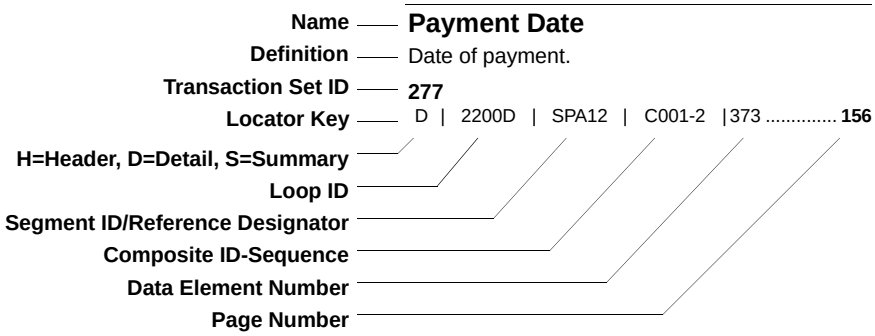
151. The segment name for the **DTP** segment changed from Service Adjudication Date to the more descriptive Line Check or Remittance Date.

152. The Remaining Patient Liability (**AMT**) segment has been added.

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.



Adjudication or Payment Date

Date of payment or denial determination by previous payer.

D | 2330B | DTP03 | - | 1251 ..... **389**
D | 2430 | DTP03 | - | 1251 ..... **486**

Adjusted Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify an adjusted claim.

D | 2300 | REF02 | - | 127 ..... **168**

Adjusted Repriced Line Item Reference Number

Identification number of an adjusted repriced line item adjusted from an original amount.

D | 2400 | REF02 | - | 127 ..... **438**

Adjustment Amount

Adjustment amount for the associated reason code.

D | 2320 | CAS03 | - | 782 ..... **360**
D | 2320 | CAS06 | - | 782 ..... **360**
D | 2320 | CAS09 | - | 782 ..... **361**
D | 2320 | CAS12 | - | 782 ..... **362**
D | 2320 | CAS15 | - | 782 ..... **362**
D | 2320 | CAS18 | - | 782 ..... **363**
D | 2430 | CAS03 | - | 782 ..... **482**
D | 2430 | CAS06 | - | 782 ..... **482**
D | 2430 | CAS09 | - | 782 ..... **483**
D | 2430 | CAS12 | - | 782 ..... **483**
D | 2430 | CAS15 | - | 782 ..... **484**
D | 2430 | CAS18 | - | 782 ..... **485**

Adjustment Quantity

Numeric quantity associated with the related reason code for coordination of benefits.

D | 2320 | CAS04 | - | 380 ..... **360**
D | 2320 | CAS07 | - | 380 ..... **361**
D | 2320 | CAS10 | - | 380 ..... **361**
D | 2320 | CAS13 | - | 380 ..... **362**
D | 2320 | CAS16 | - | 380 ..... **362**
D | 2320 | CAS19 | - | 380 ..... **363**
D | 2430 | CAS04 | - | 380 ..... **482**
D | 2430 | CAS07 | - | 380 ..... **482**
D | 2430 | CAS10 | - | 380 ..... **483**
D | 2430 | CAS13 | - | 380 ..... **484**
D | 2430 | CAS16 | - | 380 ..... **484**
D | 2430 | CAS19 | - | 380 ..... **485**

Adjustment Reason Code

Code that indicates the reason for the adjustment.

D | 2320 | CAS02 | - | 1034 ..... **360**
D | 2320 | CAS05 | - | 1034 ..... **360**
D | 2320 | CAS08 | - | 1034 ..... **361**
D | 2320 | CAS11 | - | 1034 ..... **361**
D | 2320 | CAS14 | - | 1034 ..... **362**
D | 2320 | CAS17 | - | 1034 ..... **363**
D | 2430 | CAS02 | - | 1034 ..... **482**
D | 2430 | CAS05 | - | 1034 ..... **482**
D | 2430 | CAS08 | - | 1034 ..... **483**
D | 2430 | CAS11 | - | 1034 ..... **483**
D | 2430 | CAS14 | - | 1034 ..... **484**
D | 2430 | CAS17 | - | 1034 ..... **484**

Admission Date and Hour

The date and time of the admission to the facility.

D | 2300 | DTP03 | - | 1251 ..... **151**

Admission Source Code

Code indicating the source of this admission.

D	2300	CL102		-	1314	**153**

Admission Type Code

Code indicating the priority of this admission.

D	2300	CL101		-	1315	**153**

Admitting Diagnosis Code

The diagnosis code describing the patient's diagnosis at the time of admission.

D	2300	HI01	C022-2		1271	**188**

Amount Qualifier Code

Code to qualify amount.

D	2300	AMT01		-	522	**160**
D	2320	AMT01		-	522	**364**
D	2320	AMT01		-	522	**365**
D	2320	AMT01		-	522	**366**
D	2400	AMT01		-	522	**439**
D	2400	AMT01		-	522	**440**
D	2430	AMT01		-	522	**487**

Assigned Number

Number assigned for differentiation within a transaction set.

D	2400	LX01		-	554	**423**

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	**146**

Attachment Control Number

Identification number of attachment related to the claim.

D	2300	PWK06		-	67	**157**
D	2400	PWK06		-	67	**432**

Attachment Report Type Code

Code to specify the type of attachment that is related to the claim.

D	2300	PWK01		-	755	**155**
D	2400	PWK01		-	755	**430**

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	**156**
D	2400	PWK02		-	756	**431**

Attending Provider First Name

First Name of the provider responsible for the care of the patient.

D	2310A	NM104		-	1036	**320**

Attending Provider Last Name

Last Name of the provider responsible for the care of the patient.

D	2310A	NM103		-	1035	**320**

Attending Provider Middle Name or Initial

Middle name or initial of the provider responsible for care of the patient.

D	2310A	NM105		-	1037	**320**

Attending Provider Name Suffix

Suffix to the name of the provider responsible for the care of the patient.

D	2310A	NM107		-	1039	**320**

Attending Provider Primary Identifier

Primary identifier for the provider responsible for the care of the patient.

D	2310A	NM109		-	67	**321**

Attending Provider Secondary Identifier

Additional identifier for the provider responsible for the care of the patient.

D	2310A	REF02		-	127	**325**

Auto Accident State or Province Code

State or Province where auto accident occurred.

D	2300	REF02		-	127	**172**

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	**146**
D	2320	OI03		-	1073	**367**

Billing Note Text

Free-form text providing additional information about the bill or claim being submitted.

D	2300	NTE02		-	352	**180**

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 | - | 67 ..... **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 | - | 116..... **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 | - | 127 ..... **130**

Billing Provider State or Province Code

State or province for provider or billing entity billing for services.

D | 2010AA | N402 | - | 156 ..... **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 | - | 127 ..... **90**

Bundled Line Number

Identification of line item bundled by payer in payment of benefits.

D | 2430 | SVD06 | - | 554 ..... **479**

Certification Condition Code Applies Indicator

Code indicating whether or not the condition codes apply to the patient or another entity.

D | 2300 | CRC02 | - | 1073 ..... **182**

Claim Adjustment Group Code

Code identifying the general category of payment adjustment.

