ASC X12N/005010X223

Based on Version 5, Release 1

ASC X12 Standards for Electronic Data Interchange Technical Report Type 3

Health Care Claim: Institutional (837)

MAY 2006

Contact Washington Publishing Company for more Information.

www.wpc-edi.com

WPC © 2006

Copyright for the members of ASC X12N by Washington Publishing Company. Permission is hereby granted to any organization to copy and distribute this material internally as long as this copy-right statement is included, the contents are not changed, and the copies are not sold.

Table of Contents

		_
1	Purpose and Business Information	1
1.1	Implementation Purpose and Scope	1
1.2	Version Information	1
1.3	Implementation Limitations	
	1.3.1 Batch and Real-time Usage 1.3.2 Other Usage Limitations	
1.4	-	
	1.4.1 Coordination of Benefits	
	1.4.1.1 Coordination of Benefits Data Models — Detail	4
	1.4.1.2 Crosswalking COB Data Elements	
	1.4.1.3 Coordination of Benefits Claims from Paper or	
	Proprietary Remittance Advices	17
	1.4.1.4 Coordination of Benefits - Service Line Procedure Code Bundling and Unbundling	10
	1.4.1.5 Coordination of Benefits - Medicaid	19
	Subrogation	26
	1.4.2 Property and Casualty	
	1.4.3 Data Overview	
	1.4.3.1 Loop Labeling, Sequence, and Use	
	1.4.3.2 Data Use by Business Use	27
	1.4.3.2.1 Table 1 — Transaction Control	00
	Information 1.4.3.2.2 Table 2 — Detail Information	
	1.4.4 Balancing	
	1.4.4.1 Claim Level	
	1.4.4.2 Service Line	
	1.4.5 Allowed/Approved Amount Calculation	36
1.5	Business Terminology	36
1.6	Transaction Acknowledgments	39
	1.6.1 997 Functional Acknowledgment	
	1.6.2 999 Implementation Acknowledgment	
	1.6.3 824 Application Advice	
	1.6.4 277 Health Care Claim Acknowledgment	
1.7	Related Transactions	
	1.7.1 Health Care Claim Payment/Advice (835)	40
1.8	Trading Partner Agreements	40
1.9	HIPAA Role in Implementation Guides	41
1.10	National Provider Identifier Usage within the HIPAA 83	37
	Transaction	
	1.10.1 Providers who are Not Eligible for Enumeration	
	1.10.2 Implementation Migration Strategy	41
	1.10.3 Organization Health Care Provider Subpart	40
	Representation 1.10.4 Subparts and the 2010 AA - Billing Provider Name	42
	Loop	⊿ २
		+0

1.11	Coding of Drug	s in the 837 Claim	43
		ug Billing	
	1.11.2 Compour	d Drug Billing	44
1.12	Additional Instr	uctions and Considerations	44
		Is with one Legal Name	
		Claims Based on the Inclusion of	
	Situation	al Data	
	1.12.3 Multiple F	REF Segments with the same Qualifier	45
		Tax IDs	
		Line Redundant Information	
		and Outpatient Designation	
	1.12.7 Trading P	artner Acknowledgments	
2	Transaction S	Set	
2.1	Presentation Ex	camples	47
2.2	Implementation	Usage	52
L . L		Jsage	
		Transaction Compliance Related to Industry	
		Usage	53
	2.2.2 Loops	~	
2.3	Transaction Set	t Listing	55
		tation	
		lard	
24	837 Segment D	etail	66
2.7		Transaction Set Header	
		Beginning of Hierarchical Transaction	
		Submitter Name	
	PER	Submitter EDI Contact Information	73
		Receiver Name	
		Billing Provider Hierarchical Level	
		Billing Provider Specialty Information	
		Foreign Currency Information	
		Billing Provider Name	
		Billing Provider Address Billing Provider City, State, ZIP Code	
		Billing Provider Tax Identification	
		Billing Provider Contact Information	
		Pay-to Address Name	
		Pay-to Address - ADDRESS	
	N4	Pay-To Address City, State, ZIP Code	97
		Pay-To Plan Name	
		Pay-to Plan Address	
		Pay-To Plan City, State, ZIP Code	
		Pay-to Plan Secondary Identification	
		Pay-To Plan Tax Identification Number Subscriber Hierarchical Level	
		Subscriber Information	
		Subscriber Name	
		Subscriber Address	
		Subscriber City, State, ZIP Code	

	HEALTH CARE CLAIM: INSTIT	UTIONAL
DMG	Subscriber Demographic Information	118
REF	0	
REF	Property and Casualty Claim Number	121
NM1	Payer Name	
N3	Payer Address	124
N4	Payer City, State, ZIP Code	125
REF	Payer Secondary Identification	
REF	Billing Provider Secondary Identification	
HL	Patient Hierarchical Level	
PAT	Patient Information	
NM1	Patient Name	135
N3	Patient Address	137
	Patient City, State, ZIP Code	
	Patient Demographic Information	
REF	Property and Casualty Claim Number	
CLM		
DTP		
DTP	5	
DTP		
DTP	Date - Repricer Received Date	
CL1	Institutional Claim Code	
PWK	Claim Supplemental Information	
CN1		
AMT	Patient Estimated Amount Due	
REF		
REF	Referral Number	
REF	Prior Authorization	
REF	Payer Claim Control Number	
REF	Repriced Claim Number	
REF	Adjusted Repriced Claim Number	
REF	Investigational Device Exemption Number	
REF	Claim Identifier For Transmission	
	Intermediaries	170
REF		
	Medical Record Number	
	Demonstration Project Identifier	
	Peer Review Organization (PRO) Approval	
	Number	175
K3	File Information	176
	Claim Note	
	Billing Note	
	EPSDT Referral	
	Principal Diagnosis	
	Admitting Diagnosis	
	Patient's Reason For Visit	
	External Cause of Injury	
HI	Diagnosis Related Group (DRG) Information .	
	Other Diagnosis Information	
	Principal Procedure Information	
	Other Procedure Information	
	Occurrence Span Information	
	Occurrence Information	
	Value Information	
		•.

		-
	Condition Information	
HI	Treatment Code Information 304	4
HCP	Claim Pricing/Repricing Information	3
NM1	Attending Provider Name	9
PRV	Attending Provider Specialty Information	2
REF	Attending Provider Secondary Identification 324	4
NM1	Operating Physician Name	6
REF	Operating Physician Secondary Identification 329	9
NM1	Other Operating Physician Name	1
REF	Other Operating Physician Secondary	
	Identification	4
NM1	Rendering Provider Name	6
	Rendering Provider Secondary Identification 339	
NM1	•	
N3	Service Facility Location Address	
	Service Facility Location City, State, ZIP Code 34	
REF		
	Identification	7
NM1	Referring Provider Name	
	Referring Provider Secondary Identification 352	
	Other Subscriber Information	
	Claim Level Adjustments	
AMT	•	
	Amount	4
AMT	Remaining Patient Liability	
AMT		
	Non-Covered Amount	6
OI	Other Insurance Coverage Information	
	Inpatient Adjudication Information	
	Outpatient Adjudication Information	
	Other Subscriber Name	
N3	Other Subscriber Address	0
N4	Other Subscriber City, State, ZIP Code	1
	Other Subscriber Secondary Identification	
	Other Payer Name	
N3	Other Payer Address	6
N4	Other Payer City, State, ZIP Code	7
	Claim Check or Remittance Date	
REF	Other Payer Secondary Identifier	0
REF	Other Payer Prior Authorization Number	2
REF	Other Payer Referral Number	3
REF	Other Payer Claim Adjustment Indicator 394	4
REF	Other Payer Claim Control Number	5
NM1	Other Payer Attending Provider	6
REF	Other Payer Attending Provider Secondary	
	Identification	8
NM1		
REF	Other Payer Operating Physician Secondary	
	Identification	2
NM1	Other Payer Other Operating Physician 404	4
REF	Other Payer Other Operating Physician	
	Secondary Identification 400	6
NM1	Other Payer Service Facility Location 408	
	· ·	

	REF	Other Payer Service Facility Location	
		Secondary Identification	
	NM1	Other Payer Rendering Provider Name	412
	REF	Other Payer Rendering Provider Secondary	
		Identification	
	NM1	Other Payer Referring Provider	416
	REF	Other Payer Referring Provider Secondary	
		Identification	
	NM1	Other Payer Billing Provider	420
	REF	Other Payer Billing Provider Secondary	
		Identification	
	LX	Service Line Number	423
	SV2	Institutional Service Line	424
	PWK	Line Supplemental Information	429
	DTP	Date - Service Date	433
	REF	Line Item Control Number	435
	REF	Repriced Line Item Reference Number	437
		Adjusted Repriced Line Item Reference	
		Number	438
	AMT	Service Tax Amount	
	AMT	Facility Tax Amount	440
		Third Party Organization Notes	
		Line Pricing/Repricing Information	
		Drug Identification	
		Drug Quantity	
		Prescription or Compound Drug Association	
		Number	
	NM1	Operating Physician Name	
		Operating Physician Secondary Identification	
		Other Operating Physician Name	
		Other Operating Physician Secondary	
		Identification	464
	NM1	Rendering Provider Name	
		Rendering Provider Secondary Identification	
		Referring Provider Name	
		Referring Provider Secondary Identification	
		Line Adjudication Information	
		Line Adjustment	
		Line Check or Remittance Date	
		Remaining Patient Liability	
		Transaction Set Trailer	
	02		
3	Examples		
_	•		
3.1			
		Scenario 1 — 837 Institutional Claim	489
		Scenario 2 — Two Claims for the Same	
		Scenario 3 — PPO Repriced Claim	500
		Scenario 4 — Out of Network Repriced	
	Claim		506
3.2	Property and C	asualty	511
		Scenario 1 — Automobile Accident	

Α	Exter	nal Code Sources	A.1
	5	Countries, Currencies and Funds	A.1
		States and Provinces	
		ZIP Code	
	130	Healthcare Common Procedural Coding System	A.3
	131	International Classification of Diseases, 9th Revision,	
		Clinical Modification (ICD-9-CM)	
		National Uniform Billing Committee (NUBC) Codes	
		Claim Adjustment Reason Code	
		Diagnosis Related Group Number (DRG)	
		Admission Source Code	
		Admission Type Code	
		Claim Frequency Type Code	
		Uniform Billing Claim Form Bill Type	
		Patient Status Code	
		National Drug Code by Format	A.8
	245	National Association of Insurance Commissioners	
	250	(NAIC) Code Treatment Codes	
		Remittance Advice Remark Codes	-
		Home Infusion EDI Coalition (HIEC) Product/Service	A.9
	515	Code List	٨٥
	537	Centers for Medicare and Medicaid Services National	
	557	Provider Identifier	Δ 10
	540	Centers for Medicare and Medicaid Services PlanID	
		Workers Compensation Specific Procedure and	
		Supply Codes	. A.11
	682	Health Care Provider Taxonomy	
		Health Insurance Prospective Payment System	
		(HIPPS) Rate Code for Skilled Nursing Facilities	A.12
	843	Advanced Billing Concepts (ABC) Codes	
		International Classification of Diseases, 10th	
		Revision, Procedure Coding System (ICD-10-PCS)	A.13
	897	International Classification of Diseases, 10th	
		Revision, Clinical Modification (ICD-10-CM)	A.14
	932	Universal Postal Codes	A.14
В	Nome	nclature	R 1
B.1		12 Nomenclature	
D. I			
	D.I.I	Interchange and Application Control Structures	
		B.1.1.1 Interchange Control Structure	D. I
		B.1.1.2 Application Control Structure Definitions and Concepts	DЭ
		B.1.1.3 Business Transaction Structure Definitions and	D.Z
		Concepts	Be
		B.1.1.4 Envelopes and Control Structures	
		B.1.1.5 Acknowledgments	
		-	
B.2	Object	Descriptors	B.23

С	EDI Control Directoryc.
C.1	Control Segments
D	Change SummaryD.
D.1	Change SummaryD.? Global ChangesD.?
D.1	
D.1 D.2	Global Changes

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 - <u>Transaction Acknowledgments</u>, and Section 1.7 - <u>Related Transactions</u>, 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 - <u>Coordination of Benefits Data Models -- Detail</u> 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 - <u>Coordination of Benefits Claims from</u> <u>Paper or Proprietary Remittance Advices</u> provides guidance on creating electronic COB claims when the payer's remittance was a paper or proprietary remittance advice.

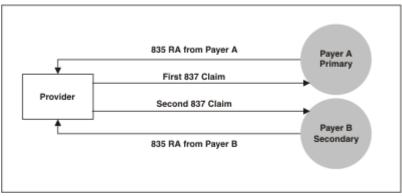
1.4.1.1 Coordination of Benefits Data Models -- Detail

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.





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.

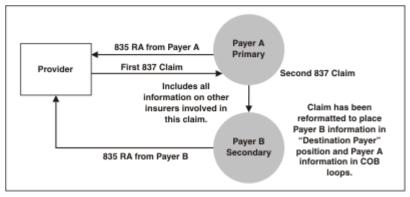
Step 3. If there are additional payers (not shown in Figure 1.1 - *Provider-to-Payer-to-Provider COB Model*), step 2 is repeated with the

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.





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 Ol05	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 0103	FOR JANE DOE
D	2300 CLM09 Release of Information	FOR JOHN DOE		2320 0106	FOR JANE DOE
D	2300 CLM10 Patient's Signature Source Code	FOR JOHN DOE		2320 0104	FOR JANE DOE
М	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
Ρ	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
١	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
١	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
1	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
١	2330F REF (LU) Service Facility Location Secondary ID	FOR XYZ INS GROUP (LU) 981		2310E REF (LU)	FOR ABC INS (LU) 675
1	2330I REF (G2) Billing Provider ID	FOR XYZ INS GROUP (G2) XYZ3434343		2010BB REF (G2)	FOR ABC INS (G2) 12345678
١	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
Ν	2400 REF (G1/2U) Prior Authorization Number	FOR XYZ INS GROUP (G1) XYZ8888888 (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
Ν	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
Ν	2420A REF (G2/2U) ⁴ Operating Physician Secondary ID	FOR XYZ INS GROUP (G2) XYZ6666666 (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
Е	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
Ρ	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	HEADER
ST*837*0002*005010X223~	ST*837*0002*005010X223~
BHT*0019*00*0123*20050730*1023*CH~	BHT*0019*00*0123*20050730*1023*CH~
1000A SUBMITTER	1000A SUBMITTER
NM1*41*2*GET WELL CLINIC*****46*567890~	NM1*41*2*GET WELL CLINIC*****46*567890~
PER*IC*MARY*TE*6155552222~	PER*IC*MARY*TE*6155552222~
1000B RECEIVER	1000B RECEIVER
NM1*40*2*MY CLEARINGHOUSE****46*988888888~	NM1*40*2*MY CLEARINGHOUSE*****46*9888888888~
2000A BILLING/PAY-TO PROVIDER HL LOOP	2000A BILLING/PAY-TO PROVIDER HL LOOP
HL*1**20*1~	HL*1**20*1~
2010AA BILLING PROVIDER	2010AA BILLING PROVIDER
NM1*85*2*GET WELL CLINIC*****XX*5876543216~	NM1*85*2*GET WELL CLINIC*****XX*5876543216~
N3*1234 MAIN ST~	N3*1234 MAIN ST~
N4*ANYWHERE*TN*37214~	N4*ANYWHERE*TN*37214~
REF*EI*111222333~	REF*EI*111222333~
2000B SUBSCRIBER HL LOOP	2000B SUBSCRIBER HL LOOP
HL*2*1*22*1~	HL*2*1*22*1~
SBR*P*******BL~	SBR*S*******CI~
2010BA SUBSCRIBER	2010BA SUBSCRIBER
NM1*IL*1*DOE*JOHN****MI*JD03398777~	NM1*IL*1*DOE*JANE****MI*JA7654321~
REF*SY*033987777~	REF*SY*765432111~
2010BB PAYER	2010BB PAYER
NM1*PR*2*ABC INS*****PI*12345~	NM1*PR*2*XYZ INS GROUP*****PI*54698~
REF*G2*12345678~	REF*G2*XYZ3434343~
REF*LU*678~	REF*LU*455~
2000C PATIENT HL LOOP	2000C PATIENT HL LOOP
HL*3*2*23*0~	HL*3*2*23*0~
PAT*19~	PAT*19~
2010CA PATIENT	2010CA PATIENT
NM1*QC*1*DOE*SALLY~	NM1*QC*1*DOE*SALLY~
N3*234 SOUTH ST~	N3*234 SOUTH ST~
N4*ANYWHERE*TN*37214~	N4*ANYWHERE*TN*37214~
DMG*D8*19930501*F~	DMG*D8*19930501*F~

2300 CLAIM	2300 CLAIM
CLM*26407789*115***13:A:1*Y**Y*Y~	CLM*26407789*115***13:A:1*Y**Y*Y~
REF*G1*ABC456~	REF*G1*XYZ345200~
REF*9F*ABC670000~	REF*9F*XYZ6798777~
HI*BK:4779*BF:2724*BF:2780*BF:53081~	HI*BK:4779*BF:2724*BF:2780*BF:53081~
2310A ATTENDING PROVIDER	2310A ATTENDING PROVIDER
NM1*AT*1*KILDARE*RICHARD****XX*9999977777~	NM1*AT*1*KILDARE*RICHARD****XX*9999977777~
REF*G2*ABC670001~	REF*G2*XYZ6798666~
REF*LU*671~	REF*LU*986~
2310D RENDERING PROVIDER	2310D RENDERING PROVIDER
NM1*82*1*CASEY*BEN****XX*99999666666~	NM1*82*1*CASEY*BEN****XX*99999666666~
REF*G2*ABC670002~	REF*G2*XYZ6798444~
REF*LU*672~	REF*LU*984~
2310E SERVICE FACILITY LOCATION	2310E SERVICE FACILITY LOCATION
NM1*77*2*ANYWHERE CLINIC*****XX*9999955555~	NM1*77*2*ANYWHERE CLINIC*****XX*9999955555~
N3*2345 STATE ST~	N3*2345 STATE ST~
N4*NASHVILLE*TN*37212~	N4*NASHVILLE*TN*37212~
REF*G2*ABC670004~	REF*G2*XYZ6798222~
REF*LU*674~	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	2330A OTHER SUBSCRIBER NAME
NM1*IL*1*DOE*JANE****MI*JA7654321~	NM1*IL*1*DOE*JOHN****MI*JD03398777~
N3*234 SOUTH ST~	N3*234 SOUTH ST~
N4*ANYWHERE*TN*37214~	N4*ANYWHERE*TN*37214~
REF*SY*765432111~	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	2330C OTHER PAYER ATTENDING PROVIDER
NM1*AT*1~	NM1*AT*1~
REF*G2*XYZ6798666~	REF*G2*ABC670001~
REF*LU*986~	REF*LU*671~
2330G OTHER PAYER RENDERING PROVIDER	2330G OTHER PAYER RENDERING PROVIDER
NM1*82*1~	NM1*82*1~
REF*G2*XYZ6798444~	REF*G2*ABC670002~
REF*LU*984~	REF*LU*672~
2330F OTHER PAYER SERVICE FACILITY LOCATION	2330F OTHER PAYER SERVICE FACILITY LOCATION
NM1*77*2~	NM1*77*2~
REF*G2*XYZ6798222~	REF*G2*ABC670004~
REF*LU*982~	REF*LU*674~

2400 SERVICE LINE	SERVICE LINE
LX*1~	LX*1~
SV2*0300*HC:99213*100*UN*1~	SV2*0300*HC:99213*100*UN*1~
DTP*472*D8*20050705~	DTP*472*D8*20050705~
REF*G1*ABC222222~	REF*G1*XYZ888888~
REF*G1*XYZ888888**2U:54698~	REF*G1*ABC222222**2U:12345~
REF*9F*ABC11111~	REF*9F*XYZ777777~
REF*9F*XYZ777777**2U:54698~	REF*9F*ABC111111**2U:12345~
2420C RENDERING PROVIDER	2420C RENDERING PROVIDER
NM1*82*1*WELBY*MARCUS****XX*1545454541~	NM1*82*1*WELBY*MARCUS****XX*1545454541~
REF*G2*ABC333333~	REF*G2*XYZ666666~
REF*LU*C333~	LU*Z666~
REF*G2*XYZ666666**2U:54698~	REF*G2*ABC333333**2U:12345~
REF*LU*Z666**2U:54698~	REF*LU*C333**2U:12345~
2420D REFERRING PROVIDER	2420D REFERRING PROVIDER
NM1*DN*1*BROWN*JOE****XX*1323232321~	NM1*DN*1*BROWN*JOE****XX*1323232321~
REF*G2*ABC8888888~	REF*G2*XYZ111111~
REF*LU*C888~	REF*LU*Z111~
REF*G2*XYZ111111**2U:54698~	REF*G2*ABC88888888**2U:12345~
REF*LU*Z111**2U:54698~	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	2400 SERVICE LINE
LX*2~	LX*2~
SV2*0300*HC:90782*15*UN*1~	SV2*0300*HC:90782*15*UN*1~
DTP*472*D8*20050705~	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	TRANSACTION SET TRAILER
SE*78*0002~	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	СО
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

ī.

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
- в = 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:C**1~ (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
- в = HCPCS code
- **100** = Submitted charge
- UN = Units code
- 1 = Units billed

SVD*PAYER ID*0*HC:C**1*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:B**1~ (Loop ID-2430)

Payer ID

- = ID of the payer who adjudicated this service line
- 60 = Payer amount paid
- HC = HCPCS qualifier
- B = Unbundled HCPCS code
- 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:C**1~

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 - <u>Table 1 -- Transaction Control Information</u>. Table 2 contains the detail information for the transaction's business function and is described in Section 1.4.3.2.2 - <u>Table 2 -- Detail Information</u>.

1.4.3.2.1 Table 1 -- Transaction Control Information

Table 1 is named the Header level (see Figure 1.3 - <u>Header Level</u>). 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*1**20*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 - <u>Inpatient</u> <u>and Outpatient Designation</u> 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 - <u>Subscriber / Patient Hierarchical Level (HL) Segments</u>, 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 - <u>Providers who are Not Eligible for Enumeration</u>).

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 - <u>Subscriber / Patient Hierarchical Level (HL) Segments</u>, 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 - <u>Crosswalking COB</u> <u>Data Elements</u>, 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 - <u>Organization Health Care Provider Subpart Representation</u>.

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.

Г

this se the im	plemer	s	BXX Insurance Trans	action Set			
		Table	1 - Header				
		SEG. ID	NAME		USAGE	REPEAT	LOOP REPEA
53	0100	-	Transaction Set Header Each seg	ment is assigned an	R	1	Segment
54	0200			specific name. Not	R	1	repeats and
60	0400			ments do not appear	R	1 -	loop repeats
62	0500		Non-US Dollars Currency		S	1	reflect actual
65	0600			p is assigned an	S	1	usage 🔨
66	0600			specific name	S	1	
68	0700	DTM	Production Date		S	1	•
			PAYER NAME				
70	0800		Payer Name		R	1	
72		N3	Payer Address	R=Required	S	1	
75		N4	Payer City, State, Zip	S=Situational	S	1	
76	1200		Additional Payer Reference Number		S	1	
78	1300	PER	Payer Contact		S	1	
			PAYEE NAME				/ ·
79		N1	Payee Name		R	1	/
81	1000	N3	Payee Address		S	1	/
82		N4	Payee City, State, Zip		S	1	/
84	1200	REF	Payee Additional Reference Number		S	>1	./
Positic	on Nun	nbers ar	nd Segment IDs retain their X12 valu	es Individual se	gments a	nd entire loo	ps are repeated

Figure 2.1. Transaction Set Key — Implementation

STANDARD	9	BXX Insurance Transaction S	Set			
this section i to the ASC X					Functi	onal Group ID: XX
See Appendi X12 Nomenci complete dea the standard	<i>lature</i> fo	or a (EDI) environment.				
POS. #	SEG. ID	NAME	REQ	. DES.	MAX USE	LOOP REPEAT
0100	ST	Transaction Set Header	1	м	1	
0200	BPR	Beginning Segment	I	М	1	
0300		Note/Special Instruction		0	>1	
0400	TRN	Trace		0	1	

Figure 2.2. Transaction Set Key — Standard

SEGMENT DETAIL					
Industry assigned Segment Name	NM1 - PATIENT NAME				
X12 Segment Name:	Individual or Organizational Name See section B.1.1.3.8 for				
X12 Purpose:	To supply the full name of an individual or organizational entity a description of these				
X12 Syntax:	1. P0809 values values values				
Industry assigned	2. C1110 If NM111 is present, then NM110 is required.				
Loop ID and Loop Name	3. C1203 If NM112 is present, then NM103 is required. Industry Loop Repeat				
Industry Segment Loop:	2100B — PATIENT NAME Loop Repeat: 1				
Segment Repeat:	1				
Industry usage Usage:	SITUATIONAL				
Situational Rule: Situational	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.				
Notes TR3 Example:	NM1*QC*1*Shepard*Sam*A***34*452114586~				
Example					

Figure 2.3. Segment Key — Implementation

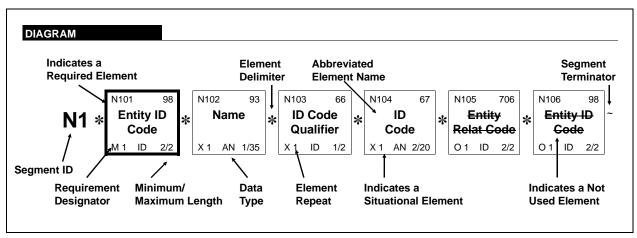


Figure 2.4. Segment Key — Diagram

USAGE	REF. DES.	DATA ELEMENT	NAME	Element I	Repeat	ATTRIB	JTES
REQUIRED	SVC01	C003	IDENT	OSITE MEDICAL PROCEDURE IFIER tify a medical procedure by its standa	M 1	es and	
Reference Designa	itor Com Num	posite ber	applica	ble modifiers			
				e Primary Payer's adjudicated Mec	lical Proce		
REQUIRED	SVC01 - 7	1	235	Product/Service ID Qualifier Code identifying the type/source of the used in Product/Service ID (234)	M he descripti	ID ve nun	2/2 nber
See the following page for complete				IMPLEMENTATION NAME: Product or Serv	ice ID Qua	lifier	
descriptions	Industry	Note —		The value in SVC01-1 qualifies the SVC01-3, SVC01-4, SVC01-5, and		SVC01	1-2,
			CODE	DEFINITION			
Select	ed Code Value	es —→	AD	American Dental Associati	on Codes		
_				CODE SOURCE 135: American De	ental Associ	ation	
ext	e Appendix A f ternal code so erence		HP	Health Insurance Prospect (HIPPS) Skilled Nursing Fa	-		tem
				CODE SOURCE 716: Health Insura Payment System (HIPPS) Ra Nursing Facilities			d
REQUIRED	SVC01 - 2	2	234	Product/Service ID Identifying number for a product or s	M ervice	AN	1/48
NOT USED	SVC01 - 3	3	1339	Procedure Modifier	ο	AN	2/2
NOT USED	SVC01 - 4	1	1339	Procedure Modifier	0	AN	2/2
NOT USED	SVC01 - 5	5	1339	Procedure Modifier	0	AN	2/2
NOT USED	SVC01 -	6	1339	Procedure Modifier	Ο	AN	2/2
NOT USED	SVC01 -	7	352	Description	0	AN	1/80
REQUIRED	SVC02	782		ary Amount	M 1	R	1/18
Da	ta Element			ary amount			
	mber			c: SVC02 is the submitted service charge.			
				alue can not be negative.			
NOT USED	SVC03	782		ary Amount	01	R	1/18
SITUATIONAL	SVC04	234		ct/Service ID ring number for a product or service	01	AN	1/48
X12 Semantic Note Situational Rule Implementation Name See Appendix E for			SEMANT	c: SVC04 is the National Uniform Billing C	ommittee Re	evenue	Code.
			consi alread	NAL RULE: Required when an NUBC r dered during adjudication in addition y identified in SVC01. If not required mentation guide, do not send.	on to a pro		
definition				NTATION NAME: National Uniform Billing	g Committe	ee Rev	enue

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).

tional).	
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 ele- ments 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 con- tent 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.</explicit>
	The alternative form is "Required when <explicit condition="" state-<br="">ment>. 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.</explicit>

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	N1/A	Sent	Yes
-	N/A	Not Sent	No
Not Used	N1/A	Sent	No
	N/A	Not Sent	Yes
Situational (Required when <explicit< td=""><td>T</td><td>Sent</td><td>Yes</td></explicit<>	T	Sent	Yes
condition statement>. If not required by this implementation guide, may be	True	Not Sent	No
provided at the sender's discretion, but	Not True	Sent	Yes
cannot be required by the receiver.)	Not the	Not Sent	Yes
Situational (Required when <explicit< td=""><td>True</td><td>Sent</td><td>Yes</td></explicit<>	True	Sent	Yes
condition statement>. If not required by	True	Not Sent	No
this implementation guide, do not send.)		Sent	No
	Not True	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	

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 - Subscriber Detail

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		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	

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

63						
55	1800	REF	Referral Number	S	1	
64	1800	REF	Prior Authorization	S	1	
66	1800	REF	Payer Claim Control Number	S	1	
67	1800	REF	Repriced Claim Number	S	1	
68	1800	REF	Adjusted Repriced Claim Number	S	1	
69	1800	REF	Investigational Device Exemption Number	S	5	
70	1800	REF	Claim Identifier For Transmission Intermediaries	S	1	
72	1800	REF	Auto Accident State	S	1	
73	1800	REF	Medical Record Number	S	1	
74	1800	REF	Demonstration Project Identifier	S	1	
75	1800	REF	Peer Review Organization (PRO) Approval Number	S	1	
76	1850	K3	File Information	S	10	
78	1900	NTE	Claim Note	S	10	
80	1900	NTE	Billing Note	S	1	
81	2200	CRC	EPSDT Referral	S	1	
84	2310	HI	Principal Diagnosis	R	1	
87	2310	HI	Admitting Diagnosis	S	1	
89	2310	HI	Patient's Reason For Visit	S	1	
93	2310	HI	External Cause of Injury	S	1	
18	2310	HI	Diagnosis Related Group (DRG) Information	S	1	
20	2310	HI	Other Diagnosis Information	S	2	
39	2310	HI	Principal Procedure Information	S	1	
42	2310	HI	Other Procedure Information	S	2	
58	2310	HI	Occurrence Span Information	S	2	
71	2310	HI	Occurrence Information	S	2	
84	2310	HI	Value Information	S	2	
94	2310	HI	Condition Information	S	2	
04	2310	HI	Treatment Code Information	S	2	
13	2410	HCP	Claim Pricing/Repricing Information	S	1	
			LOOP ID - 2310A ATTENDING PROVIDER NAME			1
19	2500	NM1	Attending Provider Name	S	1	
22	2550	PRV	Attending Provider Specialty Information	S	1	
24	2710	REF	Attending Provider Secondary Identification	S	4	
			LOOP ID - 2310B OPERATING PHYSICIAN NAME			1
26	2500	NM1	Operating Physician Name	S	1	
29	2710		Operating Physician Secondary Identification	S	4	
			LOOP ID - 2310C OTHER OPERATING PHYSICIAN			1
			NAME			
31	2500		Other Operating Physician Name	S	1	
34	2710	REF	Other Operating Physician Secondary Identification	S	4	
			LOOP ID - 2310D RENDERING PROVIDER NAME			1
36	2500	NM1	Rendering Provider Name	S	1	
39	2710	REF	Rendering Provider Secondary Identification	S	4	
			LOOP ID - 2310E SERVICE FACILITY LOCATION NAME			1
41	2500	NM1	Service Facility Location Name	S	1	
44	2650	N3	Service Facility Location Address	R	1	
45	2700	N4	Service Facility Location City, State, ZIP Code	R	1	
47	2710	REF	Service Facility Location Secondary Identification	S	3	
			LOOP ID - 2310F REFERRING PROVIDER NAME			1
	2500	NM1	Referring Provider Name	S	1	
49			Referring Provider Secondary Identification	S	3	
49 52		REF				
49 52	2710	REF				10
			LOOP ID - 2320 OTHER SUBSCRIBER INFORMATION Other Subscriber Information	S	1	10

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

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	
889	3500	DTP	Claim Check or Remittance Date	S	1	
890	3550	REF	Other Payer Secondary Identifier	S	2	
892	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	
895	3550	REF	Other Payer Claim Control Number	S	1	
			LOOP ID - 2330C OTHER PAYER ATTENDING PROVIDER			1
96	3250	NM1	Other Payer Attending Provider	S	1	
98	3550	REF	Other Payer Attending Provider Secondary Identification	R	4	
			LOOP ID - 2330D OTHER PAYER OPERATING PHYSICIAN			1
00	3250		Other Payer Operating Physician	S	1	
102	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	
106	3550	REF	Other Payer Other Operating Physician Secondary	R	4	
			Identification LOOP ID - 2330F OTHER PAYER SERVICE FACILITY LOCATION			1
108	3250	NM1	Other Payer Service Facility Location	S	1	
410	3550		Other Payer Service Facility Location Secondary	R	3	
			Identification			
			LOOP ID - 2330G OTHER PAYER RENDERING PROVIDER NAME			1
12	3250	NM1	Other Payer Rendering Provider Name	S	1	
14	3550	REF	Other Payer Rendering Provider Secondary Identification	R	4	
			LOOP ID - 2330H OTHER PAYER REFERRING PROVIDER			1
16	3250	NM1	Other Payer Referring Provider	S	1	
18	3550	REF	Other Payer Referring Provider Secondary Identification	R	3	
			LOOP ID - 23301 OTHER PAYER BILLING PROVIDER			1
20	3250	NM1	Other Payer Billing Provider	S	1	
122	3550	REF	Other Payer Billing Provider Secondary Identification	R	2	
			LOOP ID - 2400 SERVICE LINE NUMBER			99
423	3650	LX	Service Line Number	R	1	
424	3750		Institutional Service Line	R	1	
429		PWK	Line Supplemental Information	S	10	

005010X223 • 837

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	СТР	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	
64	5250	REF	Other Operating Physician Secondary Identification	S	20	
			LOOP ID - 2420C RENDERING PROVIDER NAME			1
66	5000	NM1	Rendering Provider Name	S	1	
69	5250	REF	Rendering Provider Secondary Identification	S	20	
			LOOP ID - 2420D REFERRING PROVIDER NAME			1
71	5000	NM1	Referring Provider Name	S	1	
74	5250	REF	Referring Provider Secondary Identification	S	20	
			LOOP ID - 2430 LINE ADJUDICATION INFORMATION			15
76	5400	SVD	Line Adjudication Information	S	1	
80	5450	CAS	Line Adjustment	S	5	
86	5500	DTP	Line Check or Remittance Date	R	1	
87	5505	AMT	Remaining Patient Liability	S	1	
88	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	м	1	
0100	BHT	Beginning of Hierarchical Transaction	м	1	
0150	REF	Reference Information	0	3	
		LOOP ID - 1000			10
0200	NM1	Individual or Organizational Name	0	1	
0250	N2	Additional Name Information	0	2	
0300	N3	Party Location	0	2	
0350	N4	Geographic Location	0	1	
0400	REF	Reference Information	0	2	
0450	PER	Administrative Communications Contact	0	2	

Table 2 - Detail

POS. #	SEG. ID	NAME	REQ. DES.	MAX USE	LOOP REPEAT
		LOOP ID - 2000			>1
0010	HL	Hierarchical Level	М	1	
0030	PRV	Provider Information	0	1	
0050	SBR	Subscriber Information	0	1	
0070	PAT	Patient Information	0	1	
0090	DTP	Date or Time or Period	0	5	
0100	CUR	Currency	0	1	
		LOOP ID - 2010			10
0150	NM1	Individual or Organizational Name	0	1	
0200	N2	Additional Name Information	0	2	

	••••				003010722
0250	N3	Party Location	о	2	
0300		Geographic Location	ο	1	
0320	DMG	Demographic Information	ο	1	
0350		Reference Information	0	20	
0400		Administrative Communications Contact	0	2	
		LOOP ID - 2300			10
1300	CLM	Health Claim	0	1	
1350	DTP	Date or Time or Period	ο	150	
1400		Claim Codes	0	1	
1450		Orthodontic Information	0	1	
	DN2	Tooth Summary	Ō	35	
	PWK	Paperwork	0	10	
1600	CN1	Contract Information	0	1	
	DSB	Disability Information	0	1	
1700		Peer Review Organization or Utilization Review	0	1	
	AMT	Monetary Amount Information	Ō	40	
	REF	Reference Information	0	30	
1850		File Information	0	10	
	NTE	Note/Special Instruction	0	20	
1950		Ambulance Certification	0	1	
2000	-	Chiropractic Certification	0 0	1	
2050		Durable Medical Equipment Certification	0	1	
2100		Enteral or Parenteral Therapy Certification	0	3	
	CR5	Oxygen Therapy Certification	0	1	
	CR6	Home Health Care Certification	0 0	1	
	CR8	Pacemaker Certification	0	9	
	CRC	Conditions Indicator	0 0	100	
2310		Health Care Information Codes	0 0	25	
2400	QTY	Quantity Information	0 0	10	
	HCP	Health Care Pricing	0 0	1	
2410	nor	LOOP ID - 2305		•	6
2420	CR7	Home Health Treatment Plan Certification	0	1	0
2430		Health Care Services Delivery	0 0	12	
		LOOP ID - 2310	•		9
2500	NM1	Individual or Organizational Name	0	1	3
2550	PRV	Provider Information	o	1	
2600		Additional Name Information	0	2	
2650		Party Location	•	•	
2700		Geographic Location	0	2	
	REF	Reference Information	0	20	
	PER	Administrative Communications Contact	0	20	
		LOOP ID - 2320	<u> </u>	-	10
2000	SBR	Subscriber Information	0	1	10
	CAS	Claims Adjustment	0	99	
	AMT	Monetary Amount Information	0	99 15	
	DMG	Demographic Information	0	15	
3100		Other Health Insurance Information	0	1	
	MIA	Medicare Inpatient Adjudication	0	1	
	MOA		0	1	
J200	MOA	Medicare Outpatient Adjudication	0	I	10
	NIN44	LOOP ID - 2330	2	4	10
	NM1	Individual or Organizational Name	0	1	
3300		Additional Name Information	0	2	
3320		Party Location	0	2	
3400	N4 PER	Geographic Location Administrative Communications Contact	0 0	1 2	

3500	DTP	Date or Time or Period	ο	9	
	REF	Reference Information	0	>1	
		LOOP ID - 2400	•		>1
3650	1 X	Transaction Set Line Number	Ο	1	21
3700		Professional Service	0	1	
3750		Institutional Service	0	1	
3800		Dental Service	0	1	
	T00	Tooth Identification	0	32	
	SV4	Drug Service	0	1	
4000		Durable Medical Equipment Service	0	1	
	SV6	Anesthesia Service	o	1	
4100		Drug Adjudication	0	1	
4150		Health Care Information Codes	0	25	
	PWK	Paperwork	0	10	
	CR1	Ambulance Certification	0	1	
	CR2	Chiropractic Certification	o	5	
	CR3	Durable Medical Equipment Certification	0	1	
	CR4	Enteral or Parenteral Therapy Certification	0	3	
	CR5	Oxygen Therapy Certification	0	1	
	CRC	Conditions Indicator	0	3	
	DTP	Date or Time or Period	0	15	
	QTY	Quantity Information	0	5	
	MEA	Measurements	0	20	
1650	CN1	Contract Information	0	1	
	REF	Reference Information	0	30	
1750	AMT	Monetary Amount Information	0	15	
1800	K3	File Information	0	10	
1850	NTE	Note/Special Instruction	0	10	
880	PS1	Purchase Service	0	1	
1900	IMM	Immunization Status	0	>1	
1910	HSD	Health Care Services Delivery	0	1	
920	HCP	Health Care Pricing	ο	1	
		LOOP ID - 2410			>1
1930	LIN	Item Identification	0	1	
1940	СТР	Pricing Information	0	1	
950	REF	Reference Information	ο	1	
		LOOP ID - 2420			10
5000	NM1	Individual or Organizational Name	0	1	
	PRV	Provider Information	0	1	
5100		Additional Name Information	0	2	
5140		Party Location	0	2	
5200		Geographic Location	ο	1	
	REF	Reference Information	ο	20	
	PER	Administrative Communications Contact	ο	2	
		LOOP ID - 2430			>1
5400	SVD	Service Line Adjudication	0	1	
	CAS	Claims Adjustment	0	99	
	DTP	Date or Time or Period	0	9	
	AMT	Monetary Amount Information	0	20	
		LOOP ID - 2440			>1
			•		
5510	LQ	Industry Code Identification	0	1	1
5510 5520	LQ FRM	Industry Code Identification Supporting Documentation	M	1 99	

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										
	S	Г - TR/	ANSACTION SET HEADER							
X12 Segment	Name: Tra	nsaction S	Set Header							
X12 Pur	r pose: To i	indicate th	ne start of a transaction set and to assign a control number							
Segment Ro	epeat: 1									
U	Jsage: RE	QUIRED								
TR3 Exa	mple: ST*	k837 *9 87	′654 ∗005010X223 ∼							
DIAGRAM										
ST *	01 143 TS ID Code 1 ID 3/3	ST02 TS Contr Numbe M 1 AN	· · · · · · · · · · · · · · · · · · ·							
	REF. DES.	DATA	NAME		ATTRIBU					
REQUIRED	ST01	143	AME Transaction Set Identifier Code Code uniquely identifying a Transaction Set	M 1	ID	3/3				
			SEMANTIC: The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).							
			837 Health Care Claim							
REQUIRED	ST02	329	Transaction Set Control Number Identifying control number that must be unique within the tr functional group assigned by the originator for a transaction			4/9				
			The Transaction Set Control Number in ST02 and identical. The number must be unique within a sp (ISA-IEA), but can repeat in other interchanges.							
REQUIRED	ST03	1705	Implementation Convention Reference Reference assigned to identify Implementation Convention	01	AN	1/35				
			SEMANTIC: The implementation convention reference (ST03 translation routines of the interchange partners to select the implementation convention to match the transaction set de this implementation convention reference takes precedence implementation reference specified in the GS08.	, e appro finition.	priate When					
			IMPLEMENTATION NAME: Version, Release, or Industry I	dentifi	er					
			This element must be populated with the guide in Section 1.2.	dentifi	er nam	ned in				
			This field contains the same value as GS08. Som products strip off the ISA and GS segments prior SE) processing. Providing the information from t level will ensure that the appropriate application translation time.	to ap	plicati 608 at t	his				

SEGMENT DETRIE							
	BHT - B TRANS	EGINNING OF HIERARCHICAL					
X12 Segment Name:	Beginning of I	Hierarchical Transaction					
X12 Purpose:		business hierarchical structure of the transaction set and identify application purpose and reference data, i.e., number, date, and					
Segment Repeat:	1						
Usage:	REQUIRED						
TR3 Notes:		ond example denotes the case where the entire transaction tains ENCOUNTERS.					
TR3 Example:	BHT*0019*0	00*0123*20040618*0932*CH~					
TR3 Example:	BHT*0019*0	00*44445*20040213*0345*RP~					
DIAGRAM							
BHT * Hierarch Struct Coo							
R	EF. DATA ES. ELEMENT						
		NAME ATTRIBUTES Hierarchical Structure Code M 1 ID 4/4 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 DEFINITION M 1 ID 4/4					
		0019 Information Source, Subscriber, Dependent					
REQUIRED BHTC	02 353	Transaction Set Purpose Code M 1 ID 2/2 Code identifying purpose of transaction set					
		BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status.					
		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.					

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE	005010X223 ● 837 ● BHT BEGINNING OF HIERARCHICAL TRANSACTION								
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	TimeO 1 TM4/4Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, orHHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), Sinteger seconds (00-59) and DD = decimal seconds; decimal seconds areexpressed 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 CodeO 1ID2/2Code specifying the type of transaction								
			IMPLEMENTATION NAME: Claim Identifier								
			CODE DEFINITION								
			31 Subrogation Demand								
			The subrogation demand code is only for use by state Medicaid agencies performing post payment recovery claiming with willing trading partners. <i>NOTE:</i> At the time of this writing, Subrogation Demand is not a HIPAA mandated use of the 837 transaction.								
			CH Chargeable								
			Use CH when the transaction contains only fee for service claims or claims with at least one chargeable line item. If it is not clear whether a transaction contains claims or capitated encounters, or if the transaction contains a mix of claims and capitated encounters, use CH.								

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

SEGMENT DETAIL					
	NM1 - S		ER NAME		
X12 Segment Nar	ne: Individual or	Organizational	Name		
X12 Purpo	se: To supply th	e full name of a	n individual or orgar	nizational entity	
X12 Set Not	receiver the loop	s change or ad	omitter and receiver d data in any way, th entification. The add pop.	nen they add an	occurrence to
X12 Synt		NM108 or NM1	09 is present, then t	he other is requ	uired.
	2. C1110 If NM11	1 is present, the	en NM110 is require	d.	
	3. C1203 If NM11	2 is present, the	en NM103 is require	d.	
Lo	op: 1000A — Sl	JBMITTER NA	ME Loop Repeat:	1	
Segment Repe	eat: 1				
Usa	ge: REQUIRED				
TR3 Not		omitter is the e ransaction.	ntity responsible fo	or the creation	and formatting
TR3 Examp DIAGRAM	ble: NM1*41*2*	ABC SUBMIT	TER****46*999	999999~	
NIVI 1 * Co	98 ty ID bde D 2/3 NM102 Entity T Qualif M 1 ID	ier Org Na		№105 1037 Name Middle O 1 AN 1/25	MM106 1038 Name Prefix O 1 AN 1/10
* Su	1039 me ffix N 1/10 N 1/10 N 1/10 N 1/10 N 1/10 N M108 ID Co Qualif X 1 ID	ier [*] Cod	67 e X NM110 706 Entity Relat Code X 1 ID 2/2	№ 111 98 Entity ID Gode 0 1 ID 2/3	№ № № № № № № № № № № № № № № № № № №
ELEMENT DETAIL					
USAGE	REF. DATA DES. ELEMENT	NAME			ATTRIBUTES
REQUIRED	IM101 98	Entity Identifi Code identifying individual	er Code an organizational entity,		M 1 ID 2/3 property or an
		CODE	DEFINITION		
		41	Submitter		

005010X223 • 837 • SUBMITTER NAME	1000A • NM1		ASC X12N ● IN TE(SURANCE S CHNICAL R		
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			
			2 Non-Person Entity			
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name	X 1	AN	1/60
			syntax: C1203			
			IMPLEMENTATION NAME: Submitter Last or Organization	ation Nam	e	
SITUATIONAL NM104 1036		1036	Name First Individual first name	01	AN	1/35
			SITUATIONAL RULE: Required when NM102 = 1 (per has a first name. If not required by this imple not send.	-	-	
			IMPLEMENTATION NAME: Submitter First Name			
SITUATIONAL NM105 1037		1037	Name Middle Individual middle name or initial	01	AN	1/25
			SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, o	entify the i	ndivid	
			SITUATIONAL RULE: Required when NM102 = 1 (pendemonstrated and the person is needed to identify the person identify	entify the i lo not sen	ndivid	
NOT USED	NM106	1038	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, o	entify the i lo not sen	ndivid	
	NM106 NM107	1038 1039	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or	entify the i to not send Initial	ndivid d.	ual. If
NOT USED			SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix	entify the i to not send Initial O 1 O 1 X 1	ndivid d. AN AN ID	1/10 1/10 1/10 1/2
NOT USED	NM107	1039	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structure	entify the i to not send Initial O 1 O 1 X 1	ndivid d. AN AN ID	<i>ual. If</i> 1/10 1/10 1/2
NOT USED	NM107	1039	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structure Code (67)	entify the i to not send Initial O 1 O 1 X 1	ndivid d. AN AN ID	1/10 1/10 1/10 1/2
NOT USED	NM107	1039	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structure Code (67) SYNTAX: P0809	entify the in to not send Initial O 1 O 1 X 1 re used for lo	ndivid d. AN AN ID dentifica	1/10 1/10 1/10 1/2 ation
NOT USED	NM107	1039	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structure Code (67) SYNTAX: P0809 CODE DEFINITION	initial O 1 O 1 X 1 re used for lo	AN AN ID dentifica	1/10 1/10 1/10 1/2 ation
NOT USED REQUIRED	NM107	1039	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, or implementation name: Submitter Middle Name or Name Prefix IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structure Code (67) SYNTAX: P0809 CODE DEFINITION 46 Electronic Transmitter Identifier	initial O 1 O 1 X 1 re used for lo	AN AN ID dentifica	1/10 1/10 1/10 1/2 ation
NOT USED REQUIRED	NM107 NM108	1039 66	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structur Code (67) SYNTAX: P0809 CODE DEFINITION 46 Electronic Transmitter Identific Established by trading partner	Initial O 1 O 1 X 1 re used for lo	AN AN ID dentifica	1/10 1/10 1/10 1/2 ation
NOT USED REQUIRED	NM107 NM108	1039 66	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, or implementation guide, or implementation name: Submitter Middle Name or Name Prefix IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Prefix Identification Code Qualifier Code designating the system/method of code structure Code (67) SYNTAX: P0809 CODE DEFINITION 46 Electronic Transmitter Identifier Identification Code Code designating partner	Initial O 1 O 1 X 1 re used for lo	AN AN ID dentifica	1/10 1/10 1/10 1/2 ation
NOT USED NOT USED REQUIRED REQUIRED	NM107 NM108	1039 66	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structur Code (67) SYNTAX: P0809 CODE DEFINITION 46 Electronic Transmitter Identific Established by trading partner Identification Code Code identifying a party or other code SYNTAX: P0809	Initial O 1 O 1 X 1 re used for lo	AN AN ID dentifica	1/10 1/10 1/10 1/2 ation
NOT USED REQUIRED	NM107 NM108	1039 66 67	SITUATIONAL RULE: Required when NM102 = 1 (per name or initial of the person is needed to ide not required by this implementation guide, of IMPLEMENTATION NAME: Submitter Middle Name or Name Prefix Name Suffix Identification Code Qualifier Code designating the system/method of code structur Code (67) SYNTAX: P0809 CODE DEFINITION 46 Electronic Transmitter Identifie Established by trading partner Identification Code Code identifying a party or other code SYNTAX: P0809 IMPLEMENTATION NAME: Submitter Identifier	initial O 1 O 1 X 1 re used for lo fication Nu er agreeme X 1	AN AN ID dentifica	1/10 1/10 1/2 ation (ETIN) 2/80

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 555551234. 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~

005010X223 • 837 • 1000A • PER SUBMITTER EDI CONTACT INFORMATION

	R01 366 Contact unct Code 1 ID 2/2	PER02 Name	* Comm Number Qual * Comm * Number	umber Qual 🌋 🛛 N	06 364 Comm lumber AN 1/256
*	R07 365 Comm Imber Qual ID 2/2	PER08 Comm Numbe X 1 AN 1	r <mark>* Reference</mark> ~		
ELEMENT DETAIL					
USAGE	REF. DES.	DATA ELEMENT	NAME	AT	TRIBUTES
REQUIRED	PER01	366	Contact Function Code Code identifying the major duty or responsibility	M 1 II	
			CODE DEFINITION		
			IC Information Contact		
SITUATIONAL	PER02	93	Name Free-form name	01 A	N 1/60
			AND		
			it is the first iteration of the Submitter En (PER) segment. If not required by this implementation go	uide, do not send	
REQUIRED	PER03	365	(PER) segment. If not required by this implementation get IMPLEMENTATION NAME: Submitter Contact Nat Communication Number Qualifier	uide, do not send me X 1 II	
REQUIRED	PER03	365	(PER) segment. If not required by this implementation get IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication number	uide, do not send me X 1 II	
REQUIRED	PER03	365	(PER) segment. If not required by this implementation get IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication number SYNTAX: P0304	uide, do not send me X 1 II	
REQUIRED	PER03	365	(PER) segment. If not required by this implementation grading IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION	uide, do not send me X 1 II	
REQUIRED	PER03	365	(PER) segment. If not required by this implementation grading IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION EM Electronic Mail	uide, do not send me X 1 II	
REQUIRED	PER03	365	(PER) segment. If not required by this implementation groups IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION EM Electronic Mail FX Facsimile	uide, do not send me X 1 II	
	PER03 PER04	365 364	(PER) segment. If not required by this implementation grading IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION EM Electronic Mail	uide, do not send me X 1 IE ber X 1 A	D 2/2 N 1/256
			(PER) segment. If not required by this implementation grading in the system of contact Name: IMPLEMENTATION NAME: SUBMITTER Contact Name: Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION EM Electronic Mail FX Facsimile TE Telephone Communication Number Complete communications number including complete communications number	uide, do not send me X 1 IE ber X 1 A	D 2/2 N 1/256
REQUIRED			(PER) segment. If not required by this implementation grading that the implementation number Qualifier Communication Number Qualifier Code identifying the type of communication number Qualifier SYNTAX: P0304 CODE DEFINITION EM Electronic Mail FX Facsimile TE Telephone Complete communications number including complete complete communications number including complete complete	uide, do not send me X 1 II ber X 1 A untry or area code wh	D 2/2 N 1/256
REQUIRED	PER04	364	(PER) segment. If not required by this implementation grading that the provide the symptox of communication number of communications number including complete communications number including communications number including communications number in	uide, do not send me X 1 II ber X 1 A untry or area code wh	D 2/2 N 1/256
REQUIRED	PER04	364	(PER) segment. If not required by this implementation groups IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION EM Electronic Mail FX Facsimile TE Telephone Complete communications number including couplicable SYNTAX: P0304 Communication Number Complete communications number including couplicable SYNTAX: P0304 Communication Number Qualifier Code identifying the type of communication num	uide, do not send me ber X 1 II untry or area code wh X 1 II ber X 1 II	D 2/2 N 1/256 Ien 2/2 <i>necessary</i>
REQUIRED	PER04	364	(PER) segment. If not required by this implementation gravity IMPLEMENTATION NAME: Submitter Contact Name Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 CODE DEFINITION EM Electronic Mail FX Facsimile TE Telephone Communication Number Complete communications number including couplicable SYNTAX: P0304 Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0304 Communication Number Qualifier Code identifying the type of communication num SYNTAX: P0506 SITUATIONAL RULE: Required when this inform by the submitter. If not required by this inform	uide, do not send me ber X 1 II untry or area code wh X 1 II ber X 1 II	D 2/2 N 1/256 Ien 2/2 <i>necessary</i>

			EX	Telephone Extension			
			FX	Facsimile			
			TE	Telephone			
SITUATIONAL	PER06	364	Communication Complete comm	on Number unications number including country or are	X 1 ea code		1/256
			SYNTAX: P0506				
				Required when this information is tter. If not required by this implement			-
SITUATIONAL	PER07	365		on Number Qualifier the type of communication number	X 1	ID	2/2
			syntax: P0708				
				Required when this information is tter. If not required by this implement			-
			CODE	DEFINITION			
			EM	Electronic Mail			
			EX	Telephone Extension			
			FX	Facsimile			
			TE	Telephone			
SITUATIONAL	PER08	364	Communication Complete comm applicable	on Number unications number including country or are	X 1 ea code	AN when	1/256
			SYNTAX: P0708				
				Required when this information is tter. If not required by this implement			-
NOT USED	PER09	443	Contact Inqui	ry Reference	01	AN	1/20

SEGMENT DETAIL	
NM1	- RECEIVER NAME
X12 Segment Name: Individu	ual or Organizational Name
X12 Purpose: To supp	ply the full name of an individual or organizational entity
rec the	op 1000 contains submitter and receiver information. If any intermediary evivers change or add data in any way, then they add an occurrence to a loop as a form of identification. The added loop occurrence must be the t occurrence of the loop.
X12 Syntax: 1. P08 If e	809 ither NM108 or NM109 is present, then the other is required.
2. C1 [.] If N	110 IM111 is present, then NM110 is required.
3. C1: If N	203 IM112 is present, then NM103 is required.
Loop: 1000B -	— RECEIVER NAME Loop Repeat: 1
Segment Repeat: 1	
Usage: REQUI	RED
TR3 Example: NM1*4	0*2*XYZ RECEIVER****46*111222333~
DIAGRAM	
NM1 * Entity ID Code M 1 ID 2/3 * M NM107 1039 Name *	M102 1065 NM103 1035 ntity Type Name Last/ Org Name NM104 1036 1 ID 1/1 NM106 1/1 M108 66 NM109 67 NM100 NM110 706 M10C ID Code X 1 AN 1/2 NM111 98 M101 ID Code X 1 ID 2/2 NM111 98 Mame NM109 67 NM109 67 NM101 NM102 NM111 98 Mame NM109 67 NM102 NM110 706 NM111 98 NM112 1035 Mame NM102 NM102 NM110 706 NM111 98 NM112 1035 Mame NM102 NM102 NM102 NM102 NM112 1035 Name NM102 NM102 NM102 NM102 NM102 NM102 NM102 M102 NM102 NM102 NM102 NM102 NM102 NM102 NM102 NM102
ELEMENT DETAIL	
	DATA ELEMENT NAME ATTRIBUTES
REQUIRED NM101 98	8 Entity Identifier Code M 1 ID 2/3 Code identifying an organizational entity, a physical location, property or an individual
	CODE DEFINITION
	40 Receiver
REQUIRED NM102 10	D65 Entity Type Qualifier M 1 ID 1/1 Code qualifying the type of entity M 1 ID 1/1
	SEMANTIC: NM102 qualifies NM103.
	CODE DEFINITION
	2 Non-Person Entity

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE			005010X223 • 83 F		00B • NM1 /ER NAME
REQUIRED	NM103	1035		or Organization Name	X 1	AN	1/60
			syntax: C1203	1			
			IMPLEMENTATION	NAME: Receiver Name			
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle	e	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	AN	1/10
REQUIRED	NM108	66		n Code Qualifier ing the system/method of code	X 1 ID 1 e structure used for Identification		
			syntax: P0809				
			CODE	DEFINITION			
			46	Electronic Transmitter	Identification Nu	umber	(ETIN)
REQUIRED	NM109	67	Identification Code identifyir	n Code lg a party or other code	X 1	AN	2/80
			syntax: P0809				
				NAME: Receiver Primary Id	lentifier		
NOT USED	NM110	706	Entity Relati	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identi	fier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last c	or Organization Name	01	AN	1/60

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

	HL01	628		HL02	2	734		HL03	3	735		HL04		736	
HL *	Hiera ID Nur	rch nber	*	Hi Pa	ierar irent	ch HĐ	*		ieraro vel Co		*		eraro Id Co		~
	M 1 AN	I 1/12		01	AN	1/12		M 1	ID	1/2		O 1	ID	1/1	

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES			
REQUIRED	HL01	628	Hierarchical II A unique number a hierarchical stru	assigned by the sender to identify a partic	M 1 cular d	AN ata seg	1/12 ment in			
			of the HL segment indicate the number HL01 would be ""	hall contain a unique alphanumeric numbe nt in the transaction set. For example, HL0 ber of occurrences of the HL segment, in v 1" for the initial HL segment and would be t HL segment within the transaction.	1 coul vhich c	d be us ase the	ed to value of			
			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.							
NOT USED	HL02	734	Hierarchical P	arent ID Number	01	AN	1/12			
REQUIRED	HL03	735	Hierarchical L Code defining the	evel Code e characteristic of a level in a hierarchical s	M 1 structu	ID re	1/2			
			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						
			20	Information Source						

ASC X12N • INSU TECHNICAL REP		OMMITTEE		005 BILLING PROVI	010X223 • 8 DER HIERA									
REQUIRED	HL04	736	Code indicatin	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 D Hierarchical Structure.	ata Segme	nt in 1	ſhis							

SEGMENT DETAIL						
			ILLING PROVIDER SPECIAL	ΤY		
X12 Segment N	lame: Prov	vider Info	rmation			
X12 Purj	pose: To s	specify the	e identifying characteristics of a provider			
X12 Sy	ntax: 1.	P0203				
		If either F	PRV02 or PRV03 is present, then the other is req	uired		
L	_oop: 200	0A — BIL	LING PROVIDER HIERARCHICAL LEVEL			
Segment Re	peat: 1					
U	sage: SIT	UATIONA	AL			
Situational	pro	•	nen the payer's adjudication is known to be im onomy code. If not required by this implemen	-	-	
TR3 Exa	mple: PR\	/*BI*PX	C*282NR1301X~			
DIAGRAM	- 1					
PRV * PRV *	/01 1221 Provider Code ID 1/3	PRV02 Referen Ident Qu X 1 ID	* * *	*	PRV06 Prov Org (O 1 II	Sode ~
USAGE	REF. DES.	DATA ELEMENT	NAME			
REQUIRED					ATTRIB	UTES
	PRV01	1221	Provider Code	M 1		UTES 1/3
	PRV01	1221	Provider Code Code identifying the type of provider CODE DEFINITION	M 1		
	PRV01	1221	Code identifying the type of provider CODE DEFINITION	M 1		
REQUIRED	PRV01 PRV02	1221 128	Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier	M 1		
REQUIRED			Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification		ID	1/3
REQUIRED			Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203		ID	1/3
REQUIRED			Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 CODE DEFINITION	X 1	ID	1/3
REQUIRED			Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 CODE DEFINITION PXC Health Care Provider Taxonomy Comparison	X 1	ID	1/3
REQUIRED			Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 CODE DEFINITION	X 1 Code Faxono X 1	ID ID	1/3 2/3 1/50
	PRV02	128	Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 CODE DEFINITION PXC Health Care Provider Taxonomy Concord code source 682: Health Care Provider Taxonomy Concord code source for a particular Transaction Reference Identification Reference Identification	X 1 Code Faxono X 1	ID ID	1/3 2/3 1/50
	PRV02	128	Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 CODE DEFINITION PXC Health Care Provider Taxonomy Core source 682: Health Care Provider Reference Identification Reference Identification Reference Identification Reference Identification Reference Identification Reference Identification	X 1 Code Faxono X 1	ID ID	1/3 2/3 1/50
	PRV02	128	Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 CODE DEFINITION PXC Health Care Provider Taxonomy Concord code source 682: Health Care Provider Taxonomy Concord code source 682: Health Care Provider Taxonomy Concord code source Identification Reference Identification as defined for a particular Transaction by the Reference Identification Qualifier SYNTAX: P0203	X 1 Code Faxono X 1	ID ID	1/3 2/3 1/50
REQUIRED	PRV02 PRV03	128	Code identifying the type of provider CODE DEFINITION BI Billing Reference Identification Qualifier Code qualifying the Reference Identification SYNTAX: P0203 DEFINITION PXC DEFINITION PXC Health Care Provider Taxonomy Code Code source 682: Health Care Provider Taxonomy Code Reference Identification Reference Identification Qualifier SYNTAX: P0203 IMPLEMENTATION NAME: Provider Taxonomy Code	X 1 Code Taxono X 1 Don Set	ID ID	1/3 2/3 1/50 pecified

X12 Segment Name: Currency

SEGMENT DETAIL

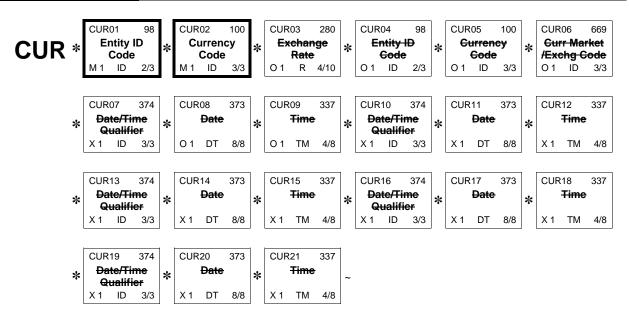
X12 Purpose:	To specify the currency (dollars, pounds, francs, etc.) used in a transaction
X12 Syntax:	1. C0807 If CUR08 is present, then CUR07 is required.
	2. C0907 If CUR09 is present, then CUR07 is required.
	3. L101112 If CUR10 is present, then at least one of CUR11 or CUR12 are required.
	4. C1110 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.

CUR - FOREIGN CURRENCY INFORMATION

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~





ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES				
REQUIRED	CUR01	98		Entity Identifier Code Code identifying an organizational entity, a physical location							
			individual	g an olganizational ontity, a physical locato	n, prop						
			CODE	DEFINITION							
			85	Billing Provider							
REQUIRED	CUR02	100	Currency Co Code (Standard	de I ISO) for country in whose currency the cha	M 1 arges a	ID ire spec	3/3 ified				
			CODE SOURCE 5:	code source 5: Countries, Currencies and Funds							
			for this eleme	The submitter must use the Currency Code, not th for this element. For example the Currency Code (dollars would be valid, while CA = Canada would b							
NOT USED	CUR03	280	Exchange Ra	ate	01	R	4/10				
NOT USED	CUR04	98	Entity Identif	ier Code	01	ID	2/3				
NOT USED	CUR05	100	Currency Co	de	01	ID	3/3				
NOT USED	CUR06	669	Currency Ma	rket/Exchange Code	01	ID	3/3				
NOT USED	CUR07	374	Date/Time Qu	ualifier	X 1	ID	3/3				
NOT USED	CUR08	373	Date		01	DT	8/8				

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

NOT USED	CUR09	337	Time	01	тм	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	тм	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	тм	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	тм	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	тм	4/8

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

 C1203

If NM112 is present, then NM103 is required.

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

Segment Repeat: 1

Usage: REQUIRED

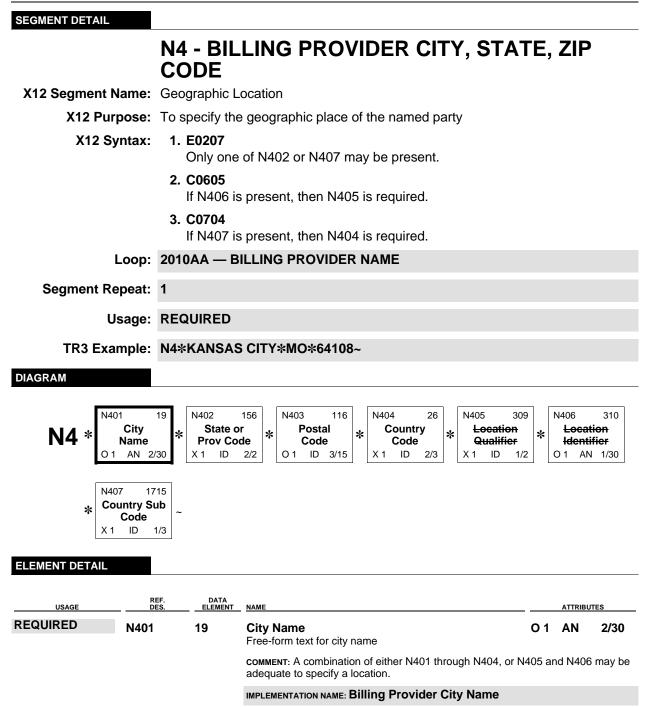
- TR3 Notes: 1. Beginning on the NPI compliance date: When the Billing Provider is an organization health care provider, the organization health care provider's NPI or its subpart's NPI is reported in NM109. When a health care provider organization has determined that it needs to enumerate its subparts, 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~

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

DIAGRAM										
	101 98 Entity ID Code ID 2/3	NM102 Entity Ty Qualifie M 1 ID	pe _米 Name La	ne [*]	NM104 1036 Name First O 1 AN 1/35	*	NM105 1037 Name Middle O 1 AN 1/25	*	NM106 Nan Prei O 1 AN	-
NM * 01	107 1039 Name Suffix AN 1/10	NM108 ID Cod Qualifie X 1 ID	· *		NM110 706 Entity Relat Code X 1 ID 2/2	*	NM111 98 Entity ID Code O 1 ID 2/3	*	NM112 Name Org N O 1 AN	ame ~
ELEMENT DETAIL	REF. DES.	DATA ELEMENT	NAME						ATTRIBU	TES
REQUIRED	NM101	98	Entity Identifie Code identifying a			аp	hysical location	M 1 , pro		2/3 an
			individual	DEFINITI	ON					
REQUIRED	NM102	1065	85 Entity Type Qu Code qualifying th	ualifier	g Provider			M 1	ID	1/1
			semantic: NM102 code	qualifie: DEFINITI						
REQUIRED	NM103	1035	2 Name Last or (Individual last name	Organia		ne		X 1	AN	1/60
			syntax: C1203	D		•				
			IMPLEMENTATION N	AME: BIII	ling Provider	Or	ganizational	Nan	ne	
NOT USED	NM104	1036	Name First					01		1/35
NOT USED	NM105	1037	Name Middle					01		1/25
NOT USED	NM106	1038	Name Prefix					01	AN	1/10
NOT USED	NM107	1039	Name Suffix					01	AN	1/10

SITUATIONAL	NM108	66	Identification Code Qualif Code designating the system/n Code (67)	ier X nethod of code structure used for		1/2 ion						
			SYNTAX: P0809									
			territories on or after the Identifier (NPI) implement receive an NPI. OR Required for providers not or after the mandated HIP implementation date when OR Required for providers pri- date when the provider has the capability to send it.	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								
			CODE DEFINITION									
				r Medicare and Medicaid S rovider Identifier	ervices							
				537: Centers for Medicare and vider Identifier	Medicaid S	ervices						
SITUATIONAL	NM109	67	Identification Code Code identifying a party or othe		1 AN	2/80						
			syntax: P0809									
			territories on or after the Identifier (NPI) implemen receive an NPI. OR Required for providers no	or providers in the United S mandated HIPAA National tation date when the provi t in the United States or its AA National Provider Iden	Provider der is elig s territorie	ible to es on						
				n the provider has received	• • •	,						
			Required for providers pr	ior to the mendated NPI im	nlementa	tion						
			date when the provider hat the capability to send it.	as received an NPI and the	-							
			the capability to send it.		submitte							
			the capability to send it.	as received an NPI and the lementation guide, do not	submitte							
NOT USED	NM110	706	the capability to send it. If not required by this imp	as received an NPI and the lementation guide, do not	submitter							
NOT USED NOT USED NOT USED	NM110 NM111	706 98	the capability to send it. If not required by this imp IMPLEMENTATION NAME: Billing F	as received an NPI and the lementation guide, do not Provider Identifier	submitter send. 1 ID	r has						

SEGMENT DETAIL												
	N3 - BIL	LING PROVIDER ADDRESS										
X12 Segment Name	: Party Locatior	1										
X12 Purpose	: To specify the	location of the named party										
Loop	: 2010AA — B	ILLING PROVIDER NAME										
Segment Repeat	t: 1											
Usage	REQUIRED	EQUIRED										
TR3 Notes	Box or L	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 MAI	N STREET~										
DIAGRAM												
N301 Addres Informat M 1 AN	ss _* Addres	on ~										
USAGE	REF. DATA DES. ELEMENT	NAME		ATTRIBU	ITES							
REQUIRED N30		Address Information Address information	M 1		1/55							
		IMPLEMENTATION NAME: Billing Provider Address Line										
SITUATIONAL N30	02 166	Address Information Address information	01	AN	1/55							
		SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not set		ss line.	. If not							
		IMPLEMENTATION NAME: Billing Provider Address Line										



ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate	X1 govern	ID Iment a	2/2 gency
			syntax: E0207			
			COMMENT: N402 is required only if city name (N401) is in th	e U.S. (or Cana	da.
			SITUATIONAL RULE: Required when the address is in t America, including its territories, or Canada. If n implementation guide, do not send.			
			IMPLEMENTATION NAME: Billing Provider State or Provi	nce Co	ode	
			CODE SOURCE 22: States and Provinces			
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding pu (zip code for United States)	O 1 nctuatio	ID on and b	3/15 blanks
			SITUATIONAL RULE: Required when the address is in t America, including its territories, or Canada, or a exists for the country in N404. If not required by implementation guide, do not send.	when a		
			IMPLEMENTATION NAME: Billing Provider Postal Zone o	r ZIP C	ode	
			code source 51: ZIP Code code source 932: Universal Postal Codes			
			When reporting the ZIP code for U.S. addresses, ZIP code must be provided.	, the fu	III nine	digit
SITUATIONAL	N404	26	Country Code Code identifying the country	X 1	ID	2/3
			syntax: C0704			
			SITUATIONAL RULE: Required when the address is out States of America. If not required by this implem not send.			
			CODE SOURCE 5: Countries, Currencies and Funds			
			Use the alpha-2 country codes from Part 1 of ISC	J 3166	-	
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	01	AN	1/30
SITUATIONAL	N407	1715	Country Subdivision Code	X 1	ID	1/3
			Code identifying the country subdivision			
			syntax: E0207, C0704		••••	
			SITUATIONAL RULE: Required when the address is not States of America, including its territories, or Ca country in N404 has administrative subdivisions limited to states, provinces, cantons, etc. If not implementation guide, do not send.	anada, s such	and th as but	e t not
			CODE SOURCE 5: Countries, Currencies and Funds			
			Use the country subdivision codes from Part 2 c	of ISO :	3166.	

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~



	REF01 128			REF	F02 127			REF03 352]	REF04 C040		
REF *	REF * Reference Ident Qual		*	Reference Ident		*	Description		*	Refer- Ident	ifior	~		
	M 1	ID 2/3		X 1	AN	1/50		X 1	AN	1/80		O 1		

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES
REQUIRED	REF01	128		entification Qualifier the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION			
			EI	Employer's Identification Number	r		
				The Employer's Identification Nurstring of exactly nine numbers with For example, "001122333" would sending "001-12-2333" or "00-112 invalid.	th no : be val	separa id, whi	itors. ile
REQUIRED	REF02	127		ntification nation as defined for a particular Transacti e Identification Qualifier	X1 on Set	AN or as sp	1/50 ecified
			syntax: R0203				
				NAME: Billing Provider Tax Identificat	ion Nu	mber	
NOT USED	REF03	352	Description		X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE	IDENTIFIER	01		

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:	 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~

005010X223 • 837 • 2010AA • PER BILLING PROVIDER CONTACT INFORMATION

DIAGRAM							
PER * FI	R07 365	O 1 AN	Number 1/60 X 1 ID 364 PER09	Imm * Comm * Comm 2/2 X 1 AN 1/256 * Mumber Qu 443 443	ual *	PER06 Com Num X 1 AN	
* Nu X 1	Imber Qual	X 1 AN 1	er [*] Refere				
ELEMENT DETAIL							
	REE	ΠΑΤΑ					
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES
REQUIRED	PER01	366	Contact Fund		M 1	ID	2/2
			Code identifying	g the major duty or responsibility of the per	son or g	group na	amed
			CODE	DEFINITION			
			IC	Information Contact			
SITUATIONAL	PER02	93	Name		01	AN	1/60
			Free-form name	9	• ·	,	.,
			Contact Infor implementati	E: Required in the first iteration of the mation segment. If not required by fon guide, do not send. NAME: Billing Provider Contact Name	' this	ng Pro	ovider
			IMPLEMENTATION		5		
REQUIRED	PER03	365		ion Number Qualifier g the type of communication number	X 1	ID	2/2
			SYNTAX: P0304				
			CODE	DEFINITION			
			EM	Electronic Mail			
			FX	Facsimile			
			TE	Telephone			
REQUIRED	PER04	364	Communicati			AN e when	1/256
			SYNTAX: P0304				
SITUATIONAL	PER05	365		ion Number Qualifier g the type of communication number	X 1	ID	2/2
			syntax: P0506				
			SITUATIONAL RULI	E: Required when this information is	s deen	ned ne	cessarv
				tter. If not required by this impleme			
			CODE	DEFINITION			
			EM	Electronic Mail			
			EX	Telephone Extension			
			FX	Facsimile			
			TE	Telephone			
				i ciebuolie			

Complete communications number including country or area code when applicable SWITAX: P0506 SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send. SITUATIONAL PER07 365 Communication Number Qualifier X 1 ID 2/2 Code identifying the type of communication number SYNITAX: P0708 SITUATIONAL RULE: Required when this information is deemed necessa 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 PER08 364 Communication Number X 1 AN SITUATIONAL PER08 364	ASC X12N • INSURA TECHNICAL REPOR		MMITTEE	005010X223 • 837 • 2010AA • PER BILLING PROVIDER CONTACT INFORMATION							
SITUATIONAL PER07 365 Communication Number Qualifier X 1 ID 2/2 Code identifying the type of communication number SYNTAX: P0708 SITUATIONAL PER07 365 Communication Number Qualifier X 1 ID 2/2 Code identifying the type of communication number SYNTAX: P0708 SITUATIONAL RULE: Required when this information is deemed necessa 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 PER08 364 Communications number including country or area code when applicable SYNTAX: P0708 SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.	SITUATIONAL	PER06	364	Complete com		1/256					
SITUATIONAL PER07 365 Communication Number Qualifier X 1 ID 2/2 Code identifying the type of communication number SYNTAX: P0708 SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send. <u>CODE</u> DEFINITION EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone SITUATIONAL PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.				syntax: P0506							
SITUATIONAL PER08 364 Communication number X 1 ib 212 Code identifying the type of communication number syntax: P0708 struational RULE: Required when this information is deemed necessa 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 Complete communications number including country or area code when applicable SYNTAX: P0708 struational RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.				by the subm		-					
SITUATIONAL RULE: Required when this information is deemed necessa 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 PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.	SITUATIONAL	PER07	365			2/2					
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 PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable SITUATIONAL RULE: Required when this information is deemed necessar by the submitter. If not required by this implementation guide, do not send.				syntax: P0708							
EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone SITUATIONAL PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable syntax: P0708 SITUATIONAL RULE: Required when this information is deemed necessar by the submitter. If not required by this implementation guide, do not send.											
EX Telephone Extension FX Facsimile TE Telephone SITUATIONAL PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable syntax: P0708 SITUATIONAL RULE: Required when this information is deemed necessar by the submitter. If not required by this implementation guide, do not send.				CODE	DEFINITION						
SITUATIONAL PER08 364 Communication Number Telephone SITUATIONAL PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable syntax: P0708 SITUATIONAL RULE: Required when this information is deemed necessal by the submitter. If not required by this implementation guide, do not send.				EM	Electronic Mail						
SITUATIONAL PER08 364 Communication Number Complete communications number including country or area code when applicable X 1 AN 1/25 SITUATIONAL PER08 364 Situations number including country or area code when applicable Situations number including country or area code when applicable Situational Rule: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.				EX	Telephone Extension						
SITUATIONAL PER08 364 Communication Number X 1 AN 1/25 Complete communications number including country or area code when applicable SYNTAX: P0708 SITUATIONAL RULE: Required when this information is deemed necessar by the submitter. If not required by this implementation guide, do not send.				FX	Facsimile						
Complete communication Number including country or area code when applicable SYNTAX: P0708 SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.				TE	Telephone						
SITUATIONAL RULE: Required when this information is deemed necessa by the submitter. If not required by this implementation guide, do not send.	SITUATIONAL	PER08	364	Complete com		1/256					
by the submitter. If not required by this implementation guide, do not send.				SYNTAX: P0708							
NOT USED DEB00 442 Contact Inquiry Beforence O.4 ANI 4/20				by the subm	•	-					
rerug 443 Contact inquiry Reference UT AN 1/2L	NOT USED	PER09	443	Contact Indu	irv Reference O 1 AN	1/20					

SEGMENT DETAIL											
	NM1 - P	AY-TC) ADD)R		4	ME				
X12 Segment Name:	Individual or C	Organizati	onal Nam	е							
X12 Purpose:	To supply the	o supply the full name of an individual or organizational entity									
X12 Set Notes:	2300. Fo	 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 N	1. P0809 If either NM108 or NM109 is present, then the other is required.									
	2. C1110 If NM111	is presen	t, then NN	И1 [.]	10 is required	d.					
	3. C1203 If NM112	is presen	t, then NN	Л1(03 is required	d.					
Loop:	2010AB — P	ΑΥ-ΤΟ ΑΙ	DDRESS	NA	ME Loop	Re	peat: 1				
Segment Repeat:	1										
Usage:	SITUATIONA	L									
Situational Rule:	Required whe Provider. If n			-	-				-		
TR3 Notes: TR3 Example:	Loop ID- from the for Pay-T	2010AB c	only conta rovider A	ain dd	is address in Iress. There	nfc	ormation wh	en	ous versions. different e identifiers		
DIAGRAM	NW170772~										
NM101 Entity ID Code M 1 ID		A	103 1035 me Last/ rg Name AN 1/60	*	NM104 1036 Name First O 1 AN 1/35	*	NM105 1037 Name Middle O 1 AN 1/25	*	NM106 1038 Name Prefix O 1 AN 1/10		
* NM107 10 Name Suffix O 1 AN 1	039 * NM108 ID Code Qualifie X 1 ID	*	109 67 HD Code AN 2/80	*	NM110 706 Entity Relat Code X 1 ID 2/2	*	NM111 98 Entity ID Code O 1 ID 2/3	*	NM112 1035 Name Last/ Org Name O 1 AN 1/60		
ELEMENT DETAIL											
	REF. DATA DES. ELEMENT	NAME					·		ATTRIBUTES		
REQUIRED NM1	01 98		entifier Co ifying an org		izational entity,	a pł		M 1			
		CODE	DEFI	NITIC	ON						
		87	Pay	-to	Provider						

ASC X12N •	INSURANCE SUBCOMMITTEE
TECHNICAL	REPORT • TYPE 3

REQUIRED	NM102	1065	Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.		M 1	ID	1/1
			2	Non-Person Entity			
NOT USED	NM103	1035	Name Last o	r Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle)	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	AN	1/10
NOT USED	NM108	66	Identification	n Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification	n Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last o	r Organization Name	O 1	AN	1/60

SEGMENT DETAIL										
	N3 - PA	Y-TO ADDRESS - ADDRESS								
X12 Segment Name:	Party Location	arty Location								
X12 Purpose:	To specify the	o specify the location of the named party								
Loop:	2010AB — P/	AY-TO ADDRESS NAME								
Segment Repeat:	1									
Usage:	REQUIRED									
TR3 Example:	N3*123 MAIN	STREET~								
DIAGRAM										
N301 1 Address Informatic M 1 AN 1/	Address	on ~								
USAGE D	EF. DATA ES. ELEMENT	NAME		ATTRIBL	JTES					
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	01	AN	1/55					
		SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not set		ss line	. If not					
		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 1. E0207 X12 Syntax: 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 N401 N402 156 N403 116 N404 N405 309 N406 310 19 26 City State or Postal Country Location **Location** N4 * * * * * * **Prov Code** Name **Qualifier Identifier** Code Code AN 2/30 Χ1 ID 2/2 01 ID 3/15 X 1 ID 2/3 X 1 ID 1/2 01 AN 1/30 O 1 N407 1715 **Country Sub** * Code Χ1 ID 1/3 ELEMENT DETAIL DATA ELEMENT REF. DES. USAGE NAME ATTRIBUTES REQUIRED N401 19 O1 AN 2/30 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 Address City Name

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate	X1 govern	ID Iment aç	2/2 gency						
			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 pu (zip code for United States)	O 1 nctuatio	ID on and b	3/15 lanks						
			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 out States of America. If not required by this implement not send.									
			CODE SOURCE 5: Countries, Currencies and Funds									
			Use the alpha-2 country codes from Part 1 of ISC	3166 0								
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2						
NOT USED	N406	310	Location Identifier	01	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 States of America, including its territories, or Ca country in N404 has administrative subdivisions limited to states, provinces, cantons, etc. If not i implementation guide, do not send.	anada, s such	and th as but	e not						
			CODE SOURCE 5: Countries, Currencies and Funds									
			Use the country subdivision codes from Part 2 a	f IGO	2166							

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

SEGMENT DETAIL							
	NM1 - P	AY-TO P	LAN NA	ME			
X12 Segment Name:	Individual or (ndividual or Organizational Name					
X12 Purpose:	To supply the	full name of a	n individual or	organizational e	ntity		
X12 Set Notes:	2300. Fo	 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 N	NM108 or NM1	09 is present,	then the other is	required.		
	2. C1110 If NM111	is present, the	en NM110 is re	equired.			
	3. C1203 If NM112	is present, the	en NM103 is re	equired.			
Loop:	2010AC — P	AY-TO PLAN	NAME Loop	Repeat: 1			
Segment Repeat:	1						
Usage:	SITUATIONA	NL					
Situational Rule:	-	en willing trac rogation payr		-	is implementation		
TR3 Notes:	1. This loo	p may only be	e used when I	BHT06 = 31.			
TR3 Example:	NM1*PE*2*	ANY STATE	MEDICAID**	***PI*12345~			
DIAGRAM							
NM1 * Entity ID Code M 1 ID 2		66 NM109	1/60 Time 1/60 O 1 A 67 NM110	me * Nam rst Midd	He * Prefix 1/25 O 1 AN 1/10 98 NM112 1035		
O 1 AN 1/	Qualifie	er Cod	e [*] Relat 2/80 X 1 II	Code Cod	e 7 Org Name 2/3 O 1 AN 1/60		
ELEMENT DETAIL							
USAGE D	EF. DATA ES. ELEMENT	NAME			ATTRIBUTES		
REQUIRED NM10	98	Entity Identifi Code identifying individual		l entity, a physical loc	M 1 ID 2/3 cation, property or an		
		CODE	DEFINITION				
		PE	Payee				
			PE is used to	o indicate the sub	rogated payee.		

005010X223 • 837 • 2010AC • NM1 PAY-TO PLAN NAME

REQUIRED	NM102	1065	Entity Type Qualifier	M 1	ID	1/1
			Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.			
			CODE DEFINITION			
			2 Non-Person Entity			
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name	X 1	AN	1/60
			syntax: C1203			
			IMPLEMENTATION NAME: Pay-To Plan Organization	nal Name		
NOT USED	NM104	1036	Name First	01	AN	1/35
NOT USED	NM105	1037	Name Middle	01	AN	1/25
NOT USED	NM106	1038	Name Prefix	01	AN	1/10
NOT USED	NM107	1039	Name Suffix	01	AN	1/10
REQUIRED	NM108	66	Identification Code Qualifier Code designating the system/method of code struct Code (67)	X 1 ure used for lo	ID dentifica	1/2 ation
			SYNTAX: P0809			
			On or after the mandated implementation d National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must	(V must be and prior to PI must be s be sent unlo	sent. o any ent. ess:	phase
			National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding	(V must be and prior to Pl must be s be sent unlo se the Nation e National P nust be sent have been	sent. o any ent. ess: nal Pla Plan ID :. In thi sent u	phase an ID, is case ising
			National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the correspondin qualifier 2U.	(V must be and prior to Pl must be s be sent unlo se the Nation e National P nust be sent have been	sent. o any ent. ess: nal Pla Plan ID :. In thi sent u	phase an ID, is case ising
			National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding QODE DEFINITION	(V must be and prior to Pl must be s be sent unlo se the Nation e National P nust be sent have been	sent. o any ent. ess: nal Pla Plan ID :. In thi sent u	phase an ID, is case ising
			National Plan Identifier (National Plan ID), XPrior to the mandated implementation date in period identified by Federal regulation, PIf a phase-in period is designated, PI must I1. Both the sender and receiver agree to us2. The receiver has a National Plan ID, and3. The sender has the capability to send theIf all of the above conditions are true, XV mthe Payer Identification Number that wouldqualifier PI can be sent in the correspondingCODEDEFINITIONPIPayor Identification	(V must be and prior to PI must be s be sent unlo se the Nation e National P nust be sent have been ng REF segr	sent. o any ent. ess: nal Pla Plan ID :. In thi sent u nent u	phase an ID, is case ising sing
			National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding QODE DEFINITION	(V must be and prior to Pl must be s be sent unlose the National P nust be sent have been ng REF segr	sent. o any ent. ess: nal Pla Plan ID In thi sent u ment u	phase- an ID, is case Ising Ising PlanID
REQUIRED	NM109	67	National Plan Identifier (National Plan ID), XPrior to the mandated implementation date in period identified by Federal regulation, PIf a phase-in period is designated, PI must I1. Both the sender and receiver agree to us2. The receiver has a National Plan ID, and3. The sender has the capability to send theIf all of the above conditions are true, XV mthe Payer Identification Number that would qualifier PI can be sent in the corresponding qualifier 2U.CODEDEFINITIONPIPayor Identification XVXVCenters for Medicare and Medicare	(V must be and prior to Pl must be s be sent unlose the Nation e National P have been by REF segr edicaid Ser dicare and Me	sent. o any ent. ess: nal Pla Plan ID In thi sent u ment u	phase- an ID, is case Ising sing PlanID
REQUIRED	NM109	67	National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding QUALIFIER CODE DEFINITION PI Payor Identification XV Centers for Medicare and Me CODE SOURCE 540: Centers for Medicare and Me PlanID Identification Code	(V must be and prior to Pl must be s be sent unlose the Nation e National P have been by REF segr edicaid Ser dicare and Me	sent. o any p ent. ess: nal Pla Plan ID . In thi sent u nent u vices l	phase an ID, is case ising sing PlanID Service
REQUIRED	NM109	67	National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding qualifier 2U. CODE DEFINITION PI Payor Identification XV Centers for Medicare and Me CODE SOURCE 540: Centers for Medicare and Me PlanID Identification Code Code identifying a party or other code	(V must be and prior to Pl must be s be sent unlose the National P aust be sent have been og REF segr edicaid Ser dicare and Me X 1	sent. o any p ent. ess: nal Pla Plan ID . In thi sent u nent u vices l	phase an ID, is case ising sing PlanID Service
	NM109	67	National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding qualifier 2U. CODE DEFINITION PI Payor Identification XV Centers for Medicare and Macone 540: Centers for Medicare 540: Centers 54	(V must be and prior to Pl must be s be sent unlose the National P aust be sent have been og REF segr edicaid Ser dicare and Me X 1	sent. o any p ent. ess: nal Pla Plan ID . In thi sent u nent u vices l	phase an ID, is case ising sing PlanID Service
REQUIRED NOT USED NOT USED			National Plan Identifier (National Plan ID), X Prior to the mandated implementation date in period identified by Federal regulation, P If a phase-in period is designated, PI must I 1. Both the sender and receiver agree to us 2. The receiver has a National Plan ID, and 3. The sender has the capability to send the If all of the above conditions are true, XV m the Payer Identification Number that would qualifier PI can be sent in the corresponding qualifier 2U. CODE DEFINITION PI Payor Identification XV Centers for Medicare and Macobe Source 540: Centers for Medicare and Macobe Source 540: Centers for Medicare and Macobe Source 540: Centers for Medicare and Macobe Source S40: Centers for Medicare and Macobe Syntax: P0809 IMPLEMENTATION NAME: Pay-To Plan Primary Ider	(V must be and prior to Pl must be s be sent unlose the Nation e National P nust be sent have been ng REF segr edicaid Ser dicare and Me X 1	sent. o any p ent. ess: nal Pla Plan ID . In thi sent u nent u vices l edicaid s	phase an ID, is case Ising PlanID Service 2/80

SEGMENT DETAIL							
V12 Segment N			Y-TO PLAN ADDRESS				
X12 Segment N		-					
X12 Purp	bose: To s	specify the	e location of the named party				
L	.oop: 201	0AC — P	AY-TO PLAN NAME				
Segment Re	peat: 1						
U	sage: REC	REQUIRED					
TR3 Exar	mple: N3*	123 MAI	N STREET~				
DIAGRAM							
	1 166 ddress ormation AN 1/55		on a				
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES	
REQUIRED	N301	166	Address Information	M 1	AN	1/55	
			Address information				
			IMPLEMENTATION NAME: Pay-To Plan Address Line				
SITUATIONAL	N302	166	Address Information Address information	01	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 - PA	Y-TO PLAN CITY, STATE, ZII	P CODE
X12 Segment Name:	Geographic L	ocation	
X12 Purpose:	To specify the	e geographic place of the named party	
X12 Syntax:	ntax: 1. E0207 Only one of N402 or N407 may be present.		
	2. C0605 If N406 is	s present, then N405 is required.	
	3. C0704 If N407 is	s present, then N404 is required.	
Loop:	2010AC — P	AY-TO PLAN NAME	
Segment Repeat:	1		
Usage:	REQUIRED		
TR3 Example:	N4*KANSAS	S CITY*MO*64108~	
DIAGRAM			
N4 * City Name 0 1 AN 2/ N407 17 Country Su Code			* Location Identifier
R	EF. DATA		
REQUIRED N401	<u>element</u> 19	NAME City Name Free-form text for city name	O 1 AN 2/30
		COMMENT: A combination of either N401 through N404, or N adequate to specify a location.	1405 and N406 may be
		IMPLEMENTATION NAME: Pay-To Plan City Name	
SITUATIONAL N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate	X 1 ID 2/2 government agency
		syntax: E0207	
		COMMENT: N402 is required only if city name (N401) is in the	e U.S. or Canada.
		SITUATIONAL RULE: Required when the address is in the America, including its territories, or Canada. If no implementation guide, do not send.	
		IMPLEMENTATION NAME: Pay-To Plan State or Province	Code
		CODE SOURCE 22: States and Provinces	

SITUATIONAL	SITUATIONAL N403 116	Postal Code Code defining international postal zone code excluding pu (zip code for United States)	O 1 Inctuatio	ID on and b	3/15 lanks			
		SITUATIONAL RULE: Required when the address is in the America, including its territories, or Canada, or exists for the country in N404. If not required by implementation guide, do not send.	when a					
			IMPLEMENTATION NAME: Pay-To Plan Postal Zone or ZI	P Code	e			
			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 out States of America. If not required by this implement 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	01	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 a	f ISO	2166			

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

SEGMENT DETAIL						
		AY-TO PLAN SECONDARY				
X12 Segment Name:	Reference In	Iformation				
X12 Purpose:	To specify id	specify identifying information				
X12 Syntax:	1. R0203 At least o	. R0203 At least one of REF02 or REF03 is required.				
Loop:	2010AC — F	PAY-TO PLAN NAME				
Segment Repeat:	1					
Usage:	SITUATION	AL				
Situational Rule:	National Pla provided in	ior to the mandated implementation date for the HIPAA In Identifier when an additional identification number to that the NM109 of this loop is necessary for the claim processor to entity. If not required by this implementation guide, do not				
TR3 Example:	REF*2U*98	3765~				
DIAGRAM						
Defense		本 、 本 、 、 、 、 、 、 、 、 、 、 、 、 、 、 、 、 、				
REF * Reference Ident Qui M 1 ID	e * Referen al Ident 2/3 X 1 AN	nce * Description * Reference				
REF * Reference Ident Qu. M 1 ID	e _* Referen	Description * Reference Identifier 1/50 X 1 AN 1/80				
REF * Reference Ident Qu. M 1 ID	REF. REF. DATA DES. REF. DATA ELEMENT	t 1/50 * Description * Reference Identifier O 1 ~ ~ ~				
REF * Reference Ident Qui M 1 ID	REF. REF. DATA DES. REF. DATA ELEMENT	Description * Reference 1/50 * 1/50 X 1 AN 1/80 NAME 0 NAME ATTRIBUTES Reference Identification Qualifier M 1 Code qualifying the Reference Identification CODE DEFINITION				
REF * Reference Ident Qui M 1 ID	REF. REF. DATA DES. REF. DATA ELEMENT	Description * Reference 1/50 * 1/50 X 1 AN 1/80 0 NAME ATTRIBUTES Reference Identification Qualifier M 1 Code qualifying the Reference Identification M 1 CODE DEFINITION 2U Payer Identification Number This code is only allowed when the National Plan				
REF * Reference Ident Qui M 1 ID	REF. REF. DATA DES. REF. DATA ELEMENT	Description * Reference Identifier 1/50 X 1 AN 1/80 • • NAME X 1 AN 1/80 • • • NAME X 1 AN 1/80 • • • • NAME X 1 AN 1/80 • • • • NAME Reference Identification Qualifier M 1 ID 2/3 Code qualifying the Reference Identification • • • • CODE DEFINITION • • • • 2U Payer Identification Number • • • This code is only allowed when the National Plan Identifier is reported in NM109 of this loop. • •				
REF * Reference Ident Qui M 1 ID	REF. D1 128	Description * Reference Identifier Attributes NAME X 1 AN 1/80 Attributes Reference Identification Qualifier Code qualifying the Reference Identification M 1 ID 2/3 Code qualifying the Reference Identification DEFINITION M1 ID 2/3 2U Payer Identification Number This code is only allowed when the National Plan Identifier is reported in NM109 of this loop. FY FY Claim Office Number National Association of Insurance Commissioners				
REF * Reference ident Qu M 1 ID ELEMENT DETAIL USAGE REQUIRED REF	REF. D1 128	Ince * Description * Reference Identifier ATTRIBUTES NAME ATTRIBUTES ATTRIBUTES M 1 ID 2/3 Reference Identification Qualifier M 1 ID 2/3 Code qualifying the Reference Identification M 1 ID 2/3 CODE DEFINITION 2U Payer Identification Number This code is only allowed when the National Plan Identifier is reported in NM109 of this loop. FY Claim Office Number NF National Association of Insurance Commissioners (NAIC) Code Commissioners (NAIC) Code Commissioners (NAIC) Code Reference Identification X 1 AN 1/50 Reference Identification Qualifier X 1 AN 1/50 SYNTAX: R0203 Syntax: R0203				
REF * Reference ident Qu M 1 ID ELEMENT DETAIL USAGE REQUIRED REF	REF. D1 128	Ince * Description * Reference Identifier · 1/50 * A I I/80 * · · · NAME A I I/80 * · · · · NAME A I ID 2/3 ·				

NOT USED	REF04	C040	REFERENCE IDENTIFIER	01

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 REF01 128 RFF02 127 RFF03 352 RFF04 C040 Reference Reference **Description** Reference REF * * * Ident Qual Ident **Identifier** ID 2/3 AN 1/50 01 M 1 X 1 AN 1/80 ELEMENT DETAIL DATA ELEMENT REF. NAME USAGE ATTRIBUTES REQUIRED REF01 128 **Reference Identification Qualifier** M 1 ID 2/3 Code qualifying the Reference Identification CODE DEFINITION EI **Employer's Identification Number** The Employer's Identification Number must be a string of exactly nine numbers with no separators. For example, "001122333" would be valid, while sending "001-12-2333" or "00-1122333" would be invalid. REQUIRED REF02 127 **Reference Identification** X1 AN 1/50 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 NOT USED REF03 352 Description X1 AN 1/80 NOT USED REF04 C040 **REFERENCE IDENTIFIER** 01

SEGMENT DETAIL							
		BSCRIBER HIERARCHICAL LE	VEL				
X12 Segment Name:	Hierarchical L	evel					
X12 Purpose:	•	b identify dependencies among and the content of hierarchically related roups of data segments					
X12 Comments:	hierarchio	egment is used to identify levels of detail information cal structure, such as relating line-item data to shipme g data to line-item data.					
	2. The HL s	egment defines a top-down/left-right ordered structure	Э.				
Loop:	2000B — SU	BSCRIBER 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.						
	destinati not know	ient is not the subscriber and cannot be identified on payer by a unique Member Identification Numb on to the sender if the Member Identification numb both this HL and the patient HL in Loop ID- 2000C	oer or it is oer is				
TR3 Example:	HL*2*1*22*	÷1~					
DIAGRAM							
HL01 6 Hierarch ID Numbe M 1 AN 1/	r [*] Hierarch Parent I	D * Level Code * Child Code \sim					
ELEMENT DETAIL							
USAGE R	EF. DATA ES. <u>ELEMENT</u>	NAME	ATTRIBUTES				
REQUIRED HL01	628	Hierarchical ID Number M 1 A unique number assigned by the sender to identify a particular of a hierarchical structure	AN 1/12 lata segment in				
		COMMENT: HL01 shall contain a unique alphanumeric number for e of the HL segment in the transaction set. For example, HL01 cou indicate the number of occurrences of the HL segment, in which e HL01 would be "1" for the initial HL segment and would be increme ach subsequent HL segment within the transaction.	ld be used to case the value of				
		The first HL01 within each ST-SE envelope must begin and be incremented by one each time an HL is used in transaction. Only numeric values are allowed in HL01	the				

005010X223 • 837 • 2000B • HL SUBSCRIBER HIERARCHICAL LEVEL			ASC X12N	N • INSURANCE SUBCOMMITTI TECHNICAL REPORT • TYPE
REQUIRED	HL02	734	Hierarchical Parent ID Number Identification number of the next higher hierarch segment being described is subordinate to	O 1 AN 1/12 nical data segment that the data
			соммемт: HL02 identifies the hierarchical ID nur the current HL segment is subordinate.	mber of the HL segment to which
REQUIRED	HL03	735	Hierarchical Level Code Code defining the characteristic of a level in a h	M 1 ID 1/2 ierarchical structure
			COMMENT: HL03 indicates the context of the series current HL segment up to the next occurrence of transaction. For example, HL03 is used to indica the HL loop form a logical grouping of data refer level information.	of an HL segment in the ate that subsequent segments in
			CODE DEFINITION	
			22 Subscriber	
REQUIRED	HL04	736	Hierarchical Child Code Code indicating if there are hierarchical child da level being described	O 1 ID 1/1 ta segments subordinate to the
	COMMENT : HL04 indicates whether or not there a segments related to the current HL segment.	are subordinate (or child) HL		
		The claim (Loop ID-2300) can be used w subordinate levels (HL04 = 0) or when H indicated (HL04 = 1).		
		In the first case (HL04 = 0), the subscrib are no dependent claims.	per is the patient and there	
			The second case (HL04 = 1) happens will dependents of the subscriber are being provider HL (for example, a spouse and same provider). In that case, the subscr is at least one dependent to this subscr (spouse) would then be sent followed be spouse. The next HL would be the depe followed by the Loop ID-2300 for the so	sent under the same billing son are both treated by the riber HL04 = 1 because ther iber. The dependent HL y the Loop ID-2300 for the endent HL for the son
			In order to send claims for the subscrib dependents, the Subscriber HL, with Re (Self), would be followed by the Subscriber's claims. Then the Subscribe followed by one or more Patient HL loo the proper Relationship Code in PAT01 respective Loop ID-2300 for each dependent	elationship Code SBR02=18 riber's Loop ID-2300 for the per HL would be repeated, ops for the dependents, with , each followed by their
			CODE DEFINITION	
			0 No Subordinate HL Segn Structure.	nent in This Hierarchical
				HL Data Segment in This

SEGMENT DETAIL							
X12 Segment Name		UBSCRIBER INFORMATION					
X12 Purpose		o record information specific to the primary insured and the insurance carrier or that insured					
Loop	2000B — SU	JBSCRIBER HIERARCHICAL LEVEL					
Segment Repeat	: 1						
Usage							
TR3 Example	SBR*P**GF	RP01020102******CI~					
DIAGRAM							
SBR * SBR01 Payer Re Seq No C M 1 ID	sp 🗸 Individu						
SBR07 * Yes/No C Resp Ce O 1 ID	X I						
ELEMENT DETAIL							
USAGE	REF. DATA DES. ELEMENT	NAME ATTRIBUTES					
REQUIRED SBR	801 1138	Payer Responsibility Sequence Number CodeM 1ID1/1Code identifying the insurance carrier's level of responsibility for a payment of a claimID1/1Within a given claim, the various values for the Payer Responsibility Sequence Number Code (other than value "U") may occur no more than once.IDID					
		A Payer Responsibility Four					
		B Payer Responsibility Five					
		C Payer Responsibility Six					
		D Payer Responsibility Seven					
		E Payer Responsibility Eight					
		FPayer Responsibility NineGPayer Responsibility Ten					
		H Payer Responsibility Eleven					
		P Primary					
		S Secondary					
		T Tertiary					

00200112211110				1201			• • • • • • •
			U	Unknown			
				This code may only be used in claims when the original payer presence of this coverage from received from this payer or who did not provide the responsibil payer.	determin eligibili en the or	ned th ty files riginal	e s claim
SITUATIONAL	SBR02	1069		ationship Code the relationship between two individuals	O1 s or entities	ID s	2/2
			SEMANTIC: SBR02	2 specifies the relationship to the perso	n insured.		
			considered to	Required when the patient is the betient is the bethe subscriber. If not require on guide, do not send.			r is
			CODE	DEFINITION			
			18	Self			
SITUATIONAL	SBR03	127		n tification nation as defined for a particular Transa e Identification Qualifier	O 1 action Set		1/50 becified
			SEMANTIC: SBR03	3 is policy or group number.			
			for the destin	Required when the subscriber's ation payer (Loop ID-2010BB) sh d by this implementation guide, o	nows a g	roup r	
				NAME: Subscriber Group or Policy	Number		
				e number uniquely identifying the criber number is submitted in Lo			
SITUATIONAL	SBR04	SBR04 93	Name Free-form name		01	AN	1/60
			SEMANTIC: SBR04	4 is plan name.			
				Required when SBR03 is not us able. If not required by this imple			
				NAME: Subscriber Group Name			
NOT USED	SBR05	1336	Insurance Typ	be Code	01	ID	1/3
NOT USED	SBR06	1143		of Benefits Code	01	ID	1/1
NOT USED	SBR07	1073	Yes/No Condi	tion or Response Code	01	ID	1/1
NOT USED	SBR08	584	Employment		01	ID	2/2
SITUATIONAL	SBR09	1032	Claim Filing In Code identifying	ndicator Code type of claim	01	ID	1/2
				Required prior to mandated use ID. If not required by this implei			le, do
			CODE	DEFINITION			
			11	Other Non-Federal Programs			
			12	Preferred Provider Organizatio	n (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
СН	Champus
CI	Commercial Insurance Co.
DS	Disability
FI	Federal Employees Program
НМ	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
МС	Medicaid
OF	Other Federal Program
	Use code OF when submitting Medicare Part D claims.
τv	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Use Code ZZ when Type of Insurance is not known.