D | 2320 | CAS01 | - | 1033 ..... **360**
D | 2430 | CAS01 | - | 1033 ..... **481**

Claim DRG Amount

Total of Prospective Payment System operating and capital amounts for this claim.

D | 2320 | MIA04 | - | 782 ..... **370**

Claim Disproportionate Share Amount

Sum of operating capital disproportionate share amounts for this claim.

D | 2320 | MIA06 | - | 782 ..... **370**

Claim Filing Indicator Code

Code identifying type of claim or expected adjudication process.

D | 2000B | SBR09 | - | 1032 .....**110**
D | 2320 | SBR09 | - | 1032 ..... **356**

Claim Frequency Code

Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.

D | 2300 | CLM05 | C023-3 | 1325 ..... **145**

Claim Identifier

Identifies type of claims in this transaction.

H | | BHT06 | - | 640 ..... **69**

Claim Indirect Teaching Amount

Total of operating and capital indirect teaching amounts for this claim.

D | 2320 | MIA18 | - | 782 ..... **372**

Claim MSP Pass-through Amount

Interim cost pass-though amount used to determine Medicare Secondary Payer liability.

D | 2320 | MIA07 | - | 782 ..... **370**

Claim Note Text

Narrative text providing additional information related to the claim.

D | 2300 | NTE02 | - | 352 ..... **179**

Claim PPS Capital Amount

Total Prospective Payment System (PPS) capital amount payable for this claim as output by PPS PRICER.

D | 2320 | MIA08 | - | 782 ..... **370**

Claim PPS Capital Outlier Amount

Total Prospective Payment System capital day or cost outlier payable for this claim, excluding operating outlier amount.

D	2320	MIA17	-	782		**372**

Claim Payment Remark Code

Code identifying the remark associated with the payment.

D	2320	MIA05	-	127		**370**
D	2320	MIA20	-	127		**372**
D	2320	MIA21	-	127		**373**
D	2320	MIA22	-	127		**373**
D	2320	MIA23	-	127		**373**
D	2320	MOA03	-	127		**375**
D	2320	MOA04	-	127		**375**
D	2320	MOA05	-	127		**375**
D	2320	MOA06	-	127		**375**
D	2320	MOA07	-	127		**375**

Code List Qualifier Code

Code identifying a specific industry code list.

D	2300	HI01	C022-1	1270		**184**
D	2300	HI01	C022-1	1270		**188**
D	2300	HI01	C022-1	1270		**190**
D	2300	HI02	C022-1	1270		**191**
D	2300	HI03	C022-1	1270		**192**
D	2300	HI01	C022-1	1270		**194**
D	2300	HI02	C022-1	1270		**196**
D	2300	HI03	C022-1	1270		**198**
D	2300	HI04	C022-1	1270		**200**
D	2300	HI05	C022-1	1270		**202**
D	2300	HI06	C022-1	1270		**204**
D	2300	HI07	C022-1	1270		**206**
D	2300	HI08	C022-1	1270		**208**
D	2300	HI09	C022-1	1270		**210**
D	2300	HI10	C022-1	1270		**212**
D	2300	HI11	C022-1	1270		**214**
D	2300	HI12	C022-1	1270		**216**
D	2300	HI01	C022-1	1270		**218**
D	2300	HI01	C022-1	1270		**221**
D	2300	HI02	C022-1	1270		**222**
D	2300	HI03	C022-1	1270		**224**
D	2300	HI04	C022-1	1270		**225**
D	2300	HI05	C022-1	1270		**227**
D	2300	HI06	C022-1	1270		**228**
D	2300	HI07	C022-1	1270		**230**
D	2300	HI08	C022-1	1270		**231**
D	2300	HI09	C022-1	1270		**233**
D	2300	HI10	C022-1	1270		**234**
D	2300	HI11	C022-1	1270		**236**
D	2300	HI12	C022-1	1270		**237**
D	2300	HI01	C022-1	1270		**240**
D	2300	HI01	C022-1	1270		**243**
D	2300	HI02	C022-1	1270		**244**
D	2300	HI03	C022-1	1270		**245**
D	2300	HI04	C022-1	1270		**246**
D	2300	HI05	C022-1	1270		**248**
D	2300	HI06	C022-1	1270		**249**
D	2300	HI07	C022-1	1270		**250**
D	2300	HI08	C022-1	1270		**251**
D	2300	HI09	C022-1	1270		**253**
D	2300	HI10	C022-1	1270		**254**
D	2300	HI11	C022-1	1270		**255**
D	2300	HI12	C022-1	1270		**256**
D	2300	HI01	C022-1	1270		**258**
D	2300	HI02	C022-1	1270		**259**
D	2300	HI03	C022-1	1270		**260**
D	2300	HI04	C022-1	1270		**261**
D	2300	HI05	C022-1	1270		**262**
D	2300	HI06	C022-1	1270		**263**
D	2300	HI07	C022-1	1270		**264**
D	2300	HI08	C022-1	1270		**265**
D	2300	HI09	C022-1	1270		**266**
D	2300	HI10	C022-1	1270		**267**
D	2300	HI11	C022-1	1270		**268**
D	2300	HI12	C022-1	1270		**269**
D	2300	HI01	C022-1	1270		**271**
D	2300	HI02	C022-1	1270		**272**
D	2300	HI03	C022-1	1270		**273**
D	2300	HI04	C022-1	1270		**274**
D	2300	HI05	C022-1	1270		**275**
D	2300	HI06	C022-1	1270		**276**
D	2300	HI07	C022-1	1270		**277**
D	2300	HI08	C022-1	1270		**278**
D	2300	HI09	C022-1	1270		**279**
D	2300	HI10	C022-1	1270		**280**
D	2300	HI11	C022-1	1270		**281**
D	2300	HI12	C022-1	1270		**282**
D	2300	HI01	C022-1	1270		**284**
D	2300	HI02	C022-1	1270		**285**
D	2300	HI03	C022-1	1270		**286**
D	2300	HI04	C022-1	1270		**287**
D	2300	HI05	C022-1	1270		**287**
D	2300	HI06	C022-1	1270		**288**
D	2300	HI07	C022-1	1270		**289**
D	2300	HI08	C022-1	1270		**290**
D	2300	HI09	C022-1	1270		**290**
D	2300	HI10	C022-1	1270		**291**
D	2300	HI11	C022-1	1270		**292**
D	2300	HI12	C022-1	1270		**293**
D	2300	HI01	C022-1	1270		**294**
D	2300	HI02	C022-1	1270		**295**
D	2300	HI03	C022-1	1270		**296**
D	2300	HI04	C022-1	1270		**297**
D	2300	HI05	C022-1	1270		**297**
D	2300	HI06	C022-1	1270		**298**
D	2300	HI07	C022-1	1270		**299**
D	2300	HI08	C022-1	1270		**300**
D	2300	HI09	C022-1	1270		**300**
D	2300	HI10	C022-1	1270		**301**
D	2300	HI11	C022-1	1270		**302**
D	2300	HI12	C022-1	1270		**303**
D	2300	HI01	C022-1	1270		**304**
D	2300	HI02	C022-1	1270		**305**
D	2300	HI03	C022-1	1270		**306**
D	2300	HI04	C022-1	1270		**307**
D	2300	HI05	C022-1	1270		**307**
D	2300	HI06	C022-1	1270		**308**
D	2300	HI07	C022-1	1270		**309**
D	2300	HI08	C022-1	1270		**309**
D	2300	HI09	C022-1	1270		**310**
D	2300	HI10	C022-1	1270		**311**
D	2300	HI11	C022-1	1270		**311**
D	2300	HI12	C022-1	1270		**312**

Code Qualifier

Code identifying the type of unit or measurement.