	NM1 ·	SUBSCR	BER NAME		
X12 Segment Na	me: Individual	l or Organizationa	l Name		
X12 Purpo	ose: To supply	the full name of	an individual or orgar	nizational entity	
X12 Set No	2300	. For example, th	formation about entiti ese entities may incl ary administrator, cor	ude billing provid	er, pay-to
X12 Syn			109 is present, then t	the other is requi	red.
	2. C11 1 If NM		en NM110 is require	d.	
	3. C120 If NM		en NM103 is require	d.	
Lo	oop: 2010BA	— SUBSCRIBER	NAME Loop Repe	eat: 1	
Segment Rep	eat: 1				
Usa	age: REQUIRI	ED			
TR3 No	"sub	-	ation or other prope a non-person entity by state.	-	
TR3 Exam	ple: NM1*IL*	<1*DOE*JOHN*	T**JR*MI*123456	~	
DIAGRAM					
\mathbf{N}	tity ID 🖕 Enti	ty Type * Name Jalifier Org N	T	Namo	* NM106 1038 * Name Prefix O 1 AN 1/10
* S	ame 🐰 ID	Code <mark>*</mark> ID ualifier Cod	*	NM111 98 Entity ID 6000 Code 7000 O 1 ID 2/3	NM112 1035 Name Last/ Org Name O 1 AN 1/60
ELEMENT DETAIL					
USAGE	REF. D. DES. <u>ELE</u>	ATA MENT NAME			ATTRIBUTES
REQUIRED	NM101 98	Entity Identif Code identifyin individual	ier Code g an organizational entity,		1 ID 2/3 property or an
		CODE	DEFINITION		
		IL	Insured or Subscril	ber	

ASC X12N • INSURAN TECHNICAL REPORT		MMITTEE	005010X2			BA • NM ER NAMI				
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							
			2 Non-Person Entity							
REQUIRED	NM103	1035	Name Last or Organization Name Individual last name or organizational name	X 1	AN	1/60				
			syntax: C1203							
			IMPLEMENTATION NAME: Subscriber Last Name							
SITUATIONAL	TUATIONAL NM104 1036		Name First Individual first name	01	AN	1/35				
			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							
SITUATIONAL	SITUATIONAL NM105 1037	1037	Name Middle Individual middle name or initial	01	AN	1/25				
		SITUATIONAL RULE: Required when NM102 = 1 (pers name or initial of the person is needed to iden not required by this implementation guide, do	tify the i	ndivid						
			IMPLEMENTATION NAME: Subscriber Middle Name or	nitial						
NOT USED	NM106	1038	Name Prefix	01	AN	1/10				
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name	01	AN	1/10				
			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.							
REQUIRED	NM108	66	Identification Code Qualifier Code designating the system/method of code structure Code (67) SYNTAX: P0809	X 1 used for lo	ID dentifica	1/2 ation				
			CODE DEFINITION II Standard Unique Health Identified in the United States	er for ea	ach Ind	dividual				
		In the United States Required if the HIPAA Individua mandated use. If not required, instead.			tifier is					

			MI	Member Identification Number			
				The code MI is intended to be the identification number as assigned example, Insured's ID, Subscribe Insurance Claim Number (HIC), et	d by th r's ID,	ne paye	er. (For
				MI is also intended to be used in the Indian Health Service/Contract (IHS/CHS) Fiscal Intermediary for reporting the Tribe Residency Co State). In the event that a Social S (SSN) is also available on an IHS/ SSN in REF02. When sending the Social Security Member ID, it must be a string of numbers with no separators. For "111002222" would be valid, whil 2222" would be invalid.	t Heal the prode (Tr Securit CHS c y Num exacti exam	ith Ser urpose ibe Co ty Num claim, p ber as y nine ple, se	vices e of unty ber out the the nding
REQUIRED	NM109	67		Code a party or other code	X 1	AN	2/80
			SYNTAX: P0809	a party of other code			
				AAME: Subscriber Primary Identifier			
NOT USED	NM110	706	Entity Relation	nship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifie	er Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	Organization Name	01	AN	1/60

SEGMENT DETAIL												
X12 Segment N	-		BSCRIBER ADDRESS									
X12 Purp	oose: To s	specify the	e location of the named party									
L	.oop: 201	010BA — SUBSCRIBER NAME										
Segment Re	peat: 1											
U	sage: SIT	ITUATIONAL										
Situational		equired when the patient is the subscriber or considered to be the beccriber. If not required by this implementation guide, do not send.										
TR3 Exar	mple: N3*	×123 MAII	N STREET~									
DIAGRAM												
	1 166 ddress ormation AN 1/55	N302 Addres Informati O 1 AN	ion ~									
ELEMENT DETAIL												
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES						
REQUIRED	N301	166	Address Information Address information	M 1	AN	1/55						
			IMPLEMENTATION NAME: Subscriber Address Line									
SITUATIONAL	N302	166	Address Information Address information	01	AN	1/55						
			SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not se		ss line.	lf not						
			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. 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 N401 19 N402 156 N403 116 N404 26 N405 309 N406 310 State or Country Location City Postal Location * * * * N4 * * **Prov Code** Identifier Name Qualifier Code Code AN 2/30 ID O 1 ID 3/15 ID AN 1/30 01 X 1 2/2 X 1 2/3 X 1 ID 1/2 01 N407 1715 **Country Sub** * Code X 1 ID 1/3 ELEMENT DETAIL REF. DATA ELEMENT USAG NAME ATTRIBUTES REQUIRED N401 19 01 AN 2/30 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 SITUATIONAL N402 156 State or Province Code X 1 ID 2/2 Code (Standard State/Province) as defined by appropriate government agency **SYNTAX: E0207** COMMENT: N402 is required only if city name (N401) is in the U.S. or Canada. SITUATIONAL RULE: 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

SITUATIONAL N403 116	Postal Code Code defining international postal zone code excluding p (zip code for United States)	O 1 ounctuation	ID on and b	3/15 blanks						
			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	01	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	2166					

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

SEGMENT DETAIL		
	DMG - S INFORM	UBSCRIBER DEMOGRAPHIC
X12 Segment Name:	Demographic	Information
X12 Purpose:	To supply der	nographic information
X12 Syntax:	1. P0102 If either D	MG01 or DMG02 is present, then the other is required.
	2. P1011 If either D	MG10 or DMG11 is present, then the other is required.
	3. C1105 If DMG11	is present, then DMG05 is required.
Loop:	2010BA — S	UBSCRIBER NAME
Segment Repeat:	1	
Usage:	SITUATIONA	L
Situational Rule:	•	en the patient is the subscriber or considered to be the f not required by this implementation guide, do not send.
TR3 Example:	DMG*D8*19	690815 * M~
DIAGRAM		
DMG * Date Tim Format Qu X 1 ID	e Note Time Jal * Period Z/3 X 1 AN 26 DMG08 Period	$\begin{array}{c c} & \bullet & \bullet \\ \hline & \bullet \\ \hline & \bullet & \bullet \\$
* Code	2/3 Basis o Verif Coo 0 1 ID	
ELEMENT DETAIL		
USAGE [REF. DATA DES. <u>ELEMENT</u>	NAME ATTRIBUTES
REQUIRED DMG	01 1250	Date Time Period Format Qualifier X 1 ID 2/3
		Code indicating the date format, time format, or date and time format syntax: P0102
		CODE DEFINITION
		D8 Date Expressed in Format CCYYMMDD
REQUIRED DMG	02 1251	Date Time PeriodX 1AN1/35Expression 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

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

REQUIRED	DMG03	1068		Gender Code Code indicating the sex of the individual		ID	1/1
				NAME: Subscriber Gender Code			
			CODE	DEFINITION			
			F	Female			
			Μ	Male			
			U	Unknown			
NOT USED	DMG04	1067	Marital Status Code		01	ID	1/1
NOT USED	DMG05	C056	COMPOSITE INFORMATIO	X 10			
NOT USED	DMG06	1066	Citizenship S	tatus Code	01	ID	1/2
NOT USED	DMG07	26	Country Code	e	01	ID	2/3
NOT USED	DMG08	659	Basis of Verification Code		01	ID	1/2
NOT USED	DMG09	380	Quantity		01	R	1/15
NOT USED	DMG10	1270	Code List Qu	alifier Code	X 1	ID	1/3
NOT USED	DMG11	1271	Industry Cod	e	X 1	AN	1/30

SEGMENT DETAIL									
			UBSCRIE	BER SECONDARY	7				
X12 Segment N	ame: Refe	rence Inf	ormation						
X12 Purp	oose: Tos	specify identifying information							
X12 Sy		R0203 At least c	one of REF02 o	r REF03 is required.					
L	.oop: 2010	0BA — SUBSCRIBER NAME							
Segment Re	peat: 1								
Us	age: SITU	UATIONAL							
Situational	NM1	Required when an additional identification number to that provided in IM109 of this loop is necessary for the claim processor to identify the entity. If not required by this implementation guide, do not send.							
TR3 Exar	nple: REF	*SY*12	3456789~						
DIAGRAM									
	01 128 ference ent Qual ID 2/3	REF02 Referent Ident X 1 AN	* ·	352 Second REF04 C040 Reference Identifier O 1					
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBUT	TES		
REQUIRED	REF01	128	Reference Ide	ntification Qualifier	M 1	ID	2/3		
			Code qualifying the	he Reference Identification					
			CODE	DEFINITION					
			SY	Social Security Number			- 6		
				The Social Security Number n exactly nine numbers with no example, sending "111002222 sending "111-00-2222" would	separator " would b	s. For e valid			
REQUIRED	REF02	127		ntification lation as defined for a particular Trans Identification Qualifier	X1 saction Set		1/50 becified		
			syntax: R0203						
			IMPLEMENTATION N	AME: Subscriber Supplemental I	dentifier				
NOT USED	REF03	352	Description		X 1	AN	1/80		
NOT USED	REF04	C040	REFERENCE I	DENTIFIER	01				

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

	REF01	128		REF	02	127		REF	03	352]	REF04	C040]
REF *		erence t Qual	*		ferer Iden		*	Des	scrip	tion	*	Refer Ident	ifior	~
	M 1	ID 2/3		X 1	AN	1/50		X 1	AN	1/80		01		

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBUTES					
REQUIRED	REF01	128		ntification Qualifier the Reference Identification	M 1	ID	2/3			
			CODE	DEFINITION						
			Y4	Agency Claim Number						
REQUIRED	REF02	127	by the Reference	ntification nation as defined for a particular Transacti e Identification Qualifier	X 1 on Set	AN or as sp	1/50 becified			
			syntax: R0203							
			IMPLEMENTATION N	IAME: Property Casualty Claim Numb	ber					
NOT USED	REF03	352	Description		X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE	IDENTIFIER	01					

NM1 - PAYER NAME X12 Segment Name: Individual or Organizational Name X12 Purpose: To supply the full name of an individual or organizational entity 1. Loop 2010 contains information about entities that apply to all claims in loop X12 Set Notes: 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 NM103 NM104 NM101 98 NM102 1065 1035 1036 NM105 1037 NM106 1038 Entity ID Entity Type Name Last/ Name Name Name **NM1** * * * * Qualifier Prefix Middle Code Org Name First ID 2/3 ID 1/1 AN 1/60 O 1 AN 1/35 01 AN 1/25 O 1 AN 1/10 M 1 X 1 M 1 NM108 NM107 1039 66 NM109 67 NM110 706 NM111 98 NM112 1035 ID Code ID Entity ID Name Entity Name Last/ * * * * * Suffix Qualifier Code Relat Code Code Org Name AN 2/80 ID O 1 01 AN 1/10 1/2X 1 ID 2/2 ID 2/3 O 1 AN 1/60 ELEMENT DETAIL

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

SEGMENT DETAIL

TECHNICAL REPOR	ANCE SUBCO RT • TYPE 3			0030	10X223 • 837		ER NAN
REQUIRED	NM102	1065	Entity Type	Qualifier g the type of entity	M 1	ID	1/1
			SEMANTIC: NM1	02 qualifies NM103.			
			CODE	DEFINITION			
			2	Non-Person Entity			
REQUIRED	NM103	1035		or Organization Name name or organizational name	X 1	AN	1/60
			syntax: C1203				
			IMPLEMENTATION	NAME: Payer Name			
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle	9	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	AN	1/10
REQUIRED	NM108	66		n Code Qualifier ing the system/method of code struct	X 1 ure used for le	ID dentifica	1/2 ation
			syntax: P0809				
			in period ide If a phase-in 1. Both the s 2. The receiv	mandated implementation date entified by Federal regulation, F period is designated, PI must sender and receiver agree to us ver has a National Plan ID, and er has the capability to send th	PI must be s be sent unl	ent. ess:	
			If all of the a the Payer Ide qualifier PI c	bove conditions are true, XV m entification Number that would an be sent in the correspondir	iust be sent have been	. In thi sent u	s case sing
			If all of the a the Payer Ide qualifier PI c qualifier 2U.	bove conditions are true, XV mentification Number that would an be sent in the correspondir	iust be sent have been	. In thi sent u	s case sing
			If all of the a the Payer Id qualifier PI o qualifier 2U.	bove conditions are true, XV mentification Number that would an be sent in the correspondir	iust be sent have been	. In thi sent u	s case sing
			If all of the a the Payer Ide qualifier PI c qualifier 2U. <u>CODE</u> PI	bove conditions are true, XV m entification Number that would an be sent in the correspondir DEFINITION Payor Identification	ust be sent have been ig REF segr	. In thi sent u nent u	s case sing sing
			If all of the a the Payer Id qualifier PI o qualifier 2U.	bove conditions are true, XV mentification Number that would an be sent in the correspondir	have been have been ng REF segr	. In thi sent u nent u vices I	s case sing sing PlanID
REQUIRED	NM109	67	If all of the a the Payer Id qualifier PI c qualifier 2U. <u>CODE</u> PI XV Identification	bove conditions are true, XV mentification Number that would can be sent in the corresponding DEFINITION Payor Identification Centers for Medicare and M code source 540: Centers for Me PlanID	have been have been og REF segr edicaid Ser dicare and Me	. In thi sent u nent u vices I	s case sing sing PlanID
REQUIRED	NM109	67	If all of the a the Payer Id qualifier PI c qualifier 2U. <u>CODE</u> PI XV Identification Code identifyin syntax: P0809	bove conditions are true, XV mentification Number that would can be sent in the corresponding DEFINITION Payor Identification Centers for Medicare and M code source 540: Centers for Me PlanID n Code Ig a party or other code	have been have been og REF segr edicaid Ser dicare and Me	. In thi sent u nent u vices I	s case sing sing PlanID Services
REQUIRED	NM109	67	If all of the a the Payer Id qualifier PI c qualifier 2U. <u>CODE</u> PI XV Identification Code identifyin syntax: P0809	bove conditions are true, XV mentification Number that would can be sent in the correspondin DEFINITION Payor Identification Centers for Medicare and M code source 540: Centers for Me PlanID n Code g a party or other code	have been have been og REF segr edicaid Ser dicare and Me	. In thi sent u nent u vices I	s case sing sing PlanID Services
	NM109 NM110	67 706	If all of the a the Payer Id qualifier PI c qualifier 2U. CODE PI XV Identification Code identifyin SYNTAX: P0809 IMPLEMENTATION	bove conditions are true, XV mentification Number that would can be sent in the corresponding DEFINITION Payor Identification Centers for Medicare and M code source 540: Centers for Me PlanID n Code Ig a party or other code	have been have been og REF segr edicaid Ser dicare and Me	. In thi sent u nent u vices I	s case sing sing PlanID Services
REQUIRED NOT USED NOT USED		-	If all of the a the Payer Id qualifier PI c qualifier 2U. CODE PI XV Identification Code identifyin SYNTAX: P0809 IMPLEMENTATION	bove conditions are true, XV mentification Number that would can be sent in the corresponding <u>DEFINITION</u> Payor Identification Centers for Medicare and M code source 540: Centers for Me PlanID n Code g a party or other code	edicaid Ser dicare and Me X 1	. In thi sent u nent u vices I edicaid \$	s case sing sing PlanID Services 2/80

	N3 - PA`	YER ADDRESS			
X12 Segment Name:	Party Location	1			
X12 Purpose:	To specify the	e location of the named party			
Loop:	2010BB — P/	AYER NAME			
Segment Repeat:	1				
Usage:	SITUATIONA	L			
Situational Rule:	for the claim	en the payer address is available and the sub to be printed on paper at the next EDI locatio se). If not required by this implementation guid	n (fo	r exar	nple, a
TR3 Example:	N3*123 MAIN	N STREET~			
DIAGRAM					
N3 * Address Informatic M 1 AN 1/	Address	on a			
ELEMENT DETAIL					
	EF. DATA ES. ELEMENT	NAME		ATTRIBU	TES
REQUIRED N301	166	Address Information Address information	M 1	AN	1/55
		IMPLEMENTATION NAME: Payer Address Line			
SITUATIONAL N302	166	Address Information Address information	01	AN	1/55
		SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not set		ss line.	If not
		IMPLEMENTATION NAME: Payer Address Line			

	-		-	, -	,	
SEGMENT DETAIL						
	N4 -	PA	(ER CITY, STATE, ZIP CODE			
X12 Segment Name	e: Geogra	phic Lo	ocation			
X12 Purpose	e: To spec	cify the	geographic place of the named party			
X12 Syntax			of N402 or N407 may be present.			
	2. C06 If N		present, then N405 is required.			
	3. C07 If N		present, then N404 is required.			
Loop	p: 2010BB	3 — P/	AYER NAME			
Segment Repea	nt: 1					
Usage	e: REQUIF	RED				
TR3 Example	e: N4*KA	NSAS	CITY*MO*64108~			
DIAGRAM	-					
R407 Country Code X 1 ID ELEMENT DETAIL	e ~ 1/3	DATA				
	DES. E	LEMENT	NAME			
REQUIRED N4	.01 19	9	City Name Free-form text for city name	01	AN	2/30
			COMMENT : A combination of either N401 through N404, or N adequate to specify a location.	405 ar	nd N406	i may be
			IMPLEMENTATION NAME: Payer City Name			
SITUATIONAL N4	.02 15	56	State or Province Code Code (Standard State/Province) as defined by appropriate	X1 govern	ID ment a	2/2 gency
			syntax: E0207			
			COMMENT: N402 is required only if city name (N401) is in the			
			SITUATIONAL RULE: Required when the address is in the America, including its territories, or Canada. If no implementation guide, do not send.			
			IMPLEMENTATION NAME: Payer State Code			

SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding pu (zip code for United States)	O 1 Inctuation	ID on and b	3/15 blanks
			SITUATIONAL RULE: Required when the address is in a America, including its territories, or Canada, or exists for the country in N404. If not required by implementation guide, do not send.	when a		
			IMPLEMENTATION NAME: Payer Postal Zone or ZIP Code	e		
			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 ou States of America. If not required by this implem not send.			
			CODE SOURCE 5: Countries, Currencies and Funds			
			Use the alpha-2 country codes from Part 1 of IS	D 3166	j.	
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2
NOT USED	N406	310	Location Identifier	01	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 no States of America, including its territories, or Ca country in N404 has administrative subdivisions limited to states, provinces, cantons, etc. If not implementation guide, do not send.	anada, s such	and th as but	e not
			CODE SOURCE 5: Countries, Currencies and Funds			
			Line the example and division as dee from Devi O .	(100	0400	

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

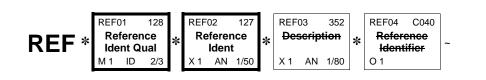
SEGMENT DETAIL				
	REF - P/	AYER SE	CONDARY IDENTIF	ICATION
X12 Segment Name:	Reference Inf	ormation		
X12 Purpose:	To specify ide	ntifying informa	ation	
X12 Syntax:	1. R0203 At least o	ne of REF02 o	r REF03 is required.	
Loop:	2010BB — P	AYER NAME		
Segment Repeat:	3			
Usage:	SITUATIONA	L		
Situational Rule:	National Plan provided in t	h Identifier when he NM109 of t	lated implementation date for t en an additional identification r his loop is necessary for the cl quired by this implementation g	number to that aim processor to
TR3 Example:	REF*FY*435	5261708~		
DIAGRAM				
ELEMENT DETAIL	2/3 X 1 AN	i/50 * Descript	1/80 * O 1	
	ES. ELEMENT			ATTRIBUTES
REQUIRED REFO	01 128		ntification Qualifier he Reference Identification	M 1 ID 2/3
		CODE	DEFINITION	
		2U	Payer Identification Number	
			This code is only allowed when the Identifier is reported in NM109 of	
		EI	Employer's Identification Number	-
			The Employer's Identification Nur string of exactly nine numbers wi	
			For example, "001122333" would sending "001-12-2333" or "00-112 invalid.	-
		FY	Claim Office Number	• · ·
		NF	National Association of Insurance (NAIC) Code	
			code source 245: National Association of Commissioners (NAIC) Code	of Insurance

REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier SYNTAX: R0203	X 1 on Set	AN or as sp	1/50 becified
			IMPLEMENTATION NAME: Payer Additional Identifier			
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

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			ATTRIBL	JTES
REQUIRED	REF01	128		ntification Qualifier the Reference Identification	M 1	ID	2/3
			CODE	DEFINITION			
			G2	Provider Commercial Number			
				This code designates a proprietar for the destination payer identifier Name loop, Loop ID-2010BB, asso claim. This is to be used by all pay Medicare, Medicaid, Blue Cross, e	d in th ociate yers ii	e Pay d with	er this
			LU	Location Number			

005010X223 • 837 BILLING PROVIDE				ASC X12N • INSURANCI TECHNICAL		
REQUIRED	REF02	127	Reference Identification Reference information as defined for a by the Reference Identification Qualifie SYNTAX: R0203			1/50 specified
			IMPLEMENTATION NAME: Billing Provid	er Secondary Identifi	er	
NOT USED	REF03	352	Description	X	1 AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	0	1	

SEGMENT DETAIL		
X12 Segment Name:	HL - PATIENT HIERARCHICAL LEVI Hierarchical Level	EL
-	To identify dependencies among and the content of hierarchic groups of data segments	cally related
X12 Comments:	 The HL segment is used to identify levels of detail inform hierarchical structure, such as relating line-item data to sl packaging data to line-item data. 	
	2. The HL segment defines a top-down/left-right ordered str	ucture.
Loop:	2000C — PATIENT HIERARCHICAL LEVEL Loop Repeat	t: >1
Segment Repeat:	1	
Usage:	SITUATIONAL	
Situational Rule:	Required when the patient is a dependent of the subscrib Loop ID-2000B and cannot be uniquely identified to the p subscriber's identifier in the Subscriber Level. If not require implementation guide, do not send.	ayer using the
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 identified to the payer by a unique Identification Num patient is considered the subscriber and is to be iden Subscriber Level.	ber, then the
TR3 Example:	HL*3*2*23*0~	
DIAGRAM		
HL * Hierarch ID Numbe M 1 AN 1/		
ELEMENT DETAIL		
USAGE R	EF. DATA ES. <u>Element</u> <u>Name</u>	ATTRIBUTES
REQUIRED HL01	628 Hierarchical ID Number	M 1 AN 1/12

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.

005010X223 • 837 • PATIENT HIERARCH				ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3
REQUIRED	HL02	734	Identification nur	Parent ID Number O 1 AN 1/12 mber of the next higher hierarchical data segment that the data lescribed is subordinate to
				dentifies the hierarchical ID number of the HL segment to which egment is subordinate.
REQUIRED	HL03	735	Hierarchical L Code defining th	e characteristic of a level in a hierarchical structure
			current HL segm transaction. For	ndicates the context of the series of segments following the ent up to the next occurrence of an HL segment in the example, HL03 is used to indicate that subsequent segments in a logical grouping of data referring to shipment, order, or item-
			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 C Code indicating level being desc	if there are hierarchical child data segments subordinate to the
				ndicates whether or not there are subordinate (or child) HL d to the current HL segment.
			CODE	DEFINITION
			0	No Subordinate HL Segment in This Hierarchical Structure.

	L		
	P	AT - P	ATIENT INFORMATION
X12 Segment	t Name: Pat	ient Inform	mation
X12 P	urpose: To a	supply pat	tient information
X12			PAT05 or PAT06 is present, then the other is required.
	2.	P0708 If either F	PAT07 or PAT08 is present, then the other is required.
	Loop: 200		ATIENT HIERARCHICAL LEVEL
Segment	Repeat: 1		
	Usage: RE	QUIRED	
TR3 E	kample: PA	Г*01~	
DIAGRAM	_		
PAT *	PAT01 1069 Individual Relat Code D 1 ID 2/2		
		PAT08	81 PAT09 1073
*	AT07 355 Unit/Basis Meas Code (1 ID 2/2		81 PAT09 1073 Yes/No Cond Resp Code O 1 ID 1/1
*	Unit/Basis Meas Code (1 ID 2/2	X 1 R	nt * <mark>Yes/No Cond</mark> Resp Code 1/10 01 ID 1/1
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X1 R	nt * Yes/No Cond Resp Code 1/10 01 ID 1/1
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Att * Yes/No Cond Resp Code ~ 1/10 * 0 1 ID 1/1 ~ NAME ATTRIBUTES ATTRIBUTES Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Att * Yes/No Cond Resp Code ~ 1/10 * O 1 ID 1/1 NAME ATTRIBUTES Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured.
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Att * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * Attributes NAME Attributes Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured. CODE DEFINITION
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Ant * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * Attributes NAME Attributes Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured. CODE DEFINITION 01 Spouse
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Ant * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * Attributes NAME Attributes Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured. CODE DEFINITION 01 Spouse 19 Child
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Ant * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * Attributes NAME Attributes Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured. CODE DEFINITION 01 Spouse
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Math * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * Attributes NAME Attributes Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured. CODE DEFINITION 01 Spouse 19 Child 20 Employee
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Ant * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * ATTRIBUTES NAME ATTRIBUTES Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities Specifies the patient's relationship to the person insured. CODE DEFINITION 01 Spouse 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor
* ELEMENT DETAIL	Unit/Basis Meas Code (1 ID 2/2	X 1 R	Int * Yes/No Cond Resp Code 0 1 ID 1/1 ~ 1/10 * Attributes NAME Attributes Individual Relationship Code 0 1 ID 2/2 Code indicating the relationship between two individuals or entities 2/2 Specifies the patient's relationship to the person insured.
ELEMENT DETAIL USAGE REQUIRED	Unit/Basis Meas Code (1 ID 2/2 REF. DES. PAT01	X 1 R	Individual Relationship Code O 1 ID 2/2 Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities 2/2 Specifies the patient's relationship to the person insured. 2/2 CODE DEFINITION 01 Spouse 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner 68 Other Relationship
ELEMENT DETAIL USAGE REQUIRED	Unit/Basis Meas Code (1 ID 2/2 PAT01	. Weigh X 1 R 	Int Yes/No Cond Artributes 1/10 1 10 1/1 NAME Attributes Attributes Individual Relationship Code 0 1 1D 2/2 Code indicating the relationship between two individuals or entities 2/2 Specifies the patient's relationship to the person insured. 2/2 CODE DEFINITION 01 Spouse 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 33 Life Partner 68 Other Relationship 01 1D 1/1
*	Unit/Basis Meas Code (1 ID 2/2 REF. DES. PAT01	X 1 R	Individual Relationship Code O 1 ID 2/2 Individual Relationship Code O 1 ID 2/2 Code indicating the relationship between two individuals or entities 2/2 Specifies the patient's relationship to the person insured. 2/2 CODE DEFINITION 01 Spouse 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner 68 Other Relationship

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

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	01	ID	1/1

SEGMENT DETAIL								
	NM1 - P	PATIENT NAME						
X12 Segment Name:	Individual or C	Individual or Organizational Name						
X12 Purpose:	To supply the	e full name of an individual or organizational entity						
X12 Set Notes:	2300. Fo	 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 N	NM108 or NM109 is present, then the other is required.						
	2. C1110 If NM111	1 is present, then NM110 is required.						
	3. C1203 If NM112	2 is present, then NM103 is required.						
Loop:	2010CA — P	PATIENT NAME Loop Repeat: 1						
Segment Repeat:	1							
Usage:	REQUIRED							
TR3 Example:	NM1*QC*1*	*DOE*SALLY*J~						
DIAGRAM								
	2/3 * Entity Ty Qualifie M 1 ID NM108 + ID Code Qualifie	fer Crg Name First Middle Prefix 1/1 X 1 AN 1/60 AN 1/35 AN O1 AN 1/25 O1 AN 1/10 66 NM109 67 NM110 706 NM111 98 NM112 1035 de * ID * Entity * NM112 1035						
OT AN I	XT ID							
ELEMENT DETAIL								
USAGE D	EF. DATA ES. ELEMENT	NAME ATTRIBUTES						
REQUIRED NM10	01 98	Entity Identifier Code M 1 ID 2/3 Code identifying an organizational entity, a physical location, property or an individual						
		QC Patient						
REQUIRED NM10	02 1065	Entity Type QualifierM 1ID1/1Code qualifying the type of entity						
		SEMANTIC: NM102 qualifies NM103.						
		CODE DEFINITION						
		1 Person						

005010X223 • 837 • 2 PATIENT NAME	010CA • NM	1	ASC X12N • I Ti	NSURANCE S ECHNICAL R					
REQUIRED	NM103 1035		Name Last or Organization Name Individual last name or organizational name	X 1	AN	1/60			
			syntax: C1203						
			IMPLEMENTATION NAME: Patient Last Name						
SITUATIONAL	NM104	1036	Name First Individual first name	01	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: Patient First Name						
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	01	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: Patient Middle Name or I	nitial					
NOT USED	NM106	1038	Name Prefix	01	AN	1/10			
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name	01	AN	1/10			
			SITUATIONAL RULE: Required when the name su the individual. If not required by this implea send.			-			
			IMPLEMENTATION NAME: Patient Name Suffix						
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	01	ID	2/3			
NOT USED	NM112	1035	Name Last or Organization Name O 1 AN						

SEGMENT DETAIL					
	N3 - PA	FIENT ADDRESS			
X12 Segment Name:	Party Locatior	1			
X12 Purpose:	To specify the	location of the named party			
Loop:	2010CA — P/				
Segment Repeat:	1				
Usage:	REQUIRED				
TR3 Example:	N3*123 MAIN	STREET~			
DIAGRAM					
N301 Address Informatic M 1 AN 1	Address	on ~			
USAGE F	REF. DATA DES. ELEMENT	NAME		ATTRIBUT	TES
REQUIRED N301		Address Information Address information	M 1		1/55
		IMPLEMENTATION NAME: Patient Address Line			
SITUATIONAL N302	2 166	Address Information Address information	01	AN	1/55
		SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not set		s line.	lf not
		Detient Address Line			

IMPLEMENTATION NAME: Patient Address Line

SEGMENT DETAIL			
	N4 - PA	TIENT CITY, STATE, ZIP COI	DE
X12 Segment Name:	Geographic L	ocation	
X12 Purpose:	To specify the	e geographic place of the named party	
X12 Syntax:	1. E0207 Only one	of N402 or N407 may be present.	
	2. C0605 If N406 is	s present, then N405 is required.	
	3. C0704 If N407 is	present, then N404 is required.	
Loop:	2010CA — P		
Segment Repeat:	1		
Usage:	REQUIRED		
TR3 Example:	N4*KANSAS	S CITY*MO*64108~	
DIAGRAM			
* Country St Code	'15		2 Location Identifier O 1 AN 1/30
USAGE R	EF. DATA ES. ELEMENT	NAME	ATTRIBUTES
REQUIRED N401	19	City Name Free-form text for city name	O 1 AN 2/30
		COMMENT: A combination of either N401 through N404, or N adequate to specify a location.	405 and N406 may be
		IMPLEMENTATION NAME: Patient City Name	
SITUATIONAL N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate	X 1 ID 2/2 government agency
		SYNTAX: E0207 COMMENT: N402 is required only if city name (N401) is in the	
		SITUATIONAL RULE: Required only if city hanne (1401) is in the America, including its territories, or Canada. If no implementation guide, do not send.	he United States of
		IMPLEMENTATION NAME: Patient State Code	
		CODE SOURCE 22: States and Provinces	

SITUATIONAL	TUATIONAL N403 116	116	Postal Code Code defining international postal zone code excluding pu (zip code for United States)	O 1 Inctuation	ID on and b	3/15 blanks				
		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 Con	de						
			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	01	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							
			Line the example and division as deadfrom Deat O	(100						

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

SEGMENT DETAIL			
			PATIENT DEMOGRAPHIC
X12 Segment Na	me: Dem	ographic	c Information
X12 Purpo	ose: To su	upply der	emographic information
X12 Synt	I	P0102 f either C P1011	DMG01 or DMG02 is present, then the other is required.
			DMG10 or DMG11 is present, then the other is required.
	3. (C1105	11 is present, then DMG05 is required.
Lo	op: 2010	CA — P	PATIENT NAME
Segment Repo	eat: 1		
	ige: REQ	UIRED	
	-		9690815*M~
			3030013×111×
DIAGRAM			
	1 1250 Time at Qual ID 2/3	DMG02 1 Date Tin Period X 1 AN	od * Code * Status Code * or Ethn Inf * Status Code
* G	7 26 untry ode ID 2/3	DMG08 Basis o Verif Coo O 1 ID	
ELEMENT DETAIL			
	REF.		
	DES.	ELEMENT	Date Time Period Format Qualifier X 1 ID 2/3
			Code indicating the date format, time format, or date and time format
			syntax: P0102
REQUIRED	DMG02	1251	D8 Date Expressed in Format CCYYMMDD Date Time Period X 1 AN 1/35
			Expression of a date, a time, or range of dates, times or dates and times
			SEMANTIC: DMG02 is the date of birth.
			IMPLEMENTATION NAME: Patient Birth Date

005010X223 • 837 • 2010CA • DMG PATIENT DEMOGRAPHIC INFORMATION

REQUIRED	DMG03	1068		Gender Code Code indicating the sex of the individual		ID	1/1
			IMPLEMENTATION I	NAME: Patient Gender Code			
			CODE	DEFINITION			
			F	Female			
			Μ	Male			
			U	Unknown			
NOT USED	DMG04	1067	Marital Status	s Code	01	ID	1/1
NOT USED	DMG05	C056	COMPOSITE INFORMATIO	RACE OR ETHNICITY N	X 10		
NOT USED	DMG06	1066	Citizenship S	tatus Code	01	ID	1/2
NOT USED	DMG07	26	Country Code	9	01	ID	2/3
NOT USED	DMG08	659	Basis of Verif	ication Code	01	ID	1/2
NOT USED	DMG09	380	Quantity		01	R	1/15
NOT USED	DMG10	1270	Code List Qualifier Code		X 1	ID	1/3
NOT USED	DMG11	1271	Industry Code	Industry Code		AN	1/30

REF - PROPERTY AND CASUALTY CLAIM NUMBER

X12 Segment Name:	Reference Information
ATZ Seyment Name.	
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

	REF0	1 128	1	REF	02	127		REF	03	352]	REF04	C040]
REF *		erence nt Qual		Reference Ident		*	Description		*	Reference Identifier		~		
	M 1	ID 2/3		X 1	AN	1/50		X 1	AN	1/80		O 1		

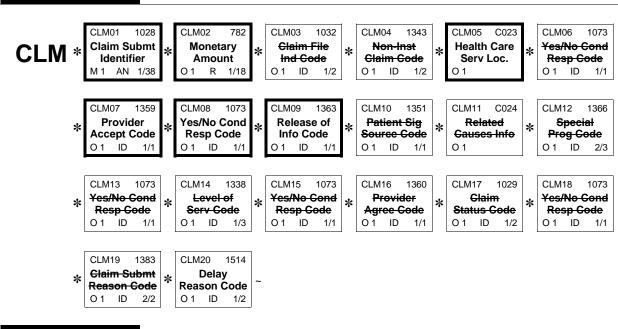
ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	TES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification			ID	2/3
			CODE	DEFINITION			
			Y4	Agency Claim Number			
REQUIRED	REF02	127	by the Reference	ntification nation as defined for a particular Transacti e Identification Qualifier	X 1 on Set	AN or as sp	1/50 becified
			syntax: R0203				
			IMPLEMENTATION N	AME: Property Casualty Claim Numb	ber		
NOT USED	REF03	352	Description		X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE	IDENTIFIER	01		

OEGMENT DETAIL	
X12 Segment Name:	
•	To specify basic data about the claim 2300 — CLAIM INFORMATION Loop Repeat: 100
Segment Repeat:	
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



_	_	_			_	
	ΕM		n	— —		
E L.	- 17		_	Ε.	AI	

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES
REQUIRED	CLM01	1028	Claim Submitter's Identifier Identifier used to track a claim from creation by the health of payment	M 1 care pro	AN ovider tl	1/38 hrough

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		ary Amo		01	R	1/18			
			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 In	dicator Code	01	ID	1/2			
NOT USED	CLM04	1343	Non-Ir	nstitution	nal Claim Type Code	01	ID	1/2			
REQUIRED	CLM05	C023	INFOR To prov	RMATION	E SERVICE LOCATION N nation that identifies the place of service of which a health care service was rendered		pe of bill	related			
REQUIRED	CLM05 - 7	1	1331	Code id and sec Services Services	y Code Value entifying where services were, or may be, ond positions of the Uniform Bill Type Co s or the Place of Service Codes for Profes s. NTATION NAME: Facility Type Code	de for li	nstitutior	nal			
REQUIRED	CLM05 - 2	2	1332	Code id semantic C023-02	2 qualifies C023-01 and C023-03.	ο	ID	1/2			
				ODE	DEFINITION						
REQUIRED	CLM05 - 3	3	A 1325	Code sp the Unif	Uniform Billing Claim Form Bill T code source 236: Uniform Billing Claim Frequency Type Code becifying the frequency of the claim; this is orm Billing Claim Form Bill Type	Form B O s the thi	ID	1/1 on of			
					URCE 235: Claim Frequency Type Code						
NOT USED	CLM06	1073	Yes/N		tion or Response Code	01	ID	1/1			

REQUIRED	CLM07	1359		ept Assignment Code O 1 ID 1/1 whether the provider accepts assignment		
			NAME: Assignment or Plan Participation Code			
		Within this of	amont the context of the word accimment is related to			
			the relationsh the field for re	ement the context of the word assignment is related to hip between the provider and the payer. This is NOT eporting whether the patient has or has not assigned he provider. The benefit assignment indicator is in		
			CODE	DEFINITION		
			Α	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.			
		В	Assignment Accepted on Clinical Lab Services Only			
			Required when the provider accepts assignment for Clinical Lab Services only.			
			С	Not Assigned		
				Required when neither codes 'A' nor 'B' apply.		
REQUIRED	CLM08	1073		ition or Response CodeO 1ID1/1a Yes or No condition or response		
			insured or autho	18 is assignment of benefits indicator. A "Y" value indicates orized person authorizes benefits to be assigned to the provider; licates benefits have not been assigned to the provider.		
				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		
			Ν	No		
			W	Not Applicable		
				Use code 'W' when the patient refuses to assign benefits.		
			Y	Yes		

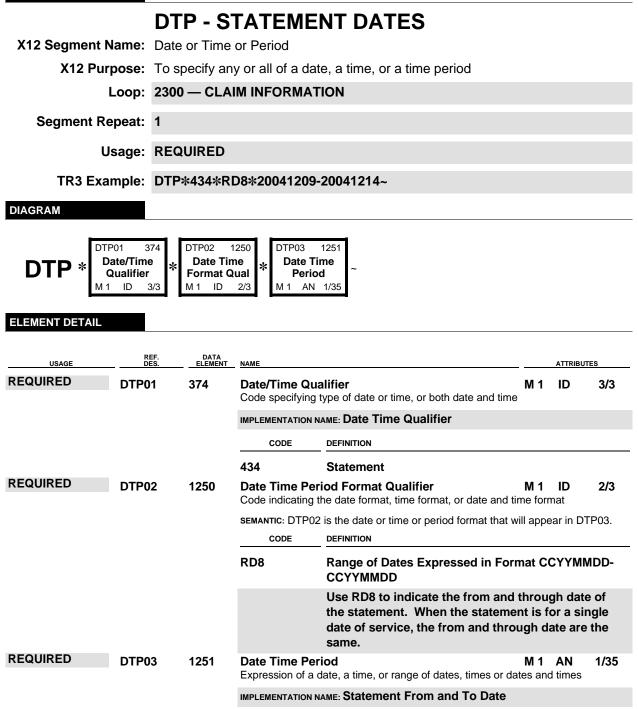
REQUIRED	CLM09 1363		Code indicating	formation Code whether the provider has on file a signe release of medical data to other organiz		ID nt by th	1/1 e patient
			The Release of carried in this	of Information response is limited s claim.	d to the i	nforma	ation
			CODE	DEFINITION			
			I	Informed Consent to Release M for Conditions or Diagnoses Re Statutes			
				Required when the provider ha signature AND state or federal signature be collected.			
			Y	Yes, Provider has a Signed Sta Release of Medical Billing Data			-
				Required when the provider ha signature. OR Required when state or federal signature be collected.			
NOT USED	CLM10	1351	Patient Signa	ture Source Code	01	ID	1/1
NOT USED	CLM11	C024	RELATED CA	USES INFORMATION	01		
NOT USED	CLM12	1366	Special Progr	ram Code	01	ID	2/3
NOT USED	CLM13	1073	Yes/No Cond	ition or Response Code	01	ID	1/1
NOT USED	CLM14	1338	Level of Servi	ice Code	01	ID	1/3
NOT USED	CLM15	1073	Yes/No Condi	ition or Response Code	01	ID	1/1
NOT USED	CLM16	1360	Provider Agre	eement Code	01	ID	1/1
NOT USED	CLM17	1029	Claim Status	Code	01	ID	1/2
NOT USED	CLM18	1073	Yes/No Cond	ition or Response Code	01	ID	1/1
NOT USED	CLM19	1383	Claim Submis	ssion Reason Code	01	ID	2/2
SITUATIONAL	CLM20	1514	Delay Reasor Code indicating	Code the reason why a request was delayed	01	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

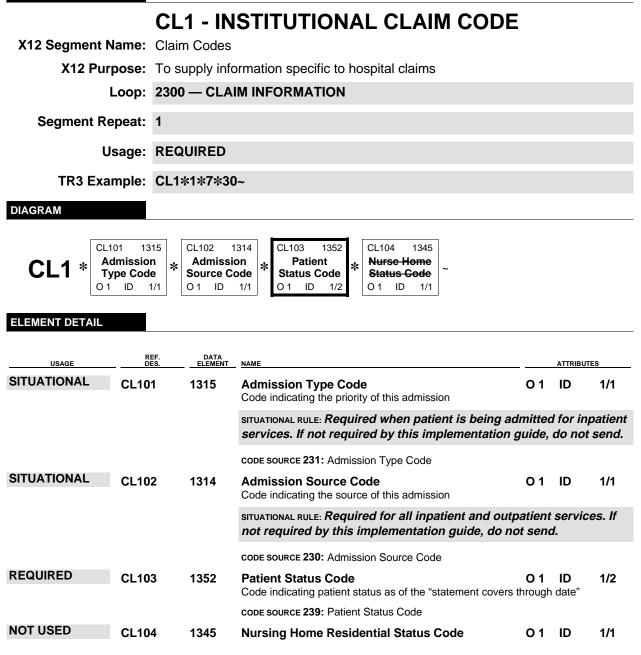
Other Natural Disaster

SEGMENT DETAIL						
	DTP - D	ISCHAR	GE HOUR			
X12 Segment Name:	Date or Time	or Period				
X12 Purpose:	To specify an	o specify any or all of a date, a time, or a time period				
Loop:	2300 — CLA	IM INFORMAT	TION			
Segment Repeat:	1					
Usage:	SITUATIONA	\L				
Situational Rule:		all final inpat ion guide, do	ient claims. If not required by thi not send.	S		
TR3 Example: DTP*096*TM*1130~						
DIAGRAM						
ELEMENT DETAIL	3/3 M 1 ID	2/3 M 1 AN	1/35			
		Date/Time Qu	alifiar	M 1		3/3
DIP	JI 374		type of date or time, or both date and time		U	3/3
			NAME: Date Time Qualifier			
		CODE	DEFINITION			
		096	Discharge			
REQUIRED DTP	02 1250		riod Format Qualifier the date format, time format, or date and tir	M 1 ne form	ID nat	2/3
			2 is the date or time or period format that wi	ll appe	ar in D1	FP03
		CODE				
REQUIRED DTP		ТМ	Time Expressed in Format HHMM			
	13 1251	Date Time Po	·	М 1	ΔN	
Dire	03 1251	Date Time Per Expression of a	·	M 1 tes and	AN I times	1/35

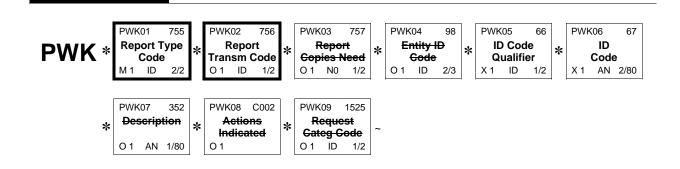


	DTP - A	DMISSION DATE/HOUR					
X12 Segment Name:	Date or Time	Date or Time or Period					
X12 Purpose:	To specify any	o specify any or all of a date, a time, or a time period					
Loop:	2300 — CLAI	300 — CLAIM INFORMATION					
Segment Repeat:	1						
Usage:	SITUATIONA	L					
Situational Rule:	-	Required on inpatient claims. If not required by this implementation guide, do not send.					
TR3 Example:	DTP*435*D	T*200410131242~					
DIAGRAM							
DTP * Date/Time Qualifier	e 🔺 Date Tim	X					
USAGE D	REF. DATA JES. ELEMENT	NAME		ATTRIBL	JTES		
USAGE B REQUIRED DTPC		NAME Date/Time Qualifier	 M 1		JTES 3/3		
		Date/Time Qualifier Code specifying type of date or time, or both date and tim					
		Date/Time Qualifier Code specifying type of date or time, or both date and tim IMPLEMENTATION NAME: Date Time Qualifier					
		Date/Time Qualifier Code specifying type of date or time, or both date and tim IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION					
	01 374	Date/Time Qualifier Code specifying type of date or time, or both date and tim IMPLEMENTATION NAME: Date Time Qualifier	е М 1	ID			
REQUIRED DTPC	01 374	Date/Time Qualifier Code specifying type of date or time, or both date and tim IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 435 Admission Date Time Period Format Qualifier	e M 1 time for	ID ID mat	3/3 2/3		
REQUIRED DTPC	01 374	Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 435 Admission Date Time Period Format Qualifier Code indicating the date format, time format, or date and	e M 1 time for will appe	ID ID mat ear in D	3/3 2/3 TP03.		
REQUIRED DTPC	01 374	Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 435 Admission Date Time Period Format Qualifier Code indicating the date format, time format, or date and semantic: DTP02 is the date or time or period format that Selection of the appropriate qualifier is designate	e M 1 time for will appe	ID ID mat ear in D	3/3 2/3 TP03.		
REQUIRED DTPC	01 374	Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 435 Admission Date Time Period Format Qualifier Code indicating the date format, time format, or date and semantic: DTP02 is the date or time or period format that Selection of the appropriate qualifier is designar Billing Manual.	e M 1 time form will appe	ID ID mat ear in D the NL	3/3 2/3 TP03.		
REQUIRED DTPC	01 374	Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 435 Admission Date Time Period Format Qualifier Code indicating the date format, time format, or date and semantic: DTP02 is the date or time or period format that Selection of the appropriate qualifier is designar Billing Manual. DEFINITION	e M 1 time for will appe ted by MMDD	ID ID mat ear in D the NL	3/3 2/3 TP03.		
REQUIRED DTPC	01 374 02 1250	Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 435 Admission Date Time Period Format Qualifier Code indicating the date format, time format, or date and SEMANTIC: DTP02 is the date or time or period format that Selection of the appropriate qualifier is designar Billing Manual. CODE DEFINITION D8 Date Expressed in Format CCYY DT Date and Time Expressed in Format	e M 1 time for will appe ted by MMDD nat M 1	ID mat ear in D the NU	3/3 2/3 TP03. JBC		

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 DTP03 DTP01 374 DTP02 1250 1251 Date/Time Date Time Date Time DTP * * Qualifier Format Qual Period ID 3/3 M 1 ID 2/3 AN 1/35 M 1 M 1 ELEMENT DETAIL DATA ELEMENT REF. DES. USAGE NAME ATTRIBUTES REQUIRED DTP01 374 **Date/Time Qualifier** M 1 ID 3/3 Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier DEFINITION CODE 050 Received REQUIRED DTP02 1250 **Date Time Period Format Qualifier** M 1 ID 2/3 Code indicating the date format, time format, or date and time format SEMANTIC: DTP02 is the date or time or period format that will appear in DTP03. CODE DEFINITION **D8** Date Expressed in Format CCYYMMDD REQUIRED DTP03 1251 **Date Time Period** M1 AN 1/35 Expression of a date, a time, or range of dates, times or dates and times IMPLEMENTATION NAME: Repricer Received Date



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:	 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

DEE	DATA					
PWK01	ELEMENT	Report Type	e Code	ATTRIBUTES		
		Code indicating the title or contents of a document, report or supporting item				
		IMPLEMENTATION NAME: Attachment Report Type Code				
		CODE	DEFINITION			
		03	Report Justifying Treatment Beyo Guidelines	nd Utilization		
		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			
		вт	Blanket Test Results			
		СВ	Chiropractic Justification			
		СК	Consent Form(s)			
		СТ	Certification			
		D2	Drug Profile Document			
		DA	Dental Models			
		DB	Durable Medical Equipment Presc	ription		
		DG	Diagnostic Report	-		
		DJ	Discharge Monitoring Report			
		DS	Discharge Summary			
		EB	Explanation of Benefits (Coordina Medicare Secondary Payor)	tion of Benefits o		
		НС	Health Certificate			
		HR	Health Clinic Records			
		15	Immunization Record			

IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
МТ	Models
NN	Nursing Notes
ОВ	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
ох	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
ХР	Photographs
Report Trans	mission Code O 1 ID 1/2

REQUIRED

PWK02 756

Report Transmission CodeO 1ID1/2Code 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	s Needed	01	N0	1/2		
NOT USED	PWK04	98	Entity Identifie	er Code	01	ID	2/3		
SITUATIONAL	PWK05	66		Code Qualifier g the system/method of code structure us	X 1 ed for le	ID dentifica	1/2 tion		
			syntax: P0506						
			соммент: PWK0 number.	5 and PWK06 may be used to identify the	addres	see by a	a code		
			SITUATIONAL RULE: Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.						
			CODE	DEFINITION					
			AC	Attachment Control Number					
SITUATIONAL	PWK06	67	Identification Code identifying	Code a party or other code	X 1	AN	2/80		
			syntax: P0506						
				Required when PWK02 = "BM", "I quired by this implementation guid					
			IMPLEMENTATION N	AME: Attachment Control Number					
				d to identify the attached electroni n PWK06 is carried in the TRN of th			ition.		
			For the purposition for the purposition for the purposition of the pur	se of this implementation, the max	imum	field le	ength		
NOT USED	PWK07	352	Description		01	AN	1/80		
NOT USED	PWK08	C002	ACTIONS IND	ICATED	01				
NOT USED	PWK09	1525	Request Cate	gory Code	01	ID	1/2		

ASC X12N • INSURA TECHNICAL REPORT		MMITTEE		005010X223 • 837 • 2300 • CN CONTRACT INFORMATION
SITUATIONAL	SITUATIONAL CN103	332	Percent, Decimal Format Percent given in decimal format (e.g., 0.0 throug 100%)	O 1 R 1/6 h 100.0 represents 0% through
		SEMANTIC: CN103 is the allowance or charge per	cent.	
		SITUATIONAL RULE: Required when the provid to supply this information on the claim. implementation guide, do not send.		
			IMPLEMENTATION NAME: Contract Percentage	
SITUATIONAL	ITUATIONAL CN104	127	Reference Identification Reference information as defined for a particular by the Reference Identification Qualifier	O 1 AN 1/50 r Transaction Set or as specified
		SEMANTIC: CN104 is the contract code.		
		SITUATIONAL RULE: Required when the provid to supply this information on the claim. implementation guide, do not send.		
			IMPLEMENTATION NAME: Contract Code	
SITUATIONAL	CN105	338	Terms Discount Percent Terms discount percentage, expressed as a per an invoice is paid on or before the Terms Discou	
		SITUATIONAL RULE: Required when the provid to supply this information on the claim. implementation guide, do not send.		
			IMPLEMENTATION NAME: Terms Discount Perce	entage
SITUATIONAL	CN106	799	Version Identifier Revision level of a particular format, program, te	O 1 AN 1/30 echnique or algorithm
			SEMANTIC: CN106 is an additional identifying num	nber for the contract.
			SITUATIONAL RULE: Required when the provid to supply this information on the claim. implementation guide, do not send.	
			IMPLEMENTATION NAME: Contract Version Iden	tifier

SEGMENT DETAIL								
	AM	T - P		ESTIMATED AMOUI	I TI	DUI	Ξ	
X12 Segment Name	: Mone	etary Ame	ount Informatio	n				
X12 Purpose	: To in	o indicate the total monetary amount						
Loop	2300	300 — CLAIM INFORMATION						
Segment Repea	t: 1	1						
Usage	: SITU	ATIONA	L					
Situational Rule	claim	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	3~					
DIAGRAM								
AMT01 522 Amount Qual Code M 1 ID 1/3 AMT02 782 Monetary Amount M 1 R 1/18 AMT03 478 Cred/Debit Flag Code O 1 ID 1/1 Code M 1 ID 1/3								
		0.474						
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	JTES	
REQUIRED AM	T01	522	Amount Qualify a		M 1	ID	1/3	
			CODE	DEFINITION				
			F3	Patient Responsibility - Estimated	I			
REQUIRED AM	T02	782	Monetary Amount Monetary amount			R	1/18	
				AME: Patient Responsibility Amount				
NOT USED AM	Т03	478	Credit/Debit Fl	ag Code	01	ID	1/1	

REF - SERVICE AUTHORIZATION EXCEPTION CODE

X12 Segment Name	: Reference Inf	ormation					
X12 Purpose	: To specify ide	entifying information					
X12 Syntax		ne of REF02 or REF03 is required.					
Loop	: 2300 — CLAI	M INFORMATION					
Segment Repeat	: 1						
Usage	: SITUATIONA	L					
Situational Rule	authorization the service w	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							
REF * ReForm Referent Ident Qu M 1 ID	ce _* Reference	* Identifier					
ELEMENT DETAIL							
USAGE	REF. DATA DES. ELEMENT	NAMEATTRIBUTES					
REQUIRED REP	-01 128	Reference Identification QualifierM 1ID2/3Code qualifying the Reference Identification					
		CODE DEFINITION					
		4N Special Payment Reference Number					
REQUIRED REP	F02 127	Reference IdentificationX 1AN1/50Reference information as defined for a particular Transaction Set or as specified					
		by the Reference Identification Qualifier					
		by the Reference Identification Qualifier SYNTAX: R0203					

005010X223 • 837 • 2300 • REF
SERVICE AUTHORIZATION EXCEPTION CODE

NOT USED	REF03	352	Description	X1 AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	O 1	

SEGMENT DETAIL							
	REF - RI	EFERRAL NUMBER					
X12 Segment Name:	Reference Info	ormation					
X12 Purpose:	To specify ide	ntifying information					
X12 Syntax:	1. R0203 At least o	ne of REF02 or REF03 is required.					
Loop:	2300 — CLAI	M INFORMATION					
Segment Repeat:	1						
Usage:	SITUATIONA	L					
Situational Rule:	Management AND a referral is in	en a referral number is assigned by the paye Organization (UMO) nvolved. d by this implementation guide, do not send		tilizati	on		
TR3 Notes:	overridde identifica the same REF segr	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: DIAGRAM	REF*9F*123	45~					
REF * Reference Ident Qua	e 👷 Referenc	* * <mark>* Identifier</mark> ~					
ELEMENT DETAIL							
USAGE R	EF. DATA ES. ELEMENT	NAME		ATTRIBUT	ree		
REQUIRED REFO		Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3		
REQUIRED REFO	02 127	CODE DEFINITION 9F Referral Number Reference Identification Reference information as defined for a particular Transaction by the Reference Identification Qualifier SYNTAX: R0203		AN or as spo	1/50 ecified		

NOT USED

NOT USED

REF03

REF04

352

C040

Description

REFERENCE IDENTIFIER

1/80

X1 AN

	REF - PF	RIOR AU	THORIZATION					
X12 Segment Name:	Reference Info	ormation						
X12 Purpose:	To specify ide	ntifying inform	ation					
X12 Syntax:	1. R0203 At least o	ne of REF02 o	or REF03 is required.					
Loop:	2300 — CLAI	M INFORMAT	ION					
Segment Repeat:	1							
Usage:	SITUATIONA	L						
Situational Rule:	AND the services	on this claim	zation number is assigned by were preauthorized. lementation guide, do not sen		/er or ∣	UMO		
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 number for this claim, report that information in the Loop ID-2330 loop REF which holds that payer's information.							
	overridde identifica the same REF segr	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*135	579~						
DIAGRAM								
REF * Reference Ident Qua	e _* Reference	*	352 tion 1/80 ★ REF04 C040 Reference Identifier O 1 ~					
	EF. DATA							
USAGE D	ES. ELEMENT				ATTRIBUT			
REQUIRED REFO	1 128		ntification Qualifier he Reference Identification	M 1	ID	2/3		
		CODE	DEFINITION					
		G1	Prior Authorization Number					

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2300 • REF PRIOR AUTHORIZATION				
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular by the Reference Identification Qualifier SYNTAX: R0203	X 1 Transaction Set		1/50 specified	
			IMPLEMENTATION NAME: Prior Authorization Nu	mber			
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	0 1			

SEGMENT DETAIL									
	RE	F - P	AYER CLAIM CONTROL NUI	MB	ER				
X12 Segment N	ame: Refe	Reference Information							
X12 Purp	oose: To s	o specify identifying information							
X12 Sy	ntax: 1.	R0203							
			one of REF02 or REF03 is required.						
L	.oop: 2300	2300 — CLAIM INFORMATION							
Segment Re	peat: 1	1							
Us	sage: SITU	SITUATIONAL							
Situational	repla	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 N		This info ID-2010E	ormation is specific to the destination payer ro BB.	eport	ed in l	Loop			
TR3 Exar	nple: REF	*F8*R5	55588~						
DIAGRAM									
	01 128 ference ent Qual ID 2/3	REF02 Reference Ident X 1 AN	* [*] Identifier [∼]						
ELEMENT DETAIL									
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES			
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3			
			CODE DEFINITION						
			F8 Original Reference Number						
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transaction by the Reference Identification Qualifier		AN or as sp	1/50 becified			
			SYNTAX: R0203						
			IMPLEMENTATION NAME: Payer Claim Control Number						
NOT USED	REF03	352	Description	X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01					

SEGMENT DETAIL									
	RE	EF - R	EPRICED CLAIM NUMBER						
X12 Segment N	ame: Refe	Reference Information							
X12 Purj	bose: To s	o specify identifying information							
X12 Sy	ntax: 1.	1. R0203							
_		At least one of REF02 or REF03 is required.							
L	_oop: 230	2300 — CLAIM INFORMATION							
Segment Re	peat: 1	1							
U	sage: SIT	SITUATIONAL							
Situational	seg	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 N	otes: 1.	This info ID-2010E	ormation is specific to the destination payer r 3B.	eport	ed in I	Loop			
TR3 Exa	mple: REF	**9A*RJ	55555~						
DIAGRAM									
	01 128 eference ent Qual ID 2/3	REF02 Referen Ident X 1 AN	* * Identifier ~						
ELEMENT DETAIL									
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES			
REQUIRED	REF01	128	Reference Identification Qualifier	M 1	ID	2/3			
			Code qualifying the Reference Identification						
REQUIRED	REF02	127	9A Repriced Claim Reference Number Reference Identification		AN	1/50			
	KLI UZ	121	Reference information as defined for a particular Transacti by the Reference Identification Qualifier						
			syntax: R0203						
			IMPLEMENTATION NAME: Repriced Claim Reference Nur	nber					
NOT USED	REF03	352	Description	X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01					

SEGMENT DETAIL									
	RE	F - A	DJUSTED REPRICED CLAIN		UME	BER			
X12 Segment Na	ame: Refe	Reference Information							
X12 Purp	oose: To s	To specify identifying information							
X12 Syr		1. R0203							
		At least one of REF02 or REF03 is required.							
L	.oop: 2300	2300 — CLAIM INFORMATION							
Segment Re	peat: 1	1							
Us	sage: SITU	SITUATIONAL							
Situational F	segi	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 No		1. This information is specific to the destination payer reported in Loop ID-2010BB.							
TR3 Exan	nple: REF	*9C*RF	4444444~						
DIAGRAM	_								
	01 128 Inference Pont Qual ID 2/3	REF02 Referen Ident X 1 AN	★ · ★ Identifier ~						
ELEMENT DETAIL									
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES			
REQUIRED REF01 128		128	Reference Identification Qualifier	M 1	ID	2/3			
			Code qualifying the Reference Identification						
REQUIRED	REF02	127	9C Adjusted Repriced Claim Reference Number Reference Identification X 1 AN 1/50						
	REFUZ	127	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier						
			syntax: R0203						
			IMPLEMENTATION NAME: Adjusted Repriced Claim Refe	rence	Numbe	ər			
NOT USED	REF03	352	Description	X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01					

SEGMENT DETAIL								
SEGMENT DETAIL			IVESTIGATIONAL DEVICE					
X12 Segment Nan	ne: Refere	Reference Information						
X12 Purpos	se: To spe	To specify identifying information						
X12 Synta		1. R0203 At least one of REF02 or REF03 is required.						
Loc	op: 2300 -	2300 — CLAIM INFORMATION						
Segment Repe	at: 5	5						
Usa	ge: SITUA	SITUATIONAL						
Situational Ru	I 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 Examp	le: REF*	LX*43	2907~					
DIAGRAM	-							
REF * REF01 Refer Ident M 1 II	ence * Qual	REF02 Referent Ident (1 AN	★ ★ ★ Hentifier					
ELEMENT DETAIL								
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES		
REQUIRED R	EF01	128	Reference Identification Qualifier Code qualifying the Reference Identification		ID	2/3		
REQUIRED R	EF02	127	LX Qualified Products List Reference Identification Reference information as defined for a particular Transaction by the Reference Identification Qualifier		AN or as sp	1/50 becified		
			syntax: R0203					
			IMPLEMENTATION NAME: Investigational Device Exempt	ion Id	entifie	r		
NOT USED R	EF03	352	Description	X 1	AN	1/80		
NOT USED R	EF04	C040	REFERENCE IDENTIFIER	01				

REF - CLAIM IDENTIFIER FOR TRANSMISSION INTERMEDIARIES

X12 Segment Name:	Reference Inf	ormation		-				
-								
-	To specify identifying information							
X12 Syntax:	1. R0203 At least o	ne of REF02 o	r REF03 is required.					
Loop.	2300 — CLAI		•					
2009.								
Segment Repeat:	1							
Usage:	SITUATIONA	L						
Situational Rule:	intermediarie attach their c	es (Automated	ation is deemed necessary b I Clearinghouses, and others aim number. If not required b not send.	who n				
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*TJ	98UU321~						
DIAGRAM								
REF * Reference Ident Qua	e 👷 Referenc	*	352 tion * REF04 C040 Reference Identifier ~ O 1					
ELEMENT DETAIL								
R	EF. DATA							
	ES. ELEMENT		u (Maatlan Qualifian					
REQUIRED REFO	1 128		ntification Qualifier he Reference Identification	M 1	ID	2/3		
	Number assigned by clearinghouse, van, etc.							
		CODE	DEFINITION					
		D9	Claim Number					

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2300 • REF CLAIM IDENTIFIER FOR TRANSMISSION INTERMEDIARIES				
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transa by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Value Added Network Trace	action Set		1/50 pecified	
			The value carried in this element is limited to a positions.	a maxim	um of	20	
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01			

	RE	F - A	UTO ACCIDENT STATE							
X12 Segment Nam	e: Refe	rence Inf	formation							
X12 Purpos	e: To s	To specify identifying information								
X12 Synta	x: 1.	R0203								
		At least o	one of REF02 or REF03 is required.							
Loo	p: 2300) — CLAI	IM INFORMATION							
Segment Repea	nt: 1									
Usag	e: SITL	JATIONA	۱L							
Situational Rul	accie state	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 Exampl	e: REF	*LU*MC)~							
DIAGRAM										
REF * Referendent dent Control Market		Reference Ident X 1 AN	* Identifier							
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIB	UTES				
REQUIRED RE	F01	128	Code qualifying the Reference Identification CODE DEFINITION	M 1	ID	2/3				
			LU Location Number							
REQUIRED RE	F02	127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier		AN or as s	1/50 pecified				
			syntax: R0203							
			IMPLEMENTATION NAME: Auto Accident State or Province	ce Co	de					
			Values in this field must be valid codes found in	code	sourc	e 22.				
NOT USED RE	F03	352	Description	X 1	AN	1/80				
NOT USED RE	F04	C040	REFERENCE IDENTIFIER	01						

SEGMENT DETAIL						
	RE	F - M	EDICAL RECORD NUMBER			
X12 Segment Nam	e: Refe	rence Inf	ormation			
X12 Purpos	e: To s	pecify ide	entifying information			
X12 Synta		R0203 At least c	one of REF02 or REF03 is required.			
Loo	p: 2300	- CLA	IM INFORMATION			
Segment Repea	at: 1					
Usag	e: SITU	IATIONA	L			
Situational Rul	actu Loop	al medic b ID-2010	en the provider needs to identify for future in al record of the patient identified in either Lo DCA for this episode of care. If not required b ion guide, do not send.	op ID	-2010	
TR3 Exampl	e: REF	*EA*44	444TH56~			
DIAGRAM						
REF * REF01 Refere Ident (M 1 ID	\times	REF02 Reference Ident X 1 AN	* * Identifier ~			
ELEMENT DETAIL						
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES
REQUIRED RE	EF01	128	Reference Identification Qualifier	M 1	ID	2/3
			Code qualifying the Reference Identification CODE DEFINITION			
REQUIRED RE	- 202	107	EA Medical Record Identification Nur Reference Identification		A NI	1/50
	EF02	127	Reference information as defined for a particular Transacti by the Reference Identification Qualifier	X 1 on Set		1/50 becified
			syntax: R0203			
			IMPLEMENTATION NAME: Medical Record Number			
NOT USED RE	EF03	352	Description	X 1	AN	1/80
NOT USED RE	EF04	C040	REFERENCE IDENTIFIER	01		

SEGMENT DETAIL						
		EF - D ENTIF	EMONSTRATION PROJECT			
X12 Segment N	ame: Ref	erence In	formation			
X12 Purp	bose: To s	specify ide	entifying information			
X12 Sy	ntax: 1.	R0203 At least o	one of REF02 or REF03 is required.			
L	.oop: 230	0 — CLA	IM INFORMATION			
Segment Re	peat: 1					
Us	sage: SIT	UATION	AL			
Situational I	way a de	/s such a emonstra	nen it is necessary to identify claims which a is content, purpose, and/or payment, as coul ation or other special project, or a clinical tria ementation guide, do not send.	d be t	he cas	se for
TR3 Exar	mple: RE	F*P4*TH	IJ1222~			
DIAGRAM						
	01 128 eference ent Qual ID 2/3	REF02 Referen Ident X 1 AN	* * Identifier ~			
ELEMENT DETAIL						
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	ITES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3
			CODE DEFINITION			
			P4 Project Code			
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transac by the Reference Identification Qualifier		AN or as sp	1/50 becified
			syntax: R0203			
			IMPLEMENTATION NAME: Demonstration Project Identif	ier		
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

REF - PEER REVIEW ORGANIZATION (PRO) APPROVAL NUMBER

X12 Segment N	ame: Refe	erence Inf	formation						
X12 Purp	ose: To s	pecify ide	entifying information						
X12 Sy		R0203 At least c	one of REF02 or REF03 is required.						
L	.oop: 2300) — CLA	IM INFORMATION						
Segment Re	peat: 1								
Us	sage: SITL	JATIONA	L						
Situational I	Num	Required when an external Peer Review Organization assigns an Appro Number to services deemed medically necessary by that organization. I not required by this implementation guide, do not send.							
TR3 Exar	nple: REF	ple: REF*G4*284746~							
DIAGRAM									
	01 128 ference ent Qual ID 2/3	REF02 Referen Ident X 1 AN	* Identifier 1/50 X 1 AN 1/80 O 1						
			NAME						
REQUIRED	REF01 REF02	128 127	Reference Identification Qualifier Code qualifying the Reference Identification CODE DEFINITION G4 Peer Review Organization (PRO Reference Identification Reference Identification Reference Identification Reference Identification SYNTAX: R0203	X 1	AN	1/50			
			IMPLEMENTATION NAME: Peer Review Authorization N	umber					
NOT USED	REF03	352	Description	X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01					

SEGMENT DETAIL	
	K3 - FILE INFORMATION
X12 Segment Name:	
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:	 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	
K301 4 Fixed Form Information M 1 AN 1/	on * Format Code * Unit of Mea

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	<u> </u>	ATTRIBU	TES
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	01	ID	1/2
NOT USED	K303	C001	COMPOSITE UNIT OF MEASURE	01		

NTE - CLAIM NOTE X12 Segment Name: Note/Special Instruction **X12 Purpose:** To transmit information in a free-form format, if necessary, for comment or special instruction X12 Comments: 1. The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processible. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment. Loop: 2300 — CLAIM INFORMATION Segment Repeat: 10 Usage: SITUATIONAL Situational Rule: Required when in the judgment of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set. OR Required when in the judgment of the provider, narrative information from the forms "Home Health Certification and Plan of Treatment" or "Medical Update and Patient Information" is needed to substantiate home health services. If not required by this implementation guide, do not send. TR3 Notes: 1. The developers of this implementation guide discourage using narrative information within the 837. Trading partners who use narrative information with claims are strongly encouraged to codify that information within the X12 environment. TR3 Example: NTE*NTR*PATIENT REQUIRES TUBE FEEDING~ DIAGRAM NTE01 363 NTE02 352 Note Ref Description NTE * Code ID 3/3 AN 1/80 M 1 $\cap 1$ ELEMENT DETAIL REF. DATA ELEMENT USAGE NAME ATTRIBUTES REQUIRED NTE01 363 **Note Reference Code** 01 ID 3/3 Code identifying the functional area or purpose for which the note applies 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 desc	M 1 AN 1/80 cription to clarify the related data elements and their content			
			INDI EMENTATION NAME. Claim Note Text				

IMPLEMENTATION NAME: Claim Note Text

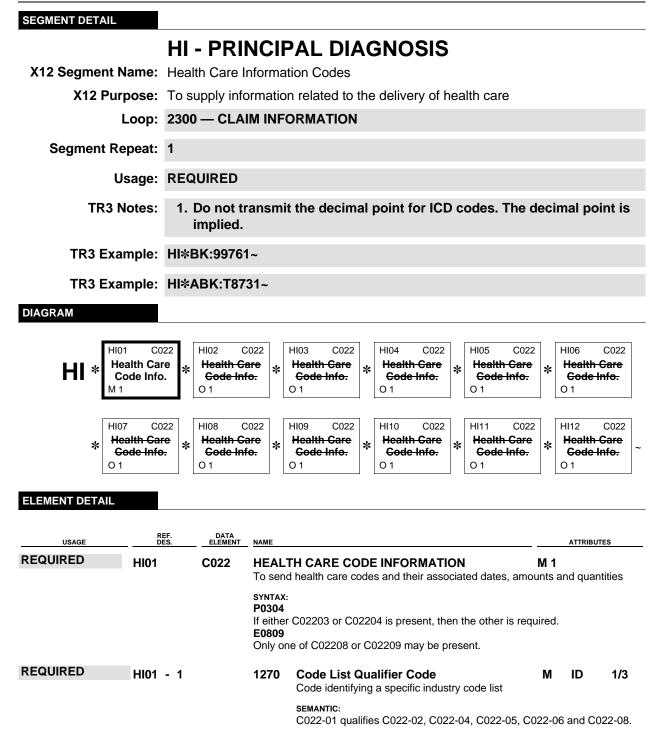
	NTE - B	ILLING NOTE						
X12 Segment Name	: Note/Special	Instruction						
X12 Purpose		transmit information in a free-form format, if necessary, for comment or ecial instruction						
X12 Comments	X12 stan NTE seg	segment permits free-form information/data wh dard implementations, is not machine processib ment should therefore be avoided, if at all possil ed environment.	le. The use of the					
Loop	: 2300 — CLA	IM INFORMATION						
Segment Repea	:: 1							
Usage	SITUATIONA	L						
Situational Rule	to substantia within the cl	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*N	IO LIABILITY, PATIENT FELL AT HOME~						
DIAGRAM								
NTE * NTE01 Note F Code 0 1 ID		~						
	REF. DATA							
REQUIRED NT	DES. ELEMENT	Name	O 1 ID 3/3					
NEGONED	E01 363	Note Reference Code Code identifying the functional area or purpose for which to code CODE DEFINITION	• • • • • •					
		ADD Additional Information						
REQUIRED NT	E02 352	Description A free-form description to clarify the related data elements	M1 AN 1/80 and their content					
		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 CRC01 1136 CRC02 1073 CRC03 1321 CRC04 1321 CRC05 1321 CRC06 1321 Yes/No Cond Certificate **Certificate** Code Certificate Certificate CRC * * * * Category **Resp Code** Cond Code Cond Code Cond Code Cond Code ID 2/2 ID ID 2/3 01 ID ID 2/3 01 ID 11 M 1 1/1 M 1 2/3 01 2/3 CRC07 1321 **Certificate** * Cond Code ID O 1 2/3 ELEMENT DETAIL REF. DES. DATA ELEMENT USAGE NAME ATTRIBUTES REQUIRED CRC01 1136 Code Category M 1 ID 2/2 Specifies the situation or category to which the code applies SEMANTIC: CRC01 qualifies CRC03 through CRC07. IMPLEMENTATION NAME: Code Qualifier CODE DEFINITION ΖZ **Mutually Defined EPSDT Screening referral information.**

005010X223 •	837 •	2300	• CRC
EPSDT REFER	RAL		

REQUIRED	CRC02	1073	Yes/No Condition or Response CodeM 1IDCode indicating a Yes or No condition or response					
			indicates the cor	2 is a Certification Condition Code applies ndition codes in CRC03 through CRC07 a ndition codes in CRC03 through CRC07 d	pply; an	"N" val		
				NAME: Certification Condition Code	Applies	Indica	ator	
			The response to the patient	answers the question: Was an EP ?	SDT re	ferral	given	
			CODE	DEFINITION				
			Ν	No				
				If no, then choose "NU" in CRC0 referral given.	3 indic	ating r	10	
			Y	Yes				
REQUIRED	CRC03	1321	Condition Ind Code indicating		M 1	ID	2/3	
			The codes for	CRC03 also can be used for CRC	04 thro	ugh C	RC05.	
			CODE	DEFINITION				
			AV	Available - Not Used				
			Patient refused referral.					
			NU	Not Used				
				This conditioner indicator must b submitter answers "N" in CRC02		d when	the	
			S2	Under Treatment				
				Patient is currently under treatm diagnostic or corrective health p			ed	
			ST	New Services Requested				
			Patient is referred to another pro or corrective treatment for at lea problem identified during an initi screening service (not including OR Patient is scheduled for another screening provider for diagnosti treatment for at least one health during an initial or periodic scree including dental referrals).	st one al or p dental appoin c or co proble	health eriodic referra tment rrectiv m iden	als). with e tified		
SITUATIONAL	CRC04	1321	Condition Ind		01	ID	2/3	
				Required when a second condition a second condition not required by this implementation and the second seco			ot	
			Use the codes	s listed in CRC03.				

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3				005010X223 • 8 EP		300 • CRC EFERRAL			
SITUATIONAL	TIONAL CRC05 1321		Condition Indicator Code indicating a condition	0 1	ID	2/3			
			•	RULE: Required when a third condition code i red by this implementation guide, do not ser					
			Use the codes listed in CRC03.						
NOT USED	CRC06	1321	Condition Indicator	01	ID	2/3			
NOT USED	CRC07	1321	Condition Indicator	01	ID	2/3			



			C	ODE	DEFINITION				
			ABK		International Classification of Dise Modification (ICD-10-CM) Principal				
					This code set is not allowed for use the time of this writing. The qualifie used: If a new rule names the ICD-10-CM code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed un OR For claims which are not covered u	as a to u der t	n only n allov se the the law	be wable code /,	
			вк		CODE SOURCE 897: International Classificati Revision, Clinical Modification (ICD-10-CM International Classification of Disea Modification (ICD-9-CM) Principal E	1) ases Diag	: Clinic nosis	al	
REQUIRED H	HI01 -	2	1271		CODE SOURCE 131: International Classificati Revision, Clinical Modification (ICD-9-CM) Ty Code	М	AN	es, 9th 1/30	
				SEMANTIC	08 is used, then C022-02 represents the be			e in a	
				IMPLEMEN	NTATION NAME: Principal Diagnosis Cod	e			
NOT USED	HI01 -	3	1250	Date Ti	me Period Format Qualifier	Х	ID	2/3	
NOT USED	HI01 -	4	1251	Date Ti	ime Period	х	AN	1/35	
NOT USED	HI01 -	5	782	Moneta	ary Amount	ο	R	1/18	
NOT USED	HI01 -	6	380	Quanti	ty	ο	R	1/15	
NOT USED	HI01 -	7	799	Versio	n Identifier	0	AN	1/30	
NOT USED	HI01 -	8	1271	Industr	ry Code	Х	AN	1/30	
SITUATIONAL H	HI01 -	9	1073		Condition or Response Code dicating a Yes or No condition or response	Х	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 occurre 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 hospit or not.							
		COMMENTS: C022-09 would only need to be reported to data collectors requiri information when C022-01 is "BF" (Diagnosis Code) and range of diagnosis codes were NOT given in C022-08.							
					TUATIONAL RULE: Required as directed by the NUBC billing				
					NTATION NAME: Present on Admission In	dica	tor		

			U	Unknown	
			W	Not Applicable	
			Y	Yes	
NOT USED	HI02	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI03	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI04	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI05	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI06	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI07	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI08	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI09	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI10	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI11	C022	HEALTH CARE	E CODE INFORMATION	01
NOT USED	HI12	C022	HEALTH CARE	E CODE INFORMATION	01

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 HI01 C022 HI02 C022 HI03 C022 HI04 C022 HI05 C022 HI06 C022 **Health Care Health Care Health Care Health Care Health Care Health Care** * * * * **HI** * * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info. 01 O 1 O 1 O 1 01 M 1 HI07 C022 HI08 C022 HI09 C022 HI10 C022 HI11 C022 HI12 C022 **Health Care Health Care Health Care Health Care Health Care Health Care** * * * * * * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info. 01 01 01 01 01 01 ELEMENT DETAIL REF. DATA ELEMENT USAGE 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.

005010X223 • 837 • 2300 • H	
ADMITTING DIAGNOSIS	

REQUIRED	HI01 - 1		1270		Qualifier Code ying a specific industry code list	М	ID	1/3
				semantic: C022-01 qua	alifies C022-02, C022-04, C022-05, C0)22-06	and C)22-08.
			с	ODE DEFI	INITION			
			ABJ		ernational Classification of Dise dification (ICD-10-CM) Admittin			
				Thi the use If a coc OR The set OR	is code set is not allowed for us e time of this writing. The qualified: new rule names the ICD-10-CM de set under HIPAA, e Secretary grants an exception as a pilot project as allowed ur	e und er ca as a to un nder t	der HIF n only n allow se the he law	PAA at be vable code
			BJ	Rev Inte Mo	ve source 897: International Classificat vision, Clinical Modification (ICD-10-Cl ernational Classification of Dise volification (ICD-9-CM) Admitting pe source 131: International Classificat	^{M)} ases Diag	Clinic nosis	al
REQUIRED	HI01 - 2		1271	Rev Industry Co	vision, Clinical Modification (ICD-9-CM) M	AN	1/30
				SEMANTIC: If C022-08 is range of code	s used, then C022-02 represents the b es.	eginni	ng value	e in a
				IMPLEMENTATIO	ION NAME: Admitting Diagnosis Co	de		
NOT USED	HI01 - 3		1250	Date Time	Period Format Qualifier	Х	ID	2/3
NOT USED	HI01 - 4		1251	Date Time	Period	Х	AN	1/35
NOT USED	HI01 - 5		782	Monetary A	Amount	0	R	1/18
NOT USED	HI01 - 6		380	Quantity		0	R	1/15
NOT USED	HI01 - 7		799	Version Ide	entifier	0	AN	1/30
NOT USED	HI01 - 8		1271	Industry Co	ode	Х	AN	1/30
NOT USED	HI01 - 9		1073	Yes/No Co	ndition or Response Code	Х	ID	1/1
NOT USED	HI02	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI03	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI04	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI05	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI06	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI07	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI08	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI09	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI10	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI11	C022	HEAL	TH CARE CO	DDE INFORMATION	01		
NOT USED	HI12	C022	HEAL	TH CARE CO	DDE INFORMATION	01		

SEGMENT DETAIL												
X12 Segment Na					A ;	SON FO	R	VISIT				
-					the	e delivery of h	nea	lth care				
•				ORMATION								
Segment Rep	eat: 1											
Usa	age: SITU	JATIONA	L									
Situational R	-			im involves lide, do not s		-	its.	. If not requi	ree	d by this		
TR3 No		Do not tr implied.	Do not transmit the decimal point for ICD codes. The decimal point is mplied.									
TR3 Exam	ple: HI*I	PR:78701	 ~									
TR3 Exam	ple: HI*/	APR:R11	0~									
DIAGRAM												
DIAGNAM												
	C022 Ith Care * de Info.	HI02 C Health Ca Code Inf O 1	X	HI03 C022 Health Care Code Info. O 1	*	HI04 C022 Health Care Code Info. O 1	*	HI05 C022 Health Care Code Info. O 1	*	HI06 C022 Health Care Code Info. O 1		
*	C022 I th Care le Info.	HI08 C Health Ca Code Inf O 1	*	HI09 C022 Health Care Code Info. O 1	*	HI10 C022 Health Care Code Info. O 1	*	HI11 C022 Health Care Code Info. O 1	*	HI12 C022 Health Care Code Info.		
ELEMENT DETAIL												
USAGE	REF.	DATA ELEMENT	NAME							ATTRIBUTES		
	HI01	C022	HEAL To sen SYNTAX P0304	nd health care co	ode	E INFORMATION	ciat	ed dates, amou		l and quantities		
			E0809			04 is present, the			irec	1.		

Only one of C02208 or C02209 may be present.

REQUIRED	HI01	- 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list			
					SEMANTIC:			
					C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.			
					ODE 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.			
		PR	CODE SOURCE 897: International Classification of Diseases Revision, Clinical Modification (ICD-10-CM) PR International Classification of Diseases Clinical Modification (ICD-9-CM) Patient's Reason for Vi					
					CODE SOURCE 131: International Classification of Diseases, 9th			
REQUIRED HI01 - 2		1271	Revision, Clinical Modification (ICD-9-CM) 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			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		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities			
				SYNTAX: P0304 If either E0809	: r C02203 or C02204 is present, then the other is required.			

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	М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05	, C022-06	3 and C	022-08
			с	DDE DEFINITION			
			APR	International Classification of D Modification (ICD-10-CM) Patier			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an except set as a pilot project as allowed OR For claims which are not covered	lifier ca CM as a ion to u under f	n only n allov se the the lav	be wable code v,	
		PR	CODE SOURCE 897: International Classif Revision, Clinical Modification (ICD-10 International Classification of D Modification (ICD-9-CM) Patient)-CM) iseases	Clinic	al	
REQUIRED HI02 - 2	2	1271	code source 131: International Classif Revision, Clinical Modification (ICD-9- Industry Code	CM) M	Diseas	ses, 9th 1/30	
		Code indicating a code from a specific industry SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.		ing valu	ie in a		
				IMPLEMENTATION NAME: Patient Reason For V	isit		
IOT USED	HI02 -	3	1250	Date Time Period Format Qualifier	х	ID	2/3
IOT USED	HI02 -	4	1251	Date Time Period	Х	AN	1/35
IOT USED	HI02 -	5	782	Monetary Amount	ο	R	1/18
OT USED	HI02 -	6	380	Quantity	ο	R	1/1
IOT USED	HI02 -	7	799	Version Identifier	ο	AN	1/30
IOT USED	HI02 -	B	1271	Industry Code	Х	AN	1/30
IOT USED	HI02 -	9	1073	Yes/No Condition or Response Code	х	ID	1/1
ITUATIONAL	HI03	C022		TH CARE CODE INFORMATION I health care codes and their associated dates, a	O 1 mounts a	ind qua	ntities
			E0809	C02203 or C02204 is present, then the other is e of C02208 or C02209 may be present.	required.		

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	12	70	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-04	S and C	022-08
				ODE DEFINITION	0022 00		022 00.
		AF	ĸ	International Classification of D Modification (ICD-10-CM) Patien			
				This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed	lifier ca CM as a on to u	n only n allow se the	be wable code
				OR			
		PR	2	For claims which are not covered code source 897: International Classif Revision, Clinical Modification (ICD-10 International Classification of D	ication of -CM) iseases	Diseas Clinic	ses, 10th al
				Modification (ICD-9-CM) Patient code source 131: International Classif			
REQUIRED HI03 - 2	12	71	Revision, Clinical Modification (ICD-9- Industry Code Code indicating a code from a specific industry	CM) M	AN	1/30	
				SEMANTIC:			
				If C022-08 is used, then C022-02 represents th range of codes.	•	ing valu	ie in a
NOT USED	HI03 - 3	12	50	If C022-08 is used, then C022-02 represents th range of codes.	•	ing valu ID	ie in a 2/3
	HI03 - 3 HI03 - 4	12 12		If C022-08 is used, then C022-02 represents th range of codes. IMPLEMENTATION NAME: Patient Reason For V	isit	-	2/3
NOT USED			51	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period	isit X	ID	2/3 1/35
NOT USED NOT USED	HI03 - 4	12	51 2	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount	isit X X	ID AN	2/3 1/35 1/18
NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5	12 78	51 2 0	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period	isit X X O	ID AN R	2/3 1/35 1/18 1/15
NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6	12 78 38 79	51 2 0	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity	isit X X O O	ID AN R R	2/3 1/35 1/18 1/15 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7	12 78 38 79 12	51 2 0 9 71	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier	isit X X O O O	ID AN R R AN	
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8	12 78 38 79 12 10	51 2 0 9 71 73	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code	isit X X O O O X	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9	12 78 38 79 12 10 C022 HE	51 2 9 71 73 EALT	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code	isit X X O O O X X X	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9 HI04	12 78 38 79 12 10 C022 HE C022 HE	251 20 99 71 73 EALT EALT	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code IH CARE CODE INFORMATION	isit X X 0 0 0 X X X 0 1	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9 HI04 HI05	12 78 38 79 12 10 C022 HE C022 HE C022 HE	51 2 9 71 73 EALT EALT	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code TH CARE CODE INFORMATION TH CARE CODE INFORMATION	isit X X 0 0 0 X X 0 1 01	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9 HI04 HI05 HI06	12 78 38 79 12 10 C022 HE C022 HE C022 HE C022 HE	51 2 0 9 71 73 EAL1 EAL1 EAL1 EAL1	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code TH CARE CODE INFORMATION TH CARE CODE INFORMATION	isit X X 0 0 0 X X X 01 01 01	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9 HI04 HI05 HI06 HI07	12 78 38 79 12 10 C022 HE C022 HE C022 HE C022 HE C022 HE	51 2 0 9 71 73 EAL1 EAL1 EAL1 EAL1	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code TH CARE CODE INFORMATION TH CARE CODE INFORMATION TH CARE CODE INFORMATION TH CARE CODE INFORMATION TH CARE CODE INFORMATION	isit X X 0 0 X X 01 01 01 01 01	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9 HI04 HI05 HI06 HI07 HI08	12 78 38 79 12 10 C022 HE C022 HE C022 HE C022 HE C022 HE C022 HE	51 2 0 9 71 73 EAL1 EAL1 EAL1 EAL1 EAL1	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code TH CARE CODE INFORMATION TH CARE CODE INFORMATION	isit X X 0 0 0 X X 0 1 0 1 0 1 0 1 0 1	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30
NOT USED NOT USED NOT USED NOT USED NOT USED	HI03 - 4 HI03 - 5 HI03 - 6 HI03 - 7 HI03 - 8 HI03 - 9 HI04 HI05 HI06 HI07 HI08 HI09	12 78 38 79 12 10 C022 HE C022 HE C022 HE C022 HE C022 HE C022 HE	51 2 0 9 71 73 EAL1 EAL1 EAL1 EAL1 EAL1 EAL1	If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Patient Reason For V Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity Version Identifier Industry Code Yes/No Condition or Response Code TH CARE CODE INFORMATION TH CARE CODE INFORMATION	isit X X 0 0 0 X X 01 01 01 01 01 01	ID AN R R AN AN	2/3 1/35 1/18 1/15 1/30 1/30

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	
HI01 C0 Health Car Code Info M 1	
HI07 C0 Health Car Code Info 0 1	
ELEMENT DETAIL	FE DATA
	EF. DATA ES. 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.

005010X223 • 837 EXTERNAL CAUS			ASC X12N • INSU TECHN	RANCE S		
REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code			
			This code set is not allowed for the time of this writing. The qual used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under t	in only in allow se the the law	be wable code /,
	BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) iseases	S Clinic	al	
			соре source 131: International Classifi Revision, Clinical Modification (ICD-9-0		f Diseas	es, 9th
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ury Cod	le	
NOT USED	HI01 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI01 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI01 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI01 - 6	380	Quantity	0	R	1/15
NOT USED	HI01 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI01 - 8	1271	Industry Code	х	AN	1/30

-										
SITUATIONAL	HI01 - 9		1073		No Condition or Response Code X ID 1/1 indicating a Yes or No condition or response					
				SYNTAX E0809						
				C022- diagno prior to NOT c unkno	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.					
				inform	NTS: 09 would only need to be reported to data collectors requiring this ation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.					
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing <i>Ial.</i>					
				IMPLEN	IENTATION NAME: Present on Admission Indicator					
			с	ODE	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.							
			must i to rep	be sen ort oth	E: Required when an additional External Cause of Injury t and the preceding HI data elements have been used er causes of injury. If not required by this ion guide, do not send.					

005010X223 • 837 EXTERNAL CAUS			ASC X12N • INSUF TECHN	RANCE S				
REQUIRED	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3		
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.		
		c	ODE DEFINITION					
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code					
			This code set is not allowed for the time of this writing. The qual used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed OR For claims which are not covere	he qualifier can only be CD-10-CM as an allowable exception to use the code llowed under the law,				
	BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10- International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) i seases	Clinic	al			
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th		
REQUIRED	HI02 - 2	1271	Industry Code Code indicating a code from a specific industry of	́ М	AN	1/30		
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	ie in a		
			IMPLEMENTATION NAME: External Cause of Inju	iry Cod	le			
NOT USED	HI02 - 3	1250	Date Time Period Format Qualifier	Х	ID	2/3		
NOT USED	HI02 - 4	1251	Date Time Period	Х	AN	1/35		
NOT USED	HI02 - 5	782	Monetary Amount	0	R	1/18		
NOT USED	HI02 - 6	380	Quantity	0	R	1/15		
NOT USED	HI02 - 7	799	Version Identifier	0	AN	1/30		
NOT USED	HI02 - 8	1271	Industry Code	Х	AN	1/30		

SITUATIONAL	HI02 - 9		1073	Voc/N	Io Condition or Response Code X ID	1/1
0.1.0.1.10.1.12	1102 - 9		1075		indicating a Yes or No condition or response	1/1
				SYNTAX E0809		
					ric : 09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occur o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it is wn whether the onset occurred prior to admission to the hosp	d is
				inform	NTS: 09 would only need to be reported to data collectors requiring ation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.	g this
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing Ial.	1
				IMPLEN	IENTATION NAME: Present on Admission Indicator	
			c	ODE	DEFINITION	
			Ν		Νο	
			U		Unknown	
			W		Not Applicable	
			Y		Yes	
SITUATIONAL	HI03	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantitie	es
			E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.	
			must i to rep	be sen ort oth	E: Required when an additional External Cause of In t and the preceding HI data elements have been us er causes of injury. If not required by this ion guide, do not send.	

005010X223 • 837 EXTERNAL CAUS			ASC X12N • INSU TECHN	RANCE S		
REQUIRED	HI03 - 1	1270	1270 Code List Qualifier Code Code identifying a specific industry code list			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code			
			This code set is not allowed for the time of this writing. The qual used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under t	n only n allow se the the law	be wable code /,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) i seases	Clinic	al
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th
REQUIRED	HI03 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ary Cod	le	
NOT USED	HI03 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI03 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI03 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI03 - 6	380	Quantity	0	R	1/15
NOT USED	HI03 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI03 - 8	1271	Industry Code	Х	AN	1/30

SITUATIONAL	HI03 - 9		1073			1/1
					indicating a Yes or No condition or response	
				SYNTAX E0809		
				diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occu o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it wn whether the onset occurred prior to admission to the hosp	d is
				inform	NTS: 09 would only need to be reported to data collectors requiring ation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.	g this
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing Ial.	1
				IMPLEN	IENTATION NAME: Present on Admission Indicator	
			с	ODE	DEFINITION	
			N		No	
			U		Unknown	
			w		Not Applicable	
			Y		Yes	
SITUATIONAL	HI04	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantiti	ies
			E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.	
			must i to rep	be sen ort oth	E: Required when an additional External Cause of I t and the preceding HI data elements have been us er causes of injury. If not required by this ion guide, do not send.	

EXTERNAL CAUS	● 2300 ● HI E OF INJURY		ASC X12N • INSU TECH	NICAL R		
REQUIRED	HI04 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05	, C022-06	6 and C	022-08
		c	ODE DEFINITION			
		ABN	International Classification of D Modification (ICD-10-CM) Extern Code			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR	llifier ca CM as a	in only in allow	be wable
			The Secretary grants an except set as a pilot project as allowed OR For claims which are not covere	under	the law	Ι,
		BN	CODE SOURCE 897: International Classif Revision, Clinical Modification (ICD-10 International Classification of D Modification (ICD-9-CM) Externa Code (E-codes))-CM) P iseases	Clinic	al
			CODE SOURCE 131: International Classif Revision, Clinical Modification (ICD-9-		f Diseas	es, 9th
REQUIRED	HI04 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents th range of codes.	ie beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inj	ury Cod	le	
NOT USED	HI04 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI04 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI04 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI04 - 6	380	Quantity	ο	R	1/15
NOT USED	HI04 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI04 - 8	1271	Industry Code	х	AN	1/30

SITUATIONAL	HI04 - 9		1073		Io Condition or Response CodeXIDindicating a Yes or No condition or response	1/1
				SYNTAX E0809		
			diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occ o admission to the hospital; an "N" indicates that the onset of occur prior to admission to the hospital; a "U" indicates that i wn whether the onset occurred prior to admission to the hos	urred lid t is	
				inform	NTS: 09 would only need to be reported to data collectors requirir ation when C022-01 is "BF" (Diagnosis Code) and range of usis codes were NOT given in C022-08.	ng this
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billin Ial.	g
				IMPLEN	IENTATION NAME: Present on Admission Indicator	
			с	ODE	DEFINITION	
			N		No	
			U		Unknown	
			W		Not Applicable	
			Y		Yes	
SITUATIONAL	HI05	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quanti	ities
			E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.	
			must i to rep	be sen ort oth	E: Required when an additional External Cause of t and the preceding HI data elements have been u er causes of injury. If not required by this ion guide, do not send.	

EXTERNAL CAUS	● 2300 ● HI E OF INJURY		ASC X12N • INSU TECH	NICAL R		
REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		C	ODE DEFINITION			
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under f	n only n allow se the the law	be wable code /,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) iseases	Clinic	al
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th
REQUIRED	HI05 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginni	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ury Cod	le	
NOT USED	HI05 - 3	1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI05 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI05 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI05 - 6	380	Quantity	0	R	1/15
NOT USED	HI05 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI05 - 8	1271	Industry Code	х	AN	1/30

SITUATIONAL	HI05 - 9)	1073		Io Condition or Response Code X ID 1/ indicating a Yes or No condition or response	/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.				
				inform	NTS: 09 would only need to be reported to data collectors requiring t ation when C022-01 is "BF" (Diagnosis Code) and range of usis codes were NOT given in C022-08.	this		
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing			
				IMPLEN	IENTATION NAME: Present on Admission Indicator			
			с	ODE	DEFINITION			
			N		No			
			U		Unknown			
			W		Not Applicable			
			Y		Yes			
SITUATIONAL	HI06	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantities	s		
		SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.						
			must i to rep	be sen ort oth	E: Required when an additional External Cause of Inj t and the preceding HI data elements have been use er causes of injury. If not required by this ion guide, do not send.			

005010X223 • 837 EXTERNAL CAUS			ASC X12N • INSUF TECHN	RANCE S			
REQUIRED	HI06 - 1	1270	1270 Code List Qualifier Code Code identifying a specific industry code list				
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.	
		c	ODE DEFINITION				
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code				
			This code set is not allowed for the time of this writing. The qual used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under t	n only n allow se the the law	be wable code v,	
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10- International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) i seases	Clinic	al	
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th	
REQUIRED	HI06 - 2	1271	Industry Code Code indicating a code from a specific industry of	́ М	AN	1/30	
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	ie in a	
			IMPLEMENTATION NAME: External Cause of Inju	iry Cod	le		
NOT USED	HI06 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3	
NOT USED	HI06 - 4	1251	Date Time Period	Х	AN	1/35	
NOT USED	HI06 - 5	782	Monetary Amount	0	R	1/18	
NOT USED	HI06 - 6	380	Quantity	0	R	1/15	
NOT USED	HI06 - 7	799	Version Identifier	0	AN	1/30	
NOT USED	HI06 - 8	1271	Industry Code	Х	AN	1/30	

SITUATIONAL	HI06 - 9		1073		No Condition or Response Code X ID 1/1 indicating a Yes or No condition or response			
				зүлта) E0809				
				diagno prior to NOT c	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occurred o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it is wn whether the onset occurred prior to admission to the hospital			
				inform	ENTS: 09 would only need to be reported to data collectors requiring this ation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.			
				SITUATI <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing <i>Ial.</i>			
				IMPLEM	IENTATION NAME: Present on Admission Indicator			
			c	ODE	DEFINITION			
			Ν		Νο			
			U		Unknown			
			W		Not Applicable			
			Y		Yes			
SITUATIONAL	HI07	C022			RE CODE INFORMATION O 1 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 must be sent and the preceding HI data elements have been to report other causes of injury. If not required by this implementation guide, do not send.						

005010X223 • 837 EXTERNAL CAUSE			ASC X12N • INSUF TECHN			MMITTEE • TYPE 3
REQUIRED	HI07 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code			
			This code set is not allowed for the time of this writing. The qual used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed OR For claims which are not covere	ifier ca CM as a on to u under t	in only in allow se the the law	be wable code v,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10- International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) seases	Clinic	al
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		f Diseas	ses, 9th
REQUIRED	HI07 - 2	1271	Industry Code Code indicating a code from a specific industry of	M	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	ie in a
			IMPLEMENTATION NAME: External Cause of Inju	iry Cod	le	
NOT USED	HI07 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI07 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI07 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI07 - 6	380	Quantity	0	R	1/15
NOT USED	HI07 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI07 - 8	1271	Industry Code	Х	AN	1/30

SITUATIONAL	HI07 - 9)	1073		Io Condition or Response Code X ID	1/1
				SYNTAX E0809		
				diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occur o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it i wn whether the onset occurred prior to admission to the hosp	d is
				inform	NTS: 09 would only need to be reported to data collectors requiring ation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.) this
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing ial.	1
				IMPLEN	IENTATION NAME: Present on Admission Indicator	
			с	ODE	DEFINITION	
			N		No	
			U		Unknown	
			W		Not Applicable	
			Y		Yes	
SITUATIONAL	HI08	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantitie	es
			E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.	
		must i to rep	be sen ort oth	E: Required when an additional External Cause of In t and the preceding HI data elements have been use er causes of injury. If not required by this ion guide, do not send.		

	E OF INJURY		ASC X12N • INSU TECH	NICAL R	EPORT	• TYPI
REQUIRED	HI08 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	Μ	ID	1/3
			земантіс: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		ABN	International Classification of D Modification (ICD-10-CM) Exterr Code			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under f	n only n allov se the the law	be wable code /,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of D Modification (ICD-9-CM) Externa Code (E-codes)	-CM) iseases	Clinic	al
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th
REQUIRED	HI08 - 2	1271	Industry Code Code indicating a code from a specific industry SEMANTIC:	M	AN	1/30
			If C022-08 is used, then C022-02 represents the range of codes.	e beginni	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ury Cod	e	
NOT USED	HI08 - 3	1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI08 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI08 - 5	782	Monetary Amount	0	R	1/18
	HI08 - 6	380	Quantity	0	R	1/15
NOT USED	HI08 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI08 - 8	1271	Industry Code	Х	AN	1/30

SITUATIONAL	HI08 - 9)	1073		Io Condition or Response Code X ID indicating a Yes or No condition or response	1/1
				SYNTAX E0809		
				diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occu o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it wn whether the onset occurred prior to admission to the hosp	d is
				inform	NTS: 09 would only need to be reported to data collectors requiring ation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.	g this
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing Ial.	7
				IMPLEN	IENTATION NAME: Present on Admission Indicator	
			с	ODE	DEFINITION	
			N		No	
			U		Unknown	
			W		Not Applicable	
			Y		Yes	
SITUATIONAL	HI09	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantiti	ies
		E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.		
		must i to rep	be sen ort oth	E: Required when an additional External Cause of I t and the preceding HI data elements have been us er causes of injury. If not required by this ion guide, do not send.		

EXTERNAL CAUS	Ø ● 2300 ● HI SE OF INJURY		ASC X12N • INSU TECH			
REQUIRED	HI09 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		C	ODE DEFINITION			
		ABN	International Classification of D Modification (ICD-10-CM) Exterr Code			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under t	n only n allow se the the law	be wable code /,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of D Modification (ICD-9-CM) Externa Code (E-codes)	-CM) iseases	Clinic	al
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th
REQUIRED	HI09 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ury Cod	le	
NOT USED	HI09 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI09 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI09 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI09 - 6	380	Quantity	0	R	1/15
NOT USED	HI09 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI09 - 8	1271	Industry Code	Х	AN	1/30

SITUATIONAL	HI09 - 9)	1073		No Condition or Response Code X ID 1/1 indicating a Yes or No condition or response
				SYNTAX E0809	
			diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occurred o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it is wn whether the onset occurred prior to admission to the hospital	
				inform	ENTS: 09 would only need to be reported to data collectors requiring this lation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing
				IMPLEN	IENTATION NAME: Present on Admission Indicator
		с	ODE	DEFINITION	
			N		No
			U		Unknown
			w		Not Applicable
			Y		Yes
SITUATIONAL	HI10	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantities
			E0809	C0220	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.
		must i to rep	be sen ort oth	E: Required when an additional External Cause of Injury t and the preceding HI data elements have been used er causes of injury. If not required by this ion guide, do not send.	

005010X223 • 837 EXTERNAL CAUS			ASC X12N • INSU TECHN	RANCE S		
REQUIRED	HI10 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		ABN	International Classification of Di Modification (ICD-10-CM) Extern Code			
			This code set is not allowed for the time of this writing. The qual used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under t	n only n allow se the the law	be wable code /,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of Di Modification (ICD-9-CM) Externa Code (E-codes)	-CM) i seases	Clinic	al
			CODE SOURCE 131: International Classifi Revision, Clinical Modification (ICD-9-0		Diseas	es, 9th
REQUIRED	HI10 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ary Cod	le	
NOT USED	HI10 - 3	1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI10 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI10 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI10 - 6	380	Quantity	0	R	1/15
NOT USED	HI10 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI10 - 8	1271	Industry Code	Х	AN	1/30

SITUATIONAL	HI10 - 9	9	1073		No Condition or Response Code X ID 1/1 indicating a Yes or No condition or response X ID 1/1
				SYNTAX E0809	
			diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occurred o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it is wn whether the onset occurred prior to admission to the hospital	
		inform	ENTS: 09 would only need to be reported to data collectors requiring this lation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.		
			SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing	
			IMPLEN	IENTATION NAME: Present on Admission Indicator	
	c	ODE	DEFINITION		
		N		Νο	
			U		Unknown
			W		Not Applicable
			Y		Yes
SITUATIONAL	HI11	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantities
			E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.
			must i to rep	E: Required when an additional External Cause of Injury t and the preceding HI data elements have been used er causes of injury. If not required by this ion guide, do not send.	

005010X223 • 837 • 2300 • HI EXTERNAL CAUSE OF INJURY			ASC X12N • INS TEC	URANCE HNICAL R		
REQUIRED	HI11 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC:			
			C022-01 qualifies C022-02, C022-04, C022-0)5, C022-00	b and C	022-08.
		C				
		ABN	International Classification of Modification (ICD-10-CM) Exte Code			
			This code set is not allowed for the time of this writing. The qu used:	ualifier ca	in only	be
			If a new rule names the ICD-10 code set under HIPAA, OR)-CM as a	in allov	wable
			The Secretary grants an exception set as a pilot project as allowed OR For claims which are not cover	ed under	the lav	Ι,
		BN	CODE SOURCE 897: International Clas Revision, Clinical Modification (ICD- International Classification of Modification (ICD-9-CM) Exter Code (E-codes)	10-CM) Diseases	s Clinic	al
			code source 131: International Clas		f Diseas	es, 9th
REQUIRED	HI11 - 2	1271	Revision, Clinical Modification (ICD- Industry Code Code indicating a code from a specific indust	M	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents range of codes.	the beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of I	njury Coc	le	
NOT USED	HI11 - 3	1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI11 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI11 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI11 - 6	380	Quantity	0	R	1/15
NOT USED	HI11 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI11 - 8	1271	Industry Code	х	AN	1/30

SITUATIONAL HI11 - 9		1073		No Condition or Response Code X ID 1/1 indicating a Yes or No condition or response X ID X	
				SYNTAX E0809	
			diagno prior to NOT o	09 is used to identify the diagnosis onset as it relates to the osis reported in C022-02. A "Y" indicates that the onset occurred o admission to the hospital; an "N" indicates that the onset did occur prior to admission to the hospital; a "U" indicates that it is wn whether the onset occurred prior to admission to the hospital	
			inform	ENTS: 09 would only need to be reported to data collectors requiring this lation when C022-01 is "BF" (Diagnosis Code) and range of osis codes were NOT given in C022-08.	
				SITUAT <i>manu</i>	IONAL RULE: Required as directed by the NUBC billing Jal.
			IMPLEN	IENTATION NAME: Present on Admission Indicator	
	c	ODE	DEFINITION		
		N		Νο	
			U		Unknown
			W		Not Applicable
			Y		Yes
SITUATIONAL	HI12	C022			RE CODE INFORMATION O 1 care codes and their associated dates, amounts and quantities
		E0809	r C02203	3 or C02204 is present, then the other is required. 2208 or C02209 may be present.	
			must i to rep	E: Required when an additional External Cause of Injury t and the preceding HI data elements have been used er causes of injury. If not required by this ion guide, do not send.	