D	2300	CRC01	-	1136		**181**
D	2410	CTP05	C001-1	355		**453**

Communication Number

Complete communications number including country or area code when applicable

H	1000A	PER04	-	364		**74**
H	1000A	PER06	-	364		**75**
H	1000A	PER08	-	364		**75**
D	2010AA	PER04	-	364		**92**
D	2010AA	PER06	-	364		**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 ..... **294**
D | 2300 | HI02 | C022-2 | 1271 ..... **295**
D | 2300 | HI03 | C022-2 | 1271 ..... **296**
D | 2300 | HI04 | C022-2 | 1271 ..... **297**
D | 2300 | HI05 | C022-2 | 1271 ..... **297**
D | 2300 | HI06 | C022-2 | 1271 ..... **298**
D | 2300 | HI07 | C022-2 | 1271 ..... **299**
D | 2300 | HI08 | C022-2 | 1271 ..... **300**
D | 2300 | HI09 | C022-2 | 1271 ..... **300**
D | 2300 | HI10 | C022-2 | 1271 ..... **301**
D | 2300 | HI11 | C022-2 | 1271 ..... **302**
D | 2300 | HI12 | C022-2 | 1271 ..... **303**

Condition Indicator

Code indicating a condition

D | 2300 | CRC03 | - | 1321 ..... **182**
D | 2300 | CRC04 | - | 1321 ..... **182**
D | 2300 | CRC05 | - | 1321 ..... **183**

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 | - | 782 ..... **158**

Contract Code

Code identifying the specific contract, established by the payer.

D | 2300 | CN104 | - | 127 ..... **159**

Contract Percentage

Percent of charges payable under the contract

D | 2300 | CN103 | - | 332 ..... **159**

Contract Type Code

Code identifying a contract type

D | 2300 | CN101 | - | 1166..... **158**

Contract Version Identifier

Identification of additional or supplemental contract provisions, or identification of a particular version or modification of contract.

D | 2300 | CN106 | - | 799 ..... **159**

Cost Report Day Count

The number of days that may be claimed as Medicare patient days on a cost report.

D | 2320 | MIA15 | - | 380 ..... **372**

Country Code

Code indicating the geographic location.

D | 2010AA | N404 | - | 26 ..... **89**
D | 2010AB | N404 | - | 26 ..... **98**
D | 2010AC | N404 | - | 26 ..... **103**
D | 2010BA | N404 | - | 26 ..... **117**
D | 2010BB | N404 | - | 26 ..... **126**
D | 2010CA | N404 | - | 26 ..... **139**
D | 2310E | N404 | - | 26 ..... **346**
D | 2330A | N404 | - | 26 ..... **382**
D | 2330B | N404 | - | 26 ..... **388**

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 ..... **346**
D | 2330A | N407 | - | 1715 ..... **382**
D | 2330B | N407 | - | 1715 ..... **388**

Covered Days or Visits Count

Number of days or visits covered by the primary payer or days/visits that would have been covered had Medicare been primary.

D | 2320 | MIA01 | - | 380 ..... **369**

Currency Code

Code for country in whose currency the charges are specified.

D | 2000A | CUR02 | - | 100 ..... **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 ..... **149**
D | 2300 | DTP02 | - | 1250 ..... **150**
D | 2300 | DTP02 | - | 1250 ..... **151**
D | 2300 | DTP02 | - | 1250 ..... **152**
D | 2300 | HI01 | C022-3 | 1250 ..... **240**
D | 2300 | HI01 | C022-3 | 1250 ..... **243**
D | 2300 | HI02 | C022-3 | 1250 ..... **244**
D | 2300 | HI03 | C022-3 | 1250 ..... **246**
D | 2300 | HI04 | C022-3 | 1250 ..... **247**
D | 2300 | HI05 | C022-3 | 1250 ..... **248**
D | 2300 | HI06 | C022-3 | 1250 ..... **249**

D	2300	HI07	C022-3	1250	**251**
D	2300	HI08	C022-3	1250	**252**
D	2300	HI09	C022-3	1250	**253**
D	2300	HI10	C022-3	1250	**254**
D	2300	HI11	C022-3	1250	**256**
D	2300	HI12	C022-3	1250	**257**
D	2300	HI01	C022-3	1250	**259**
D	2300	HI02	C022-3	1250	**260**
D	2300	HI03	C022-3	1250	**261**
D	2300	HI04	C022-3	1250	**262**
D	2300	HI05	C022-3	1250	**263**
D	2300	HI06	C022-3	1250	**264**
D	2300	HI07	C022-3	1250	**265**
D	2300	HI08	C022-3	1250	**266**
D	2300	HI09	C022-3	1250	**267**
D	2300	HI10	C022-3	1250	**268**
D	2300	HI11	C022-3	1250	**269**
D	2300	HI12	C022-3	1250	**270**
D	2300	HI01	C022-3	1250	**272**
D	2300	HI02	C022-3	1250	**273**
D	2300	HI03	C022-3	1250	**274**
D	2300	HI04	C022-3	1250	**275**
D	2300	HI05	C022-3	1250	**276**
D	2300	HI06	C022-3	1250	**277**
D	2300	HI07	C022-3	1250	**278**
D	2300	HI08	C022-3	1250	**279**
D	2300	HI09	C022-3	1250	**280**
D	2300	HI10	C022-3	1250	**281**
D	2300	HI11	C022-3	1250	**282**
D	2300	HI12	C022-3	1250	**283**
D	2330B	DTP02	-	1250	**389**
D	2400	DTP02	-	1250	**434**
D	2430	DTP02	-	1250	**486**

Date Time Qualifier

Code specifying the type of date or time or both date and time.

D	2300	DTP01	-	374	**149**
D	2300	DTP01	-	374	**150**
D	2300	DTP01	-	374	**151**
D	2300	DTP01	-	374	**152**
D	2330B	DTP01	-	374	**389**
D	2400	DTP01	-	374	**434**
D	2430	DTP01	-	374	**486**

Delay Reason Code

Code indicating the reason why a request was delayed.

D	2300	CLM20	-	1514	**147**

Demonstration Project Identifier

Identification number for a Medicare demonstration project.

D	2300	REF02	-	127	**174**

Description

A free-form description to clarify the related data elements and their content.

D	2400	SV202	C003-7	352	**427**

Diagnosis Related Group (DRG) Code

Diagnosis related group for this claim.

D	2300	HI01	C022-2	1271	**219**

Discharge Time

Time the patient was discharged from the inpatient care.

D	2300	DTP03	-	1251	**149**

End Stage Renal Disease Payment Amount

Amount of payment under End Stage Renal Disease benefit.

D	2320	MOA08	-	782	**376**

Entity Identifier Code

Code identifying an organizational entity, a physical location, property or an individual.