005010X223 • 837 EXTERNAL CAUS			ASC X12N • INSU TECH	RANCE S		
REQUIRED	HI12 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		ABN	International Classification of D Modification (ICD-10-CM) Exterr Code			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-0 code set under HIPAA, OR The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	lifier ca CM as a on to u under t	in only in allow se the the law	be wable code /,
		BN	CODE SOURCE 897: International Classifi Revision, Clinical Modification (ICD-10 International Classification of D Modification (ICD-9-CM) Externa Code (E-codes)	-CM) iseases	Clinic	al
			code source 131: International Classifi Revision, Clinical Modification (ICD-9-0		f Diseas	es, 9th
REQUIRED	HI12 - 2	1271	Industry Code Code indicating a code from a specific industry	́ М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
			IMPLEMENTATION NAME: External Cause of Inju	ury Cod	le	
NOT USED	HI12 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI12 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI12 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI12 - 6	380	Quantity	ο	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	х	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
 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
Ν	No
U	Unknown
W	Not Applicable
Y	Yes

SEGMENT DETAIL												
		- DIAC FORM			EL	ATED C	GF	ROUP ([DF	RG)		
X12 Segment Nam	ne: Heal	th Care Ir	nforma	ation Codes								
X12 Purpos	se: To su	upply info	rmatic	on related to	the	e delivery of h	nea	alth care				
Loc	p: 2300	— CLAI	M INF									
Segment Repe	at: 1											
Usag	ge: SITU		L	-								
Situational Ru	and	quired when an inpatient hospital is under DRG contract with a payer d the contract requires the provider to identify the DRG to the payer. If t required by this implementation guide, do not send.										
TR3 Examp	le: HI*C	DR:123~										
DIAGRAM												
HI01 Health Code M 1 HI07 Health Code M 1 HI07 Health Code O 1 ELEMENT DETAIL	C022	Health Ca Code Info O 1	022 176 *	HI03 C022 Health Care Code Info. O 1 HI09 C022 Health Care Code Info. O 1	* *	HI04 C022 Health Care Gode Info. O 1 HI10 C022 Health Care Gode Info. O 1	* *	HI05 C022 Health Care Gode Info. O 1 HI11 C022 Health Care Gode Info. O 1	* *	HI06 C022 Health Care Gode Info. O 1 HI12 C022 Health Care Gode Info. O 1 ~		
REQUIRED H	101	C022	To sen SYNTAX P0304 If eithe E0809	nd health care co :: or C02203 or C0	ode	E INFORMATI as and their asso 04 is present, the 02209 may be p	cia en t	ted dates, amou		and quantities		
REQUIRED H	101 - 1		1270	Code identify SEMANTIC:	ring	alifier Code a specific indus es C022-02, C02			M 22-0	ID 1/3		
			0			ON						
			DR	Dia	gn	osis Related	Gro	oup (DRG)				

CODE SOURCE 229: Diagnosis Related Group Number (DRG)

REQUIRED	HI01 - 2		1271	Industry Code	м	AN	1/30
	11101 - 2		1271	Code indicating a code from a specific industry of			1/50
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginni	ing valu	e in a
				IMPLEMENTATION NAME: Diagnosis Related Gro	oup (DF	RG) Co	ode
NOT USED	HI01 - 3		1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI01 - 4		1251	Date Time Period	Х	AN	1/35
NOT USED	HI01 - 5		782	Monetary Amount	0	R	1/18
NOT USED	HI01 - 6		380	Quantity	0	R	1/15
NOT USED	HI01 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI01 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI01 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
NOT USED	HI02	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI03	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI04	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI05	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI06	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI07	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI08	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI09	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI10	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI11	C022	HEAL	TH CARE CODE INFORMATION	01		
NOT USED	HI12	C022	HEAL	TH CARE CODE INFORMATION	01		

SEGMENT DETAIL											
	HI - OT	HER DIAGN	OSIS INFORMA	TION							
X12 Segment Nar	ne: Health Care	e Information Codes									
X12 Purpo	se: To supply in	nformation related to	the delivery of health care								
Lo	op: 2300 — CL	AIM INFORMATION	l								
Segment Repe	eat: 2										
Usa	ge: SITUATIO	NAL									
Situational Ru	during the	equired when other condition(s) coexist or develop(s) subsequently uring the patient's treatment. If not required by this implementation uide, do not send.									
TR3 Not		. Do not transmit the decimal point for ICD codes. The decimal point is implied.									
TR3 Examp	ole: HI*BF:482	1:::::N*HI*BF:250	000:::::Y~								
TR3 Examp	ole: HI*ABF:J1	51::::::N*ABF:E11	9:::::Y~								
DIAGRAM											
HIO7	C022 h Care h Info. * Hi02 Health Code O 1 C022 Hi08	Info. * Code Info. 0 1 0 0 C022 HI09 C022	* Health Care Code Info. 0 1 * Health Code Info. Code Info. 0 1 HI10 C022 HI11	* Code Info. 0 1 C022 HI12 C022							
×	h Care * Health e Info. Code	×	* Health Care Code Info. Code Info.	*							
O 1	O 1	O 1	01 01	O 1							
ELEMENT DETAIL											
USAGE	REF. DATA DES. ELEME	NT NAME		ATTRIBUTES							
REQUIRED	ll01 C022		DDE INFORMATION	M 1							
		SYNTAX: P0304 If either C02203 or C0 E0809	odes and their associated dates, 02204 is present, then the other is or C02209 may be present.	·							

REQUIRED	HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3	
			SEMANTIC:				
			C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.	
		C	CODE DEFINITION				
		ABF	ABF International Classification of Diseases C Modification (ICD-10-CM) Diagnosis				
			This code set is not allowed for u the time of this writing. The qual used: If a new rule names the ICD-10-C code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed to OR For claims which are not covered	ifier ca M as a on to u under t	in only in allow se the the law	v be wable code v,	
		BF	CODE SOURCE 897: International Classific Revision, Clinical Modification (ICD-10- International Classification of Dis Modification (ICD-9-CM) Diagnos	CM) seases			
			CODE SOURCE 131: International Classific		f Diseas	ses, 9th	
REQUIRED	HI01 - 2	1271	Revision, Clinical Modification (ICD-9-C Industry Code Code indicating a code from a specific industry c	́ М	AN	1/30	
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginn	ing valu	ie in a	
			IMPLEMENTATION NAME: Other Diagnosis				
NOT USED	HI01 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3	
NOT USED	HI01 - 4	1251	Date Time Period	х	AN	1/35	
NOT USED	HI01 - 5	782	Monetary Amount	ο	R	1/18	
NOT USED	HI01 - 6	380	Quantity	ο	R	1/15	
NOT USED	HI01 - 7	799	Version Identifier	ο	AN	1/30	
NOT USED	HI01 - 8	1271	Industry Code	Х	AN	1/30	
SITUATIONAL	HI01 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or respon	X se	ID	1/1	
			syntax: E0809				
			SEMANTIC:				

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
			C	CODE DEFINITION
			Ν	Νο
			U	Unknown
			W	Not Applicable
			Y	Yes
SITUATIONAL	HI02	C022		TH CARE CODE INFORMATION O 1 and health care codes and their associated dates, amounts and quantities
			E0809	er C02203 or C02204 is present, then the other is required.
			diagn report	IONAL RULE: Required when it is necessary to report an additional nosis and the preceding HI data elements have been used to "t other diagnoses. If not required by this implementation e, do not send.
REQUIRED	HI02 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			C	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
			BF	Revision, Clinical Modification (ICD-10-CM) 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
	пі02 - 0		300	Quantity U K 1/15

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

NOT USED	HI02 - 7		799	Versio	n Identifier	ο	AN	1/30
NOT USED	HI02 - 8		1271	Industr	y Code	х	AN	1/30
SITUATIONAL	HI02 - 9		1073		Condition or Response Code dicating a Yes or No condition or response	X	ID	1/1
				SYNTAX: E0809				
				diagnosi prior to a NOT occ	: 9 is used to identify the diagnosis onset as it is reported in C022-02. A "Y" indicates that admission to the hospital; an "N" indicates to cur prior to admission to the hospital; a "U" in whether the onset occurred prior to admission	t the (hat th indica	onset oc ne onset ates that	ccurred t did t it is
				informat	rs: 9 would only need to be reported to data co ion when C022-01 is "BF" (Diagnosis Code is codes were NOT given in C022-08.			
				SITUATION <i>manua</i>	NAL RULE: Required as directed by the I.	NU	BC billi	ing
					NTATION NAME: Present on Admission Ir	ndica	ator	
			C	ODE	DEFINITION			
			N		No			
			U		Unknown			
			w		Not Applicable			
			Y		Yes			
SITUATIONAL	HI03	C022			E CODE INFORMATION are codes and their associated dates, amou	O 1 unts a	and quar	ntities
		SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.						
			SITUATIO	NAL RULE:	Required when it is necessary to re	port	an add	ditional

guide, do not send.

005010X223 • 837 • 2 OTHER DIAGNOSIS I		N	ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3						
REQUIRED	HI03 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C0)22-0(6 and C	022-08.			
		C	ODE DEFINITION						
		ABF	International Classification of Dise Modification (ICD-10-CM) Diagnosi		S Clinic	al			
			used: If a new rule names the ICD-10-CM code set under HIPAA, OR The Secretary grants an exception	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 For claims which are not covered						
		BF	CODE SOURCE 897: International Classificat Revision, Clinical Modification (ICD-10-Cl International Classification of Dise	ation of Diseases, 10th CM) eases Clinical					
			Modification (ICD-9-CM) Diagnosis code source 131: International Classificat		f Diseas	es, 9th			
REQUIRED	HI03 - 2	1271	Revision, Clinical Modification (ICD-9-CM Industry Code Code indicating a code from a specific industry code) M	AN	1/30			
			SEMANTIC: If C022-08 is used, then C022-02 represents the b range of codes.			e in a			
			IMPLEMENTATION NAME: Other Diagnosis						
NOT USED	HI03 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3			
NOT USED	HI03 - 4	1251	Date Time Period	Х	AN	1/35			
NOT USED	HI03 - 5	782	Monetary Amount	0	R	1/18			
NOT USED	HI03 - 6	380	Quantity	0	R	1/15			
NOT USED	HI03 - 7	799	Version Identifier	0	AN	1/30			
NOT USED	HI03 - 8	1271	Industry Code	Х	AN	1/30			
SITUATIONAL	HI03 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	X	ID	1/1			
			syntax: E0809						
			SEMANTIC: C022-09 is used to identify the diagnosis onset as diagnosis reported in C022-02. A "Y" indicates tha prior to admission to the hospital; an "N" indicates NOT occur prior to admission to the hospital; a "U" unknown whether the onset occurred prior to admi or not.	t the o that th indica	onset o ne onse ates tha	ccurred t did t it is			

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							
			с	CODE DEFINITION							
			Ν	No							
			U	Unknown							
			w	Not Applicable							
			Y	Yes							
SITUATIONAL	HI04	C022		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities							
			E0809	: r C02203 or C02204 is present, then the other is required. ne of C02208 or C02209 may be present.							
			diagno report	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 CodeMID1/3Code identifying a specific industry code list							
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.							
			C	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							
			BF	Revision, Clinical Modification (ICD-10-CM) 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	Versio	on Identifier	ο	AN	1/30		
NOT USED	HI04 -	8	1271	Indus	try Code	Х	AN	1/30		
SITUATIONAL	HI04 -	9	1073		o Condition or Response Code ndicating 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.						
				informa	vrs : 19 would only need to be reported to data co ttion when C022-01 is "BF" (Diagnosis Code sis codes were NOT given in C022-08.					
			SITUATIO <i>manu</i> a	DNAL RULE: Required as directed by the al.	NUE	BC billi	ing			
				IMPLEM	ENTATION NAME: Present on Admission Ir	ndica	tor			
			C	ODE	DEFINITION					
			N		No					
			U		Unknown					
			W		Not Applicable					
			Y		Yes					
SITUATIONAL	HI05	C022			E CODE INFORMATION care codes and their associated dates, amou	O 1 unts a	and quar	ntities		
			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 when it is necessary to re the preceding HI data elements hav					

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 Code identifying a specific industry code list	М	ID	1/3			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.						
		с	ODE DEFINITION						
		ABF	International Classification of Dise Modification (ICD-10-CM) Diagnosi		Clinic	al			
		BF	This code set is not allowed for use the time of this writing. The qualifie used: If a new rule names the ICD-10-CM code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed un OR For claims which are not covered u code source 897: International Classificat Revision, Clinical Modification (ICD-10-CM International Classification of Dise Modification (ICD-0, CM) Diagnocia	to u der f unde ion of (1) ases	n only n allov se the the law r HIPA	v be wable code v, A. ses, 10th			
REQUIRED	EQUIRED HI05 - 2	1271	Modification (ICD-9-CM) Diagnosis code source 131: International Classificati Revision, Clinical Modification (ICD-9-CM) Industry Code Code indicating a code from a specific industry cod	ion of) M	Diseas	ses, 9th 1/30			
			SEMANTIC: If C022-08 is used, then C022-02 represents the be range of codes.		ing valu	ie in a			
			IMPLEMENTATION NAME: Other Diagnosis						
NOT USED	HI05 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3			
NOT USED	HI05 - 4	1251	Date Time Period	Х	AN	1/35			
NOT USED	HI05 - 5	782	Monetary Amount	0	R	1/18			
NOT USED	HI05 - 6	380	Quantity	0	R	1/15			
NOT USED	HI05 - 7	799	Version Identifier	0	AN	1/30			
NOT USED	HI05 - 8	1271	Industry Code	Х	AN	1/30			
SITUATIONAL	HI05 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	Х	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								
			c	ODE DEFINITION								
			Ν	No								
			U	Unknown								
			w	Not Applicable								
			Y	Yes								
SITUATIONAL	HI06	C022		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities								
			E0809	r C02203 or C02204 is present, then the other is required. ne of C02208 or C02209 may be present.								
			diagno report	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 CodeMID1/3Code identifying a specific industry code list								
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.								
			с	ODE 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.								
			BF	CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) International Classification of Diseases Clinical Modification (ICD-9-CM) Diagnosis								
				CODE SOURCE 131: International Classification of Diseases, 9th								
REQUIRED	HI06 - 2		1271	Revision, Clinical Modification (ICD-9-CM)Industry CodeMAN1/30Code 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.								
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			-									
NOT USED	HI06 - 5		782									
NOT USED	HI06 - 6		380	Quantity O R 1/15								

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

NOT USED	HI06 -	7	799	Version	Identifier	ο	AN	1/30			
NOT USED	HI06 - 3	3	1271	Industry	y Code	х	AN	1/30			
SITUATIONAL	HI06 - 9	Э	1073		Condition or Response Code icating a Yes or No condition or response	X	ID	1/1			
				SYNTAX: E0809							
				diagnosis prior to a NOT occ	is used to identify the diagnosis onset as is reported in C022-02. A "Y" indicates that dmission to the hospital; an "N" indicates t ur prior to admission to the hospital; a "U" whether the onset occurred prior to admis	t the hat th indic	onset oc ne onset ates tha	ccurred t did t it is			
				informatio	s: would only need to be reported to data co on when C022-01 is "BF" (Diagnosis Code s codes were NOT given in C022-08.						
				SITUATION	AL RULE: Required as directed by the	NU	BC billi	'ng			
				IMPLEMENTATION NAME: Present on Admission Indicator							
			C	ODE	DEFINITION						
				 N No							
			Ν		No						
			N U		No Unknown						
			U		Unknown						
SITUATIONAL	HI07	C022	U W Y HEAL1	TH CARE	Unknown Not Applicable Yes	O 1 unts a	and quar	ntities			
SITUATIONAL	HI07	C022	U W Y HEALT To send SYNTAX: P0304 If either E0809	TH CARE d health car	Unknown Not Applicable Yes CODE INFORMATION	unts a	and quar	ntities			

report other diagnoses. If not required by this implementation guide, do not send.

005010X223 • 837 • 2300 • HI OTHER DIAGNOSIS INFORMATION			ASC X12N • INSURAI TECHNIC			
REQUIRED	HI07 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C0	22-0	6 and C	022-08.
		c				
		ABF	International Classification of Dise Modification (ICD-10-CM) Diagnosi		s Clinic	al
			This code set is not allowed for us the time of this writing. The qualifie used: If a new rule names the ICD-10-CM code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed un OR For claims which are not covered u	as a to u der	in only in allow ise the the law	be wable code /,
		BF	CODE SOURCE 897: International Classificat Revision, Clinical Modification (ICD-10-CM International Classification of Dise Modification (ICD-9-CM) Diagnosis	/I) ases		
REQUIRED HI07 - 2		1271	CODE SOURCE 131: International Classificat Revision, Clinical Modification (ICD-9-CM Industry Code Code indicating a code from a specific industry cod SEMANTIC: If C022-08 is used, then C022-02 represents the be range of codes.) M le list	AN	1/30
			IMPLEMENTATION NAME: Other Diagnosis			
NOT USED	HI07 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI07 - 4	1251	Date Time Period	X	AN	1/35
NOT USED	HI07 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI07 - 6	380	Quantity	ο	R	1/15
NOT USED	HI07 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI07 - 8	1271	Industry Code	х	AN	1/30
SITUATIONAL	HI07 - 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 diagnosis reported in C022-02. A "Y" indicates tha prior to admission to the hospital; an "N" indicates t NOT occur prior to admission to the hospital; a "U"	t the hat tl	onset oo he onse	ccurred t 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:

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
			c	CODE DEFINITION
			Ν	No
			U	Unknown
			W	Not Applicable
			Y	Yes
SITUATIONAL	HI08	C022		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities
			E0809	: r C02203 or C02204 is present, then the other is required. ne of C02208 or C02209 may be present.
			diagn report	DNAL RULE: Required when it is necessary to report an additional osis and the preceding HI data elements have been used to t other diagnoses. If not required by this implementation , do not send.
REQUIRED	HI08 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list
				земантіс: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			c	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.
			BF	CODE SOURCE 897: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) 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
	11100 - 0			

NOT USED	HI08	- 7	799	Versio	on Identifier	ο	AN	1/30
NOT USED	HI08	- 8	1271	Indust	ry Code	х	AN	1/30
SITUATIONAL	HI08	- 9	1073		o Condition or Response Code ndicating 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 hospita or not.					
		informa	ιτs : 9 would only need to be reported to data co tion when C022-01 is "BF" (Diagnosis Code sis codes were NOT given in C022-08.					
				SITUATIO manua	DNAL RULE: Required as directed by the al.	NU	BC billi	ing
				IMPLEME	ENTATION NAME: Present on Admission Ir	ndica	ator	
			C	ODE	DEFINITION			
			Ν		No			
			U		Unknown			
			W		Not Applicable			
			Y		Yes			

005010X223 • 837 • 2300 • HI OTHER DIAGNOSIS INFORMATION

SITUATIONAL HI09

09

C022

HEALTH CARE CODE INFORMATION 01

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

SYNTAX:

P0304

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

E0809

Only one of C02208 or C02209 may be present.

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

REQUIRED	HI09 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C0	22-06	and C	022-08.
		с	ODE DEFINITION			
			International Classification of Disea Modification (ICD-10-CM) Diagnosis		Clinic	al
			This code set is not allowed for use the time of this writing. The qualifie used: If a new rule names the ICD-10-CM code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed un OR For claims which are not covered u	er ca as a to us der t inde	n only n allow se the he law r HIPA	be wable code v, A.
	BF	CODE SOURCE 897: International Classificati Revision, Clinical Modification (ICD-10-CM International Classification of Dise Modification (ICD-9-CM) Diagnosis	1)		,	
			CODE SOURCE 131: International Classificati Revision, Clinical Modification (ICD-9-CM)		Diseas	es, 9th
REQUIRED	HI09 - 2	1271	Industry Code Code indicating a code from a specific industry cod	M e list	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the be range of codes.	eginni	ng valu	ie in a
			IMPLEMENTATION NAME: Other Diagnosis			
NOT USED	HI09 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI09 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI09 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI09 - 6	380	Quantity	0	R	1/15
NOT USED	HI09 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI09 - 8	1271	Industry Code	Х	AN	1/30
SITUATIONAL	HI09 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	Х	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	
			с	DE DEFINITION	
			N	No	
			U	Unknown	
			W	Not Applicable	
			Y	Yes	
SITUATIONAL	HI10	C022	HEAL	H CARE CODE INFORMATION O 1 health care codes and their associated dates, amounts and quant	tities
			E0809	C02203 or C02204 is present, then the other is required. a of C02208 or C02209 may be present.	
			diagno report	NAL RULE: Required when it is necessary to report an add sis and the preceding HI data elements have been used other diagnoses. If not required by this implementation do not send.	d to
REQUIRED	HI10 - 1		1270	Code List Qualifier CodeMIDCode identifying a specific industry code list	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C02	22-08.
			с	DE DEFINITION	
			ABF	International Classification of Diseases Clinica Modification (ICD-10-CM) Diagnosis	l
				This code set is not allowed for use under HIP, the time of this writing. The qualifier can only b used:	
				If a new rule names the ICD-10-CM as an allow code set under HIPAA, OR	able
				The Secretary grants an exception to use the c set as a pilot project as allowed under the law, OR	
				For claims which are not covered under HIPAA	۱.
			BF	CODE SOURCE 897: International Classification of Disease Revision, Clinical Modification (ICD-10-CM) International Classification of Diseases Clinica Modification (ICD-9-CM) Diagnosis	
				code source 131: International Classification of Disease	s, 9th
REQUIRED	HI10 - 2		1271	Revision, Clinical Modification (ICD-9-CM) Industry Code M AN Code indicating a code from a specific industry code list	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value range of codes.	in a
				IMPLEMENTATION NAME: Other Diagnosis	
NOT USED	HI10 - 3		1250	Date Time Period Format Qualifier X ID	2/3
NOT USED	HI10 - 4		1250	Date Time Period X AN	1/35
NOT USED	-		-		
NOT USED	HI10 - 5		782	Monetary Amount O R	1/18
NOT USED	HI10 - 6		380	Quantity O R	1/15

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

NOT USED	HI10 - 7	,	799	Versio	n Identifier	ο	AN	1/30
NOT USED	HI10 - 8	3	1271	Indust	ry Code	х	AN	1/30
SITUATIONAL	HI10 - 9)	1073		Condition or Response Code dicating a Yes or No condition or response	X	ID	1/1
				syntax: E0809				
				diagnos prior to NOT oc	c : 9 is used to identify the diagnosis onset as sis reported in C022-02. A "Y" indicates tha admission to the hospital; an "N" indicates t cur prior to admission to the hospital; a "U" in whether the onset occurred prior to admis	t the that tl indic	onset or ne onse ates tha	ccurred t did it it is
				informa	τ s : 9 would only need to be reported to data co tion when C022-01 is "BF" (Diagnosis Code is codes were NOT given in C022-08.			
				SITUATIO manua	NAL RULE: Required as directed by the	NU	BC bill	ing
				manac				
					NTATION NAME: Present on Admission Ir	ndica	ator	
			C			ndica	ator	
			c	IMPLEME	NTATION NAME: Present on Admission Ir	ndica	ator	
				IMPLEME	NTATION NAME: Present on Admission Ir	ndica	ator	
			N	IMPLEME	NTATION NAME: Present on Admission Ir DEFINITION No	ndica	ator	
			N U	IMPLEME	NTATION NAME: Present on Admission Ir DEFINITION No Unknown	ndica	ator	
SITUATIONAL	HI11	C022	N U W Y HEAL1		NTATION NAME: Present on Admission Ir - DEFINITION No Unknown Not Applicable	01		ntities
SITUATIONAL	HI11	C022	N U W Y HEALT To send SYNTAX: P0304 If either E0809	IMPLEME ODE TH CAR d health c C02203	NTATION NAME: Present on Admission Ir DEFINITION No Unknown Not Applicable Yes E CODE INFORMATION	O 1 unts a	and qua	ntities

report other diagnoses. If not required by this implementation guide, do not send.

005010X223 • 837 • OTHER DIAGNOSIS			ASC X12N • INSURA TECHNIC			• TYPE 3		
REQUIRED	HI11 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3		
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C0)22-0(6 and C	022-08.		
		с	ODE DEFINITION					
		ABF	ABF International Classification of Diseases C Modification (ICD-10-CM) Diagnosis					
		This code set is not allowed for us the time of this writing. The qualifi- used: If a new rule names the ICD-10-CM code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed un OR	er ca as a to u	in only in allow se the	be wable code			
			For claims which are not covered					
	BF	CODE SOURCE 897: International Classificat Revision, Clinical Modification (ICD-10-Cl International Classification of Dise Modification (ICD-9-CM) Diagnosis	۸) ases					
REQUIRED HI11 - 2	1271	code source 131: International Classificat Revision, Clinical Modification (ICD-9-CM Industry Code Code indicating a code from a specific industry code) M	AN	ses, 9th 1/30			
		SEMANTIC: If C022-08 is used, then C022-02 represents the b range of codes.			e in a			
			IMPLEMENTATION NAME: Other Diagnosis					
NOT USED	HI11 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3		
NOT USED	HI11 - 4	1251	Date Time Period	х	AN	1/35		
NOT USED	HI11 - 5	782	Monetary Amount	ο	R	1/18		
NOT USED	HI11 - 6	380	Quantity	ο	R	1/15		
NOT USED	HI11 - 7	799	Version Identifier	ο	AN	1/30		
NOT USED	HI11 - 8	1271	Industry Code	х	AN	1/30		
SITUATIONAL	HI11 - 9	1073	Yes/No Condition or Response Code Code indicating a Yes or No condition or response	Х	ID	1/1		
			SYNTAX: E0809					
			SEMANTIC: C022-09 is used to identify the diagnosis onset as diagnosis reported in C022-02. A "Y" indicates tha prior to admission to the hospital; an "N" indicates in NOT occur prior to admission to the hospital; a "U" unknown whether the onset occurred prior to admis or not.	t the that th indic	onset oo ne onse ates tha	ccurred t did t it is		

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
			c	CODE DEFINITION
			Ν	Νο
			U	Unknown
			W	Not Applicable
			Y	Yes
SITUATIONAL	HI12	C022		TH CARE CODE INFORMATION O 1 ad health care codes and their associated dates, amounts and quantities
			E0809	or C02203 or C02204 is present, then the other is required.
			diagn report	NONAL RULE: Required when it is necessary to report an additional nosis and the preceding HI data elements have been used to to to ther diagnoses. If not required by this implementation e, do not send.
REQUIRED	HI12 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			C	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
			BF	Revision, Clinical Modification (ICD-10-CM) 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
NOT USED	HI12 - 8
SITUATIONAL	HI12 - 9

799	Version Identifier	0	AN	1/30
1271	Industry Code	Х	AN	1/30
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
Ν		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. 1. Do not transmit the decimal point for ICD codes. The decimal point is TR3 Notes: implied. TR3 Example: HI*BR:3121:D8:20051119~ TR3 Example: HI*BBR:0B110F5:D8:20050321~ DIAGRAM HI01 C022 HI02 C022 HI03 C022 HI04 C022 HI05 C022 HI06 C022 **Health Care Health Care Health Care Health Care Health Care Health Care** * * * * **HI** * * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info. 01 O 1 01 O 1 01 M 1 HI07 C022 HI08 C022 HI09 C022 HI10 C022 HI11 C022 HI12 C022 **Health Care Health Care Health Care Health Care Health Care Health Care** * * * * * * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info. 01 01 01 01 01 01 ELEMENT DETAIL REF. DATA ELEMENT USAGE 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.

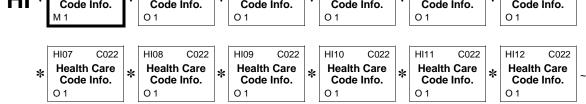
E0809

Only one of C02208 or C02209 may be present.

005010X223 • 837 • 2300 • HI PRINCIPAL PROCEDURE INFORMATION	N	ASC X12N • INSU TECH			MMITTER
REQUIRED HI01 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
		SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
	с	ODE DEFINITION			
	BBR	International Classification of D Modification (ICD-10-PCS) Princ Codes			
		This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10-F code set under HIPAA, OR	lifier ca	n only	be
		The Secretary grants an excepti set as a pilot project as allowed OR For claims which are not covere	under	the law	Ι,
	BR	CODE SOURCE 896: International Classifi Revision, Procedure Coding System (I International Classification of D Modification (ICD-9-CM) Princip	CD-10-P iseases	CS) Clinic	al
	САН	code source 131: International Classifi Revision, Clinical Modification (ICD-9-0 Advanced Billing Concepts (AB	CM)		es, 9th
REQUIRED HI01 - 2	1271	CODE SOURCE 843: Advanced Billing Co Industry Code Code indicating a code from a specific industry	́М`	ABC) Co AN	odes 1/30
		SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
		IMPLEMENTATION NAME: Principal Procedure C	Code		
REQUIRED HI01 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 ormat
		syntax: P0304			
		SEMANTIC:	000.04		
	с	C022-03 is the date format that will appear in C ODE DEFINITION	022-04.		
	D8	Date Expressed in Format CCY	MMDD)	
REQUIRED HI01 - 4	1251	Date Time Period Expression of a date, a time, or range of dates,	Х	AN	1/35 nd times
		syntax: P0304			
		IMPLEMENTATION NAME: Principal Procedure I	Date		
NOT USED HI01 - 5	782	Monetary Amount	ο	R	1/18
NOT USED HI01 - 6	380	Quantity	0	R	1/15
NOT USED HI01 - 7	799	Version Identifier	ο	AN	1/30
NOT USED HI01 - 8	1271	Industry Code	х	AN	1/30
NOT USED HI01 - 9	1073	Yes/No Condition or Response Code	х		

NOT USED	HI02	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI03	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI04	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI05	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI06	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI07	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI08	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI09	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI10	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI11	C022	HEALTH CARE CODE INFORMATION	01
NOT USED	HI12	C022	HEALTH CARE CODE INFORMATION	01

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 HI01 C022 HI02 C022 HI03 C022 HI04 C022 HI05 C022 HI06 C022 **Health Care Health Care Health Care** Health Care **Health Care Health Care** * * * * **HI** * * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info.



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	uirod	
			If either C02203 or C02204 is present, then the other is req E0809	ulled.	

Only one of C02208 or C02209 may be present.

REQUIRED	HI01 - 1	1270	Code List Qualifier Code	М	ID	1/3		
			Code identifying a specific industry code list					
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05	, C022-06	6 and C	022-08.		
		C						
		BBQ	International Classification of E Modification (ICD-10-PCS) Othe					
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10- code set under HIPAA, OR The Secretary grants an except set as a pilot project as allowed	alifier ca PCS as ion to u	n only an allo se the	v be owable code		
			OR For claims which are not cover	ed unde	r HIPA	A.		
		BQ	CODE SOURCE 896: International Classi Revision, Procedure Coding System (International Classification of E Modification (ICD-9-CM) Other	ICD-10-P Diseases	CS) Clinic	cal		
			CODE SOURCE 131: International Classi Revision, Clinical Modification (ICD-9-		Diseas	ses, 9th		
REQUIRED HI01 - 2	1271	Industry Code Code indicating a code from a specific industry	M	AN	1/30			
		SEMANTIC: If C022-08 is used, then C022-02 represents th range of codes.	ne beginn	ing valu	ie in a			
			IMPLEMENTATION NAME: Procedure Code					
REQUIRED	HI01 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, o	X r date and	ID d time fo	2/3 ormat		
			SYNTAX: P0304					
			SEMANTIC: C022-03 is the date format that will appear in C	022-04.				
		C	ODE DEFINITION	DEFINITION				
		D8	Date Expressed in Format CCY	YMMDD	1			
REQUIRED	HI01 - 4	1251	Date Time Period Expression of a date, a time, or range of dates	X , times or	AN dates a	1/35 and times		
			syntax: P0304					
			IMPLEMENTATION NAME: Procedure Date					
NOT USED	HI01 - 5	782	Monetary Amount	ο	R	1/18		
NOT USED	HI01 - 6	380	Quantity	0	R	1/15		
NOT USED	HI01 - 7	799	Version Identifier	0	AN	1/30		
NOT USED	HI01 - 8	1271	Industry Code	Х	AN	1/30		
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	х	ID	1/1		

SITUATIONAL	HI02	C022			CODE INFORMATION O 1 re codes and their associated dates, amounts and quantities
			E0809	or C02204 is present, then the other is required. 08 or C02209 may be present.	
			proce report	dure and	Required when it is necessary to report an additional the preceding HI data elements have been used to ocedures. If not required by this implementation send.
REQUIRED	HI02 - 1		1270		ist Qualifier Code M ID 1/3 entifying a specific industry code list
				semantic C022-01	:: qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			C	ODE	DEFINITION
			BBQ		International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes
					This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used:
					If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR
					The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
			BQ		code source 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes
					CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
REQUIRED	HI02 - 2		1271	Industr Code ind	
				SEMANTIC If C022-0 range of	08 is used, then C022-02 represents the beginning value in a
				IMPLEMEN	ITATION NAME: Procedure Code
REQUIRED	HI02 - 3		1250		me Period Format Qualifier X ID 2/3 licating the date format, time format, or date and time format
				syntax : P0304	
				SEMANTIC C022-03	e is the date format that will appear in C022-04.
			C	ODE	DEFINITION
			D8		Date Expressed in Format CCYYMMDD

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE		005010) OTHER PROCE			2300 • HI RMATION
REQUIRED	HI02 - 4		1251	Date Time Period Expression of a date, a time, or range of dates, tim	X es or	AN dates a	1/35 nd times
				syntax: P0304			
				IMPLEMENTATION NAME: Procedure Date			
NOT USED	HI02 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI02 - 6		380	Quantity	ο	R	1/15
NOT USED	HI02 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI02 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI02 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI03	C022		TH CARE CODE INFORMATION I health care codes and their associated dates, amount	O 1 unts a	nd quai	ntities
			E0809 Only on situatio proceed report	C02203 or C02204 is present, then the other is require of C02208 or C02209 may be present. NAL RULE: <i>Required when it is necessary to redure and the preceding HI data elements ha other procedures. If not required by this im</i>	port ve be	en us	ed to
			guide,	do not send.			
REQUIRED	HI03 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	Μ	ID	1/3
			_	SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, CC	22-06	and C	022-08.
						0	
			BBQ	International Classification of Dise Modification (ICD-10-PCS) Other P			
				This code set is not allowed for us the time of this writing. The qualific used: If a new rule names the ICD-10-PC code set under HIPAA, OR The Secretary grants an exception set as a pilot project as allowed un OR For claims which are not covered u	er ca S as to u ider f	n only an allo se the he law	be wable code
			BQ	CODE SOURCE 896: International Classificat Revision, Procedure Coding System (ICD International Classification of Dise Modification (ICD-9-CM) Other Pro- CODE SOURCE 131: International Classificat Revision, Clinical Modification (ICD-9-CM)	-10-P ases cedu ion of	CS) Clinic re Coc	al les
REQUIRED	HI03 - 2		1271	Industry Code Code indicating a code from a specific industry code	M	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the be range of codes.	eginni	ng valu	e in a
				IMPLEMENTATION NAME: Procedure Code			

005010X223 • 837 • 2 OTHER PROCEDURE		NC		ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3
REQUIRED	HI03 - 3		1250	Date Time Period Format QualifierXID2/3Code 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.
			c	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	SITUATIONAL HI04 C022			TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities
			E0809	r C02203 or C02204 is present, then the other is required.
			proce report	ONAL RULE: Required when it is necessary to report an additional edure and the preceding HI data elements have been used to t other procedures. If not required by this implementation b, do not send.
REQUIRED	HI04 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			c	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 1271 1250	International Classification of Dise Modification (ICD-9-CM) Other Pro code source 131: International Classificat Revision, Clinical Modification (ICD-9-CM Industry Code Code indicating a code from a specific industry cod SEMANTIC: If C022-08 is used, then C022-02 represents the b range of codes. IMPLEMENTATION NAME: Procedure Code Date Time Period Format Qualifier Code indicating the date format, time format, or da SYNTAX: P0304 SEMANTIC:	cedu tion of) M de list eginn	f Diseas AN ing valu	les es, 9th 1/30 e in a 2/3		
		Revision, Clinical Modification (ICD-9-CM Industry Code Code indicating a code from a specific industry cod SEMANTIC: If C022-08 is used, then C022-02 represents the b range of codes. IMPLEMENTATION NAME: Procedure Code Date Time Period Format Qualifier Code indicating the date format, time format, or da SYNTAX: P0304 SEMANTIC:	l) M de list eginn X	AN ing valu ID	1/30 e in a 2/3		
		Code indicating a code from a specific industry cod SEMANTIC: If C022-08 is used, then C022-02 represents the b range of codes. IMPLEMENTATION NAME: Procedure Code Date Time Period Format Qualifier Code indicating the date format, time format, or da SYNTAX: P0304 SEMANTIC:	de list eginn X	ing valu	e in a 2/3		
	1250	If C022-08 is used, then C022-02 represents the b range of codes. IMPLEMENTATION NAME: Procedure Code Date Time Period Format Qualifier Code indicating the date format, time format, or da SYNTAX: P0304 SEMANTIC:	X	ID	2/3		
	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or da syntax: P0304 SEMANTIC:					
	1250	Code indicating the date format, time format, or da SYNTAX: P0304 SEMANTIC:					
		P0304 Semantic:					
		SEMANTIC: C022-03 is the date format that will appear in C022-04.					
	c	ODE DEFINITION					
	D8	Date Expressed in Format CCYYM	MDD)			
EQUIRED HI04 - 4		Date Time Period Expression of a date, a time, or range of dates, time	X nes or	AN dates a	1/35 nd times		
		syntax: P0304					
		IMPLEMENTATION NAME: Procedure Date					
	782	Monetary Amount	ο	R	1/18		
	380	Quantity	ο	R	1/15		
	799	Version Identifier	ο	AN	1/30		
	1271	Industry Code	Х	AN	1/30		
	1073	Yes/No Condition or Response Code	Х	ID	1/1		
C022			O1 unts a	and quai	ntities		
	P0304 If either E0809	$^{\rm r}$ C02203 or C02204 is present, then the other is requ	uired.				
		1251 782 380 799 1271 1073 C022 HEAL To serve SYNTAX: P0304 If either E0809 Only or SITUATIO	1251 Date Time Period Expression of a date, a time, or range of dates, times SYNTAX: P0304 IMPLEMENTATION NAME: Procedure Date 782 Monetary Amount 380 Quantity 799 Version Identifier 1271 Industry Code 1073 Yes/No Condition or Response Code C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, amo SYNTAX: P0304 If either C02203 or C02204 is present, then the other is requee E0809 Only one of C02208 or C02209 may be present. SITUATIONAL RULE: Required when it is necessary to red	1251 Date Time Period Expression of a date, a time, or range of dates, times or SYNTAX: P0304 X IMPLEMENTATION NAME: Procedure Date IMPLEMENTATION NAME: Procedure Date 782 Monetary Amount 0 380 Quantity 0 799 Version Identifier 0 1271 Industry Code X 1073 Yes/No Condition or Response Code X C022 HEALTH CARE CODE INFORMATION 01 To send health care codes and their associated dates, amounts a SYNTAX: P0304 SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.	1251 Date Time Period X AN Expression of a date, a time, or range of dates, times or dates a SYNTAX: P0304 IMPLEMENTATION NAME: Procedure Date 0 R 782 Monetary Amount 0 R 380 Quantity 0 R 799 Version Identifier 0 AN 1271 Industry Code X AN 1073 Yes/No Condition or Response Code X ID C022 HEALTH CARE CODE INFORMATION 01 To send health care codes and their associated dates, amounts and quar SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809		

procedure and the preceding HI data elements have been used report other procedures. If not required by this implementation guide, do not send.

005010X223 • 837 OTHER PROCEDL	• 2300 • HI JRE INFORMATION		ASC X12N • INSU TECH	IRANCE : INICAL R		
REQUIRED	HI05 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05	5, C022-06	6 and C	022-08.
		с	ODE DEFINITION			
		BBQ	International Classification of E Modification (ICD-10-PCS) Othe			
			This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10- code set under HIPAA, OR The Secretary grants an except set as a pilot project as allowed OR For claims which are not cover	alifier ca PCS as tion to u d under t	n only an allo se the the law	be owable code /,
		BQ	CODE SOURCE 896: International Classi Revision, Procedure Coding System (International Classification of E Modification (ICD-9-CM) Other	(ICD-10-P Diseases	CS) Clinic	al
REQUIRED HI05 - 2	1271	CODE SOURCE 131: International Classi Revision, Clinical Modification (ICD-9- Industry Code Code indicating a code from a specific industry	-CM) M	Diseas	es, 9th 1/30	
			SEMANTIC: If C022-08 is used, then C022-02 represents th range of codes.	ne beginn	ing valu	e in a
			IMPLEMENTATION NAME: Procedure Code			
REQUIRED	HI05 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, o	X or date and	ID d time fo	2/3 ormat
			syntax: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C	C022-04.		
		C D8	ODE DEFINITION			
REQUIRED	HI05 - 4	1251	Date Expressed in Format CCY Date Time Period	Х	AN	1/35
			Expression of a date, a time, or range of dates SYNTAX: P0304	, umes or	uales a	na umes
NOT USED	HI05 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI05 - 6	380	Quantity	0	R	1/10
NOT USED	HI05 - 7	799	Version Identifier	0	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	1,50

SITUATIONAL	HI06	C022		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities
			E0809	r C02203 or C02204 is present, then the other is required.
			proce report	ONAL RULE: Required when it is necessary to report an additional edure and the preceding HI data elements have been used to t other procedures. If not required by this implementation b, do not send.
REQUIRED	HI06 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			c	CODE DEFINITION
			BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes
				This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
			BQ	CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes
				CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
REQUIRED	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 QualifierXID2/3Code 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.
			D8	Date Expressed in Format CCYYMMDD

005010X223 • 837 • 23 OTHER PROCEDURE		ON		ASC X12N • INSURANCE SUBCOMMITTE TECHNICAL REPORT • TYPE							
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: Procedure 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	SITUATIONAL HI07 C022		To send	TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities							
			E0809	r C02203 or C02204 is present, then the other is required.							
			Only On	Only one of C02208 or C02209 may be present.							
			proced report	DNAL RULE: Required when it is necessary to report an additional dure and the preceding HI data elements have been used to t other procedures. If not required by this implementation , do not send.							
REQUIRED	HI07 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list							
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.							
			C	ODE DEFINITION							
			BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes							
			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.								
			BQ	CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th							
REQUIRED	HI07 - 2		1271	Revision, Clinical Modification (ICD-9-CM) 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							

ASC X12N • INSURA TECHNICAL REPOR				OTHER PRO			2300 • RMATIC
REQUIRED	HI07 - 3	1250		me Period Format Qualifier licating the date format, time format, or o	X date and	ID d time fo	2/3 ormat
			syntax: P0304				
			semantic C022-03	: is the date format that will appear in C0	22-04.		
		C	ODE	DEFINITION			
		D8		Date Expressed in Format CCYY	MMDD	1	
REQUIRED	HI07 - 4	1251		me Period on of a date, a time, or range of dates, t	X imes or	AN dates a	1/35 nd times
			зүнтах : Р0304				
			IMPLEMEN	TATION NAME: Procedure Date			
NOT USED	HI07 - 5	782	Moneta	ry Amount	ο	R	1/18
NOT USED	HI07 - 6	380	Quantit	у	ο	R	1/15
NOT USED	HI07 - 7	799	Versior	Identifier	ο	AN	1/30
NOT USED	HI07 - 8	1271	Industr	y Code	х	AN	1/30
NOT USED	HI07 - 9	1073	Yes/No	Condition or Response Code	х	ID	1/1
SITUATIONAL	HI08		-	E CODE INFORMATION re codes and their associated dates, arr	O 1 nounts a	and quai	ntities
		E0809 Only on	e of C022	r C02204 is present, then the other is re 08 or C02209 may be present. Required when it is necessary to	report		
		report		the preceding HI data elements h ocedures. If not required by this i rend.			
REQUIRED	HI08 - 1	1270		ist Qualifier Code Intifying a specific industry code list	М	ID	1/3
			SEMANTIC C022-01	: qualifies C022-02, C022-04, C022-05, 0	022-06	6 and C	022-08.
		C	ODE	DEFINITION			
		BBQ		International Classification of Dis Modification (ICD-10-PCS) Other			
				This code set is not allowed for u the time of this writing. The quali	ise un	der HIF	PAA at
				used: If a new rule names the ICD-10-P code set under HIPAA, OR	CS as	an allo	wable
				The Secretary grants an exception			
				set as a pilot project as allowed u OR For claims which are not covered			

005010X223 • 837 • 2 OTHER PROCEDURE			ASC X12N • INSURA TECHNI			• TYPE 3
		BQ	International Classification of Dis Modification (ICD-9-CM) Other Pro			
REQUIRED	HI08 - 2	1271	CODE SOURCE 131: International Classifica Revision, Clinical Modification (ICD-9-CN Industry Code Code indicating a code from a specific industry code	И) М	AN	es, 9th 1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the l range of codes.			e in a
			IMPLEMENTATION NAME: Procedure Code			
REQUIRED	HI08 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date	X ate an	ID d time fo	2/3 ormat
			syntax: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C02	2-04.		
		C	CODE DEFINITION			
		D8	Date Expressed in Format CCYYN	IMDD)	
REQUIRED	EQUIRED HI08 - 4		Date Time Period Expression of a date, a time, or range of dates, tir	X nes or	AN dates a	1/35 nd times
			SYNTAX: P0304			
			IMPLEMENTATION NAME: Procedure Date			
NOT USED	HI08 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI08 - 6	380	Quantity	0	R	1/15
NOT USED	HI08 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI08 - 8	1271	Industry Code	Х	AN	1/30
NOT USED	HI08 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI09 C022		TH CARE CODE INFORMATION d health care codes and their associated dates, amo	O 1 ounts a	and qua	ntities
		E0809	r C02203 or C02204 is present, then the other is rec	quired.		
		proce report	DNAL RULE: Required when it is necessary to r dure and the preceding HI data elements ha t other procedures. If not required by this ir , do not send.	ave b	een us	ed to

1/3	ID	м	Code List Qualifier Code	1270	- 1	HI09 -	REQUIRED
			Code identifying a specific industry code list				
022-08.	and C	C022-06	SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05				
			DE DEFINITION	C			
			International Classification of D Modification (ICD-10-PCS) Othe	BBQ			
/ be owable e code	n only an alle se the	lifier ca PCS as	This code set is not allowed for the time of this writing. The qua used: If a new rule names the ICD-10- code set under HIPAA, OR The Secretary grants an except set as a pilot project as allowed OR				
AA.	r HIPA	d unde	For claims which are not covere				
cal	CS) Clinio	CD-10-P i seases	CODE SOURCE 896: International Classid Revision, Procedure Coding System (International Classification of D Modification (ICD-9-CM) Other F	BQ			
ses, 9th	Diseas		CODE SOURCE 131: International Classid Revision, Clinical Modification (ICD-9-				
1/30	AN	M	Industry Code Code indicating a code from a specific industry	1271	REQUIRED HI09 - 2		
ue in a	ng valu	e beginni	SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.				
			IMPLEMENTATION NAME: Procedure Code				
2/3 ormat	ID I time f	X date and	Date Time Period Format Qualifier Code indicating the date format, time format, or	1250	- 3	HI09 -	REQUIRED
			зүнтах: Р0304				
		022-04.	SEMANTIC: C022-03 is the date format that will appear in C				
DEFINITION							
			Date Expressed in Format CCY	D8			
1/35 and times	AN dates a	X times or	Date Time Period Expression of a date, a time, or range of dates,	1251	- 4	HI09 -	REQUIRED
			syntax: P0304				
			IMPLEMENTATION NAME: Procedure Date				
1/18	R	ο	Monetary Amount	782	- 5	HI09 -	IOT USED
1/15	R	0	Quantity	380		HI09 -	
1/30	AN	ο	Version Identifier	799	- 7	HI09 -	IOT USED
1/30	AN	х	Industry Code	1271	- 8	HI09 -	IOT USED
			-			HI09 -	IOT USED

SITUATIONAL	HI10	C022			E CODE INFORMATION O 1 are codes and their associated dates, amounts and quantities					
			E0809	r C02203 (or C02204 is present, then the other is required.					
			proce report	dure and	Required when it is necessary to report an additional I the preceding HI data elements have been used to rocedures. If not required by this implementation send.					
REQUIRED	HI10 - 1		1270		ist Qualifier CodeMID1/3entifying a specific industry code list					
				SEMANTIC C022-01	c: I qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.					
			CODE		CODE DEFINITION					
			BBQ		International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes					
					This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable					
					code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law,					
					OR For claims which are not covered under HIPAA.					
			BQ		code source 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes					
					CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)					
REQUIRED	HI10 - 2		1271		M AN 1/30 dicating a code from a specific industry code list					
				SEMANTIC If C022- range of	08 is used, then C022-02 represents the beginning value in a					
				IMPLEMEN	NTATION NAME: Procedure Code					
REQUIRED	HI10 - 3		1250		ime Period Format Qualifier X ID 2/3 dicating the date format, time format, or date and time format					
				зүнтах : Р0304						
				SEMANTIC C022-03	c: 3 is the date format that will appear in C022-04.					
			с	ODE						
			D8		Date Expressed in Format CCYYMMDD					

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE		005010X223 ● 837 ● 2300 ● HI OTHER PROCEDURE INFORMATION
REQUIRED	HI10 - 4		1251	Date Time PeriodXAN1/35Expression of a date, a time, or range of dates, times or dates and times
				syntax: P0304
				IMPLEMENTATION NAME: Procedure 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		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities
			E0809 Only on SITUATIC procee report	r C02203 or C02204 is present, then the other is required. The of C02208 or C02209 may be present. DNAL RULE: <i>Required when it is necessary to report an additional dure and the preceding HI data elements have been used to to ther procedures. If not required by this implementation</i>
			guide,	, do not send.
REQUIRED	HI11 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list
		- 1	C	SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.
			BBQ	International Classification of Diseases Clinical Modification (ICD-10-PCS) Other Procedure Codes
				This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the ICD-10-PCS as an allowable code set under HIPAA, OR The Secretary grants an exception to use the code set as a pilot project as allowed under the law, OR For claims which are not covered under HIPAA.
			BQ	CODE SOURCE 896: International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) International Classification of Diseases Clinical Modification (ICD-9-CM) Other Procedure Codes CODE SOURCE 131: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
REQUIRED	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: Procedure Code

005010X223 • 837 • 2 OTHER PROCEDURE			ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3					
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.					
		C	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					
			зултах: Р0304					
			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					
	ATIONAL HI12 C022		LTH CARE CODE INFORMATION O 1 Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes and their associated dates, amounts and quantities X: Ind health care codes or Co2204 is present, then the other is required. Ind health care codes or Co2209 may be present. INDUAL RULE: Required when it is necessary to report an additional					
		proce report	edure and the preceding HI data elements have been used to rt other procedures. If not required by this implementation e, do not send.					
REQUIRED	HI12 - 1	1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list					
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08.					
		C	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)					

ASC X12N • INSURA TECHNICAL REPOR	ANCE SUBCOMMITTEE		005010 OTHER PROC			2300 • HI RMATION
		BQ	International Classification of Dis Modification (ICD-9-CM) Other Pro			
REQUIRED	HI12 - 2	1271	CODE SOURCE 131: International Classifica Revision, Clinical Modification (ICD-9-CM Industry Code Code indicating a code from a specific industry code	۸) M	AN	es, 9th 1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginn	ing valu	e in a
			IMPLEMENTATION NAME: Procedure Code			
REQUIRED	HI12 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or d	X ate an	ID d time fo	2/3 prmat
			syntax: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C02	22-04.		
		C	ODE DEFINITION			
		D8	Date Expressed in Format CCYYN	MDD)	
REQUIRED	HI12 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, tin	X	AN datas a	1/35
			SYNTAX: P0304	1165 01	uales a	
			IMPLEMENTATION NAME: Procedure Date			
NOT USED	HI12 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI12 - 6	380	Quantity	0	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	Х	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1

SEGMENT DETAIL						
	HI - C	OCCUR	RENC	E SPAN IN	FORMA	ΓΙΟΝ
X12 Segment Name:	Health C	are Informa	tion Codes	3		
•		•		o the delivery of h	nealth care	
Loop:	2300 —		ORMATIO	N		
Segment Repeat:	2					
Usage:	SITUATI	ONAL				
Situational Rule:	-			ccurrence Span implementation		
TR3 Example:	HI*BI:70):RD8:2005	1202-200	51212*BI:74:RD	8:20051214-20	051216~
DIAGRAM						
HI01 C Health Ca Code Info M 1	*	C022 alth Care ode Info.	HI03 C02 Health Care Code Info. O 1	e \star Health Care	HI05 C022 Health Care Code Info. O 1 O	HI06 C022 Health Care Code Info. O 1 O 1
HI07 C Health Ca Code Infe O 1	*	C022 alth Care ode Info.	HI09 C02 Health Care Code Info. O 1	e _ Health Care	HI11 C022 Health Care Code Info. 0 1 0	HI12 C022 Health Care Code Info. O 1 O 1
ELEMENT DETAIL						
		DATA EMENT <u>NAME</u>				ATTRIBUTES
REQUIRED HI01	CO			CODE INFORMATI	-	M 1
		SYNTAX P0304 If either E0809	: r C02203 or (C02204 is present, th 3 or C02209 may be p	en the other is requ	
REQUIRED HI01	- 1	1270		t Qualifier Code tifying a specific indus	stry code list	M ID 1/3
			земантіс : C022-01 q	ualifies C022-02, C02	22-04, C022-05, C0	22-06 and C022-08.
		C		EFINITION		
		BI		Occurrence Span		
REQUIRED HI01	0	4074	С	ode source 132: Natio odes	onal Uniform Billing	
REQUIRED HI01	- 2	1271	Industry Code indic	Code ating a code from a s	pecific industry cod	M AN 1/30 e list
			SEMANTIC: If C022-08 range of co	is used, then C022-0 odes.	2 represents the be	eginning value in a
			IMPLEMENTA	ATION NAME: Occurre	nce Span Code	