H	1000A	NM101	-	98	**71**
H	1000B	NM101	-	98	**76**
D	2000A	CUR01	-	98	**82**
D	2010AA	NM101	-	98	**85**
D	2010AB	NM101	-	98	**94**
D	2010AC	NM101	-	98	**99**
D	2010BA	NM101	-	98	**112**
D	2010BB	NM101	-	98	**122**
D	2010CA	NM101	-	98	**135**
D	2310A	NM101	-	98	**319**
D	2310B	NM101	-	98	**327**
D	2310C	NM101	-	98	**332**
D	2310D	NM101	-	98	**337**
D	2310E	NM101	-	98	**342**
D	2310F	NM101	-	98	**350**
D	2330A	NM101	-	98	**378**
D	2330B	NM101	-	98	**384**
D	2330C	NM101	-	98	**397**
D	2330C	NM101	-	98	**397**
D	2330D	NM101	-	98	**401**
D	2330E	NM101	-	98	**405**
D	2330F	NM101	-	98	**409**
D	2330G	NM101	-	98	**413**
D	2330H	NM101	-	98	**417**
D	2330I	NM101	-	98	**421**
D	2420A	NM101	-	98	**457**
D	2420B	NM101	-	98	**462**
D	2420C	NM101	-	98	**467**
D	2420D	NM101	-	98	**472**

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	**320**
D	2310B	NM102	-	1065	**327**
D	2310C	NM102	-	1065	**332**
D	2310D	NM102	-	1065	**337**
D	2310E	NM102	-	1065	**342**
D	2310F	NM102	-	1065	**350**
D	2330A	NM102	-	1065	**378**
D	2330B	NM102	-	1065	**384**
D	2330C	NM102	-	1065	**397**
D	2330C	NM102	-	1065	**397**
D	2330D	NM102	-	1065	**401**
D	2330E	NM102	-	1065	**405**
D	2330F	NM102	-	1065	**409**
D	2330G	NM102	-	1065	**413**

D	2330H	NM102	-	1065		**417**
D	2330I	NM102	-	1065		**421**
D	2420A	NM102	-	1065		**457**
D	2420B	NM102	-	1065		**462**
D	2420C	NM102	-	1065		**467**
D	2420D	NM102	-	1065		**472**

Exception Code

Exception code generated by the Third Party Organization.

D	2300	HCP15	-	1527		**318**
D	2400	HCP15	-	1527		**448**

External Cause of Injury Code

Code identifying the cause of the injury.

D	2300	HI01	C022-2	1271		**194**
D	2300	HI02	C022-2	1271		**196**
D	2300	HI03	C022-2	1271		**198**
D	2300	HI04	C022-2	1271		**200**
D	2300	HI05	C022-2	1271		**202**
D	2300	HI06	C022-2	1271		**204**
D	2300	HI07	C022-2	1271		**206**
D	2300	HI08	C022-2	1271		**208**
D	2300	HI09	C022-2	1271		**210**
D	2300	HI10	C022-2	1271		**212**
D	2300	HI11	C022-2	1271		**214**
D	2300	HI12	C022-2	1271		**216**

Facility Code Qualifier

Code identifying the type of facility referenced.

D	2300	CLM05	C023-2	1332		**145**

Facility Tax Amount

The amount of facility tax or surcharge applicable to the reported service.

D	2400	AMT02	-	782		**440**

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		**145**

Fixed Format Information

Data in fixed format agreed upon by sender and receiver

D	2300	K301	-	449		**177**

HCPCS Payable Amount

Amount due under Medicare HCPCS system.

D	2320	MOA02	-	782		**375**

Hierarchical Child Code

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

D	2000A	HL04	-	736		**79**
D	2000B	HL04	-	736		**108**
D	2000C	HL04	-	736		**132**

Hierarchical ID Number

A unique number assigned by the sender to identify a particular data segment in a hierarchical structure.

D	2000A	HL01	-	628		**78**
D	2000B	HL01	-	628		**107**
D	2000C	HL01	-	628		**131**

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure.

D	2000A	HL03	-	735		**78**
D	2000B	HL03	-	735		**108**
D	2000C	HL03	-	735		**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	-	734		**108**
D	2000C	HL02	-	734		**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	-	66		**72**
H	1000B	NM108	-	66		**77**
D	2010AA	NM108	-	66		**86**
D	2010AC	NM108	-	66		**100**
D	2010BA	NM108	-	66		**113**
D	2010BB	NM108	-	66		**123**
D	2300	PWK05	-	66		**157**
D	2310A	NM108	-	66		**321**
D	2310B	NM108	-	66		**328**
D	2310C	NM108	-	66		**333**
D	2310D	NM108	-	66		**338**
D	2310E	NM108	-	66		**342**
D	2310F	NM108	-	66		**351**
D	2330A	NM108	-	66		**379**
D	2330B	NM108	-	66		**385**
D	2400	PWK05	-	66		**432**
D	2420A	NM108	-	66		**458**
D	2420B	NM108	-	66		**463**
D	2420C	NM108	-	66		**468**
D	2420D	NM108	-	66		**473**

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		**355**

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 ..... **356**

Investigational Device Exemption Identifier

Number or reference identifying exemption assigned to an ivestigational device referenced in the claim.

D | 2300 | REF02 | - | 127 ..... **169**

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 ..... **344**
D | 2310E | N302 | - | 166 ..... **344**

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 ..... **345**

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 ..... **342**

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..... **346**

Laboratory or Facility Primary Identifier

Identification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.

D | 2310E | NM109 | - | 67 ..... **342**

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 ..... **348**

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 ..... **346**

Lifetime Psychiatric Days Count

Number of lifetime psychiatric days used for this claim.

D | 2320 | MIA03 | - | 380 ..... **370**

Line Item Charge Amount

Charges related to this service.

D | 2400 | SV203 | - | 782 ..... **427**

Line Item Control Number

Identifier assigned by the submitter/provider to this line item.

D | 2400 | REF02 | - | 127 ..... **436**

Line Item Denied Charge or Non-Covered Charge Amount

Line item charges denied or not covered.

D | 2400 | SV207 | - | 782 ..... **428**

Line Note Text

Narrative text providing additional information related to the service line.

D | 2400 | NTE02 | - | 352 ..... **441**

Medical Record Number

A unique number assigned to patient by the provider to assist in retrieval of medical records.

D | 2300 | REF02 | - | 127 ..... **173**

Monetary Amount

Monetary amount.

D | 2400 | HCP02 | - | 782 ..... **443**
D | 2400 | HCP03 | - | 782 ..... **443**
D | 2400 | HCP07 | - | 782 ..... **444**

National Drug Code

The national drug identification number assigned by the Federal Drug Administration (FDA).

D | 2410 | LIN03 | - | 234 ..... **451**

National Drug Unit Count

The dispensing quantity, based upon the unit of measure as defined by the National Drug Code.

D | 2410 | CTP04 | - | 380 ..... **452**

Non-Covered Charge Amount

Charges pertaining to the related revenue center code that the primary payer will not cover.

D	2320	AMT02	-	782	.....	**366**

Non-Payable Professional Component Billed Amount

Amount of non-payable charges included in the bill related to professional services.

D	2320	MIA19	-	782	.....	**372**
D	2320	MOA09	-	782	.....	**376**

Note Reference Code

Code identifying the functional area or purpose for which the note applies.

D	2300	NTE01	-	363	.....	**178**
D	2300	NTE01	-	363	.....	**180**
D	2400	NTE01	-	363	.....	**441**

Occurrence Code

A code defining a significant event relating to this bill that may affect payer processing.

D	2300	HI01	C022-2	1271	.....	**271**
D	2300	HI02	C022-2	1271	.....	**272**
D	2300	HI03	C022-2	1271	.....	**273**
D	2300	HI04	C022-2	1271	.....	**274**
D	2300	HI05	C022-2	1271	.....	**275**
D	2300	HI06	C022-2	1271	.....	**276**
D	2300	HI07	C022-2	1271	.....	**277**
D	2300	HI08	C022-2	1271	.....	**278**
D	2300	HI09	C022-2	1271	.....	**279**
D	2300	HI10	C022-2	1271	.....	**280**
D	2300	HI11	C022-2	1271	.....	**281**
D	2300	HI12	C022-2	1271	.....	**282**

Occurrence Code Date

Date associated with the Occurrence Code reported in this composite element.

D	2300	HI01	C022-4	1251	.....	**272**
D	2300	HI02	C022-4	1251	.....	**273**
D	2300	HI03	C022-4	1251	.....	**274**
D	2300	HI04	C022-4	1251	.....	**275**
D	2300	HI05	C022-4	1251	.....	**276**
D	2300	HI06	C022-4	1251	.....	**277**
D	2300	HI07	C022-4	1251	.....	**278**
D	2300	HI08	C022-4	1251	.....	**279**
D	2300	HI09	C022-4	1251	.....	**280**
D	2300	HI10	C022-4	1251	.....	**281**
D	2300	HI11	C022-4	1251	.....	**282**
D	2300	HI12	C022-4	1251	.....	**283**

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	.....	**258**
D	2300	HI02	C022-2	1271	.....	**259**
D	2300	HI03	C022-2	1271	.....	**260**
D	2300	HI04	C022-2	1271	.....	**261**
D	2300	HI05	C022-2	1271	.....	**262**
D	2300	HI06	C022-2	1271	.....	**263**
D	2300	HI07	C022-2	1271	.....	**264**
D	2300	HI08	C022-2	1271	.....	**265**
D	2300	HI09	C022-2	1271	.....	**266**
D	2300	HI10	C022-2	1271	.....	**267**
D	2300	HI11	C022-2	1271	.....	**268**
D	2300	HI12	C022-2	1271	.....	**269**

Occurrence Span Code Date

Date associated with the Occurrence Span Code reported in this composite element.

D	2300	HI01	C022-4	1251	.....	**259**
D	2300	HI02	C022-4	1251	.....	**260**
D	2300	HI03	C022-4	1251	.....	**261**
D	2300	HI04	C022-4	1251	.....	**262**
D	2300	HI05	C022-4	1251	.....	**263**
D	2300	HI06	C022-4	1251	.....	**264**
D	2300	HI07	C022-4	1251	.....	**265**
D	2300	HI08	C022-4	1251	.....	**266**
D	2300	HI09	C022-4	1251	.....	**267**
D	2300	HI10	C022-4	1251	.....	**268**
D	2300	HI11	C022-4	1251	.....	**269**
D	2300	HI12	C022-4	1251	.....	**270**

Old Capital Amount

The amount for old capital for this claim.

D	2320	MIA12	-	782	.....	**371**

Operating Physician First Name

First name of the physician performing the principle procedure.

D	2310B	NM104	-	1036	.....	**327**
D	2420A	NM104	-	1036	.....	**457**

Operating Physician Last Name

Last name of the physician performing the principle procedure.

D	2310B	NM103	-	1035	.....	**327**
D	2420A	NM103	-	1035	.....	**457**

Operating Physician Middle Name or Initial

Middle name or initial of the physician performing the principal procedure.

D	2310B	NM105	-	1037	.....	**327**
D	2420A	NM105	-	1037	.....	**457**

Operating Physician Name Suffix

Suffix to the name of the physician performing the principal procedure.

D	2310B	NM107	-	1039	.....	**327**
D	2420A	NM107	-	1039	.....	**457**

Operating Physician Primary Identifier

Primary identifier of the physician performing the principle procedure.

D	2310B	NM109	-	67	.....	**328**
D	2420A	NM109	-	67	.....	**458**

Operating Physician Secondary Identifier

Additional identifier for the physician performing the principal procedure.

D	2310B	REF02	-	127	.....	**330**
D	2420A	REF02	-	127	.....	**460**

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	.....	**221**
D	2300	HI02	C022-2	1271	.....	**222**
D	2300	HI03	C022-2	1271	.....	**224**
D	2300	HI04	C022-2	1271	.....	**225**
D	2300	HI05	C022-2	1271	.....	**227**
D	2300	HI06	C022-2	1271	.....	**228**
D	2300	HI07	C022-2	1271	.....	**230**
D	2300	HI08	C022-2	1271	.....	**231**
D	2300	HI09	C022-2	1271	.....	**233**
D	2300	HI10	C022-2	1271	.....	**234**
D	2300	HI11	C022-2	1271	.....	**236**
D	2300	HI12	C022-2	1271	.....	**237**

Other Insured Additional Identifier

Number providing additional identification of the other insured.

D	2330A	REF02	-	127	.....	**383**

Other Insured Address Line

Address line of the additional insured individual's mailing address.

D	2330A	N301	-	166	.....	**380**
D	2330A	N302	-	166	.....	**380**

Other Insured City Name

The city name of the additional insured individual.

D	2330A	N401	-	19	.....	**381**

Other Insured First Name

The first name of the additional insured individual.

D	2330A	NM104	-	1036	.....	**378**

Other Insured Group Name

Name of the group or plan through which the insurance is provided to the other insured.

D	2320	SBR04	-	93	.....	**356**

Other Insured Identifier

An identification number, assigned by the third party payer, to identify the additional insured individual.

D	2330A	NM109	-	67	.....	**379**

Other Insured Last Name

The last name of the additional insured individual.

D	2330A	NM103	-	1035	.....	**378**

Other Insured Middle Name

The middle name of the additional insured individual.

D	2330A	NM105	-	1037	.....	**378**

Other Insured Name Suffix

The suffix to the name of the additional insured individual.

D	2330A	NM107	-	1039	.....	**378**

Other Insured Postal Zone or ZIP Code

The Postal ZIP code of the additional insured individual's mailing address.

D	2330A	N403	-	116	.....	**382**

Other Insured State Code

The state code of the additional insured individual's mailing address.

D	2330A	N402	-	156	.....	**382**

Other Operating Physician First Name

First Name of the individual performing a secondary surgical procedure or assisting the Operating Physician.

D	2310C	NM104	-	1036	.....	**332**
D	2420B	NM104	-	1036	.....	**462**

Other Operating Physician Identifier

National identifier for the individual performing a secondary surgical procedure or assisting the Operating Physician.

D	2310C	NM109	-	67	.....	**333**
D	2420B	NM109	-	67	.....	**463**

Other Operating Physician Last Name

Last Name of the individual performing a secondary surgical procedure or assisting the Operating Physician.