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

Expression of a date, a time, or range of dates, times or dates and ti SYNTAX: P0304 MOT USED HI01 - 5 782 Monetary Amount 0 R 1// NOT USED HI01 - 6 380 Quantity 0 R 1// NOT USED HI01 - 7 799 Version Identifier 0 AN 1// NOT USED HI01 - 7 799 Version Identifier 0 AN 1// NOT USED HI01 - 8 1271 Industry Code X AN 1// NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION 0 1 - SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION 0 1 - SITUATIONAL HI02 C022 To send health care codes and their associated dates, amounts and quantitie - - SITUATIONAL <th>REQUIRED</th> <th>HI01 - 3</th> <th>1250</th> <th>Date Time Period Format Qualifier Code indicating the date format, time format, o</th> <th>X r date and</th> <th>ID d time fo</th> <th>2/3 prmat</th>	REQUIRED	HI01 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, o	X r date and	ID d time fo	2/3 prmat	
C022-03 is the date format that will appear in C022-04. CO22-03 is the date format that will appear in C022-04. REQUIRED HI01 - 4 RD3 Range of Dates Expressed in Format CCYYMMDD CCYYMMDD CCYYMMDD Service in Format CCYYMMDD CCYYMMDD CCYYMMDD Service in Format CCYYMMDD CCYYMMDD Service in Format CCYYMMDD Service in Format CCYYMMDD Service in Format CCYYMMDD NOT USED HI01 - 5 782 Monetary Amount O R 1/ NOT USED HI01 - 7 799 Version Identifier O AN 1/ NOT USED HI01 - 8 1073 Yes/No Condition or Response Code X N 1/ Service in Format CCYYMMDD Version Identifier O AN 1/ NOT USED HI01 - 8 1073 Yes/No Condition or Response Code X N 1/ Service in Code is on Coze0 or								
RD8 Range of Dates Expressed in Format CCYYMMDD CCYYMMDD REQUIRED HI01 - 4 1251 Date Time Period X AN 1/ Expression of a date, a time, or range of dates, times or dates and it swrrax: P0304 NOT USED HI01 - 5 782 Monetary Amount O R 1/ R NOT USED HI01 - 6 380 Quantity O R 1/ R NOT USED HI01 - 7 799 Version Identifier O AN 1/ R NOT USED HI01 - 8 1271 Industry Code X AN 1/ R NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 NOT USED HI02 C022 HEALTH CARE CODE INFORMATION O 1 SITUATIONAL HI02 C022 HEALTH CARE CODE OF INFORMATION O 1 SITUATIONAL HI02 C022 HEALTH CARE CODE OF INFORMATION O 1 SITUATIONAL HI02 1 To send health care codes and their associated dates, amounts and quantitie set and their associated dates, amounts and quantitie set and their associated dates, amounts and quantitie set and the alemernts have been used to					022-04.			
CCYYMDDD CCYYMDDD REQUIRED HI01 - 4 1251 Date Time Period X AN 1/1 Switzer NOT USED HI01 - 5 782 Monetary Amount O R 1/1 NOT USED HI01 - 6 380 Quantity O R 1/1 NOT USED HI01 - 7 799 Version Identifier O AN 1/1 NOT USED HI01 - 8 1271 Industry Code X AN 1/1 NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 NOT USED HI02 C022 HEALTH CARE CODE INFORMATION O1 To send health care codes and their associated dates, amounts and quantitie symmetry 9304 If either C02203 or C02203 or C02203 or C02204 is present, then the other is required. E609 Only one of C02203 or C02203 or C02209 may be present. E009 Only one of C02208 or C02209 may be present. E000 E001 or equire by this implementation guide, do not send. E0022-01 (ualifier Code M ID 1 CO22-01 yualifies C022-02, C022-04, C022-0				CODE DEFINITION				
Itel			RD8		ormat C	CYYM	MDD-	
P0304 IMPLEMENTATION NAME: Occurrence Span Code Date NOT USED HI01 - 5 782 Monetary Amount O R 1/ NOT USED HI01 - 6 380 Quantity O R 1/ NOT USED HI01 - 7 799 Version Identifier O AN 1/ NOT USED HI01 - 8 1271 Industry Code X AN 1/ NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION O 1 To send health care codes and their associated dates, amounts and quantitie SYNTA: 70304 If either CO2203 or C02204 is present, then the other is required. E0609 Only one of C02208 or C02209 may be present. STUATIONAL RULE: Required when it is necessary to report an additic occurrence span code and the preceding HI data elements have been used to report other occurrence span codes. If not requires by this implementation guide, do not send. REQUIRED HI02 - 1 1270 Code List Qualifier Code Co22-05, C022-06 and C022-05 (co22-01 qualifier Code codes) M ID 1 <td colspan<="" t<="" td=""><td>REQUIRED</td><td>HI01 - 4</td><td>1251</td><td></td><td></td><td></td><td>1/35 and times</td></td>	<td>REQUIRED</td> <td>HI01 - 4</td> <td>1251</td> <td></td> <td></td> <td></td> <td>1/35 and times</td>	REQUIRED	HI01 - 4	1251				1/35 and times
NOT USED HI01 - 5 782 Monetary Amount 0 R 1// NOT USED HI01 - 6 380 Quantity 0 R 1// NOT USED HI01 - 7 799 Version Identifier 0 AN 1// NOT USED HI01 - 8 1271 Industry Code X AN 1// NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C022 C022 HEALTH CARE CODE INFORMATION 0 1 To send health care codes and their associated dates, amounts and quantitie SWITAX: P0304 If either C02203 or C02209 may be present. E0809 Only one of C02208 or C02208 or C02209 may be present. SITUATIONAL RULE: Required when it is necessary to report an additio 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 Code List Qualifier Code Code: List Qualifier Code Code: C								
NOT USED HI01 = 0 102 Indicating Announce 0 R 1/1 NOT USED HI01 = 6 380 Quantity 0 R 1/1 NOT USED HI01 = 7 799 Version Identifier 0 AN 1/1 NOT USED HI01 = 8 1271 Industry Code X AN 1/1 NOT USED HI01 = 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION 0 1 To send health care codes and their associated dates, amounts and quantitie SYNTAX: P0304 If either C02203 or C02209 or C02209 may be present. If either C02203 or C02209 may be present. SITUATIONAL RULE: Required when it is necessary to report an additio 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. ID 1 REQUIRED HI02 - 1 1270 Code List Qualifier Code Code M ID 1 SEMANTIC: CODE DEFINITION BI Occurrence Span code source 132: National Uniform Billing Committee (NUE Code Soce Source 132: National Uniform Billing Co				IMPLEMENTATION NAME: Occurrence Span Co	de Date	1		
NOT USED HI01 - 7 799 Version Identifier O AN 1/ NOT USED HI01 - 7 799 Version Identifier O AN 1/ NOT USED HI01 - 8 1271 Industry Code X AN 1/ NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C02 HEALTH CARE CODE INFORMATION O 1 To send health care codes and their associated dates, amounts and quantitie SWNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0609 Color Color Color Color Color E0609 Color Co	NOT USED	HI01 - 5	782	Monetary Amount	ο	R	1/18	
NOT USED HI01 - 7 100 Version Relatives 0 Version Relatives NOT USED HI01 - 8 1271 Industry Code X AN 1/ NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION O 1 To send health care codes and their associated dates, amounts and quantitie SWTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present. STUATIONAL RULE: Required when it is necessary to report an additic 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 identifying a specific industry code list M ID 1 CO22-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-0 C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-0 C022-06 C022-06 C022-06 REQUIRED HI02 - 2 1271 Industry Code M N 1/ CODE DEFINITION EI 0 Courrence Span code scit as unditin the to the specific i	NOT USED	HI01 - 6	380	Quantity	0	R	1/15	
NOT USED HI01 - 9 1073 Yes/No Condition or Response Code X ID 1 SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION O 1 0 To send health care codes and their associated dates, amounts and quantitie 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 additic 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 CODE DEFINITION BI Occurrence Span code send C022-02, C022-04, C022-05, C022-06 and C022-02-02 co22-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-02 codes REQUIRED HI02 - 2 1271 Industry Code Code from a specific industry code list SEMANTIC: Code indicating a code from a specific industry code list SEMANTIC: If C022-02 is used, then C022-02 represents the beginning value in	NOT USED	HI01 - 7	799	Version Identifier	ο	AN	1/30	
SITUATIONAL HI02 C022 HEALTH CARE CODE INFORMATION O 1 To send health care codes and their associated dates, amounts and quantitie 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 additic 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 CO22-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-02-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-02-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-02-02 codes REQUIRED HI02 - 2 1271 Industry Code M AN 1/ Code identifying a specific industry code list SEMANTIC: C02E-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-02-02 REQUIRED HI02 - 2 1271 Industry Code M AN 1/ Code identifying a specific industry code list SEMANTIC: Industry Code M AN 1/ Code identifying a specific industry code list SEMANTIC: Industry Code M	NOT USED	HI01 - 8	1271	Industry Code	Х	AN	1/30	
INDEXEMPTION INDEX	NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1	
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 additic 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 Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022- CODE DEFINITION BI Occurrence Span codes ource 132: National Uniform Billing Committee (NUE Codes REQUIRED HI02 - 2 1271 Industry 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 SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a	SITUATIONAL	HI02				and qua	ntities	
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 Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-02 C0DE DEFINITION BI Occurrence Span code source 132: National Uniform Billing Committee (NUE Codes REQUIRED HI02 - 2 1271 Industry Code Code M AN 1/2 REQUIRED HI02 - 2 1271 Industry Code Code M AN 1/2			P0304 If eithe E0809	er C02203 or C02204 is present, then the other is	required.			
Index = 1 Index = 1 <thindex 1<="" =="" th=""> <thindex 1<="" =="" th=""> <thindex 1<="" =="" th=""></thindex></thindex></thindex>			occu been	rrence span code and the preceding HI da used to report other occurrence span co	ata elem	ents h	ave	
C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-0 CODE DEFINITION BI Occurrence Span CODE source 132: National Uniform Billing Committee (NUE Codes REQUIRED HI02 - 2 1271 Industry Code M AN 1/ 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	REQUIRED	HI02 - 1	1270		М	ID	1/3	
BI Occurrence Span CODE SOURCE 132: National Uniform Billing Committee (NUE Codes REQUIRED HI02 - 2 1271 Industry Code M AN 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					, C022-0(6 and C	022-08.	
CODE SOURCE 132: National Uniform Billing Committee (NUE Codes REQUIRED HI02 - 2 1271 Industry Code M AN 1/ 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 specific industry code indicating a code from a sp								
REQUIRED HI02 - 2 1271 Industry Code Code indicating a code from a specific industry code list M AN 1/ SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a			BI	Occurrence Span				
REQUIRED HI02 - 2 1271 Industry Code Code indicating a code from a specific industry code list M AN 1/ SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a					lling Com	imittee (NUBC)	
If C022-08 is used, then C022-02 represents the beginning value in	REQUIRED	HI02 - 2	1271	Industry Code			1/30	
-				If C022-08 is used, then C022-02 represents the	ıe beginn	ing valu	e in a	
IMPLEMENTATION NAME: Occurrence Span Code				IMPLEMENTATION NAME: Occurrence Span Co	de			

005010X223 • 837 • DCCURRENCE SPA		TION		ASC X12N • IN TEC	SURANCE CHNICAL R		
REQUIRED	HI02 - 3	3	1250	Date Time Period Format Qualifier Code indicating the date format, time format	X , or date an	ID d time f	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in	n C022-04.		
			c	DDE DEFINITION			
			RD8	Range of Dates Expressed in CCYYMMDD	Format C	CYYM	MDD-
REQUIRED	HI02 - 4	4	1251	Date Time Period Expression of a date, a time, or range of date	X es, times or	AN dates a	1/35 and time
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Span (Code Date)	
NOT USED	HI02 - 4	5	782	Monetary Amount	ο	R	1/18
NOT USED	HI02 - (6	380	Quantity	ο	R	1/15
NOT USED	HI02 - 7	7	799	Version Identifier	ο	AN	1/30
NOT USED	HI02 - 8	3	1271	Industry Code	х	AN	1/30
NOT USED	HI02 - 9	Ð	1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI02 - 9 HI03 C022		To send syntax: P0304	TH CARE CODE INFORMATION I health care codes and their associated dates C02203 or C02204 is present, then the other		·	ntities
			SITUATIC occurr been u	e of C02208 or C02209 may be present. NAL RULE: Required when it is necessary rence span code and the preceding HI used to report other occurrence span of s implementation guide, do not send.	data elem	ents h	ave
REQUIRED	HI03 - 7	1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-	M 05, C022-0	ID 6 and C	1/3
			с	DDE DEFINITION	,		
			BI	Occurrence Span			
				code source 132: National Uniform Codes	Billing Corr	mittee	(NUBC)
REQUIRED	HI03 - 2	2	1271	Industry Code Code indicating a code from a specific indus	M try code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents	s the beginn	ing valu	ue in a
				SEMANTIC: If C022-08 is used, then C022-02 represents range of codes.		ing valu	ue in a

	T • TYPE 3				RRENCE SPA		
REQUIRED	HI03 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time form		ID d time f	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear	ar in C022-04.		
			C	DE DEFINITION			
			RD8	Range of Dates Expressed CCYYMMDD	in Format C	CYYN	MDD-
REQUIRED	HI03 - 4		1251	Date Time Period Expression of a date, a time, or range of	X dates, times or	AN dates a	1/35 and times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Spa	n Code Date		
NOT USED	HI03 - 5		782	Monetary Amount	0	R	1/18
NOT USED	HI03 - 6		380	Quantity	0	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI03 - 8		1271	Industry Code	Х	AN	1/30
IOT USED	HI03 - 9		1073	Yes/No Condition or Response Co	de X	ID	1/1
SITUATIONAL	HI04			CO2203 or CO2204 is present, then the ot of CO2208 or CO2209 may be present.		and qua	ntities
			occuri been u by this	NAL RULE: Required when it is necess ence span code and the preceding sed to report other occurrence spa implementation guide, do not send	HI data elem In codes. If n	ents l ot req	ave
REQUIRED	HI04 - 1		1270	Code List Qualifier Code		ID	1/3
REQUIRED	HI04 - 1		1270	Code List Qualifier Code Code identifying a specific industry code SEMANTIC: C022-01 qualifies C022-02, C022-04, C0	list		
REQUIRED	HI04 - 1			Code identifying a specific industry code SEMANTIC: C022-01 qualifies C022-02, C022-04, C0 DE DEFINITION	list		
REQUIRED	HI04 - 1			Code identifying a specific industry code SEMANTIC: C022-01 qualifies C022-02, C022-04, C0 DDE DEFINITION Occurrence Span	list 22-05, C022-06	6 and C	:022-08.
REQUIRED	HI04 - 1		C	Code identifying a specific industry code SEMANTIC: C022-01 qualifies C022-02, C022-04, C0 DE DEFINITION	list 22-05, C022-00 orm Billing Com M	6 and C	:022-08.
			c	Code identifying a specific industry code SEMANTIC: C022-01 qualifies C022-02, C022-04, C0 DE DEFINITION DEFINITION Occurrence Span CODE source 132: National Unifo Codes Industry Code	list 22-05, C022-00 orm Billing Com M dustry code list	5 and C mittee AN	:022-08: (NUBC) 1/30

005010X223 • 837 • 2300 • HI OCCURRENCE SPAN INFORMATION

	HI04 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 prmat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C0)22-04.		
			C	ODE DEFINITION			
			RD8	Range of Dates Expressed in Fo	rmat C	CYYM	MDD-
REQUIRED	HI04 - 4		1251	Date Time Period Expression of a date, a time, or range of dates,	X times or	AN dates a	1/35 nd times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Span Coc	le Date		
NOT USED	HI04 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI04 - 6		380	Quantity	ο	R	1/15
NOT USED	HI04 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI04 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI04 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI05	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, ar	O 1 nounts a	ind quai	ntities
			SYNTAX: P0304				
			If either E0809	C02203 or C02204 is present, then the other is m ne of C02208 or C02209 may be present.	equired.		
			If either E0809 Only on SITUATIO OCCUTI been U		report ta elem	ents h	ave
REQUIRED	HI05 - 1		If either E0809 Only on SITUATIO OCCUTI been U	ne of C02208 or C02209 may be present. NAL RULE: <i>Required when it is necessary to</i> rence span code and the preceding HI dat used to report other occurrence span code	report ta elem	ents h	ave
REQUIRED	HI05 - 1		If either E0809 Only on SITUATIO OCCUTI been u by this	ne of C02208 or C02209 may be present. NAL RULE: Required when it is necessary to rence span code and the preceding HI dat used to report other occurrence span cod s implementation guide, do not send. Code List Qualifier Code	report ta elem les. If n M	ents h ot requ ID	ave Jired 1/3
REQUIRED	HI05 - 1		If either E0809 Only on SITUATIO OCCUTI been u by this 1270	the of C02208 or C02209 may be present. EXAL RULE: Required when it is necessary to rence span code and the preceding HI dat used to report other occurrence span code implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	report ta elem les. If n M	ents h ot requ ID	ave Jired 1/3
REQUIRED	HI05 - 1		If either E0809 Only on SITUATIO OCCUTI been u by this 1270	ne of C02208 or C02209 may be present. NNAL RULE: Required when it is necessary to rence span code and the preceding HI dat used to report other occurrence span code implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	report ta elem les. If n M	ents h ot requ ID	ave Jired 1/3
REQUIRED	HI05 - 1		If either E0809 Only on SITUATIO OCCUTT been L by this 1270	The of C02208 or C02209 may be present. ADVAL RULE: Required when it is necessary too rence span code and the preceding HI data used to report other occurrence span code implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence Span code source 132: National Uniform Bill	report ta elem les. If n M C022-06	ents h ot requ ID	ave Jired 1/3 022-08.
REQUIRED	HI05 - 1 HI05 - 2		If either E0809 Only on SITUATIO OCCUTT been L by this 1270	The of C02208 or C02209 may be present. ADVAL RULE: Required when it is necessary too rence span code and the preceding HI data used to report other occurrence span code implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence Span	report ta elem les. If n M C022-06 ing Com	ents h ot requ ID	ave Jired 1/3 022-08.
			If either E0809 Only on SITUATIO OCCUITI been u by this 1270	The of C02208 or C02209 may be present. ADVAL RULE: Required when it is necessary to rence span code and the preceding HI dat used to report other occurrence span code implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence Span code source 132: National Uniform Bill Codes Industry Code	report ta elem les. If n M C022-06 ing Com M code list	ents h ot requ ID 6 and C mittee (AN	ave J/3 022-08. NUBC) 1/30

			4050	Deta Tima Dania d Farmat Ovalitian	v		0/0
REQUIRED	HI05 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or o	X date and	ID d time fo	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C0	22-04.		
			C	ODE DEFINITION			
			RD8	Range of Dates Expressed in For CCYYMMDD	mat C	СҮҮМ	MDD-
REQUIRED	HI05 - 4		1251	Date Time Period Expression of a date, a time, or range of dates, ti	X imes or	AN dates a	1/35 nd times
				SYNTAX: P0304			
				IMPLEMENTATION NAME: OCCURRENCE Span Cod	e Date		
NOT USED	HI05 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI05 - 6		380	Quantity	0	R	1/15
NOT USED	HI05 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI05 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI05 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI06	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, arr	O 1 nounts a	and qua	ntities
		E0809	C02203 or C02204 is present, then the other is re ne of C02208 or C02209 may be present.	quired.			
		occuri been u	DNAL RULE: Required when it is necessary to rence span code and the preceding HI data used to report other occurrence span code	a elem	ents h	ave	
			by this	s implementation guide, do not send.			uneu
REQUIRED	HI06 - 1		<i>by thi</i> : 1270	Code List Qualifier Code Code identifying a specific industry code list	Μ	ID	1/3
REQUIRED	HI06 - 1		-	Code List Qualifier Code			1/3
REQUIRED	HI06 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list			1/3
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, C			1/3
REQUIRED	HI06 - 1		1270 c	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, 0 ODE DEFINITION Occurrence Span code source 132: National Uniform Billing	022-06	6 and C	1/3 022-08.
REQUIRED	HI06 - 1 HI06 - 2		1270 c	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-04 ODE DEFINITION Occurrence Span	C022-06	6 and C	1/3 022-08.
			1270 	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C ODE DEFINITION DEFINITION Occurrence Span CODE SOURCE 132: National Uniform Billin Codes Industry Code	c022-06 ng Com M ode list	5 and C mittee (AN	1/3 022-08. NUBC) 1/30

ASC X12N • INSURANCE SUBCOMMITTEE

005010X223 • 837 • 2300 • HI

REQUIRED	HI06 - 3	1250		od Format Qualifier e date format, time format, d	X or date and	ID d time fo	2/3 prmat
			syntax: P0304				
			SEMANTIC: C022-03 is the dat	e format that will appear in	C022-04.		
			ODE DEFINITION	1			
		RD8	Range c CCYYM	of Dates Expressed in F MDD	Format C	СҮҮМ	MDD-
REQUIRED	HI06 - 4	1251	Date Time Peric Expression of a da	od te, a time, or range of dates	X s, times or	AN dates a	1/35 nd times
			SYNTAX: P0304				
			IMPLEMENTATION NAM	ME: Occurrence Span Co	ode Date	1	
NOT USED	HI06 - 5	782	Monetary Amou	Int	ο	R	1/18
NOT USED	HI06 - 6	380	Quantity		ο	R	1/15
NOT USED	HI06 - 7	799	Version Identifie	er	ο	AN	1/30
NOT USED	HI06 - 8	1271	Industry Code		Х	AN	1/30
NOT USED	HI06 - 9	1073	Yes/No Condition	on or Response Code	Х	ID	1/1
SITUATIONAL	HI07		TH CARE CODE I d health care codes a	NFORMATION and their associated dates,	O1 amounts a	and qua	ntities
		E0809	r C02203 or C02204	is present, then the other is 209 may be present.	required.		
		occu been	rence span code used to report oth	d when it is necessary i and the preceding HI d her occurrence span co guide, do not send.	lata elem	ents h	ave
REQUIRED	HI07 - 1	1270	Code List Quali Code identifying a	fier Code specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies (C022-02, C022-04, C022-0	5, C022-0	6 and C	022-08.
			CODE DEFINITION				
		BI	Occurre	ence Span			
			code sour Codes	RCE 132: National Uniform E	Billing Corr	imittee (NUBC)
REQUIRED	HI07 - 2	1271	Industry Code	code from a specific industr	M y code list	AN	1/30
			SEMANTIC: If C022-08 is used, range of codes.	, then C022-02 represents t	he beginn	ing valu	e in a
			IMPLEMENTATION NAM	ME: Occurrence Span Co	ode		

REQUIRED	T • TYPE 3				005010X223 RENCE SPA		
REQUIRED	HI07 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format	X It, or date and	ID d time fo	2/3 prmat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear	in C022-04.		
			C	DDE DEFINITION			
			RD8	Range of Dates Expressed in CCYYMMDD	n Format C	CYYM	MDD-
REQUIRED	HI07 - 4		1251	Date Time Period Expression of a date, a time, or range of da	X ites, times or	AN dates a	1/35 Ind times
				зүнтах: Р0304			
				IMPLEMENTATION NAME: Occurrence Span	Code Date	•	
NOT USED	HI07 - 5		782	Monetary Amount	0	R	1/18
NOT USED	HI07 - 6		380	Quantity	0	R	1/15
NOT USED	HI07 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI07 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI07 - 9		1073	Yes/No Condition or Response Cod	e X	ID	1/1
SITUATIONAL	11107 - 5			TH CARE CODE INFORMATION I health care codes and their associated date	O 1 es, amounts a	and qua	ntities
		E0809	C02203 or C02204 is present, then the othe e of C02208 or C02209 may be present.	r is required.			
			occur	NAL RULE: Required when it is necessal rence span code and the preceding H ised to report other occurrence span	l data elem	ents h	
				s implementation guide, do not send.	codes. Il li	ot req	
REQUIRED	HI08 - 1			S implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code lis SEMANTIC :	M t	ID	uired 1/3
REQUIRED	HI08 - 1		by this	s implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list	M t	ID	uired 1/3
REQUIRED	HI08 - 1		<i>by thi</i> s	S implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code lis SEMANTIC: C022-01 qualifies C022-02, C022-04, C022 DDE DEFINITION	M t	ID	uired 1/3
REQUIRED	HI08 - 1		<i>by thi</i> s	S implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022 DDE DEFINITION Occurrence Span	M t 2-05, C022-0	ID 6 and C	uired 1/3 022-08.
REQUIRED	HI08 - 1		<i>by this</i> 1270 	S implementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code lis SEMANTIC: C022-01 qualifies C022-02, C022-04, C022 DDE DEFINITION	M t 2-05, C022-0 n Billing Corr M	ID 6 and C mittee	uired 1/3 022-08.

005010X223 • 837 • 2300 • HI	
OCCURRENCE SPAN INFORMATION	

REQUIRED	HI08 - 3		1250	Date Time Period Format Qualifier X ID 2/3 Code indicating the date format, time format, or date and time format Code indicating the date format, time format Code indicating the date format Code ing the date format	3
				syntax: P0304	
				SEMANTIC: C022-03 is the date format that will appear in C022-04.	
			C	ODE DEFINITION	
			RD8	Range of Dates Expressed in Format CCYYMMDD CCYYMMDD	-
REQUIRED	HI08 - 4		1251	Date Time PeriodXAN1/3Expression of a date, a time, or range of dates, times or dates and time	-
				syntax: P0304	
				IMPLEMENTATION NAME: Occurrence Span Code Date	
NOT USED	HI08 - 5		782	Monetary Amount O R 1/1	8
NOT USED	HI08 - 6		380	Quantity O R 1/1	5
NOT USED	HI08 - 7		799	Version Identifier O AN 1/3	0
NOT USED	HI08 - 8		1271	Industry Code X AN 1/3	0
NOT USED	HI08 - 9		1073	Yes/No Condition or Response Code X ID 1/1	1
SITUATIONAL	HI09	C022		TH CARE CODE INFORMATION O 1 d health care codes and their associated dates, amounts and quantities	
			E0809	C02203 or C02204 is present, then the other is required. ne of C02208 or C02209 may be present.	
			occuri been u	DNAL RULE: Required when it is necessary to report an addition rence span code and the preceding HI data elements have used to report other occurrence span codes. If not required s implementation guide, do not send.	
REQUIRED	HI09 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list	3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-08	8.
			C	ODE DEFINITION	
			BI	Occurrence Span	
				CODE SOURCE 132: National Uniform Billing Committee (NUBC	C)
REQUIRED	HI09 - 2		1271	Codes Industry Code M AN 1/3 Code indicating a code from a specific industry code list	0
				SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	
				IMPLEMENTATION NAME: Occurrence Span Code	

ASC X12N • INSU TECHNICAL REP	RANCE SUBCOMMIT	ſEE	
REQUIRED	HI09 - 3	1250	Date Ti Code ind
			SYNTAX:

REQUIRED	HI09 - 3		1250	Date Time Period Format QualifierXID2/3Code indicating the date format, time format, or date and time format	3
				syntax: P0304	
				SEMANTIC: C022-03 is the date format that will appear in C022-04.	
			C	DDE DEFINITION	
			RD8	Range of Dates Expressed in Format CCYYMMDD	
REQUIRED	HI09 - 4		1251	Date Time PeriodXAN1/3Expression of a date, a time, or range of dates, times or dates and time	-
				syntax: P0304	
				IMPLEMENTATION NAME: Occurrence Span Code Date	
NOT USED	HI09 - 5		782	Monetary Amount O R 1/1	8
NOT USED	HI09 - 6		380	Quantity O R 1/1	5
NOT USED	HI09 - 7		799	Version Identifier O AN 1/3	0
NOT USED	HI09 - 8		1271	Industry Code X AN 1/3	0
NOT USED	HI09 - 9		1073	Yes/No Condition or Response Code X ID 1/	1
SITUATIONAL	HI10	C022		H CARE CODE INFORMATION O 1 health care codes and their associated dates, amounts and quantities	
			E0809	C02203 or C02204 is present, then the other is required. e of C02208 or C02209 may be present.	
			occuri been u	NAL RULE: Required when it is necessary to report an addition ence span code and the preceding HI data elements have used to report other occurrence span codes. If not required is implementation guide, do not send.	
REQUIRED	HI10 - 1		1270	Code List Qualifier CodeMID1/3Code identifying a specific industry code list	3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-06 and C022-0	8.
			C	DDE DEFINITION	
			BI	Occurrence Span	
				CODE SOURCE 132: National Uniform Billing Committee (NUBC	C)
REQUIRED	HI10 - 2		1271	Codes M AN 1/3 Industry Code M AN 1/3 Code indicating a code from a specific industry code list Industry code list Industry code list	0
				SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.	

OCCURRENCE SPA	2300 • HI N INFORMA				ASC X12N • INSURAN TECHNIC			
REQUIRED	HI10 - 3	3	1250	Date Time Period Fo	rmat Qualifier format, time format, or dat	X e and	ID time fo	2/3 prmat
				SYNTAX: P0304				
				SEMANTIC: C022-03 is the date form	nat that will appear in C022	-04.		
			C	DE DEFINITION				
			RD8	Range of Da	es Expressed in Form	at C	CYYM	MDD-
REQUIRED	HI10 - 4	4	1251	Date Time Period Expression of a date, a t	ime, or range of dates, time	X es or	AN dates a	1/35 nd times
				SYNTAX: P0304				
				IMPLEMENTATION NAME: O	currence Span Code I	Date		
NOT USED	HI10 -	5	782	Monetary Amount		ο	R	1/18
NOT USED	HI10 -	6	380	Quantity		0	R	1/15
NOT USED	HI10 -	7	799	Version Identifier		ο	AN	1/30
NOT USED	HI10 - 3	8	1271	Industry Code		х	AN	1/30
NOT USED	HI10 - 9	9	1073	Yes/No Condition or	Response Code	Х	ID	1/1
SITUATIONAL	HI11	C022		H CARE CODE INFO health care codes and th	RMATION eir associated dates, amou	O 1 ints a	nd qua	ntities
			E0809	C02203 or C02204 is pre e of C02208 or C02209 n	sent, then the other is requ ay be present.	ired.		
			occuri been u	ence span code and	en it is necessary to re the preceding HI data e ccurrence span codes. le, do not send.	elem	ents h	ave
REQUIRED	HI11 -	1	1270	Code List Qualifier (Code identifying a speci		М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-	02, C022-04, C022-05, C0	22-06	and C	022-08.
			C		02, C022-04, C022-05, C0	22-06	and C	022-08.
			c BI	C022-01 qualifies C022-		22-06	and C	022-08.
				C022-01 qualifies C022- DE DEFINITION Occurrence CODE SOURCE 13				
REQUIRED	HI11 - :	2		C022-01 qualifies C022- DE DEFINITION Occurrence CODE SOURCE 13 Codes Industry Code	Span	Comi M		
REQUIRED	HI11 - :	2	BI	C022-01 qualifies C022- DE DEFINITION COLE SOURCE 13 Codes Industry Code Code indicating a code f SEMANTIC:	Span 2: National Uniform Billing	Comi M e list	mittee (AN	NUBC) 1/30

	T • TYPE 3			OCCUR	RENCE SPA	N INFO	RMATIO
REQUIRED	HI11 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format	X at, or date an	ID d time f	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear	in C022-04.		
			C	DDE DEFINITION			
			RD8	Range of Dates Expressed i CCYYMMDD	n Format C	CYYM	MDD-
REQUIRED	HI11 - 4		1251	Date Time Period Expression of a date, a time, or range of da	X ates, times or	AN dates a	1/35 and times
				зүлтах: Р0304			
				IMPLEMENTATION NAME: Occurrence Span	Code Date)	
NOT USED	HI11 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI11 - 6		380	Quantity	0	R	1/15
NOT USED	HI11 - 7		799	Version Identifier	О	AN	1/30
NOT USED	HI11 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI11 - 9		1073	Yes/No Condition or Response Cod	e X	ID	1/1
SITUATIONAL	HI12	C022		TH CARE CODE INFORMATION	O 1 es, amounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the othe e of C02208 or C02209 may be present.	er is required.		
			occuri been u	NAL RULE: Required when it is necessa rence span code and the preceding H ised to report other occurrence span s implementation guide, do not send.	ll data elen codes. If r	nents h	ave
REQUIRED	HI12 - 1		1270	Code List Qualifier Code Code identifying a specific industry code lis SEMANTIC:		ID	1/3
REQUIRED	HI12 - 1		-	Code identifying a specific industry code lis SEMANTIC: C022-01 qualifies C022-02, C022-04, C022	st		
REQUIRED	HI12 - 1		C	Code identifying a specific industry code lis SEMANTIC: C022-01 qualifies C022-02, C022-04, C022 DDE DEFINITION	st		
REQUIRED	HI12 - 1		-	Code identifying a specific industry code lis SEMANTIC: C022-01 qualifies C022-02, C022-04, C022 DDE DEFINITION Occurrence Span	st 2-05, C022-0	6 and C	022-08.
REQUIRED	HI12 - 1		C	Code identifying a specific industry code lis SEMANTIC: C022-01 qualifies C022-02, C022-04, C022 DDE DEFINITION	st 2-05, C022-0 m Billing Con M	6 and C nmittee AN	022-08.

005010X223 • 837 OCCURRENCE SP	● 2300 ● HI PAN INFORMATION		ASC X12N • INSUR TECHN			MMITTEE • TYPE 3
REQUIRED	HI12 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or o	X late an	ID d time fo	2/3 ormat
			syntax: P0304			
			SEMANTIC: C022-03 is the date format that will appear in C0	22-04.		
		C	ODE DEFINITION			
		RD8	Range of Dates Expressed in For CCYYMMDD	mat C	CYYM	MDD-
REQUIRED	HI12 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, ti	X mes or	AN dates a	1/35 and times
			syntax: P0304			
			IMPLEMENTATION NAME: Occurrence Span Cod	e Date)	
NOT USED	HI12 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI12 - 6	380	Quantity	ο	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	х	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1

SEGMENT DETAIL				
	HI - OC	URRENC	E INFORMA	ΓΙΟΝ
X12 Segment Name:	Health Care	nformation Codes		
X12 Purpose:	To supply ir	rmation related to	o the delivery of healt	h care
Loop:	2300 — CL	M INFORMATIO	N	
Segment Repeat:	2			
Usage:	SITUATION	L		
Situational Rule:	-		currence Code that a ion guide, do not se	applies to this claim. If not nd.
TR3 Example:	HI*BH:42:I	:20051208*BH:/	A3:D8:20051203~	
DIAGRAM				
HI01 Co Health Ca Code Info M 1	×	*	* Health Care * Code Info.	HI05 C022 Health Care Code Info. 0 1 HI06 C022 Health Care Code Info. 0 1
HI07 CI Health Ca Code Info O 1	×.	The second secon	* * Health Care Code Info. *	HI11 C022 Health Care Code Info. > 1 HI12 C022 Health Care Code Info. O 1
ELEMENT DETAIL				
USAGE	REF. DATA DES. ELEMEN	NAME		ATTRIBUTES
USAGE HI01	REF. DATA DES. ELEMEN C022			ATTRIBUTES M 1
REQUIRED HI01	<u>ELEMEN</u> C022	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208	codes and their associated C02204 is present, then the or C02209 may be presen	M 1 d dates, amounts and quantities e other is required. t.
REQUIRED HI01	<u>ELEMEN</u> C022	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi	codes and their associated	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3
REQUIRED HI01	<u>ELEMEN</u> C022	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi SEMANTIC:	codes and their associated C02204 is present, then the or C02209 may be present Qualifier Code fying a specific industry co	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3
REQUIRED HI01	<u>ELEMEN</u> C022	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi SEMANTIC: C022-01 qu	codes and their associated C02204 is present, then the or C02209 may be present Qualifier Code fying a specific industry co	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3 de list
REQUIRED HI01	<u>ELEMEN</u> C022	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi SEMANTIC: C022-01 qu CODE DE BH O	Codes and their associated CO2204 is present, then the or CO2209 may be present Qualifier Code fying a specific industry co ualifies CO22-02, CO22-04, FINITION CCURRENCE	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3 de list C022-05, C022-06 and C022-08.
REQUIRED HI01	- 1	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi SEMANTIC: C022-01 qu CODE DE BH O CCC	Codes and their associated CO2204 is present, then the or CO2209 may be present c Qualifier Code fying a specific industry co ralifies CO22-02, CO22-04, FINITION CCURRENCE DDE SOURCE 132: National Updes	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3 de list C022-05, C022-06 and C022-08.
REQUIRED HI01	- 1	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi SEMANTIC: C022-01 qu CODE DE BH O CC CA	Codes and their associated CO2204 is present, then the or CO2209 may be present c Qualifier Code fying a specific industry co ralifies CO22-02, CO22-04, FINITION CCURRENCE DDE SOURCE 132: National Updes	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3 de list C022-05, C022-06 and C022-08.
REQUIRED HI01	- 1	HEALTH CARE C To send health care SYNTAX: P0304 If either C02203 or C E0809 Only one of C02208 1270 Code List Code identi SEMANTIC: C022-01 qu CODE DE BH O CC 1271 Industry C Code indica SEMANTIC:	Codes and their associated CO2204 is present, then the or CO2209 may be present Qualifier Code fying a specific industry co ualifies CO22-02, CO22-04, FINITION CCURTENCE DOE SOURCE 132: National U Dodes Code ating a code from a specific is used, then CO22-02 repu	M 1 d dates, amounts and quantities e other is required. t. M ID 1/3 de list C022-05, C022-06 and C022-08.

REQUIRED	HI01 - 3	12	50	Date Time Period Format Qualifier Code indicating the date format, time format, or	X r date and	ID d time fo	2/3 prmat
				SYNTAX: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C	022-04.		
		. <u> </u>	со	DE DEFINITION			
		D8	5	Date Expressed in Format CCY	YMMDD		
REQUIRED	HI01 - 4	12	51	Date Time Period Expression of a date, a time, or range of dates,	X times or	AN dates a	1/35 and times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Da	te		
NOT USED	HI01 - 5	782	2	Monetary Amount	ο	R	1/18
NOT USED	HI01 - 6	38	0	Quantity	ο	R	1/15
NOT USED	HI01 - 7	79	9	Version Identifier	ο	AN	1/30
NOT USED	HI01 - 8	12	71	Industry Code	Х	AN	1/30
NOT USED	HI01 - 9	10	73	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI02			H CARE CODE INFORMATION health care codes and their associated dates, a	O 1 mounts a	nd qua	ntities
		P0: If e E08	809	C02203 or C02204 is present, then the other is e of C02208 or C02209 may be present.	required.		
		oc us	curre ed to	NAL RULE: Required when it is necessary to ence code and the preceding HI data ele o report other occurrence codes. If not r nentation guide, do not send.	ements l	have b	een
REQUIRED	HI02 - 1	12	70	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05	, C022-06	6 and C	022-08.
			со	DE DEFINITION			
		BH	1	Occurrence			
REQUIRED	HI02 - 2	12	71	code source 132: National Uniform Bi Codes Industry Code Code indicating a code from a specific industry	M	mittee (AN	(NUBC) 1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.		ng valu	ie in a
				IMPLEMENTATION NAME: Occurrence Code			

REQUIRED	• TYPE 3			0000	JRRENC	E INFO	RMATIO
	HI02 -	3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 prmat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C	022-04.		
			c	ODE DEFINITION			
			D8	Date Expressed in Format CCY	YMMDD)	
REQUIRED	HI02 -	4	1251	Date Time Period Expression of a date, a time, or range of dates,	X times or	AN dates a	1/35 Ind times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Da	te		
NOT USED	HI02 -	5	782	Monetary Amount	ο	R	1/18
NOT USED	HI02 -	6	380	Quantity	ο	R	1/15
NOT USED	HI02 -	7	799	Version Identifier	ο	AN	1/30
NOT USED	HI02 -	8	1271	Industry Code	х	AN	1/30
NOT USED	HI02 -	9	1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI03	C022	HEAL	TH CARE CODE INFORMATION	01		
			SITUATIO	ne of C02208 or C02209 may be present.	o report	an ad	ditional
			used t	rence code and the preceding HI data ele to report other occurrence codes. If not r		have b	een
			used t			have b	een
REQUIRED	HI03 -	1	used t	o report other occurrence codes. If not r		have b	een
REQUIRED	HI03 -	1	used t implei	o report other occurrence codes. If not re mentation guide, do not send. Code List Qualifier Code	equired M	have b I by thi ID	een s 1/3
REQUIRED	HI03 -	1	used t impler 1270	to report other occurrence codes. If not re mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	equired M	have b I by thi ID	een s 1/3
REQUIRED	HI03 -	1	used t impler 1270	to report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	equired M	have b I by thi ID	een s 1/3
REQUIRED	HI03 -	1	used t implei 1270 c	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Bill	equired M , C022-00	have b I by thi ID 6 and C	een s 1/3 022-08.
REQUIRED	HI03 - HI03 -		used t implei 1270 c	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence	equired M , C022-00 lling Com	have b by thi ID 6 and C mittee	een s 1/3 022-08.
			used t implei 1270 c BH	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Bil Codes Industry Code	equired M , C022-00 lling Corr M code list	have b by thi ID 6 and C amittee (AN	een s 1/3 022-08. (NUBC) 1/30

005010X223 • 837 • 2 OCCURRENCE INFO				ASC X12N • INSUF TECHN			• TYPE
REQUIRED	HI03 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 prmat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C0)22-04.		
			c	ODE DEFINITION			
			D8	Date Expressed in Format CCYY	MMDD		
REQUIRED	HI03 - 4		1251	Date Time Period Expression of a date, a time, or range of dates,	х	AN	1/35 and times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Dat	е		
NOT USED	HI03 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI03 - 6		380	Quantity	ο	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI03 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI03 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI04	C022		TH CARE CODE INFORMATION	O 1 nounts a	ind qua	ntities
			E0809	C02203 or C02204 is present, then the other is rene of C02208 or C02209 may be present.	equired.		
			occur used t	NAL RULE: Required when it is necessary to rence code and the preceding HI data eler to report other occurrence codes. If not re mentation guide, do not send.	ments l	have b	een
REQUIRED	HI04 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
			C	ODE DEFINITION			
			BH	Occurrence			
REQUIRED	HI04 - 2		1271	code source 132: National Uniform Bill Codes Industry Code	м	mittee (AN	NUBC) 1/30
				Code indicating a code from a specific industry of SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.		ing valu	e in a
				IMPLEMENTATION NAME: Occurrence Code			

REQUIRED HI04 - 3 1250 Date Time Period Format Qualifier Code indicating the date format, time format, or or SYNTAX: P0304 REQUIRED HI04 - 4 250 Date Time Period Format Qualifier Code indicating the date format, time format, or or SYNTAX: P0304 REQUIRED HI04 - 4 251 Date Expressed in Format CCYYI REQUIRED HI04 - 4 1251 Date Time Period Expression of a date, a time, or range of dates, ti SYNTAX: P0304 NOT USED HI04 - 5 782 Monetary Amount NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304	022-04. MMDE X times or e 0 0 0 X X X 0 1	D AN r dates R R AN AN ID	1/35
P0304 SEMANTIC: CO22-03 is the date format that will appear in CO2 CODE DEFINITION D8 Date Expressed in Format CCYYI D8 Date Expression of a date, a time, or range of dates, time, or use of dates, time, or use of the date	r MMDE X times or e O O X X X O 1	R R AN AN ID	and times 1/18 1/15 1/30 1/30
CO22-03 is the date format that will appear in CO2 CODE DEFINITION D8 Date Expressed in Format CCYYI D8 Date Expressed in Format CCYYI D8 Date Expression of a date, a time, or range of dates, time NOT USED HI04 - 5 782 Monetary Amount NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am	r MMDE X times or e O O X X X O 1	R R AN AN ID	and times 1/18 1/15 1/30 1/30
REQUIRED HI04 - 4 Date Expressed in Format CCYYI 1251 Date Time Period Expression of a date, a time, or range of dates, time SYNTAX: P0304 NOT USED HI04 - 5 782 NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 HI04 - 9 1271 Industry Code NOT USED HI04 - 9 NOT USED HI04 - 9 NOT USED HI04 - 8 NOT USED HI04 - 9 NOT USED HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated	x times or e O O X X X O 1	AN r dates R R AN AN ID	and times 1/18 1/15 1/30 1/30
REQUIRED HI04 - 4 1251 Date Time Period Expression of a date, a time, or range of dates, til SYNTAX: P0304 NOT USED HI04 - 5 782 Monetary Amount NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304	x times or e O O X X X O 1	AN r dates R R AN AN ID	and times 1/18 1/15 1/30 1/30
International File international Expression of a date, a time, or range of dates, ti SYNTAX: P0304 IMPLEMENTATION NAME: Occurrence Code Date NOT USED HI04 - 5 782 Monetary Amount NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304	e O O X X X O 1	R R AN AN ID	and times 1/18 1/15 1/30 1/30
P0304 IMPLEMENTATION NAME: Occurrence Code Date NOT USED HI04 - 5 782 Monetary Amount NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304 P0304	0 0 0 X X 01	R AN AN ID	1/15 1/30 1/30
NOT USED HI04 - 5 782 Monetary Amount NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304 P0304	0 0 0 X X 01	R AN AN ID	1/15 1/30 1/30
NOT USED HI04 - 6 380 Quantity NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304 P0304	0 0 X X 0 1	R AN AN ID	1/15 1/30 1/30
NOT USED HI04 - 7 799 Version Identifier NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304 P0304	0 X X 01	AN AN ID	1/30 1/30
NOT USED HI04 - 8 1271 Industry Code NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304 P0304	X X O 1	AN ID	1/30
NOT USED HI04 - 9 1073 Yes/No Condition or Response Code SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304 P0304	X 0 1	ID	
SITUATIONAL HI05 C022 HEALTH CARE CODE INFORMATION To send health care codes and their associated dates, am SYNTAX: P0304	01		1/1
To send health care codes and their associated dates, am SYNTAX: P0304		and av	
SYNTAX: P0304	nounts	and av	
If either C02203 or C02204 is present, then the other is re E0809 Only one of C02208 or C02209 may be present.	equired.		
SITUATIONAL RULE: Required when it is necessary to a occurrence code and the preceding HI data elemused to report other occurrence codes. If not required to report other occurrence codes. If not required to report at a send.	ments	have	been
REQUIRED HI05 - 1 1270 Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C	C022-0)6 and (C022-08.
CODE DEFINITION			
BH Occurrence			
CODE SOURCE 132: National Uniform Billin Codes	U		,
REQUIRED HI05 - 2 1271 Industry Code Code indicating a code from a specific industry code	M code list	AN t	1/30
SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	ə beginr	ning val	ue in a

	2300 • HI ORMATION			ASC X12N • INSUR TECHN			• TYPE
REQUIRED	HI05 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C0	22-04.		
			C				
			D8	Date Expressed in Format CCYY	MMDD		
REQUIRED	HI05 - 4		1251	Date Time Period Expression of a date, a time, or range of dates, t	X imes or	AN dates a	1/35 nd times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Date	e		
NOT USED	HI05 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI05 - 6		380	Quantity	ο	R	1/15
NOT USED	HI05 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI05 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI05 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI06	C022		TH CARE CODE INFORMATION	O 1	ind qua	ntities
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.				
				NAL RULE: Required when it is necessary to rence code and the preceding HI data eler	-		ditiona
				to report other occurrence codes. If not re nentation guide, do not send.			
REQUIRED	HI06 - 1			to report other occurrence codes. If not re- mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list			
REQUIRED	HI06 - 1		impler	o report other occurrence codes. If not re nentation guide, do not send. Code List Qualifier Code	quired M	by thi	s 1/3
REQUIRED	HI06 - 1		impler 1270	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	quired M	by thi	s 1/3
REQUIRED	HI06 - 1		impler 1270	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	quired M	by thi	s 1/3
REQUIRED	HI06 - 1		impler 1270 	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Billi	quired M C022-06	by thi	s 1/3 022-08.
REQUIRED	HI06 - 1		impler 1270 	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence	quired M C022-06 ng Com	by thi	s 1/3 022-08.
			impler 1270 c BH	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, DEFINITION DEFINITION Occurrence Code source 132: National Uniform Billi Codes Industry Code	M C022-06 ng Com M code list	by thi	s 1/3 022-08. NUBC) 1/30

DEOLIIDED	「• TYPE 3			0000	RRENC	e info		
REQUIRED	HI06 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 prmat	
				syntax: P0304				
				SEMANTIC: C022-03 is the date format that will appear in Co	022-04.			
			CODE DEFINITION					
			D8	Date Expressed in Format CCYY	MMDD)		
REQUIRED	HI06 - 4		1251	Date Time Period Expression of a date, a time, or range of dates,	X times or	AN dates a	1/35 and time:	
				syntax: P0304				
				IMPLEMENTATION NAME: Occurrence Code Dat	е			
NOT USED	HI06 - 5		782	Monetary Amount	ο	R	1/18	
NOT USED	HI06 - 6		380	Quantity	0	R	1/15	
NOT USED	HI06 - 7		799	Version Identifier	ο	AN	1/30	
NOT USED	HI06 - 8		1271	Industry Code	х	AN	1/30	
NOT USED	HI06 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1	
SITUATIONAL	HI07	C022	HEAL	TH CARE CODE INFORMATION	01			
			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					
			used t	to report other occurrence codes. If not re				
REGURED			used t implei	to report other occurrence codes. If not re mentation guide, do not send.	equired	by thi	s	
REQUIRED	HI07 - 1		used t	to report other occurrence codes. If not re				
REQUIRED	HI07 - 1		used t implei	to report other occurrence codes. If not re mentation guide, do not send. Code List Qualifier Code	equired M	l by thi	s 1/3	
REQUIRED	HI07 - 1		used t impler 1270	to report other occurrence codes. If not re- mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	equired M	l by thi	s 1/3	
REQUIRED	HI07 - 1		used t impler 1270	to report other occurrence codes. If not re- mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	equired M	l by thi	s 1/3	
REQUIRED	HI07 - 1		used t implei 1270 c	to report other occurrence codes. If not re- mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Bill	equired M C022-00	I by thi	s 1/3 022-08.	
REQUIRED	HI07 - 1 HI07 - 2		used t implei 1270 c	to report other occurrence codes. If not re- mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence	equired M C022-00 ing Com	I by thi	s 1/3 022-08.	
			used t implei 1270 c BH	to report other occurrence codes. If not re- mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence CODE SOURCE 132: National Uniform Bill Codes Industry Code	equired M C022-00 ing Corr M code list	ID 6 and C mmittee (AN	s 1/3 022-08. (NUBC) 1/30	

005010X223 • 837 • 2 OCCURRENCE INFO				ASC X12N • INSU TECHI			• TYPE		
REQUIRED	HI07 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 prmat		
				syntax: P0304					
				SEMANTIC: C022-03 is the date format that will appear in C	022-04.				
			с	ODE DEFINITION					
			D8	Date Expressed in Format CCY	MMDD				
REQUIRED	HI07 - 4		1251	Date Time Period Expression of a date, a time, or range of dates,	Х	AN	1/35 nd times		
				SYNTAX: P0304					
				IMPLEMENTATION NAME: Occurrence Code Date	te				
NOT USED	HI07 - 5		782	Monetary Amount	ο	R	1/18		
NOT USED	HI07 - 6		380	Quantity	ο	R	1/15		
NOT USED	HI07 - 7		799	Version Identifier	ο	AN	1/30		
NOT USED	HI07 - 8		1271	Industry Code	х	AN	1/30		
NOT USED	HI07 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1		
SITUATIONAL	HI08	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, a	O 1 mounts a	and qua	ntities		
			SYNTAX: P0304 If either C02203 or C02204 is present, then the other is required. E0809 Only one of C02208 or C02209 may be present.						
			occur used t	DNAL RULE: Required when it is necessary to rence code and the preceding HI data ele to report other occurrence codes. If not re mentation guide, do not send.	ments	have b	een		
REQUIRED	HI08 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	Μ	ID	1/3		
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.		
			BH	Occurrence					
REQUIRED	HI08 - 2		1271	code source 132: National Uniform Bil Codes Industry Code Code indicating a code from a specific industry	М	AN	NUBC) 1/30		
				SEMANTIC: If C022-08 is used, then C022-02 represents th range of codes.			e in a		
				IMPLEMENTATION NAME: Occurrence Code					

	F • TYPE 3			0000			
REQUIRED	HI08 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C0)22-04.		
			C	ODE DEFINITION			
			D8	Date Expressed in Format CCYY	MMDD		
REQUIRED	HI08 - 4		1251	Date Time Period Expression of a date, a time, or range of dates,	X times or	AN dates a	1/35 nd times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Dat	e		
NOT USED	HI08 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI08 - 6		380	Quantity	ο	R	1/15
NOT USED	HI08 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI08 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI08 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI09	C022	HEAL	TH CARE CODE INFORMATION	01		
			E0809 Only or SITUATIO	CO2203 or CO2204 is present, then the other is more of CO2208 or CO2209 may be present. NAL RULE: <i>Required when it is necessary to rence code and the preceding HI data elements</i>	report ments l	have b	een
				to report other occurrence codes. If not re mentation guide, do not send.	equired	by thi	S
REQUIRED	HI09 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
			C		C022-06	6 and C	022-08.
			c BH	C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
			BH	C022-01 qualifies C022-02, C022-04, C022-05, DEFINITION Occurrence CODE SOURCE 132: National Uniform Bill Codes	ing Com	mittee (NUBC)
REQUIRED	HI09 - 2			C022-01 qualifies C022-02, C022-04, C022-05, DEFINITION Occurrence CODE SOURCE 132: National Uniform Bill	ing Com M		
REQUIRED	HI09 - 2		BH	C022-01 qualifies C022-02, C022-04, C022-05, DEFINITION Occurrence CODE SOURCE 132: National Uniform Bill Codes Industry Code	ing Com M code list	mittee (AN	NUBC) 1/30

	RMATION			ASC X12N • INSUF TECHN	IICAL R		• TYP
REQUIRED	HI09 -	3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C0)22-04.		
			c	ODE DEFINITION			
			D8	Date Expressed in Format CCYY	MMDD		
REQUIRED	HI09 -	4	1251	Date Time Period Expression of a date, a time, or range of dates, t	X times or	AN dates a	1/35 and time
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Date	е		
NOT USED	HI09 -	5	782	Monetary Amount	ο	R	1/18
NOT USED	HI09 -	6	380	Quantity	0	R	1/15
NOT USED	HI09 -	7	799	Version Identifier	ο	AN	1/30
NOT USED	HI09 -	8	1271	Industry Code	х	AN	1/30
NOT USED	HI09 -	9	1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI10	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, ar	O 1 nounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is rene of C02208 or C02209 may be present.	equired.		
			occur used t	DNAL RULE: Required when it is necessary to rence code and the preceding HI data eler to report other occurrence codes. If not re mentation guide, do not send.	ments	have b	een
REQUIRED	HI10 -	1	1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	М	ID	
REQUIRED	HI10 -	1	1270	Code identifying a specific industry code list			
REQUIRED	HI10 -	1	-	Code identifying a specific industry code list SEMANTIC:			
REQUIRED	HI10 -	1	-	Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION OCCURRENCE	C022-00	6 and C	
	HI10 -		C	Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION	C022-00	6 and C	022-08
REQUIRED			c BH	Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence CODE SOURCE 132: National Uniform Bill Codes	C022-00 ing Com	6 and C	022-08 (NUBC)
			c BH	Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence CODE SOURCE 132: National Uniform Bill Codes Industry Code	C022-00 ing Com M code list	5 and C mittee (AN	022-08 (NUBC 1/3(

MAY 2006

DEOLIDED	「• TYPE 3			0050 OCCI	URRENC	e info	RMATIO
REQUIRED	HI10 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, o	X r date and	ID d time fo	2/3 ormat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C	022-04.		
			c	ODE DEFINITION			
			D8	Date Expressed in Format CCY	YMMDD)	
REQUIRED	HI10 - 4		1251	Date Time Period Expression of a date, a time, or range of dates	X , times or	AN dates a	1/35 nd times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Da	te		
NOT USED	HI10 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI10 - 6		380	Quantity	0	R	1/15
NOT USED	HI10 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI10 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI10 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI11	C022	HEAL	TH CARE CODE INFORMATION	01		
			E0809 Only or SITUATIO	CO2203 or CO2204 is present, then the other is ne of CO2208 or CO2209 may be present. DNAL RULE: <i>Required when it is necessary to</i> rence code and the preceding HI data ele	o report	an ad	
				to report other occurrence codes. If not r			
				to report other occurrence codes. If not r mentation guide, do not send.			
REQUIRED	HI11 - 1			•			
REQUIRED	HI11 - 1		impler	mentation guide, do not send. Code List Qualifier Code	equired M	l by thi	s 1/3
REQUIRED	HI11 - 1		implei 1270	Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	equired M	l by thi	s 1/3
REQUIRED	HI11 - 1		implei 1270	Code List Qualifier CodeCode identifying a specific industry code listSEMANTIC:C022-01 qualifies C022-02, C022-04, C022-05	equired M	l by thi	s 1/3
REQUIRED	HI11 - 1		implei 1270 c	mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05 ODE DEFINITION Occurrence CODE SOURCE 132: National Uniform Bit	equired M , C022-00	ID ID 6 and C	s 1/3 022-08.
REQUIRED	HI11 - 1 HI11 - 2		implei 1270 c	mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05 ODE DEFINITION Occurrence	, C022-00 Iling Com	ID 1D 6 and C 1mittee (AN	s 1/3 022-08.
			implei 1270 c BH	Definition guide, do not send. Code List Qualifier Code Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05 C0DE DEFINITION Occurrence CODE DEFINITION Occurrence CODE SOURCE 132: National Uniform Bicodes Industry Code Industry Code	, C022-00 Illing Com M code list	ID 6 and C umittee (AN	s 1/3 022-08. NUBC) 1/30

	2300 • HI RMATION			ASC X12N • INSUI TECH			• TYPE
REQUIRED	HI11 - 3		1250	Date Time Period Format Qualifier Code indicating the date format, time format, or	X date and	ID d time fo	2/3 prmat
				syntax: P0304			
				SEMANTIC: C022-03 is the date format that will appear in C	022-04.		
			c	ODE DEFINITION			
			D8	Date Expressed in Format CCY	MMDD)	
REQUIRED	HI11 - 4		1251	Date Time Period Expression of a date, a time, or range of dates,	х	AN	1/35 nd times
				syntax: P0304			
				IMPLEMENTATION NAME: Occurrence Code Dat	е		
NOT USED	HI11 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI11 - 6		380	Quantity	ο	R	1/15
NOT USED	HI11 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI11 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI11 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI12	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, and	O 1 nounts a	and quai	ntities
			E0809	C02203 or C02204 is present, then the other is r ne of C02208 or C02209 may be present.	equired.		
				NAL RULE: Required when it is necessary to rence code and the preceding HI data ele		an ad	ditional
			used t	to report other occurrence codes. If not re mentation guide, do not send.			een
REQUIRED	HI12 - 1		used t	o report other occurrence codes. If not re			een
REQUIRED	HI12 - 1		used t impler	o report other occurrence codes. If not re mentation guide, do not send. Code List Qualifier Code	equired M	l by thi	een s 1/3
REQUIRED	HI12 - 1		used t impler 1270	To report other occurrence codes. If not re mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	equired M	l by thi	een s 1/3
REQUIRED	HI12 - 1		used t impler 1270	to report other occurrence codes. If not re mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	equired M	l by thi	een s 1/3
			used t implei 1270 c BH	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Bill Codes	equired M C022-00	I by thi	een s 1/3 022-08. NUBC)
REQUIRED	HI12 - 1 HI12 - 2		used t impler 1270 c	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Bill	equired M C022-00 ing Com M	I by this ID 6 and C mmittee (AN	een s 1/3 022-08.
			used t implei 1270 c BH	To report other occurrence codes. If not rementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Occurrence code source 132: National Uniform Bill Codes Industry Code	equired M C022-00 ing Corr M code list	ID 6 and C mmittee (AN	een s 1/3 022-08. NUBC) 1/30

ASC X12N • INSUR TECHNICAL REPO	ANCE SUBCOMMITTEE RT • TYPE 3		005010X223 • 837 • OCCURRENCE INFOR				
REQUIRED	HI12 - 3	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or d	X ate and	ID d time fo	2/3 prmat	
			syntax: P0304				
			SEMANTIC: C022-03 is the date format that will appear in C02	22-04.			
		C	ODE DEFINITION				
		D8	Date Expressed in Format CCYY	MDD)		
REQUIRED	HI12 - 4	1251	Date Time Period Expression of a date, a time, or range of dates, time	X mes or	AN dates a	1/35 and times	
			syntax: P0304				
			IMPLEMENTATION NAME: Occurrence Code Date				
NOT USED	HI12 - 5	782	Monetary Amount	ο	R	1/18	
NOT USED	HI12 - 6	380	Quantity	ο	R	1/15	
NOT USED	HI12 - 7	799	Version Identifier	ο	AN	1/30	
NOT USED	HI12 - 8	1271	Industry Code	х	AN	1/30	
NOT USED	HI12 - 9	1073	Yes/No Condition or Response Code	Х	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 C022 HI01 C022 HI02 C022 HI03 HI04 C022 HI05 C022 HI06 C022 **Health Care Health Care Health Care Health Care Health Care Health Care** * * * * * **H**| * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info. 01 O 1 O 1 O 1 01 M 1 HI07 C022 HI08 C022 HI09 C022 HI10 C022 HI11 C022 HI12 C022 Health Care Health Care **Health Care Health Care** Health Care Health Care * * * * * * Code Info. Code Info. Code Info. Code Info. Code Info. Code Info. O 1 01 01 01 01 01 ELEMENT DETAIL DATA REF. USAGE 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** Μ 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. DEFINITION CODE BE Value CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes REQUIRED HI01 - 2 1271 1/30 **Industry Code** М AN Code indicating a code from a specific industry code list SEMANTIC: If C022-08 is used, then C022-02 represents the beginning value in a range of codes.

IMPLEMENTATION NAME: Value Code

NOT USED	HI01 - 3	1250	Date Time Period Format Qualifier	v	п	a /a
NOT USED				X	ID	2/3
REQUIRED	HI01 - 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI01 - 5	782	Monetary Amount Monetary amount	0	R	1/18
			IMPLEMENTATION NAME: Value Code Amount			
NOT USED	HI01 - 6	380	Quantity	ο	R	1/15
NOT USED	HI01 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI01 - 8	1271	Industry Code	Х	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI02		TH CARE CODE INFORMATION	01		
		To sen	d health care codes and their associated dates, an	nounts a	ind qua	ntities
		SYNTAX P0304				
		If either	r C02203 or C02204 is present, then the other is re	equired.		
		E0809 Only or	ne of C02208 or C02209 may be present.			
		SITUATI	DNAL RULE: Required when it is necessary to	renorf	an ad	ditional
			code and the preceding HI data elements			
		-	t other value codes. If not required by this	impler	nentat	ion
		guide	, do not send.			
REQUIRED	HI02 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
		c	ODE DEFINITION			
		BE	Value			
			CODE SOURCE 132: National Uniform Billi	ing Com	mittee	NUBC)
REQUIRED	HI02 - 2	1271	Codes Industry Code	м	AN	1/30
			Code indicating a code from a specific industry of	ode list		
			SEMANTIC: If C022-08 is used, then C022-02 represents the	beginni	ing valu	e in a
			range of codes.			
NOT USED	11100 0	4050			15	0.10
NOT USED	HI02 - 3	1250	Date Time Period Format Qualifier	X	ID	2/3
REQUIRED	HI02 - 4	1251	Date Time Period	X	AN	1/35
REQUIRED	HI02 - 5	782	Monetary Amount Monetary amount	0	R	1/18
			IMPLEMENTATION NAME: Value Code Amount			
NOT USED	HI02 - 6	380	Quantity	ο	R	1/15
NOT USED	HI02 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI02 - 8	1271	Industry Code	х	AN	1/30
NOT USED	HI02 - 9	1073	Yes/No Condition or Response Code	X	ID	1/1
		1010		~		

SITUATIONAL	HI03	C022			CODE INFORMATION	O 1 mounts a	and qua	ntities
			E0809	[.] C02203 o	or C02204 is present, then the other is 0	required.		
			value report	code and	Required when it is necessary to I the preceding HI data elements Ilue codes. If not required by this send.	s have b	een u	sed to
REQUIRED	HI03 - 1		1270	Code ide	ist Qualifier Code entifying a specific industry code list	М	ID	1/3
				SEMANTIC C022-01	:: qualifies C022-02, C022-04, C022-05	, C022-00	6 and C	022-08.
			c	ODE	DEFINITION			
			BE		Value			
REQUIRED	HI03 - 2		1271	Industr	CODE SOURCE 132: National Uniform Bi Codes	lling Com M	mittee	(NUBC) 1/30
	11105 - 2		1271		licating a code from a specific industry			1/50
				SEMANTIC If C022-(range of	08 is used, then C022-02 represents th	e beginn	ing valu	ie in a
				IMPLEMEN	ITATION NAME: Value Code			
NOT USED	HI03 - 3		1250	Date Ti	me Period Format Qualifier	х	ID	2/3
NOT USED	HI03 - 4		1251	Date Ti	me Period	х	AN	1/35
REQUIRED	HI03 - 5		782		r y Amount y amount	0	R	1/18
				IMPLEMEN	ITATION NAME: Value Code Amount			
NOT USED	HI03 - 6		380	Quantit	y	ο	R	1/15
NOT USED	HI03 - 7		799	Versior	Identifier	ο	AN	1/30
NOT USED	HI03 - 8		1271	Industr	y Code	х	AN	1/30
NOT USED	HI03 - 9		1073	Yes/No	Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI04	C022		-	CODE INFORMATION re codes and their associated dates, a	O 1 mounts a	and qua	ntities
			E0809	[.] C02203 o	or C02204 is present, then the other is 0	required.		
			value report	code and	Required when it is necessary to I the preceding HI data elements Ilue codes. If not required by this send.	s have b	een u	sed to

ASC X12N • INSURA TECHNICAL REPOR						5010X223 VALU		RMATIO
REQUIRED	HI04 - 1	1	1270	Code List Qu Code identifyin	alifier Code g a specific industry code list	Μ	ID	1/3
				seмanтic : C022-01 qualifi	es C022-02, C022-04, C022-	05, C022-06	3 and C	022-08.
		_	C	DDE DEFINIT	TION			
		E	BE	Value)			
				CODE S	OURCE 132: National Uniform	Billing Com	mittee	(NUBC)
REQUIRED	HI04 - 2	1	1271	Industry Cod	le	м	AN	1/30
				-	a code from a specific indust	ry code list		
				SEMANTIC: If C022-08 is us range of codes	sed, then C022-02 represents	the beginn	ing valu	ie in a
				IMPLEMENTATION	NAME: Value Code			
NOT USED	HI04 - 3	1	1250	Date Time Pe	eriod Format Qualifier	х	ID	2/3
NOT USED	HI04 - 4	1	1251	Date Time Pe	eriod	х	AN	1/35
REQUIRED	HI04 - 5	7	782	Monetary An Monetary amou		0	R	1/18
				IMPLEMENTATION	NAME: Value Code Amour	t		
NOT USED	HI04 - 6	3	380	Quantity		ο	R	1/15
NOT USED	HI04 - 7	7	799	Version Iden	tifier	ο	AN	1/30
NOT USED	HI04 - 8	1	1271	Industry Coc	le	х	AN	1/30
NOT USED	HI04 - 9	1	1073	Yes/No Cond	lition or Response Code	х	ID	1/1
SITUATIONAL	HI05				E INFORMATION es and their associated dates	O 1 , amounts a	and qua	ntities
		F	E0809		204 is present, then the other 202209 may be present.	is required.		
		1	value (report	code and the	ired when it is necessary preceding HI data elemen odes. If not required by t	nts have b	een us	sed to
REQUIRED	HI05 - 1	1	1270	Code List Qu Code identifyin	alifier Code g a specific industry code list	Μ	ID	1/3
				semantic: C022-01 qualifi	es C022-02, C022-04, C022-	05, C022-06	6 and C	022-08.
		-	C	DDE DEFINIT	rion			
		E	BE	Value	9			
				CODE S	OURCE 132: National Uniform	Billing Com	mittee	(NUBC)

005010X223 • 837 • 2300 • HI
VALUE INFORMATION

REQUIRED	HI05 - 2		1271	Industry Code	м	AN	1/30
				Code indicating a code from a specific industry of		,	.,
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginni	ing valu	ie in a
				IMPLEMENTATION NAME: Value Code			
NOT USED	HI05 - 3		1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI05 - 4		1251	Date Time Period	Х	AN	1/35
REQUIRED	HI05 - 5		782	Monetary Amount Monetary amount	ο	R	1/18
				IMPLEMENTATION NAME: Value Code Amount			
NOT USED	HI05 - 6		380	Quantity	ο	R	1/1
NOT USED	HI05 - 7		799	Version Identifier	0	AN	1/3
NOT USED	HI05 - 8		1271	Industry Code	Х	AN	1/3
NOT USED	HI05 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI06	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, an	O 1 nounts a	ind qua	ntities
			Only or	ne of C02208 or C02209 may be present.			
REQUIRED	HI06 - 1		situatio value report	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code	have b	een u	sed to tion
REQUIRED	HI06 - 1		situatio value report guide,	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send.	have b impler M	een u nentai ID	sed to tion 1/3
REQUIRED	HI06 - 1		situatio value report guide, 1270	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	have b impler M	een u nentai ID	sed to tion 1/3
REQUIRED	HI06 - 1		situatic value report guide, 1270	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION	have b impler M	een u nentai ID	sed to tion 1/3
REQUIRED	HI06 - 1		situatio value report guide, 1270	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	have b impler M C022-06	een us nentat ID	sed to tion 1/3 022-08
REQUIRED	HI06 - 1		situatic value report guide, 1270	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value code source 132: National Uniform Billic Codes Industry Code	have b impler. M C022-06 ing Com	een us nentat ID	sed to tion 1/3 022-08
			situatio value report guide, 1270 c BE	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value code source 132: National Uniform Billic Codes	have b impler M C022-06 ing Com M code list	inentation ID S and C mittee AN	sed to tion 1/3 :022-08 (NUBC 1/3
			situatio value report guide, 1270 c BE	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value code source 132: National Uniform Billi Code indicating a code from a specific industry code SEMANTIC: Industry Code Code indicating a code from a specific industry code SEMANTIC: If C022-08 is used, then C022-02 represents the	have b impler M C022-06 ing Com M code list	inentation ID S and C mittee AN	sed to tion 1/3 022-08 (NUBC 1/3
REQUIRED			situatio value report guide, 1270 c BE	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value codes Industry Code Code indicating a code from a specific industry code si is used, then C022-02 represents the range of codes.	have b impler M C022-06 ing Com M code list	inentation ID S and C mittee AN	sed to tion 1/3 :022-08 (NUBC 1/3 ue in a
REQUIRED NOT USED	HI06 - 2		SITUATIO value report guide, 1270 	DNAL RULE: Required when it is necessary to code and the preceding HI data elements of ther value codes. If not required by this do not send. Code List Qualifier Code Code list Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value Codes Industry Code Code indicating a code from a specific industry code indicating a code from a specific industry code range of codes. IMPLEMENTATION NAME: Value Code	have b impler M C022-00 ing Com M code list	ing valu	sed to tion 1/3 022-08 (NUBC 1/3 ue in a 2/3
REQUIRED NOT USED NOT USED	HI06 - 2 HI06 - 3		SITUATIO value report guide, 1270 C BE 1271	DNAL RULE: Required when it is necessary to code and the preceding HI data elements of ther value codes. If not required by this of a not send. Code List Qualifier Code Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value code source 132: National Uniform Billi Codes Industry Code Code indicating a code from a specific industry of semantic: If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Value Code Date Time Period Format Qualifier	have b impler M C022-00 ing Com M code list beginni	ing valu	sed to tion 1/3 022-08 (NUBC 1/3 ue in a 2/3 1/3
	HI06 - 2 HI06 - 3 HI06 - 4		SITUATIC value report guide, 1270 C BE 1271 1250 1251	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION Value code identify code Code indicating a code from a specific industry code Industry Code Code indicating a code from a specific industry code If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Value Code Date Time Period Format Qualifier Date Time Period Monetary Amount	have b impler M C022-00 ing Com M code list e beginni & X X	ing value	sed to tion 1/3 022-08 (NUBC 1/3

ASC X12N • INSURAI TECHNICAL REPORT			INTIEE			005010X223 VALU		2300 • I RMATIO		
NOT USED	HI06	- 7		799	Version Identifier	Ο	AN	1/30		
NOT USED	HI06	- 8		1271	Industry Code	Х	AN	1/30		
NOT USED	HI06	- 9		1073	Yes/No Condition or Response C	ode X	ID	1/1		
SITUATIONAL	HI07		C022	HEALTH CARE CODE INFORMATIONO 1To send health care codes and their associated dates, amounts and quantities						
				E0809	C02203 or C02204 is present, then the o e of C02208 or C02209 may be present.	other is required.				
				value report	NAL RULE: Required when it is neces code and the preceding HI data ele other value codes. If not required do not send.	ements have b	een u	sed to		
REQUIRED	HI07	- 1		1270	Code List Qualifier Code Code identifying a specific industry code	M e list	ID	1/3		
					SEMANTIC: C022-01 qualifies C022-02, C022-04, C	:022-05, C022-0	6 and C	022-08.		
				с						
				BE	Value					
					CODE SOURCE 132: National Un	form Billing Corr	mittee	(NUBC)		
REQUIRED	HI07	- 2		1271	Codes Industry Code Code indicating a code from a specific i	M ndustry code list	AN	1/30		
					SEMANTIC: If C022-08 is used, then C022-02 repre range of codes.	sents the beginn	ing valu	ie in a		
					IMPLEMENTATION NAME: Value Code					
NOT USED	HI07	- 3		1250	Date Time Period Format Qualifie	er X	ID	2/3		
NOT USED	HI07	- 4		1251	Date Time Period	Х	AN	1/35		
REQUIRED	HI07	- 5		782	Monetary Amount Monetary amount	0	R	1/18		
					IMPLEMENTATION NAME: Value Code An	nount				
NOT USED	HI07	- 6		380	Quantity	0	R	1/15		
NOT USED	HI07	- 7		799	Version Identifier	0	AN	1/30		
NOT USED	HI07	- 8		1271	Industry Code	Х	AN	1/30		
NOT USED	HI07	- 9		1073	Yes/No Condition or Response C	ode X	ID	1/1		
SITUATIONAL	HI08		C022		TH CARE CODE INFORMATION	O 1 dates, amounts a	and qua	ntities		
				SYNTAX: P0304 If either E0809			·			
				value report	NAL RULE: Required when it is neces code and the preceding HI data ele other value codes. If not required do not send.	ements have b	een u	sed to		

005010X223 • 837 • 2300 •	нι
VALUE INFORMATION	

REQUIRED	HI08 - 1	1270		List Qualifier Code entifying a specific industry code list	М	ID	1/3
			semanti C022-0	c : 1 qualifies C022-02, C022-04, C022-05, C	022-0	6 and C	022-08.
			CODE	DEFINITION			
		BE		Value			
				CODE SOURCE 132: National Uniform Billin	ng Corr	nmittee	(NUBC)
REQUIRED	HI08 - 2	1271		Codes ry Code dicating a code from a specific industry co	M ode list	AN	1/30
				c: 08 is used, then C022-02 represents the f codes.	beginn	iing valu	ie in a
			IMPLEME	NTATION NAME: Value Code			
NOT USED	HI08 - 3	1250	Date T	ime Period Format Qualifier	х	ID	2/3
NOT USED	HI08 - 4	1251	Date T	ime Period	х	AN	1/35
REQUIRED	HI08 - 5	782		ary Amount ry amount	0	R	1/18
			IMPLEME	NTATION NAME: Value Code Amount			
NOT USED	HI08 - 6	380	Quanti	ity	ο	R	1/15
NOT USED	HI08 - 7	799	Versio	n Identifier	ο	AN	1/30
NOT USED	HI08 - 8	1271	Indust	ry Code	х	AN	1/30
NOT USED	HI08 - 9	1073	Yes/No	Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI09 (-	E CODE INFORMATION	01		
				are codes and their associated dates, am	ounts a	and qua	ntities
		SYNTA P0304	4				
		E0809	Ð	or C02204 is present, then the other is re	quired.		
		Only o	one of C022	208 or C02209 may be present.			
		value repo	e code an	Required when it is necessary to d the preceding HI data elements I alue codes. If not required by this send.	have k	been u	sed to
REQUIRED	HI09 - 1	1270		List Qualifier Code entifying a specific industry code list	Μ	ID	1/3
			semanti C022-0	c: 1 qualifies C022-02, C022-04, C022-05, C	022-0	6 and C	022-08.
			CODE	DEFINITION			
		BE		Value			
				CODE SOURCE 132: National Uniform Billir Codes	ng Corr	nmittee	(NUBC)

ASC X12N • INSURA TECHNICAL REPOR		IMITTEE			005010X223 VALU		2300 • H RMATION
REQUIRED	HI09 - 2		1271	Industry Code Code indicating a code from a specific i	M ndustry code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 repre range of codes.	sents the beginr	ing valu	ie in a
				IMPLEMENTATION NAME: Value Code			
NOT USED	HI09 - 3		1250	Date Time Period Format Qualifie	er X	ID	2/3
NOT USED	HI09 - 4		1251	Date Time Period	х	AN	1/35
REQUIRED	HI09 - 5		782	Monetary Amount Monetary amount	0	R	1/18
				IMPLEMENTATION NAME: Value Code An	nount		
NOT USED	HI09 - 6		380	Quantity	0	R	1/15
NOT USED	HI09 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI09 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI09 - 9		1073	Yes/No Condition or Response C	ode X	ID	1/1
SITUATIONAL	HI10	C022		TH CARE CODE INFORMATION	01		
REQUIRED	HI10 - 1		SITUATIC value report	e of C02208 or C02209 may be present. NAL RULE: Required when it is necess code and the preceding HI data ele other value codes. If not required do not send. Code List Qualifier Code Code identifying a specific industry code SEMANTIC:	ements have b by this imple M e list	been u menta ID	sed to tion 1/3
			C	C022-01 qualifies C022-02, C022-04, C	022-05, C022-0	6 and C	022-08.
			BE	Value			
				code source 132: National Un	form Billing Con	mittee	(NUBC)
REQUIRED	HI10 - 2		1271	Codes Industry Code Code indicating a code from a specific i	M ndustry code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 repre range of codes.	sents the beginr	ing valu	ie in a
				IMPLEMENTATION NAME: Value Code			
NOT USED	HI10 - 3		1250	Date Time Period Format Qualifie	er X	ID	2/3
NOT USED	HI10 - 4		1251	Date Time Period	X	AN	1/35
REQUIRED	HI10 - 5		782	Monetary Amount Monetary amount	0	R	1/18
				IMPLEMENTATION NAME: Value Code An	nount		
NOT USED	HI10 - 6		380	Quantity	0	R	1/15
	1110 - 0		500	wannity	0	n	1/13

005010X223 • 837 • 2 VALUE INFORMATIO				ASC X12N • INSUF TECHN			MMITTEE • TYPE 3
NOT USED	HI10 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI10 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI10 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI11	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, ar	O 1 nounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is rene of C02208 or C02209 may be present.	equired.		
			value report	DNAL RULE: Required when it is necessary to code and the preceding HI data elements to ther value codes. If not required by this do not send.	have b	een u	sed to
REQUIRED	HI11 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
			с	ODE DEFINITION			
			BE	Value			
				CODE SOURCE 132: National Uniform Bill	ing Com	mittee	(NUBC)
REQUIRED	HI11 - 2		1271	Codes Industry Code Code indicating a code from a specific industry of	M code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	ie in a
				IMPLEMENTATION NAME: Value Code			
NOT USED	HI11 - 3		1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI11 - 4		1251	Date Time Period	х	AN	1/35
REQUIRED	HI11 - 5		782	Monetary Amount Monetary amount	ο	R	1/18
				IMPLEMENTATION NAME: Value Code Amount			
NOT USED	HI11 - 6		380	Quantity	ο	R	1/15
NOT USED	HI11 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI11 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI11 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI12	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, ar	O 1 nounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is rene of C02208 or C02209 may be present.	equired.		
			value report	DNAL RULE: Required when it is necessary to code and the preceding HI data elements other value codes. If not required by this do not send.	have b	een u	sed to

REQUIRED	HI12 - 1	1270	Code identifying a specific industry code list		М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022		022-06	6 and C	022-08.
		C	ODE	DEFINITION			
		BE		Value			
				CODE SOURCE 132: National Uniform Billin Codes	ng Com	mittee	NUBC)
REQUIRED	HI12 - 2	1271		ry Code	М	AN	1/30
				dicating a code from a specific industry co	ode list		
				c: -08 is used, then C022-02 represents the f codes.	beginn	ing valu	e in a
			IMPLEME	NTATION NAME: Value Code			
NOT USED	HI12 - 3	1250	Date T	ime Period Format Qualifier	Х	ID	2/3
NOT USED	HI12 - 4	1251	Date T	ime Period	х	AN	1/35
REQUIRED	HI12 - 5	782		ary Amount ry amount	0	R	1/18
			IMPLEME	NTATION NAME: Value Code Amount			
NOT USED	HI12 - 6	380	Quant	ity	ο	R	1/15
NOT USED	HI12 - 7	799	Versio	n Identifier	ο	AN	1/30
NOT USED	HI12 - 8	1271	Indust	ry Code	Х	AN	1/30
NOT USED	HI12 - 9	1073	Yes/No	o Condition or Response Code	Х	ID	1/1

SEGMENT DETAIL						
	HI - COI	NDIT	ION INF	ORMAT	ION	
X12 Segment Name:	Health Care I	Informa	tion Codes			
X12 Purpose:				he delivery of h	nealth care	
Loop:	2300 — CLA	IM INFO	ORMATION			
Segment Repeat:	2					
Usage:	SITUATION	AL .				
Situational Rule:	-			lition Code tha n guide, do no		is claim. If not
TR3 Example:	HI*BG:17*E	3G:67~				
DIAGRAM						
HI01 CO Health Ca Code Info M 1	re 🐰 Health C	are *	HI03 C022 Health Care Code Info. O 1	HI04 C022 Health Care Code Info. O 1	HI05 C022 Health Care Code Info. O 1 O 1	HI06 C022 Health Care Code Info. O 1
HI07 C0 Health Ca Code Info O 1	re 🔺 Health C	are *	HI09 C022 Health Care Code Info. O 1	HI10 C022 Health Care Code Info. O 1 O 1	HI11 C022 Health Care Code Info. 0 1 0	HI12 C022 Health Care Code Info. 0 1 ~
ELEMENT DETAIL						
	REF. DATA DES. <u>ELEMENT</u>	NAME				ATTRIBUTES
REQUIRED HI01	C022			DE INFORMATI	ON I	M 1
REQUIRED HI01	- 1	SYNTAX: P0304 If either E0809	r C02203 or C02 ne of C02208 or		en the other is requi	·
		1210		ing a specific indus	try code list	
			seмantic: C022-01 qual	ifies C022-02, C02	2-04, C022-05, C02	22-06 and C022-08.
		c		NITION		
		BG		dition		
REQUIRED HI01		4074	Code	es	onal Unitorm Billing	Committee (NUBC)
REQUIRED HI01	- 2	1271	Industry Co Code indicatir		pecific industry code	M AN 1/30 e list
			SEMANTIC: If C022-08 is range of code		2 represents the be	ginning value in a
			IMPLEMENTATIC	ON NAME: Conditio	n Code	

NOT USED	HI01 - 3	1250 Da	ate Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI01 - 4	1251 Da	ate Time Period	Х	AN	1/35
NOT USED	HI01 - 5	782 M	onetary Amount	0	R	1/18
NOT USED	HI01 - 6	380 Q	uantity	Ο	R	1/15
NOT USED	HI01 - 7	799 Ve	ersion Identifier	0	AN	1/30
NOT USED	HI01 - 8	1271 In	dustry Code	х	AN	1/30
NOT USED	HI01 - 9	1073 Y	es/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI02 C02	To send he SYNTAX: P0304 If either C0 E0809 Only one of SITUATIONAL condition to report	CARE CODE INFORMATION walth care codes and their associated dates, and 2203 or C02204 is present, then the other is r f C02208 or C02209 may be present. RULE: Required when it is necessary to be code and the preceding HI data elem other condition codes. If not required intation guide, do not send.	required. The report The report of the second secon	an ad ve bee	ditional
REQUIRED	HI02 - 1	Co	ode List Qualifier Code ode identifying a specific industry code list :MANTIC: 022-01 qualifies C022-02, C022-04, C022-05, 			
REQUIRED		1071 In	Codes	•		
	HI02 - 2	Co se If ra	Idustry Code ode indicating a code from a specific industry IMANTIC: C022-08 is used, then C022-02 represents th nge of codes. PLEMENTATION NAME: Condition Code		AN ing valu	1/30 e in a
NOT USED	HI02 - 3	1250 D	ate Time Period Format Qualifier	х	ID	2/3
NOT USED	HI02 - 4	1251 Da	ate Time Period	х	AN	1/35
NOT USED	HI02 - 5	782 M	onetary Amount	ο	R	1/18
NOTHERD						
NOT USED	HI02 - 6	380 Q	uantity	0	R	1/15
NOT USED	HI02 - 6 HI02 - 7		uantity ersion Identifier	0 0	R AN	1/15 1/30
		799 Ve	•			
NOT USED	HI02 - 7	799 Vo 1271 In	ersion Identifier	ο	AN	1/30

SITUATIONAL	HI03	C022		TH CARE CODE INFORMATION	O 1 nounts a	and qua	ntities	
			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 BULLE: Required when it is precessary to report an additi					
			condit to rep	NAL RULE: Required when it is necessary to ion code and the preceding HI data eleme ort other condition codes. If not required mentation guide, do not send.	ents ha	ve bee		
REQUIRED	HI03 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3	
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.	
			c	DDE DEFINITION				
			BG	Condition				
				code source 132: National Uniform Bill Codes	ing Com	mittee	(NUBC)	
REQUIRED	HI03 - 2		1271	Industry Code Code indicating a code from a specific industry	M code list	AN	1/30	
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginni	ing valu	e in a	
				IMPLEMENTATION NAME: Condition Code				
NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	Х	ID	2/3	
NOT USED	HI03 - 4		1251	Date Time Period	Х	AN	1/35	
NOT USED	HI03 - 5		782	Monetary Amount	0	R	1/18	
NOT USED	HI03 - 6		380	Quantity	0	R	1/15	
NOT USED	HI03 - 7		799	Version Identifier	0	AN	1/30	
NOT USED	HI03 - 8		1271	Industry Code	Х	AN	1/30	
	HI03 - 9		1073	Yes/No Condition or Response Code	X	ID	1/1	
SITUATIONAL	HI04	C022		"H CARE CODE INFORMATION I health care codes and their associated dates, ar	O 1 nounts a	and qua	ntities	
			E0809	C02203 or C02204 is present, then the other is r e of C02208 or C02209 may be present.	equired.			
			condit to rep	NAL RULE: Required when it is necessary to ion code and the preceding HI data eleme ort other condition codes. If not required mentation guide, do not send.	ents ha	ve bee		

ASC X12N • INSURAI FECHNICAL REPORT		OMMITTEE			005010X223 CONDITIO		
REQUIRED	HI04 -	1	1270	Code List Qualifier Code Code identifying a specific industry code lis	M	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C02	2-05, C022-06	6 and C	022-08.
			C	ODE DEFINITION			
			BG	Condition			
				code source 132: National Unifor Codes	m Billing Com	mittee (NUBC)
REQUIRED	HI04 -	2	1271	Industry Code Code indicating a code from a specific indu	M ustry code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represer range of codes.	its the beginn	ing valu	e in a
				IMPLEMENTATION NAME: Condition Code			
NOT USED	HI04 -	3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI04 -	4	1251	Date Time Period	х	AN	1/35
NOT USED	HI04 -	5	782	Monetary Amount	0	R	1/18
NOT USED	HI04 -	6	380	Quantity	0	R	1/15
NOT USED	HI04 -	7	799	Version Identifier	0	AN	1/30
NOT USED	HI04 -	8	1271	Industry Code	Х	AN	1/30
NOT USED	HI04 -	9	1073	Yes/No Condition or Response Cod	le X	ID	1/1
SITUATIONAL	HI05	C022	To send SYNTAX: P0304 If either E0809 Only on SITUATIO	TH CARE CODE INFORMATION d health care codes and their associated date c C02203 or C02204 is present, then the other he of C02208 or C02209 may be present. NAL RULE: <i>Required when it is necessa</i> tion code and the preceding HI data e	er is required. ry to report	an ad	ditiona
			to rep	ort other condition codes. If not requ mentation 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, C02	2-05, C022-06	6 and C	022-08.
			C	ODE DEFINITION			
			BG	Condition			
				code source 132: National Unifor Codes	m Billing Com	imittee (NUBC)
		<u>^</u>	1271	Industry Code	M ustry code list	AN	1/30
REQUIRED	HI05 -	2		Code indicating a code from a specific indu	,		
REQUIRED	HI05 -	2		SEMANTIC: If C022-08 is used, then C022-02 represer range of codes.	-	ing valu	e in a
REQUIRED	HI05 -	2		SEMANTIC: If C022-08 is used, then C022-02 represer	-	ing valu	e in a
REQUIRED NOT USED	HI05 - HI05 -		1250	SEMANTIC: If C022-08 is used, then C022-02 represer range of codes.	-	ing valu ID	e in a 2/3

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3 005010X223 • 837 • 2300 • HI CONDITION INFORMATION NOT USED HI05 - 5 R 782 **Monetary Amount** ο 1/18 NOT USED HI05 - 6 380 Quantity Ο R 1/15 NOT USED HI05 - 7 799 **Version Identifier** AN 1/30 ο NOT USED HI05 - 8 1271 **Industry Code** Х AN 1/30 NOT USED HI05 - 9 1073 Х 1/1 Yes/No Condition or Response Code ID SITUATIONAL **HEALTH CARE CODE INFORMATION** HI06 C022 01 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 quide, do not send. REQUIRED HI06 - 1 1270 **Code List Qualifier Code** Μ 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** AN 1/30 Μ 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** Х ID 2/3 NOT USED HI06 - 4 1251 **Date Time Period** Х AN 1/35 NOT USED HI06 - 5 782 **Monetary Amount** 0 R 1/18 NOT USED HI06 - 6 380 Quantity 0 R 1/15 NOT USED HI06 - 7 Version Identifier 799 0 AN 1/30 NOT USED HI06 - 8 1271 **Industry Code** Х AN 1/30 NOT USED HI06 - 9 1073 Yes/No Condition or Response Code Х ID 1/1

MAY 2006

SITUATIONAL	HI07	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, and	O 1 nounts a	and quai	ntities
			E0809	C02203 or C02204 is present, then the other is respected or C02208 or C02209 may be present.	equired.		
			Only of				
			condit to rep	NAL RULE: Required when it is necessary to tion code and the preceding HI data eleme ort other condition codes. If not required mentation guide, do not send.	ents ha	ve bee	
REQUIRED	HI07 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
			c	ODE DEFINITION			
			BG	Condition			
				code source 132: National Uniform Billi Codes	ing Com	mittee (NUBC)
REQUIRED	HI07 - 2		1271	Industry Code Code indicating a code from a specific industry of	M code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginni	ing valu	e in a
				IMPLEMENTATION NAME: Condition Code			
NOT USED	HI07 - 3		1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI07 - 4		1251	Date Time Period	Х	AN	1/35
NOT USED	HI07 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI07 - 6		380	Quantity	ο	R	1/15
NOT USED	HI07 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI07 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI07 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI08	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, an	O 1 nounts a	and quai	ntities
			E0809	C02203 or C02204 is present, then the other is rene of C02208 or C02209 may be present.	equired.		
			condit to rep	DNAL RULE: Required when it is necessary to tion code and the preceding HI data eleme ort other condition codes. If not required mentation guide, do not send.	ents ha	ve bee	

005010X223 • 837 • 2 CONDITION INFORM					ASC X12N • INSUF TECHN			MMITTEE • TYPE 3
REQUIRED	HI08 - 1		1270		ist Qualifier Code entifying a specific industry code list	М	ID	1/3
				SEMANTIC C022-01	c: I qualifies C022-02, C022-04, C022-05,	C022-06	and C	022-08.
			с	ODE	DEFINITION			
			BG		Condition			
					CODE SOURCE 132: National Uniform Bill	ing Com	mittee (NUBC)
REQUIRED	HI08 - 2		1271		Codes r y Code dicating a code from a specific industry o	M code list	AN	1/30
				SEMANTIC If C022- range of	08 is used, then C022-02 represents the	e beginni	ng valu	e in a
				IMPLEME	NTATION NAME: Condition Code			
NOT USED	HI08 - 3		1250	Date Ti	ime Period Format Qualifier	х	ID	2/3
NOT USED	HI08 - 4		1251	Date Ti	ime Period	х	AN	1/35
NOT USED	HI08 - 5		782	Moneta	ary Amount	ο	R	1/18
NOT USED	HI08 - 6		380	Quanti	ty	ο	R	1/15
NOT USED	HI08 - 7		799	Versio	n Identifier	ο	AN	1/30
NOT USED	HI08 - 8		1271	Industi	ry Code	Х	AN	1/30
NOT USED	HI08 - 9		1073	Yes/No	Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI09	C022		-	E CODE INFORMATION are codes and their associated dates, ar	01		
			E0809 Only or situatic condit to rep	ne of C022 DNAL RULE: tion code ort other	or C02204 is present, then the other is n 208 or C02209 may be present. Required when it is necessary to e and the preceding HI data eleme r condition codes. If not required	report ents ha		
REQUIRED			-		n guide, do not send.			
	HI09 - 1		1270		.ist Qualifier Code entifying a specific industry code list	М	ID	1/3
				SEMANTIC C022-01	c: I qualifies C022-02, C022-04, C022-05,	C022-06	and C	022-08.
			с	ODE	DEFINITION			
			BG		Condition			
					CODE SOURCE 132: National Uniform Bill Codes	ing Com	mittee (NUBC)
REQUIRED	HI09 - 2		1271		r y Code dicating a code from a specific industry o	M code list	AN	1/30
					_			
				SEMANTIC If C022- range of	08 is used, then C022-02 represents the	e beginni	ng valu	e in a
				If C022- range of	08 is used, then C022-02 represents the	e beginni	ng valu	e in a
NOT USED	HI09 - 3		1250	If C022- range of	08 is used, then C022-02 represents the codes.	e beginni X	ng valu ID	e in a 2/3

TECHNICAL REPORT • TYPE 3 CONDITION INFORMATION NOT USED HI09 - 5 R 782 **Monetary Amount** ο 1/18 NOT USED HI09 - 6 380 Quantity Ο R 1/15 NOT USED HI09 - 7 799 **Version Identifier** AN 1/30 ο NOT USED HI09 - 8 1271 **Industry Code** Х AN 1/30 NOT USED HI09 - 9 1073 Х 1/1 Yes/No Condition or Response Code ID SITUATIONAL **HEALTH CARE CODE INFORMATION** HI10 C022 01 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 quide, do not send. REQUIRED HI10 - 1 1270 Code List Qualifier Code Μ 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 HI10 - 2 1271 **Industry Code** AN 1/30 Μ Code indicating a code from a specific industry code list SEMANTIC If C022-08 is used, then C022-02 represents the beginning value in a range of codes. IMPLEMENTATION NAME: Condition Code NOT USED HI10 - 3 1250 **Date Time Period Format Qualifier** Х ID 2/3 NOT USED HI10 - 4 1251 **Date Time Period** Х AN 1/35 NOT USED HI10 - 5 782 **Monetary Amount** 0 R 1/18 NOT USED HI10 - 6 380 0 R 1/15 Quantity NOT USED Version Identifier HI10 - 7 799 0 AN 1/30 NOT USED 1271 **Industry Code** Х AN 1/30 HI10 - 8 NOT USED HI10 - 9 1073 Х ID 1/1 Yes/No Condition or Response Code

ASC X12N • INSURANCE SUBCOMMITTEE

005010X223 • 837 • 2300 • HI

SITUATIONAL	HI11	C022		TH CARE CODE INFORMATION I health care codes and their associated dates, a	O 1 mounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is r e of C02208 or C02209 may be present.	equired.		
			condit to rep	NAL RULE: Required when it is necessary to ion code and the preceding HI data elem ort other condition codes. If not required nentation guide, do not send.	ents ha	ve bee	
REQUIRED	HI11 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08.
			с	DDE DEFINITION			
			BG	Condition			
				code source 132: National Uniform Bil Codes	ing Com	mittee (NUBC)
REQUIRED	HI11 - 2		1271	Industry Code Code indicating a code from a specific industry	M code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents th range of codes.	e beginni	ing valu	e in a
				IMPLEMENTATION NAME: Condition Code			
NOT USED	HI11 - 3		1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI11 - 4		1251	Date Time Period	Х	AN	1/35
NOT USED	HI11 - 5		782	Monetary Amount	0	R	1/18
NOT USED	HI11 - 6		380	Quantity	0	R	1/15
NOT USED	HI11 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI11 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI11 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI12	C022		TH CARE CODE INFORMATION I health care codes and their associated dates, a	O 1 mounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is r e of C02208 or C02209 may be present.	equired.		
			condit to rep	NAL RULE: Required when it is necessary to ion code and the preceding HI data elem ort other condition codes. If not required nentation guide, do not send.	ents ha	ve bee	

ASC X12N • INSURA TECHNICAL REPOR	ANCE SUBCOMMITTEE T • TYPE 3				005010X223 • 837 • 2300 • H CONDITION INFORMATION				
REQUIRED	HI12 - 1	1270	Code List Qualifier Code Code identifying a specific industry cod	M e list	ID	1/3			
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C	C022-05, C022-0	6 and C	022-08.			
		C	ODE DEFINITION						
		BG	Condition						
			code source 132: National Un Codes	iform Billing Corr	mittee	(NUBC)			
REQUIRED	HI12 - 2	1271	Industry Code Code indicating a code from a specific	M Induced a list	AN	1/30			
			SEMANTIC:						
			If C022-08 is used, then C022-02 repre- range of codes.	esents the beginn	ing valu	ie in a			
			IMPLEMENTATION NAME: Condition Cod	e					
NOT USED	HI12 - 3	1250	Date Time Period Format Qualifi	er X	ID	2/3			
NOT USED	HI12 - 4	1251	Date Time Period	Х	AN	1/35			
NOT USED	HI12 - 5	782	Monetary Amount	0	R	1/18			
NOT USED	HI12 - 6	380	Quantity	0	R	1/15			
NOT USED	HI12 - 7	799	Version Identifier	0	AN	1/30			
NOT USED	HI12 - 8	1271	Industry Code	Х	AN	1/30			
NOT USED	HI12 - 9	1073	Yes/No Condition or Response (Code X	ID	1/1			

SEGMENT DETAIL													
		HI	- TRE		MENT	CC	DDE INF	-0	RMATI	0	Ν		
X12 Segment N	lame:	Healt	th Care I	nforma	ation Codes								
X12 Purp	pose:	To su	upply info	ormatio	on related to	o the	e delivery of	hea	alth care				
L	_oop:	2300	— CLA	IM INF	ORMATIO	N							
Segment Re	peat:	2											
U	sage:	SITU	ATIONA	L									
Situational		infor	mation u	under		yer	contracts.		report Plan ot required			nent	
TR3 Exar	mple:	HI*T	C:A01~										
DIAGRAM	-												
HI01	C02 C02		HI02 C	:022	HI03 C02		HI04 C022		HI05 C022 Health Care		HI06 Health	C022	
	ode Info.	*	Code Inf	X	Code Info.	*	Code Info.	*	Code Info.	*	Code		
M 1			01		01		01		01		01		
HI07	7 C02	2	HI08 C	:022	HI09 C02	2	HI10 C022	2	HI11 C022		HI12	C022	
~	alth Care ode Info.	*	Health Ca Code Inf	*	Health Care Code Info.	*	Health Care Code Info.	*	Health Care Code Info.	*	Health Code		~
O 1			01		01		01		01		01		
ELEMENT DETAIL													
USAGE	REI	=. 3.	DATA ELEMENT	NAME							ATTRIBU	UTES	
REQUIRED	HI01		C022				E INFORMAT		-	M 1	-		
						code	es and their ass	ocia	ated dates, amo	unts	and qua	intities	
				SYNTAX P0304	Ļ		04 is present th		the other is read	.:	1		
				E0809)				the other is requ	lirec	1.		
				Only c	one of C02208	or C	02209 may be	pres	sent.				
REQUIRED	HI01 -	1		1270			alifier Code	Istry	code list	М	ID	1/3	
					SEMANTIC:	Jifi		- 	04, C022-05, C0	122-1	06 and C	022-08	
								22-0	J4, CUZZ-03, CC	/22-(,022-00.	
						FINIT	-						
				тс			ment Codes ource 359: Trea	atme	ent Codes				
						220		aann					

ASC X12N • INSURA TECHNICAL REPORT	T • TYPE 3		TREATMEN			RMATIO
REQUIRED	HI01 - 2	1271	Industry Code Code indicating a code from a specific industry co	M ode list	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginni	ing valu	e in a
			IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI01 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI01 - 4	1251	Date Time Period	х	AN	1/35
NOT USED	HI01 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI01 - 6	380	Quantity	ο	R	1/15
NOT USED	HI01 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI01 - 8	1271	Industry Code	Х	AN	1/30
NOT USED	HI01 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI02 C02		TH CARE CODE INFORMATION d health care codes and their associated dates, am	O 1 ounts a	ind quai	ntities
		E0809	: r C02203 or C02204 is present, then the other is re ne of C02208 or C02209 may be present.	quired.		
		SITUATIO	DNAL RULE: Required when it is necessary to			
REQUIRED	HI02 - 1	situation treatm to rep	DNAL RULE: Required when it is necessary to ment code and the preceding HI data eleme fort other treatment codes. If not required k mentation guide, do not send. Code List Qualifier Code	nts ha	ve bee	
REQUIRED	HI02 - 1	situation treatm to rep implei	DNAL RULE: Required when it is necessary to nent code and the preceding HI data eleme ort other treatment codes. If not required k mentation guide, do not send.	nts ha by this M	ID	en used 1/3
REQUIRED	HI02 - 1	situatic treatm to rep implei 1270	DNAL RULE: Required when it is necessary to the nent code and the preceding HI data element of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC:	nts ha by this M	ID	en used 1/3
REQUIRED	HI02 - 1	situatio treatm to rep implei 1270	DNAL RULE: Required when it is necessary to the preceding HI data element code and the preceding HI data element of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-04 CODE DEFINITION	nts ha by this M	ID	en used 1/3
REQUIRED	HI02 - 1 HI02 - 2	situatic treatm to rep implei 1270	DNAL RULE: Required when it is necessary to the nent code and the preceding HI data element of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C	nts ha by this M C022-00 M	ID	en used 1/3
		situatic treatm to rep implei 1270 C TC	DNAL RULE: Required when it is necessary to the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code list Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C CODE DEFINITION Treatment Codes code source 359: Treatment Codes Industry Code	M C022-00 M code list	ID 3 and C AN	1/3 022-08. 1/30
		situatic treatm to rep implei 1270 C TC	DNAL RULE: Required when it is necessary to the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code list Qualifier Code Code identifying a specific industry code list SEMANTIC: CODE DEFINITION Treatment Codes code source 359: Treatment Codes Industry Code Code indicating a code from a specific industry code SEMANTIC: If C022-08 is used, then C022-02 represents the	M C022-00 M code list	ID 3 and C AN	1/3 022-08. 1/30
		situatic treatm to rep implei 1270 C TC	DNAL RULE: Required when it is necessary to the treatment codes. If not required is mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: CODE DEFINITION Treatment Codes Industry Code Code indicating a code from a specific industry code SEMANTIC: CODE DEFINITION Treatment Codes Code indicating a code from a specific industry code SEMANTIC: If CO22-08 is used, then C022-02 represents the range of codes.	M C022-00 M code list	ID 3 and C AN	1/3 022-08. 1/30
REQUIRED	HI02 - 2	situation treatin to rep implei 1270 C TC 1271	DNAL RULE: Required when it is necessary to the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C022-04, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C022-04, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C022-02, C022-05, C022-02, C022-05, C022-02, C022-05, C022-02, C0	M C022-06 M ode list beginni	ID 6 and C AN ing valu	1/3 022-08. 1/30 e in a
REQUIRED NOT USED	HI02 - 2 HI02 - 3	situation treating to rep implea 1270 TC 1271	DNAL RULE: Required when it is necessary to the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code lidentifying a specific industry code list SEMANTIC: CODE DEFINITION Treatment Codes Code indicating a code from a specific industry code SEMANTIC: CODE DEFINITION Treatment Codes code indicating a code from a specific industry code SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Treatment Code Date Time Period Format Qualifier	M CO22-00 M ode list beginni	ID and C AN ing valu ID	en used 1/3 022-08. 1/30 e in a 2/3
REQUIRED NOT USED NOT USED	HI02 - 2 HI02 - 3 HI02 - 4	situation to rep implea 1270 TC 1271 1250 1251	DNAL RULE: Required when it is necessary to the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code lidentifying a specific industry code list SEMANTIC: CO22-01 qualifies C022-02, C022-04, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C	M C022-00 M ode list beginni X X	ID 5 and C AN ing valu ID AN	en used 1/3 022-08. 1/30 e in a 2/3 1/35
REQUIRED NOT USED NOT USED NOT USED	HI02 - 2 HI02 - 3 HI02 - 4 HI02 - 5 HI02 - 6	SITUATIC treatin to rep implei 1270 TC 1271 1250 1251 782	DNAL RULE: Required when it is necessary to the forment code and the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, C DEFINITION Treatment Codes CODE DEFINITION Treatment Codes Code indicating a code from a specific industry code SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Treatment Code Date Time Period Format Qualifier Date Time Period Monetary Amount Quantity	M CO22-00 M ode list beginni X X Q	ID and C AN ing valu ID AN R	en used 1/3 022-08. 1/30 e in a 2/3 1/35 1/18
REQUIRED NOT USED NOT USED NOT USED NOT USED	HI02 - 2 HI02 - 3 HI02 - 4 HI02 - 5	SITUATIC treatin to rep implei 1270 TC 1271 1250 1251 782 380	DNAL RULE: Required when it is necessary to the preceding HI data elements of the treatment codes. If not required to mentation guide, do not send. Code List Qualifier Code Code lidentifying a specific industry code list SEMANTIC: CO22-01 qualifies C022-02, C022-04, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C022-05, C022-01 qualifies C022-02, C022-04, C022-05, C	M CO22-00 M ode list beginni X X O O	ID 5 and C AN ing valu ID AN R R R	en used 1/3 022-08. 1/30 e in a 2/3 1/35 1/18 1/15

SITUATIONAL	HI03	C022		TH CARE CODE INFORMATION	O 1 nounts a	and qua	ntities
			SYNTAX:			·	
			P0304 If either	C02203 or C02204 is present, then the other is re-	equired.		
			E0809 Only on	e of C02208 or C02209 may be present.			
				www.awa Boguirad whan it is papasary to	roport	on ad	ditional
				NAL RULE: Required when it is necessary to ent code and the preceding HI data eleme	-		
			-	ort other treatment codes. If not required nentation guide, do not send.	by this	;	
REQUIRED	HI03 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
				SEMANTIC:	C000 0/	C and C	000 00
				C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	s and C	022-08.
			тс	Treatment Codes			
REQUIRED	HI03 - 2		1271	CODE SOURCE 359: Treatment Codes Industry Code Code indicating a code from a specific industry of	M code list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginn	ing valu	e in a
				IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI03 - 3		1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI03 - 4		1251	Date Time Period	х	AN	1/35
NOT USED	HI03 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI03 - 6		380	Quantity	ο	R	1/15
NOT USED	HI03 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI03 - 8		1271	Industry Code	Х	AN	1/30
NOT USED	HI03 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI04	C022		TH CARE CODE INFORMATION I health care codes and their associated dates, ar	O 1 nounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is re e of C02208 or C02209 may be present.	equired.		
			treatm	NAL RULE: Required when it is necessary to tent code and the preceding HI data element out other treatment codes. If not required	ents ha	ve bee	

to report other treatment codes. If not required by this implementation guide, do not send.