D	2310C	NM103	-	1035	.....	**332**
D	2420B	NM103	-	1035	.....	**462**

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 ..... **332**
D | 2420B | NM105 | - | 1037 ..... **462**

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 ..... **332**
D | 2420B | NM107 | - | 1039 ..... **462**

Other Payer Address Line

Address line of the other payer's mailing address.

D | 2330B | N301 | - | 166 ..... **386**
D | 2330B | N302 | - | 166 ..... **386**

Other Payer Attending Provider Secondary Identifier

The non-destination (COB) payer's attending provider identification.

D | 2330C | REF02 | - | 127 ..... **399**

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 ..... **422**

Other Payer City Name

The city name of the other payer's mailing address.

D | 2330B | N401 | - | 19 ..... **387**

Other Payer Claim Adjustment Indicator

Indicates the other payer has made a previous claim adjustment to this claim.

D | 2330B | REF02 | - | 127 ..... **394**

Other Payer Last or Organization Name

The name of the other payer organization.

D | 2330B | NM103 | - | 1035 ..... **385**

Other Payer Operating Provider Secondary Identifier

The non-destination (COB) payer's operating provider identification.

D | 2330D | REF02 | - | 127 ..... **403**

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 ..... **407**

Other Payer Postal Zone or ZIP Code

The ZIP code of the other payer's mailing address.

D | 2330B | N403 | - | 116..... **388**

Other Payer Primary Identifier

An identification number for the other payer.

D | 2330B | NM109 | - | 67 ..... **385**
D | 2420A | REF04 | C040-2 | 127 ..... **460**
D | 2420B | REF04 | C040-2 | 127 ..... **465**
D | 2420C | REF04 | C040-2 | 127 ..... **470**
D | 2420D | REF04 | C040-2 | 127 ..... **475**
D | 2430 | SVD01 | - | 67 ..... **476**

Other Payer Prior Authorization Number

The non-destination (COB) payer's prior authorization number.

D | 2330B | REF02 | - | 127 ..... **392**

Other Payer Prior Authorization or Referral Number

The non-destination (COB) payer's prior authorization or referral number.

D | 2330B | REF02 | - | 127 ..... **393**

Other Payer Referring Provider Identifier

The non-destination (COB) payer's referring provider identifier.

D | 2330H | REF02 | - | 127 ..... **419**

Other Payer Rendering Provider Secondary Identifier

The non-destination (COB) payer's rendering provider identifier.

D | 2330G | REF02 | - | 127 ..... **415**

Other Payer Secondary Identifier

Additional identifier for the other payer organization

D | 2330B | REF02 | - | 127 ..... **391**

Other Payer Service Facility Location Identifier

The non-destination (COB) payer's service facility location identifier.

D | 2330F | REF02 | - | 127 ..... **410**

Other Payer State Code

The state or province code of the other payer's mailing address.

D | 2330B | N402 | - | 156 ..... **387**

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 ..... **395**

Other Provider Secondary Identifier

Additional identification number of the other provider as defined by the payer organization.

D | 2310C | REF02 | - | 127 ..... **335**
D | 2420B | REF02 | - | 127 ..... **465**

PPS-Capital DSH DRG Amount

PPS-capital disproportionate share amount for this claim as output by PPS-PRICER.

D | 2320 | MIA11 | - | 782 ..... **371**

PPS-Capital Exception Amount

A per discharge payment exception paid to the hospital. It is a flat-rate add-on to the PPS payment.

D | 2320 | MIA24 | - | 782 ..... **373**

PPS-Capital FSP DRG Amount

PPS-capital federal portion for this claim as output by PPS-PRICER.

D | 2320 | MIA09 | - | 782 ..... **371**

PPS-Capital HSP DRG Amount

Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.

D | 2320 | MIA10 | - | 782 ..... **371**

PPS-Capital IME amount

PPS-capital indirect medical expenses for this claim as output by PPS-PRICER.

D | 2320 | MIA13 | - | 782 ..... **371**

PPS-Operating Federal Specific DRG Amount

Sum of federal operating portion of the DRG amount this claim as output by PPS-PRICER.

D | 2320 | MIA16 | - | 782 ..... **372**

PPS-Operating Hospital Specific DRG Amount

Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.

D | 2320 | MIA14 | - | 782 ..... **371**

Paid Service Unit Count

Units of service paid by the payer for coordination of benefits.

D | 2430 | SVD05 | - | 380 ..... **479**

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 ..... **144**

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 ..... **190**
D | 2300 | HI02 | C022-2 | 1271 ..... **191**
D | 2300 | HI03 | C022-2 | 1271 ..... **192**

Patient Responsibility Amount

The amount determined to be the patient's responsibility for payment.

D | 2300 | AMT02 | - | 782 ..... **160**

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 ..... **153**

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 | - | 19 ..... **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 | - | 67 ..... **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 | - | 19 ..... **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 | - | 19 ..... **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 ..... **166**

Payer Identifier

Number identifying the payer organization.

D | 2010BB | NM109 | - | 67 ..... **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 | - | 782 ..... **364**

Payer Postal Zone or ZIP Code

The ZIP Code of the Payer's claim mailing address for this particular payer organization identification and claim office.

D | 2010BB | N403 | - | 116..... **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..... **355**

Payer State Code

State Postal Code of the Payer's claim mailing address for this particular payor organization identification and claim office.

D | 2010BB | N402 | - | 156 ..... **125**

Peer Review Authorization Number

Authorization number provided by a review organization after review completed.

D | 2300 | REF02 | - | 127 ..... **175**

Policy Compliance Code

The code that specifies policy compliance.

D | 2300 | HCP14 | - | 1526 ..... **317**
D | 2400 | HCP14 | - | 1526 ..... **448**

Prescription Number

The unique identification number assigned by the pharmacy or supplier to the prescription.

D | 2410 | REF02 | - | 127 ..... **455**

Present on Admission Indicator

Code which provides an indication as to whether the diagnosis was present at the time of adimission.

D | 2300 | HI01 | C022-9 | 1073 ..... **185**
D | 2300 | HI01 | C022-9 | 1073 ..... **195**
D | 2300 | HI02 | C022-9 | 1073 ..... **197**
D | 2300 | HI03 | C022-9 | 1073 ..... **199**
D | 2300 | HI04 | C022-9 | 1073 ..... **201**
D | 2300 | HI05 | C022-9 | 1073 ..... **203**
D | 2300 | HI06 | C022-9 | 1073 ..... **205**
D | 2300 | HI07 | C022-9 | 1073 ..... **207**
D | 2300 | HI08 | C022-9 | 1073 ..... **209**
D | 2300 | HI09 | C022-9 | 1073 .....**211**
D | 2300 | HI10 | C022-9 | 1073 ..... **213**
D | 2300 | HI11 | C022-9 | 1073 ..... **215**
D | 2300 | HI12 | C022-9 | 1073 ..... **217**
D | 2300 | HI01 | C022-9 | 1073 ..... **221**
D | 2300 | HI02 | C022-9 | 1073 ..... **223**
D | 2300 | HI03 | C022-9 | 1073 ..... **224**
D | 2300 | HI04 | C022-9 | 1073 ..... **226**
D | 2300 | HI05 | C022-9 | 1073 ..... **227**
D | 2300 | HI06 | C022-9 | 1073 ..... **229**
D | 2300 | HI07 | C022-9 | 1073 ..... **230**
D | 2300 | HI08 | C022-9 | 1073 ..... **232**
D | 2300 | HI09 | C022-9 | 1073 ..... **233**
D | 2300 | HI10 | C022-9 | 1073 ..... **235**
D | 2300 | HI11 | C022-9 | 1073 ..... **236**
D | 2300 | HI12 | C022-9 | 1073 ..... **238**

Pricing Methodology

Pricing methodology at which the claim or line item has been priced or repriced.

D | 2300 | HCP01 | - | 1473 ..... **314**
D | 2400 | HCP01 | - | 1473 ..... **443**

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 ..... **185**

Principal Procedure Code

Code identifying the principal procedure, product or service.

D | 2300 | HI01 | C022-2 | 1271 ..... **240**

Principal Procedure Date

Date on which the Principal Procedure was performed.

D | 2300 | HI01 | C022-4 | 1251 ..... **240**

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 | - | 127 ..... **165**

Procedure Code

Code identifying the procedure, product or service.

D | 2300 | HI01 | C022-2 | 1271 ..... **243**
D | 2300 | HI02 | C022-2 | 1271 ..... **244**
D | 2300 | HI03 | C022-2 | 1271 ..... **245**
D | 2300 | HI04 | C022-2 | 1271 ..... **247**
D | 2300 | HI05 | C022-2 | 1271 ..... **248**
D | 2300 | HI06 | C022-2 | 1271 ..... **249**
D | 2300 | HI07 | C022-2 | 1271 ..... **250**
D | 2300 | HI08 | C022-2 | 1271 ..... **252**
D | 2300 | HI09 | C022-2 | 1271 ..... **253**
D | 2300 | HI10 | C022-2 | 1271 ..... **254**
D | 2300 | HI11 | C022-2 | 1271 ..... **255**
D | 2300 | HI12 | C022-2 | 1271 ..... **257**

D	2400	SV202	C003-2	234	**426**
D	2430	SVD03	C003-2	234	**478**

Procedure Code Description

Description clarifying the Product/Service Procedure Code and related data elements.

D	2430	SVD03	C003-7	352	**479**

Procedure Date

Date when the health care procedure was performed.

D	2300	HI01	C022-4	1251	**243**
D	2300	HI02	C022-4	1251	**245**
D	2300	HI03	C022-4	1251	**246**
D	2300	HI04	C022-4	1251	**247**
D	2300	HI05	C022-4	1251	**248**
D	2300	HI06	C022-4	1251	**250**
D	2300	HI07	C022-4	1251	**251**
D	2300	HI08	C022-4	1251	**252**
D	2300	HI09	C022-4	1251	**253**
D	2300	HI10	C022-4	1251	**255**
D	2300	HI11	C022-4	1251	**256**
D	2300	HI12	C022-4	1251	**257**

Procedure Modifier

This identifies special circumstances related to the performance of the service.

D	2400	SV202	C003-3	1339	**426**
D	2400	SV202	C003-4	1339	**426**
D	2400	SV202	C003-5	1339	**427**
D	2400	SV202	C003-6	1339	**427**
D	2430	SVD03	C003-3	1339	**478**
D	2430	SVD03	C003-4	1339	**478**
D	2430	SVD03	C003-5	1339	**478**
D	2430	SVD03	C003-6	1339	**479**

Product or Service ID

Identifying number for a product or service.

D	2400	HCP08	-	234	**445**

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	**425**
D	2400	HCP09	-	235	**445**
D	2410	LIN02	-	235	**451**
D	2430	SVD03	C003-1	235	**477**

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**

Provider Code

Code identifying the type of provider.

D	2000A	PRV01	-	1221	**80**
D	2310A	PRV01	-	1221	**322**

Provider Taxonomy Code

Code designating the provider type, classification, and specialization.

D	2000A	PRV03	-	127	**80**
D	2310A	PRV03	-	127	**322**

Quantity

Numeric value of quantity.

D	2400	HCP12	-	380	**447**

Rate

Rate expressed in the standard monetary denomination for the currency specified.

D	2400	HCP05	-	118	**444**

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	-	67	**77**

Reference Identification

The identification value assigned by the sender for this particular transaction.

D	2400	HCP04	-	127	**444**
D	2400	HCP06	-	127	**444**

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	2300	REF01	-	128	**161**
D	2300	REF01	-	128	**163**
D	2300	REF01	-	128	**164**
D	2300	REF01	-	128	**166**
D	2300	REF01	-	128	**167**
D	2300	REF01	-	128	**168**
D	2300	REF01	-	128	**169**
D	2300	REF01	-	128	**170**
D	2300	REF01	-	128	**172**
D	2300	REF01	-	128	**173**
D	2300	REF01	-	128	**174**
D	2300	REF01	-	128	**175**
D	2310A	PRV02	-	128	**322**
D	2310A	REF01	-	128	**324**
D	2310B	REF01	-	128	**329**
D	2310C	REF01	-	128	**334**
D	2310D	REF01	-	128	**339**
D	2310E	REF01	-	128	**347**
D	2310F	REF01	-	128	**352**
D	2330A	REF01	-	128	**383**
D	2330B	REF01	-	128	**390**

D	2330B	REF01	-	128	**392**
D	2330B	REF01	-	128	**393**
D	2330B	REF01	-	128	**394**
D	2330B	REF01	-	128	**395**
D	2330C	REF01	-	128	**398**
D	2330C	REF01	-	128	**398**
D	2330D	REF01	-	128	**402**
D	2330E	REF01	-	128	**406**
D	2330F	REF01	-	128	**410**
D	2330G	REF01	-	128	**414**
D	2330H	REF01	-	128	**418**
D	2330I	REF01	-	128	**422**
D	2400	REF01	-	128	**435**
D	2400	REF01	-	128	**437**
D	2400	REF01	-	128	**438**
D	2410	REF01	-	128	**454**
D	2420A	REF01	-	128	**459**
D	2420A	REF04	C040-1	128	**460**
D	2420B	REF01	-	128	**464**
D	2420B	REF04	C040-1	128	**465**
D	2420C	REF01	-	128	**469**
D	2420C	REF04	C040-1	128	**470**
D	2420D	REF01	-	128	**474**
D	2420D	REF04	C040-1	128	**475**

Referral Number

Referral authorization number.

D	2300	REF02	-	127	**163**

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	**350**
D	2420D	NM104	-	1036	**472**

Referring Provider Identifier

The identification number for the referring physician.

D	2310F	NM109	-	67	**351**
D	2420D	NM109	-	67	**473**

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	**350**
D	2420D	NM103	-	1035	**472**

Referring Provider Middle Name or Initial

Middle name or initial of the provider who is referring patient for care.

D	2310F	NM105	-	1037	**350**
D	2420D	NM105	-	1037	**472**

Referring Provider Name Suffix

Suffix to the name of the provider referring the patient for care.

D	2310F	NM107	-	1039	**350**
D	2420D	NM107	-	1039	**472**

Referring Provider Secondary Identifier

Additional identification number for the provider referring the patient for service.

D	2310F	REF02	-	127	**353**
D	2420D	REF02	-	127	**475**

Reimbursement Rate

Rate used when payment is based upon a percentage of applicable charges.

D	2320	MOA01	-	954	**374**

Reject Reason Code

Code assigned by issuer to identify reason for rejection.

D	2300	HCP13	-	901	**317**
D	2400	HCP13	-	901	**447**

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	**147**
D	2320	OI06	-	1363	**368**

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	-	782	**365**
D	2430	AMT02	-	782	**487**

Rendering Provider First Name

The first name of the provider who performed the service.

D	2310D	NM104	-	1036	**337**
D	2420C	NM104	-	1036	**467**

Rendering Provider Identifier

The identifier assigned by the Payor to the provider who performed the service.

D	2310D	NM109	-	67	**338**
D	2420C	NM109	-	67	**468**

Rendering Provider Last Name

The last name of the provider who performed the service.

D	2310D	NM103	-	1035	**337**
D	2420C	NM103	-	1035	**467**

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	**337**
D	2420C	NM105	-	1037	**467**

Rendering Provider Name Suffix

Name suffix of the provider who has provided the services to the patient.

D | 2310D | NM107 | - | 1039 ..... **337**
D | 2420C | NM107 | - | 1039 ..... **467**

Rendering Provider Secondary Identifier

Additional identifier for the provider providing care to the patient.

D | 2310D | REF02 | - | 127 ..... **340**
D | 2420C | REF02 | - | 127 ..... **470**

Repriced Allowed Amount

The maximum amount determined by the repricer as being allowable under the provisions of the contract prior to the determination of the actual payment.

D | 2300 | HCP02 | - | 782 ..... **314**

Repriced Approved Amount

The amount allowed by the repricer for the claim or service line net of adjustments.

D | 2300 | HCP07 | - | 782 ..... **315**

Repriced Approved DRG Code

The Diagnosis Related Group approved by the repricer for payment for this claim

D | 2300 | HCP06 | - | 127 ..... **315**

Repriced Approved HCPCS Code

The HCPCS code that describes the services as approved by the repricer.

D | 2400 | HCP10 | - | 234 ..... **446**

Repriced Approved Revenue Code

UB92 revenue code approved by the repricer for payment on the claim.

D | 2300 | HCP08 | - | 234 ..... **316**

Repriced Approved Service Unit Count

Number of service units approved by pricing or repricing entity.

D | 2300 | HCP12 | - | 380 ..... **316**

Repriced Claim Reference Number

Identification number, assigned by a repricing organization, to identify the claim.

D | 2300 | REF02 | - | 127 ..... **167**

Repriced Line Item Reference Number

Identification number of a line item repriced by a third party or prior payer.

D | 2400 | REF02 | - | 127 ..... **437**

Repriced Saving Amount

The amount of savings related to Third Party Organization claims.

D | 2300 | HCP03 | - | 782 ..... **314**

Repricer Received Date

Date the claim was received by the repricer organization.

D | 2300 | DTP03 | - | 1251 ..... **152**

Repricing Organization Identifier

Reference or identification number of the repricing organization.

D | 2300 | HCP04 | - | 127 ..... **315**

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..... **315**

Service Authorization Exception Code

Code identifying the service authorization exception.

D | 2300 | REF02 | - | 127 ..... **161**

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 ..... **434**

Service Line Paid Amount

Amount paid by the indicated payer for a service line

D | 2430 | SVD02 | - | 782 ..... **477**

Service Line Revenue Code

UB92 Revenue Code pertaining to the service line.

D | 2400 | SV201 | - | 234 ..... **424**

Service Tax Amount

The amount of service tax or surcharge applicable to the reported service.

D | 2400 | AMT02 | - | 782 ..... **439**

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 ..... **428**

Statement From and To Date

The date of the start or end of the period covered on the claim.

D | 2300 | DTP03 | - | 1251 ..... **150**

Submitter Contact Name

Name of the person at the submitter organization to whom inquiries about the transaction should be directed.

H | 1000A | PER02 | - | 93 ..... **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 | - | 67 ..... **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 | - | 19 .....**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 | - | 93 .....**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 | - | 67 .....**114**

Subscriber State Code

The State Postal Code of the insured individual or subscriber to the coverage.

D | 2010BA | N402 | - | 156 .....**116**

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	-		338	**159**

Total Claim Charge Amount

The sum of all charges included within this claim.

D	2300	CLM02	-		782	**145**

Transaction Segment Count

A tally of all segments between the ST and the SE segments including the ST and SE segments.

D		SE01	-		96	**488**

Transaction Set Control Number

The unique identification number within a transaction set.

H		ST02	-		329	**67**
D		SE02	-		329	**488**

Transaction Set Creation Date

Identifies the date the submitter created the transaction.

H		BHT04	-		373	**69**

Transaction Set Creation Time

Time file is created for transmission.

H		BHT05	-		337	**69**

Transaction Set Identifier Code

Code uniquely identifying a Transaction Set.

H		ST01	-		143	**67**

Transaction Set Purpose Code

Code identifying purpose of transaction set.

H		BHT02	-		353	**68**

Treatment Code

Codes describing the treatment ordered by the physician.

D	2300	HI01	C022-2		1271	**305**
D	2300	HI02	C022-2		1271	**305**
D	2300	HI03	C022-2		1271	**306**
D	2300	HI04	C022-2		1271	**307**
D	2300	HI05	C022-2		1271	**307**
D	2300	HI06	C022-2		1271	**308**
D	2300	HI07	C022-2		1271	**309**
D	2300	HI08	C022-2		1271	**309**
D	2300	HI09	C022-2		1271	**310**
D	2300	HI10	C022-2		1271	**311**
D	2300	HI11	C022-2		1271	**311**
D	2300	HI12	C022-2		1271	**312**

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	-		355	**316**
D	2400	SV204	-		355	**428**
D	2400	HCP11	-		355	**447**

Value Added Network Trace Number

Unique Identification number for a transaction assigned by a Value Added Network, Clearinghouse, or other transmission entity.

D	2300	REF02	-		127	**171**

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	**284**
D	2300	HI02	C022-2		1271	**285**
D	2300	HI03	C022-2		1271	**286**
D	2300	HI04	C022-2		1271	**287**
D	2300	HI05	C022-2		1271	**288**
D	2300	HI06	C022-2		1271	**288**
D	2300	HI07	C022-2		1271	**289**
D	2300	HI08	C022-2		1271	**290**
D	2300	HI09	C022-2		1271	**291**
D	2300	HI10	C022-2		1271	**291**
D	2300	HI11	C022-2		1271	**292**
D	2300	HI12	C022-2		1271	**293**

Value Code Amount

Amount associated with the value code reported in this composite element.

D	2300	HI01	C022-5		782	**285**
D	2300	HI02	C022-5		782	**285**
D	2300	HI03	C022-5		782	**286**
D	2300	HI04	C022-5		782	**287**
D	2300	HI05	C022-5		782	**288**
D	2300	HI06	C022-5		782	**288**
D	2300	HI07	C022-5		782	**289**
D	2300	HI08	C022-5		782	**290**
D	2300	HI09	C022-5		782	**291**
D	2300	HI10	C022-5		782	**291**
D	2300	HI11	C022-5		782	**292**
D	2300	HI12	C022-5		782	**293**

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**