	T • TYPE 3		TREATM	ENT COD	e info	2300 • H RMATIO
REQUIRED	HI04 - 1	127	Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-04	5, C022-06	6 and C	022-08.
			CODE DEFINITION			
		тс	Treatment Codes			
REQUIRED	HI04 - 2	127	CODE SOURCE 359: Treatment Codes I Industry Code Code indicating a code from a specific industr	M y code list	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents t range of codes.	he beginn	ing valu	e in a
			IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI04 - 3	125	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI04 - 4	125	I Date Time Period	Х	AN	1/35
NOT USED	HI04 - 5	782	Monetary Amount	0	R	1/18
NOT USED	HI04 - 6	380	Quantity	0	R	1/15
NOT USED	HI04 - 7	799	Version Identifier	0	AN	1/30
NOT USED	HI04 - 8	127	I Industry Code	Х	AN	1/30
NOT USED	HI04 - 9	107	3 Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI05		LTH CARE CODE INFORMATION end health care codes and their associated dates,	O 1 amounts a	and qua	ntities
		E08	14 ner C02203 or C02204 is present, then the other is	s required.		
		P03 If eit E08 Only SITU <i>trea</i> <i>to r</i>	14 ner C02203 or C02204 is present, then the other is 19	to report ments ha	an ad ive bee	
REQUIRED	HI05 - 1	P03 If eit E08 Only SITU <i>trea</i> <i>to r</i>	A her C02203 or C02204 is present, then the other is 9 one of C02208 or C02209 may be present. TIONAL RULE: <i>Required when it is necessary</i> <i>timent code and the preceding HI data elei</i> <i>eport other treatment codes. If not require</i> <i>lementation guide, do not send.</i>	to report ments ha	an ad ive bee	
REQUIRED	HI05 - 1	P03 If eit E08 Only situ trea to r imp	A her C02203 or C02204 is present, then the other is one of C02208 or C02209 may be present. TIONAL RULE: <i>Required when it is necessary</i> <i>timent code and the preceding HI data elei</i> <i>eport other treatment codes. If not require</i> <i>lementation guide, do not send.</i> O Code List Qualifier Code	to report ments ha d by this M	an ad ve bee ID	en used 1/3
REQUIRED	HI05 - 1	P03 If eit E08 Only situ trea to r imp	 her C02203 or C02204 is present, then the other is present, then the other is one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary the treatment code and the preceding HI data elementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: 	to report ments ha d by this M	an ad ve bee ID	en used 1/3
REQUIRED	HI05 - 1	P03 If eit E08 Only situ trea to r imp	 her C02203 or C02204 is present, then the other is present of C02208 or C02209 may be present. TIONAL RULE: Required when it is necessary transferent code and the preceding HI data elementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-03. 	to report ments ha d by this M	an ad ve bee ID	en used 1/3
REQUIRED	HI05 - 1 HI05 - 2	P03 If eit E08 Only sirru, trea to r imp 127	14 her C02203 or C02204 is present, then the other is 19 one of C02208 or C02209 may be present. ITIONAL RULE: Required when it is necessary tment code and the preceding HI data elementation guide, do not send. D Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-03 CODE DEFINITION Treatment Codes CODE DEFINITION Treatment Codes CODE DEFINITION	to report ments ha d by this M 5, C022-06	ID	en used 1/3
		P03 If eit E08 Only situ, trea to r imp 127	14 her C02203 or C02204 is present, then the other is 19 one of C02208 or C02209 may be present. ITIONAL RULE: Required when it is necessary tment code and the preceding HI data elementation guide, do not send. 0 Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-03 CODE DEFINITION Treatment Codes CODE DEFINITION	to report ments ha d by this M 5, C022-06 M y code list	in an ad ave bee ID S and C AN	1/3 022-08.
		P03 If eit E08 Only situ, trea to r imp 127	14 her C02203 or C02204 is present, then the other is 19 one of C02208 or C02209 may be present. ITIONAL RULE: Required when it is necessary timent code and the preceding HI data elere 10 11 11 12 13 14 14 14 15 16 17 17 16 17 17 17 17 16 17 16 16 16 17 17 18 19 19 11 11 11 12 12 14 15 16 16 17 17 18 18 18 19 19 10 10	to report ments ha d by this M 5, C022-06 M y code list	in an ad ave bee ID S and C AN	en used 1/3 022-08. 1/30
	HI05 - 2	P03 If eit E08 Only situ, trea to r imp 127	14 her C02203 or C02204 is present, then the other is 19 one of C02208 or C02209 may be present. ITIONAL RULE: Required when it is necessary timent code and the preceding HI data element to the reatment codes. If not require lementation guide, do not send. 0 Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-02 CODE DEFINITION Treatment Codes Industry Code Code indicating a code from a specific industry SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes. IMPLEMENTATION NAME: Treatment Code Implementation name: Treatment Code	to report ments ha d by this M 5, C022-06 M y code list	in an ad ave bee ID S and C AN	en used 1/3 022-08. 1/30
REQUIRED		P03 If eit E08 Only sirru, trea to r imp 127 TC 127	14 her C02203 or C02204 is present, then the other is 19 one of C02208 or C02209 may be present. ITIONAL RULE: Required when it is necessary timent code and the preceding HI data elementation guide, do not send. 10 Code List Qualifier Code code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-04 CODE DEFINITION Treatment Codes code indicating a code from a specific industr SEMANTIC: Industry Code Code indicating a code from a specific industr SEMANTIC: If C022-08 is used, then C022-02 represents to range of codes. IMPLEMENTATION NAME: Treatment Code Date Time Period Format Qualifier	to report ments ha d by this M 5, C022-06 M y code list the beginn	ing value	1/3 022-08. 1/30 e in a

							• TYP
	HI05 - 6		380	Quantity	0	R	1/15
	HI05 - 7		799	Version Identifier	0	AN	1/30
	HI05 - 8		1271	Industry Code	Х	AN	1/30
	HI05 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI06	C022	To send	TH CARE CODE INFORMATION I health care codes and their associated dates, an	O 1 nounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is re e of C02208 or C02209 may be present.	equired.		
			treatm to rep	NAL RULE: Required when it is necessary to ent code and the preceding HI data eleme ort other treatment codes. If not required mentation guide, do not send.	ents ha	ve bee	
REQUIRED	HI06 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
				SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-06	6 and C	022-08
			С	ODE DEFINITION			
			тс	Treatment Codes			
REQUIRED	HI06 - 2		1271	CODE SOURCE 359: Treatment Codes Industry Code Code indicating a code from a specific industry of SEMANTIC:	M code list	AN	1/30
				If C022-08 is used, then C022-02 represents the range of codes.	beginn	ing valu	e in a
				IMPLEMENTATION NAME: Treatment Code			
IOT USED	HI06 - 3		1250	Date Time Period Format Qualifier	Х	ID	2/3
IOT USED	HI06 - 4		1251	Date Time Period	Х	AN	1/3
IOT USED	HI06 - 5		782	Monetary Amount	0	R	1/18
IOT USED	HI06 - 6		380	Quantity	0	R	1/1
NOT USED	HI06 - 7		799	Version Identifier	0	AN	1/3
NOT USED	HI06 - 8		1271	Industry Code	Х	AN	1/3
IOT USED	HI06 - 9		1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI07	C022		TH CARE CODE INFORMATION I health care codes and their associated dates, an	O 1 nounts a	and qua	ntities
			E0809	C02203 or C02204 is present, then the other is re e of C02208 or C02209 may be present.	equired.		

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.

	T • TYPE 3					RMATIC
REQUIRED	HI07 - 1	127	0 Code List Qualifier Code Code identifying a specific industry code list	Μ	ID	1/3
			ѕемантіс: С022-01 qualifies C022-02, C022-04, C022-0	05, C022-06	6 and C	022-08.
		тс	Treatment Codes			
REQUIRED	HI07 - 2	127	CODE SOURCE 359: Treatment Codes 1 Industry Code Code indicating a code from a specific indust	М	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents range of codes.	the beginn	ing valu	ie in a
			IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI07 - 3	125	0 Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI07 - 4	125	1 Date Time Period	х	AN	1/35
NOT USED	HI07 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI07 - 6	380	Quantity	ο	R	1/15
NOT USED	HI07 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI07 - 8	127	1 Industry Code	х	AN	1/30
NOT USED	HI07 - 9	107	3 Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI08		ALTH CARE CODE INFORMATION end health care codes and their associated dates,	O1, amounts a	and qua	ntities
		E08	04 her C02203 or C02204 is present, then the other i	is required.		
		P03 If eit E08 Only SITU <i>trea</i> <i>to r</i>	04 her C02203 or C02204 is present, then the other i 09	to report ements ha	an ad ave bee	
REQUIRED	HI08 - 1	P03 If eit E08 Only SITU <i>trea</i> <i>to r</i>	04 her C02203 or C02204 is present, then the other i 09 one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary itment code and the preceding HI data ele eport other treatment codes. If not require ilementation guide, do not send.	to report ements ha	an ad ave bee	
REQUIRED	HI08 - 1	P03 If eit E08 Only situ trea to r imp	 ber C02203 or C02204 is present, then the other in the c02203 or C02204 is present, then the other in the other in the other in the other is one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary internet code and the preceding HI data element the other treatment codes. If not required the internet and the preceding HI data element the other treatment codes. If not required the other treatment codes. If not required the internet and the preceding HI data element the other treatment codes. If not required the other treatment codes. If not required the other treatment code and the preceding HI data element the other treatment codes. If not required the other treatment codes. If not required the other treatment codes. Code List Qualifier Code 	to report ements ha ed by this M	an ad ave bee	en useo 1/3
REQUIRED	HI08 - 1	P03 If eit E08 Only situ trea to r imp	 ber C02203 or C02204 is present, then the other it in the other it is necessary of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary internet code and the preceding HI data elementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: 	to report ements ha ed by this M	an ad ave bee	en useo 1/3
REQUIRED	HI08 - 1	P03 If eit E08 Only situ trea to r imp	 be CO2203 or CO2204 is present, then the other it op one of CO2208 or CO2209 may be present. ATIONAL RULE: Required when it is necessary attent code and the preceding HI data eleeport other treatment codes. If not required alementation guide, do not send. Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: CO22-01 qualifies CO22-02, CO22-04, CO22-04. 	to report ements ha ed by this M	an ad ave bee	en useo 1/3
REQUIRED	HI08 - 1	P03 If eit E08 Only situ trea to r imp 127	04 her C02203 or C02204 is present, then the other if 09 one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary internet code and the preceding HI data elee eport other treatment codes. If not required idementation guide, do not send. 0 Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-04 CODE DEFINITION Treatment Codes code source 359: Treatment Codes 1 Industry Code	to report ements ha ed by this M 05, C022-00	an ad ave bea ID 6 and C	en usec 1/3
		P03 If eit E08 Only situ. <i>trea</i> <i>to r</i> <i>imp</i> 127	04 her C02203 or C02204 is present, then the other if 09 one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary internet code and the preceding HI data elee eport other treatment codes. If not required elementation guide, do not send. 0 Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-04 CODE DEFINITION Treatment Codes code source 359: Treatment Codes	to report ements ha ed by this M 05, C022-00 M ry code list	i an ad ave bed ID 6 and C	1/3 022-08. 1/30
		P03 If eit E08 Only situ. <i>trea</i> <i>to r</i> <i>imp</i> 127	D4 her C02203 or C02204 is present, then the other if D9 r one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary internet code and the preceding HI data elee eport other treatment codes. If not required elementation guide, do not send. 0 Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-04 CODE DEFINITION Treatment Codes code indicating a code from a specific indust SEMANTIC: Industry Code Code indicating a code from a specific indust SEMANTIC: If C022-08 is used, then C022-02 represents	to report ements ha ed by this M 05, C022-00 M ry code list	i an ad ave bed ID 6 and C	1/3 022-08. 1/30
REQUIRED	HI08 - 2	P03 If eit E08 Only situ. <i>trea</i> <i>to r</i> <i>imp</i> 127	04 her C02203 or C02204 is present, then the other if 09 one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary of the code and the preceding HI data element at code and the preceding HI data element at on guide, do not send. 0 Code List Qualifier Code CODE DEFINITION CODE DEFINITION Treatment Codes Code source 359: Treatment Codes 1 Industry Code Code indicating a code from a specific indust SEMANTIC: If C022-08 is used, then C022-02 represents range of codes. IMPLEMENTATION NAME: Treatment Code	to report ements ha ed by this M 05, C022-00 M ry code list	i an ad ave bed ID 6 and C	1/3 022-08. 1/30
		P03 If eit E08 Only situ trea to r imp 127 TC 127	04 her C02203 or C02204 is present, then the other if 09 r one of C02208 or C02209 may be present. ATIONAL RULE: Required when it is necessary internt code and the preceding HI data elementation guide, do not send. 0 Code List Qualifier Code Code identifying a specific industry code list SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-04 CODE DEFINITION Treatment Codes code industry Code Code indicating a code from a specific indust SEMANTIC: If C022-08 is used, then C022-02 represents range of codes. IMPLEMENTATION NAME: Treatment Code 0 Date Time Period Format Qualifier	to report ements ha ed by this M 05, C022-00 M ry code list the beginn	an ad ave bea ID 6 and C AN	1/3 022-08. 1/30 Ie in a

005010X223 • 837 • TREATMENT CODE		l		ASC X12N • INSU TECHI	RANCE NICAL R		
NOT USED	HI08 - 6		380	Quantity	0	R	1/15
NOT USED	HI08 - 7		799	Version Identifier	0	AN	1/30
NOT USED	HI08 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI08 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI09	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, a	O 1 mounts a	and qua	ntities
			E0809	: r C02203 or C02204 is present, then the other is r ne of C02208 or C02209 may be present.	equired.		
			Only or	he 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 Code identifying a specific industry code list	М	ID	1/3
			SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05,	C022-0	6 and C	022-08.
		C	CODE DEFINITION			
		тс	Treatment Codes			
REQUIRED		4074	code source 359: Treatment Codes			4/00
REGUIRED	HI09 - 2	1271	Industry Code Code indicating a code from a specific industry of	M code list	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginn	iing valu	e in a
			IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI09 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI09 - 4	1251	Date Time Period	х	AN	1/35
NOT USED	HI09 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI09 - 6	380	Quantity	ο	R	1/15
NOT USED	HI09 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI09 - 8	1271	Industry Code	Х	AN	1/30
NOT USED	HI09 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI10 CO		TH CARE CODE INFORMATION d health care codes and their associated dates, an	O 1 nounts a	and qua	ntities
		E0809	: r C02203 or C02204 is present, then the other is re ne of C02208 or C02209 may be present.	∋quired.		

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.

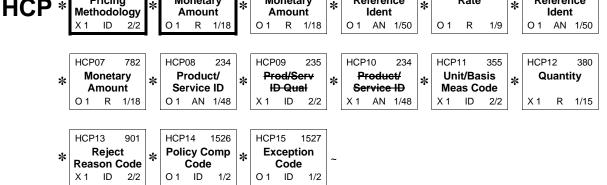
ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

1/15

REQUIRED	HI10 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	м	ID	1/3
				земалтіс: C022-01 qualifies C022-02, C022-04, C022-05, C	022-06	6 and C	022-08.
			с	ODE DEFINITION			
			тс	Treatment Codes			
				CODE SOURCE 359: Treatment Codes			
REQUIRED	HI10 - 2		1271	Industry Code Code indicating a code from a specific industry co	M ode list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginn	ing valu	e in a
				IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI10 - 3		1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI10 - 4		1251	Date Time Period	х	AN	1/35
NOT USED	HI10 - 5		782	Monetary Amount	ο	R	1/18
NOT USED	HI10 - 6		380	Quantity	ο	R	1/15
NOT USED	HI10 - 7		799	Version Identifier	ο	AN	1/30
NOT USED	HI10 - 8		1271	Industry Code	х	AN	1/30
NOT USED	HI10 - 9		1073	Yes/No Condition or Response Code	х	ID	1/1
SITUATIONAL	HI11	C022		TH CARE CODE INFORMATION d health care codes and their associated dates, am	O1 ounts a	ind quai	ntities
			E0809 Only or	CO2203 or CO2204 is present, then the other is reached of CO2208 or CO2209 may be present.		an ad	ditional
			treatm to rep	nent code and the preceding HI data eleme ort other treatment codes. If not required b mentation guide, do not send.	nts ha	ve bee	
REQUIRED	HI11 - 1		1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
				земалтіс: C022-01 qualifies C022-02, C022-04, C022-05, C	022-06	6 and C	022-08.
			с	ODE DEFINITION			
			тс	Treatment Codes			
REQUIRED				CODE SOURCE 359: Treatment Codes			
REQUIRED	HI11 - 2		1271	Industry Code Code indicating a code from a specific industry co	M ode list	AN	1/30
				SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	beginn	ing valu	e in a
				IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI11 - 3		1250	Date Time Period Format Qualifier	Х	ID	2/3
NOT USED	HI11 - 4		1251	Date Time Period	Х	AN	1/35

005010X223 • 837 • 2 TREATMENT CODE			ASC X12N • INSUR TECHN			• TYPE 3
NOT USED	HI11 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI11 - 6	380	Quantity	0	R	1/15
NOT USED	HI11 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI11 - 8	1271	Industry Code	Х	AN	1/30
NOT USED	HI11 - 9	1073	Yes/No Condition or Response Code	Х	ID	1/1
SITUATIONAL	HI12 C022		TH CARE CODE INFORMATION d health care codes and their associated dates, an	O 1 nounts a	ind quai	ntities
		E0809	C02203 or C02204 is present, then the other is rene of C02208 or C02209 may be present.	equired.		
		treatm to rep	DNAL RULE: Required when it is necessary to ment code and the preceding HI data eleme ort other treatment codes. If not required i mentation guide, do not send.	ents ha	ve bee	
REQUIRED	HI12 - 1	1270	Code List Qualifier Code Code identifying a specific industry code list	М	ID	1/3
		C	SEMANTIC: C022-01 qualifies C022-02, C022-04, C022-05, ODE DEFINITION	C022-06	6 and C	022-08.
		тс	Treatment Codes			
REQUIRED	HI12 - 2	1271	code source 359: Treatment Codes Industry Code Code indicating a code from a specific industry of	M code list	AN	1/30
			SEMANTIC: If C022-08 is used, then C022-02 represents the range of codes.	e beginn	ing valu	e in a
			IMPLEMENTATION NAME: Treatment Code			
NOT USED	HI12 - 3	1250	Date Time Period Format Qualifier	х	ID	2/3
NOT USED	HI12 - 4	1251	Date Time Period	Х	AN	1/35
NOT USED	HI12 - 5	782	Monetary Amount	ο	R	1/18
NOT USED	HI12 - 6	380	Quantity	ο	R	1/15
NOT USED	HI12 - 7	799	Version Identifier	ο	AN	1/30
NOT USED	HI12 - 8	1271	Industry Code	Х	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	
DIAORAII	
HCP01 14 Pricing	73 HCP02 782 HCP03 782 HCP04 127 HCP05 118 HCP06 127 y Monetary y Reference y Rate y Reference



ELEMENT DETAIL										
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES			
REQUIRED	HCP01	1473	Pricing Meth Code specifyir priced or reprid	ng pricing methodology at which the claim or	X 1 line iter	ID m has b	2/2 been			
			syntax: R0113	3						
			-	de use is determined by Trading Partr nces in contracting policies in the ind	_		ent due			
			CODE							
			00	Zero Pricing (Not Covered Under	Contra	act)				
			01	Priced as Billed at 100%						
			02	Priced at the Standard Fee Sched	ule					
			03	Priced at a Contractual Percentag	е					
				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 An Monetary amo		01	R	1/18			
			SEMANTIC: HCF	P02 is the allowed amount.						
			IMPLEMENTATIO	N NAME: Repriced Allowed Amount						
SITUATIONAL	HCP03	782	Monetary An Monetary amo		01	R	1/18			
			SEMANTIC: HCF	P03 is the savings amount.						
			SEMANTIC: HOPOS 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.							
			IMPLEMENTATIO	N NAME: Repriced Saving Amount						
			This information is specific to the destination payer reported in Loop ID-2010BB.							

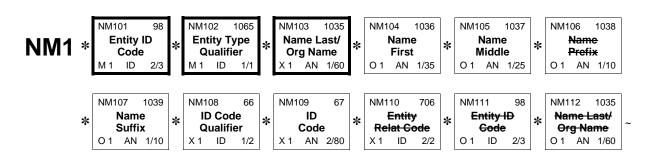
SITUATIONAL	HCP04	127	Reference IdentificationO 1 AN 1/50Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier					
			SEMANTIC: HCP04 is the repricing organization identification number.					
			SITUATIONAL RULE: Required when this 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 IdentificationO 1 AN 1/50Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier					
			SEMANTIC: HCP06 is the approved DRG code.					
			СОММЕНТ: 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 AmountO 1R1/18Monetary 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/Servi Identifying numb	ce ID er for a product or service	01	AN	1/48		
			SEMANTIC: HCP08	3 is the approved revenue code.					
			by the reprice information is	Required when this information r. The segment is not completed completed by repricers only. If r on guide, do not send.	by prov	iders.	The		
			IMPLEMENTATION N	AME: Repriced Approved Revenue	e Code				
			This informati Loop ID-2010	on is specific to the destination 3B.	payer re	ported	l in		
NOT USED	HCP09	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2		
NOT USED	HCP10	234	Product/Servi	ce ID	X 1	AN	1/48		
SITUATIONAL	HCP11	355		for Measurement Code the units in which a value is being expr has been taken	X 1 essed, or	ID manner	2/2 in which		
			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.						
				AME: Repriced Approved Service	Unit Cou	unt			
			This informati Loop ID-2010	on is specific to the destination	payer re	ported	l in		
			The maximum When a decim	length for this field is 8 digits e					

SITUATIONAL	HCP13	901	Reject Reasor Code assigned b	Code by issuer to identify reason for rejection	X 1	ID	2/2
		syntax: R0113					
		SEMANTIC: HCP13	B is the rejection message returned from th	e third	party		
		by the reprice information is	Required when this information is r. The segment is not completed by completed by repricers only. If not on guide, do not send.	rov	iders. T	The	
			This informati Loop ID-2010	on is specific to the destination pages. 3B.	yer rej	ported i	in
			CODE	DEFINITION			
		T1	Cannot Identify Provider as TPO (Third Party Organization) Participant				
		T2	Cannot Identify Payer as TPO (Third Party Organization) Participant				
		Т3	3 Cannot Identify Insured as TPO (Third Party Organization) Participant				
		Т4	Payer Name or Identifier Missing				
			Т5	Certification Information Missing			
			Т6	Claim does not contain enough in pricing	forma	ition foi	r re-
SITUATIONAL	HCP14	1526	Policy Compli Code specifying	ance Code policy compliance	01	ID	1/2
			by the reprice information is	Required when this information is r. The segment is not completed by completed by repricers only. If not on guide, do not send.	rov	iders. T	The
			This informati Loop ID-2010	on is specific to the destination pages. 3B.	yer rej	ported i	in
			CODE	DEFINITION			
			1	Procedure Followed (Compliance))		
			2	Not Followed - Call Not Made (Nor Not Made)	ו-Com	pliance	e Call
			3	Not Medically Necessary (Non-Co Medically Necessary)	mplia	nce Noi	n-
			4	Not Followed Other (Non-Complia	nce O	ther)	
			5	Emergency Admit to Non-Network	(Hosp	oital	

SITUATIONAL HCP15	1527	Exception CodeO 1ID1/2Code specifying the exception reason for consideration of out-of-network health care servicesImage: Code service servi						
			SEMANTIC: HCP1	5 is the exception reason generated by a third party organization.				
		by the reprice information is	Required when this information is deemed necessary er. The segment is not completed by providers. The s completed by repricers only. If not required by this on 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				

	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:	 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	



USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	ITES		
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical locatio individual			M 1 ID 2 on, property or an			
			CODE	DEFINITION					
			71	Attending Physician					
				When used, the term physician is provider filling this role.	any ty	pe of			

005010X223 • 837 • 23 ATTENDING PROVIDE				INSURANCE STECHNICAL R					
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	SITUATIONAL NM104 1036		Name First Individual first name	01	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	t Name					
SITUATIONAL	NM105	1037	Name Middle Individual middle name or initial	01	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 Mide	dle Name or I	nitial				
NOT USED	NM106	1038	Name Prefix	01	AN	1/10			
SITUATIONAL	NM107	1039	Name Suffix Suffix to individual name	01	AN	1/10			
			SITUATIONAL RULE: Required when the name s the individual. If not required by this imple send.			-			
			IMPLEMENTATION NAME: Attending Provider Nam	ne Suffix					

SITUATIONAL	NM108	66	Identification Code QualifierX 1ID1/2Code designating the system/method of code structure used for IdentificationCode (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.							
			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 CodeX 1AN2/80Code 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							
			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							
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								
			TTENDIN IATION	IG PROVIDER SPEC		LTY	,	
X12 Segment Na	ame: Prov	ider Infor	mation					
X12 Purp	ose: To s	pecify the	e identifying cha	aracteristics of a provider				
X12 Syr		P0203 If either F	PRV02 or PRV0	03 is present, then the other is req	uired			
L	oop: 2310	0A — AT	TENDING PRO	OVIDER NAME				
Segment Rep	beat: 1							
Us	age: SITU	ATIONA	L					
Situational F	paye prov	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 Exam	nple: PRV	*AT*PX	(C*208D0000)X~				
DIAGRAM								
	ovider Code ID 1/3	Reference Ident Qu X 1 ID	ial [*] Ident	* *	*	Provi Org C D 1 ID	Fode 7 3/3	
REQUIRED	PRV01	1221	Provider Code)	M 1	ID	1/3	
REQUIRED	PRV02 PRV03	128	Code identifying <u>CODE</u> AT Reference Ide Code qualifying t SYNTAX: P0203 <u>CODE</u> PXC Reference Ide Reference Ide Reference Ide	DEFINITION Attending ntification Qualifier he Reference Identification DEFINITION Health Care Provider Taxonomy C code source 682: Health Care Provider Taxonomy C	X 1 Code Taxonc X 1	ID my AN	2/3	
				AME: Provider Taxonomy Code				
NOT USED NOT USED	PRV04	156	State or Provi		01	ID	2/2	
NOT USED	PRV05	C035	PROVIDER SP	PECIALTY INFORMATION	01			

ASC X12N • INSURANCE SUBCOMMITTEE
TECHNICAL REPORT • TYPE 3

NOT USED	PRV06	1223	Provider Organization Code	O1 ID	3/3
----------	-------	------	----------------------------	-------	-----

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

RFF01 REF02 REF03 REF04 128 352 C040 127 Reference Reference **Description** Reference REF * * * **Ident Qual** Ident **Identifier** ID AN 1/50 O 1 M 1 2/3 X 1 AN 1/80 X 1

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES
REQUIRED	REF01	128		Reference Identification Qualifier Code qualifying the Reference Identification			2/3
			CODE	DEFINITION			
			0B	State License Number			
			1G	Provider UPIN Number			
				UPINs must be formatted as eithe XXX999.	r X999	999 or	
			G2	Provider Commercial Number			
				This code designates a proprietar for the destination payer identified Name loop, Loop ID-2010BB, asso claim. This is to be used by all pay Medicare, Medicaid, Blue Cross, e	d in th ociated yers ir	e Paye d with	er this
			LU	Location Number			

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2310A • REF ATTENDING PROVIDER SECONDARY IDENTIFICATION			
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Tr by the Reference Identification Qualifier SYNTAX: R0203		AN or as s	1/50 pecified
			IMPLEMENTATION NAME: Attending Provider Seco	ondary Ident	ifier	
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

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:	 Loop 2310 contains information about the rendering, referring, or attending provider.
X12 Syntax:	 P0809 If either NM108 or NM109 is present, then the other is required.
	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	
NM101 Entity ID Code M 1 ID	98 NM102 1065 NM103 1035 NM104 1036 2/3 NM102 1065 NM103 1035 NM104 1036 2/3 NM10 1/1 NM103 1035 NM104 1036 Name Name Name Name Name Name N1 ID 1/1 N1/60 N1/60 01 AN 1/25
NM107 10 * Name Suffix O 1 AN 1/	* ID Code Qualifier * ID Code * Entity * Entity ID Code * Code * * * * * * * * * * * * * * * * * * *

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	TES
REQUIRED	NM101	98	Entity Identif Code identifyin individual	f ier Code g an organizational entity, a physical locat	M 1 ion, prop	ID perty or	2/3 an
			CODE	DEFINITION			
			72	Operating Physician			
REQUIRED	NM102	1065	Entity Type (Code qualifying	Qualifier 9 the type of entity	M 1	ID	1/1
			SEMANTIC: NM1	02 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
REQUIRED	NM103	1035		r Organization Name name or organizational name	X 1	AN	1/60
			syntax: C1203				
			IMPLEMENTATION	NAME: Operating Physician Last Nar	ne		
SITUATIONAL	FIONAL NM104 1036	1036	Name First Individual first r	name	01	AN	1/35
			ε: Required when the person has a this implementation guide, do not s		ame. If	not	
				NAME: Operating Physician First Nat	ne		
SITUATIONAL	NM105	1037	Name Middle Individual midd	e name or initial	01	AN	1/25
			person is ne	E: Required when the middle name eded to identify the individual. If no ion guide, do not send.			
			IMPLEMENTATION	NAME: Operating Physician Middle N	lame o	r Initia	l
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
SITUATIONAL	NM107	1039	Name Suffix Suffix to individ		01	AN	1/10
				E: Required when the name suffix is al. If not required by this implement			-
			IMPLEMENTATION	NAME: Operating Physician Name Su	uffix		

IMPLEMENTATION NAME: Operating Physician Name Suffix

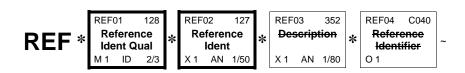
SITUATIONAL	NM108	66	Identification Code Qualifier X 1 Code designating the system/method of code structure used for Ide Code (67)	ID 1/2 entification				
			syntax: P0809					
			SITUATIONAL RULE: Required for providers in the United States or its territories on or after the mandated HIPAA National 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 Serv National Provider Identifier	ices				
			code source 537: Centers for Medicare and Med National Provider Identifier	licaid Services				
SITUATIONAL	NM109	67	Identification Code X 1 Code identifying a party or other code X 1	AN 2/80				
			SYNTAX: P0809					
			SITUATIONAL RULE: Required for providers in the United State territories on or after the mandated HIPAA National Pro- Identifier (NPI) implementation date when the provider receive an NPI. OR Required for providers not in the United States or its te or after the mandated HIPAA National Provider Identifie implementation date when the provider has received an OR Beguired for providers prior to the mandated NPI imple	ovider is eligible to erritories on er (NPI) n NPI.				
			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 ser IMPLEMENTATION NAME: Operating Physician Primary Identifie					
NOT USED	NM110	706	Entity Relationship Code X 1	ID 2/2				
NOT USED	NM110 NM111	706 98	Entity Identifier Code 01	ID 2/2 ID 2/3				
NOT USED	NM112	90 1035	•	AN 1/60				
				,				

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~

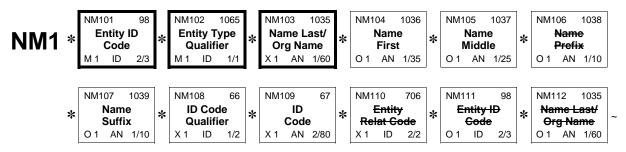
DIAGRAM



USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	
REQUIRED	REF01	128		entification Qualifier M 1 ID 2/3 the Reference Identification	\$
			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.	er
			LU	Location Number	

005010X223 • 837 • 2310B • REF OPERATING PHYSICIAN SECONDARY IDENTIFICATION			ASC X12N • IN ITIFICATION TE	ISURANCE CHNICAL R		
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Tra by the Reference Identification Qualifier SYNTAX: R0203		AN or as s	1/50 Decified
			IMPLEMENTATION NAME: Operating Physician Seco	ondary Ider	ntifier	
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

	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:	 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	

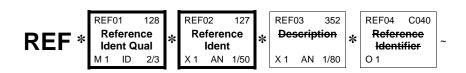


USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBUT	ES		
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, individual		M 1 n, prop	ID berty or a	2/3 n		
			CODE	DEFINITION					
			ZZ	Mutually Defined					
				ZZ is used to indicate Other Opera	ting	Physici	an.		
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1		
			SEMANTIC: NM10	02 qualifies NM103.					
			CODE	DEFINITION					
			1	Person					
REQUIRED	NM103	1035		r Organization Name name or organizational name	X 1	AN	1/60		
			syntax: C1203						
			IMPLEMENTATION	NAME: Other Operating Physician Last	Nam	ne			
SITUATIONAL	NM104	1036	Name First Individual first n	ame	01	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	t Nan	ne			
SITUATIONAL	NM105	1037	Name Middle Individual middl	e name or initial	01	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 Mide	dle Na	ame or	Initial		
NOT USED	NM106	1038	Name Prefix		01	AN	1/10		
SITUATIONAL	NM107	1039	Name Suffix Suffix to individ	ual name	01	AN	1/10		
				E: Required when the name suffix is r II. If not required by this implementat					
			IMPLEMENTATION	NAME: Other Operating Physician Nam	ne Su	ffix			

SITUATIONAL	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67) 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.
			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 CodeX 1AN2/80Code 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.
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 NameO 1AN1/60

SEGMENT DETAIL **REF - OTHER OPERATING PHYSICIAN** SECONDARY IDENTIFICATION X12 Segment Name: Reference Information X12 Purpose: To specify identifying information 1. R0203 X12 Syntax: 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



USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBUT	ES
REQUIRED	REF01	128		entification Qualifier M the Reference Identification	/1	ID	2/3
			CODE	DEFINITION			
			0B	State License Number			
			1G	Provider UPIN Number			
				UPINs must be formatted as either X XXX999.	(9999	99 or	
			G2	Provider Commercial Number			
				This code designates a proprietary p for the destination payer identified in Name loop, Loop ID-2010BB, associa claim. This is to be used by all payer Medicare, Medicaid, Blue Cross, etc.	n the ated rs in	e Paye with t	er this
			LU	Location Number			

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2310C • REF OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION				
REQUIRED	REF02	127	Reference IdentificationX 1AIReference information as defined for a particular Transaction Set or a by the Reference Identification QualifierSYNTAX: R0203				
			IMPLEMENTATION NAME: Other Provider Secondary Ide	entifier			
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01			

OEGINERT 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:	 Loop 2310 contains information about the rendering, referring, or attending provider.
X12 Syntax:	 P0809 If either NM108 or NM109 is present, then the other is required.
	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	

NM101 98 NM102 1065 NM103 1035 NM104 1036 NM105 1037 NM106 1038 Entity ID Entity Type Name Last/ Name Name Name **NM1** * * * * * * Qualifier Prefix Code Org Name First Middle M1 ID M1 ID X 1 AN 1/60 O 1 AN 1/35 O 1 AN 1/25 O 1 AN 1/10 2/3 1/1 NM107 1039 NM108 NM109 NM110 NM111 NM112 1035 66 67 706 98 ID Code ID Entity Entity ID Name Name Last/ * * * * * * ~ Suffix Qualifier Code Relat Code Code Org Name O 1 AN 1/10 X 1 AN 2/80 ID 01 ID O 1 AN 1/60 ID 1/2 X 1 X 1 2/2 2/3

MAY 2006

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBUTES			
REQUIRED	EQUIRED NM101 98		Entity Identif Code identifyin individual	f ier Code g an organizational entity, a physical locat	M 1 ion, prop	ID perty or a	2/3 an	
			CODE	DEFINITION				
			82	Rendering Provider				
REQUIRED	NM102	1065	Entity Type (Code qualifying	Qualifier g the type of entity	M 1	ID	1/1	
			semantic: NM1	02 qualifies NM103.				
			CODE	DEFINITION				
			1	Person				
REQUIRED NM103 1035		1035		or Organization Name name or organizational name	X 1	AN	1/60	
			syntax: C1203					
			IMPLEMENTATION NAME: Rendering Provider Last Name					
SITUATIONAL NM104 1	1036	Name First Individual first r	name	01	AN	1/35		
			LE: Required when the person has a this implementation guide, do not s		ame. If	not		
				NAME: Rendering Provider First Nan	ne			
SITUATIONAL	NM105	1037	Name Middle Individual midd	e lle name or initial	01	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.					
				NAME: Rendering Provider Middle N	ame or	Initial		
NOT USED	NM106	1038	Name Prefix		01	AN	1/10	
SITUATIONAL	NM107	1039	Name Suffix Suffix to individ		01	AN	1/10	
			LE: Required when the name suffix i al. If not required by this implement			-		
			IMPLEMENTATION	INAME: Rendering Provider Name Su	ffix			

IMPLEMENTATION NAME: Rendering Provider Name Suffix

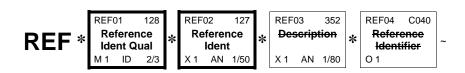
SITUATIONAL	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67) Code (67)								
			syntax: P0809								
			SITUATIONAL RULE: Required for providers in the United States or its territories on or after the mandated 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.								
			CODE DEFINITION								
			XX Centers	for Medicare and Medica I Provider Identifier	aid Ser	vices					
				RCE 537: Centers for Medicare Provider Identifier	and Me	edicaid S	Services				
SITUATIONAL	NM109	67	Identification Code Code identifying a party or o	other code	X 1	AN	2/80				
			syntax: P0809								
			territories on or after t Identifier (NPI) implem receive an NPI. OR Required for providers or after the mandated I	d for providers in the Unit he mandated HIPAA Nati entation date when the p not in the United States HIPAA National Provider h hen the provider has reco	onal Pi rovide or its to Identifi	rovider r is elig erritori ier (NPi	gible to es on				
			OR	-			ation				
		Required for providers prior to the mandated NPI implement date when the provider has received an NPI and the submit the capability to send it.									
			If not required by this i	mplementation guide, do	not se	end.					
			IMPLEMENTATION NAME: Renc	lering Provider Identifier							
NOT USED	NM110	706	Entity Relationship Co	de	X 1	ID	2/2				
NOT USED	NM111	98	Entity Identifier Code		01	ID	2/3				
NOT USED	NM112	1035	Name Last or Organiza	tion Name	01	AN	1/60				

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



USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	
REQUIRED	REF01	128		entification Qualifier M 1 ID 2/3 the Reference Identification	\$
			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.	er
			LU	Location Number	

005010X223 • 837 • RENDERING PROVI			ASC X12N • INSUR TIFICATION TECHN			MMITTEE • TYPE 3		
REQUIRED	REF02	127	Reference IdentificationX 1AN1/50Reference information as defined for a particular Transaction Set or as specified by the Reference Identification QualifierSYNTAX: R0203					
			IMPLEMENTATION NAME: Rendering Provider Secondar	y Iden	tifier			
NOT USED	REF03	352	Description	X 1	AN	1/80		
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01				

	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:	 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:	 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	
NM101 Entity ID Code M 1 ID	98 * NM102 1065 * NM103 1035 * NM104 1036 * NM105 1037 * NM106 1038 2/3 M 1 ID 1/1 * NM106 1036 * * NM105 1037 * NM106 1038 2/3 M 1 ID 1/1 * X 1 AN 1/60 O 1 AN 1/35 O 1 AN 1/25 NM106 1038

M1 ID
 1/1
 X 1
 AN
 1/60
 O 1
 AN
 1/35
 O 1
 AN
 1/25
 O 1
 AN
 1/10
 2/3 M 1 ID NM107 1039 NM108 66 NM109 67 NM110 706 NM111 98 NM112 1035 Name ID Code ID Entity Entity ID Name Last/ * * * * * * Org Name Suffix Qualifier Code Relat Code Code O 1 AN 1/10 X 1 ID 1/2 X 1 AN 2/80 X 1 ID 2/2 01 ID 2/3 O 1 AN 1/60

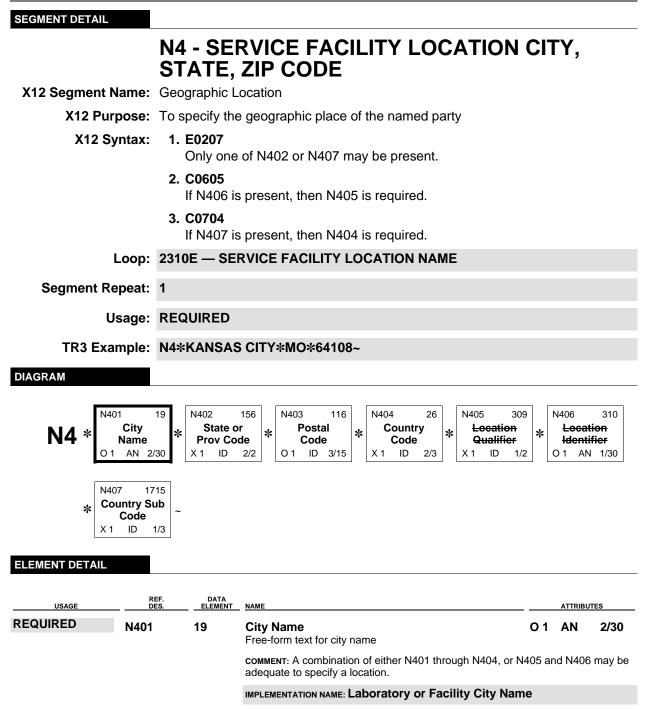
005010X223 • 837 • 2310E • NM1 SERVICE FACILITY LOCATION NAME

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	ITES
REQUIRED	NM101	98	Entity Identifie Code identifying individual	er Code an organizational entity, a physical location	M 1 n, prop	ID perty or a	2/3 an
			CODE	DEFINITION			
			77	Service Location			
REQUIRED	NM102	1065	Entity Type Q Code qualifying t		M 1	ID	1/1
			SEMANTIC: NM102	2 qualifies NM103.			
			CODE	DEFINITION			
			2	Non-Person Entity			
REQUIRED	NM103	1035		Organization Name me or organizational name	X 1	AN	1/60
			syntax: C1203				
			IMPLEMENTATION N	IAME: Laboratory or Facility Name			
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle		01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	AN	1/10
SITUATIONAL	NM108	66		Code Qualifier g the system/method of code structure use	X1 d for lo	ID dentifica	1/2 ation
			SYNTAX: P0809				
			SITUAL F 0009 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.				tified
			CODE	DEFINITION			
			XX	Centers for Medicare and Medicaio	d Ser	vices	
				code source 537: Centers for Medicare a	nd Me	edicaid \$	Services
SITUATIONAL	NM109	67	Identification Code identifying	National Provider Identifier Code a party or other code	X 1	AN	2/80
			SYNTAX: P0809				
			has an NPI an Provider entit	Required when the service location In is not a component or subpart of y. I by this implementation guide, do r	the B	Billing	tified
				IAME: Laboratory or Facility Primary I	denti	fier	
NOT USED	NM110	706	Entity Relation	nship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifie	-	01	ID	2/3

ASC X12N • INSURANCE SUBCOMMITTEE
TECHNICAL REPORT • TYPE 3

NOT USED	NM112	1035	Name Last or Organization Name	O1 AN	1/60
----------	-------	------	--------------------------------	-------	------

SEGMENT DETAIL									
			RVICE FACILITY LOCATION	AD	DR	ESS			
X12 Segment Na									
X12 Purp	ose: To sp	To specify the location of the named party							
L	oop: 2310	2310E — SERVICE FACILITY LOCATION NAME							
Segment Rep	peat: 1								
Us	age: REQ	UIRED							
TR3 No	á (address example	e facility location is in an area where there are es, enter a description of where the service w , "crossroad of State Road 34 and 45" or "Exi 265 on Interstate 80".)	as re	ndere	•			
TR3 Exam	nple: N3*	123 MAII	N STREET~						
DIAGRAM									
	166 ddress rmation AN 1/55	N302 Addres Informati O 1 AN	on ~						
ELEMENT DETAIL									
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES			
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	01	AN	1/55			
			SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not se		ss line.	If not			
			IMPLEMENTATION NAME: Laboratory or Facility Address	Line					



005010X223 • 837 • 2310E • N4	
SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE	

SITUATIONAL	N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate	X1 govern	ID Iment ag	2/2 jency		
			syntax: E0207					
			COMMENT: N402 is required only if city name (N401) is in the	ə U.S. (or Canad	da.		
			SITUATIONAL RULE: Required when the address is in the Unite America, including its territories, or Canada. If not requir implementation guide, do not send.					
			IMPLEMENTATION NAME: Laboratory or Facility State or	Provir	nce Co	de		
			CODE SOURCE 22: States and Provinces					
SITUATIONAL	N403	116	Postal Code Code defining international postal zone code excluding pur (zip code for United States)	O 1 nctuatio	ID on and b	3/15 lanks		
			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 Z	one o	r ZIP Co	ode		
			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 out States of America. If not required by this implem not send.					
			CODE SOURCE 5: Countries, Currencies and Funds					
			Use the alpha-2 country codes from Part 1 of ISC) 3166	•			
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2		
NOT USED	N406	310	Location Identifier	01	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 o	f ISO (3166.			

Name loop, Loop ID-2010BB, associated with this claim. This is to be used by all payers including:

Medicare, Medicaid, Blue Cross, etc.

Location Number

SEGMENT DETAIL

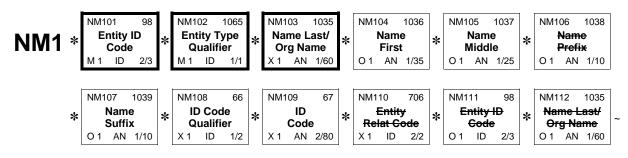
REF - SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION

	SECON		ENTIFICATION				
X12 Segment Name:	Reference Information						
X12 Purpose:	To specify identifying information						
X12 Syntax:	1. R0203 At least o	one of REF02 of	or REF03 is required.				
Loop:	2310E — SEI	RVICE FACILI	ITY LOCATION NAME				
Segment Repeat:	3						
Usage:	SITUATIONA	L					
Situational Rule:	implementation necessary for OR Required on entity is not identifier is r	ion date wher or the receiver or after the m a Health Care necessary for	dated HIPAA National Provider n an identification number other to identify the provider. nandated NPI implementation of provider (a.k.a. an atypical pro the claims processor to identi lementation guide, do not sen	er than late wh ovider) fy the e	the N en th , and	PI is e an	
TR3 Example:	REF*G2*123	345~					
DIAGRAM							
REF * Reference Ident Qua		*	352 tion 1/80 REF04 C040 Reference Identifier ○ 1 ~				
ELEMENT DETAIL							
USAGE R	EF. DATA ES. ELEMENT				ATTRIBU	TES	
REQUIRED REFO	1 128		entification Qualifier the Reference Identification	M 1	ID	2/3	
		CODE	DEFINITION				
		0B	State License Number				
		G2	Provider Commercial Number				
			This code designates a proprieta for the destination payer identifi				

LU

005010X223 • 837 • 2310E • REF SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION			ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3					
REQUIRED	REF02	127	Reference Identification Reference information as defined for a p by the Reference Identification Qualifier SYNTAX: R0203	articular Transactio		AN or as s	1/50 Decified	
			IMPLEMENTATION NAME: Laboratory or Facility Secondary Identifier					
NOT USED	REF03	352	Description		X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER		01			

	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:	 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								



USAGE	REF. DES.	DATA ELEMENT	NAME ATTRIBUTES				TES	
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical locati individual			ID perty or	2/3 an	
			CODE	DEFINITION				
			DN	Referring Provider				
REQUIRED NM102		1065	Entity Type C Code qualifying	Qualifier 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: Referring Provider Last Name					
SITUATIONAL NM104 1036		1036	Name First Individual first name		01	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: Referring Provider First Name				
SITUATIONAL	SITUATIONAL NM105 1037		Name Middle Individual middle		01	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: Referring Provider Middle Name or Initial					
NOT USED	NM106	1038	Name Prefix		01	AN	1/10	
SITUATIONAL NM107 1039		1039	Name Suffix Suffix to individu	ual name	01	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: Referring Provider Name Suffix	x			

IMPLEMENTATION NAME: Referring Provider Name Suffix

SITUATIONAL	NM108	66		Code Qualifier g the system/method of code structure use	X1 ed for le	ID dentificat	1/2 tion
			syntax: P0809				
			HIPAA Nation the provider h submitter. OR Required for p implementation submitter has	Required for providers on or after al Provider Identifier (NPI) implement has received an NPI and the NPI is a providers prior to the mandated HII on date when the provider has rece the capability to send it. I by this implementation guide, do	entatio availal PAA N ived a	on date ble to ti IPI In NPI a	when he
			CODE	DEFINITION			
			ХХ	Centers for Medicare and Medica National Provider Identifier	id Ser	vices	
SITUATIONAL	NM109	67	Identification	code source 537: Centers for Medicare National Provider Identifier		edicaid S	ervices 2/80
		07		a party or other code	~ 1		2/00
			SYNTAX: P0809				
			HIPAA Nation the provider h submitter. OR Required for p implementation submitter has	Required for providers on or after al Provider Identifier (NPI) implement has received an NPI and the NPI is a providers prior to the mandated HII on date when the provider has rece the capability to send it. I by this implementation guide, do	entatio availal PAA N ived a	on date ble to ti IPI In NPI a	when he
				NAME: Referring Provider Identifier			
NOT USED	NM110	706	Entity Relation	nship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifie	er Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	Organization Name	01	AN	1/60

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

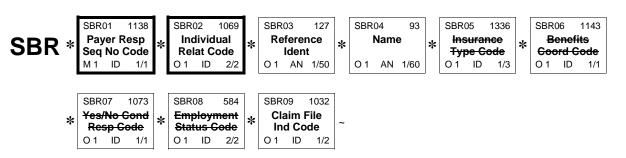
i														-
	REF0	1 128		REF	02	127		REF	03	352		REF04	C040	
REF *		erence nt Qual	*	Re	eferer Iden		*	Des	scrip	tion	*	Refer-		~
	M 1	ID 2/3		X 1	AN	1/50		X 1	AN	1/80		01		

ELEMENT DETAIL

USAGE	REF. DES.	DATA	NAME	ATTRIBUTES	6
REQUIRED	REF01	128		Identification Qualifier M 1 ID g the Reference Identification ID	2/3
			CODE	DEFINITION	
			0B	State License Number	
			1G	Provider UPIN Number	
				UPINs must be formatted as either X99999 or XXX999.	

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE		005010X REFERRING PROVIDER SECO	223 • 837 • 2310F • REF NDARY IDENTIFICATION
			G2	Provider Commercial Number	
				This code designates a proprieta for the destination payer identifi Name loop, Loop ID-2010BB, as claim. This is to be used by all p Medicare, Medicaid, Blue Cross,	ed in the Payer sociated with this ayers including:
REQUIRED	REF02	127		entification nation as defined for a particular Transac e Identification Qualifier	X 1 AN 1/50 ction Set or as specified
			syntax: R0203		
				NAME: Referring Provider Secondary	/ Identifier
NOT USED	REF03	352	Description		X 1 AN 1/80
NOT USED	REF04	C040	REFERENCE	IDENTIFIER	01

	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:	 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		nsibility Sequence Number Code g the insurance carrier's level of responsibili	M 1 ID 1/1 ity for a payment of a
				n claim, the various values for the P by Sequence Number Code (other th re than once.	
			CODE	DEFINITION	
			Α	Payer Responsibility Four	
			В	Payer Responsibility Five	
			С	Payer Responsibility Six	
			D	Payer Responsibility Seven	
			E	Payer Responsibility Eight	
			F	Payer Responsibility Nine	
			G	Payer Responsibility Ten	
			н	Payer Responsibility Eleven	
			Р	Primary	
		S	Secondary		
		т	Tertiary		
		U	Unknown		
				This code may only be used in pa claims when the original payer de presence of this coverage from el received from this payer or when did not provide the responsibility payer.	termined the ligibility files the original claim
REQUIRED	SBR02	1069		lationship Code the relationship between two individuals or	O 1 ID 2/2 entities
			SEMANTIC: SBR0	02 specifies the relationship to the person in	isured.
			CODE	DEFINITION	
			01	Spouse	
			18	Self	
			19	Child	
			20	Employee	
			21	Unknown	
			39	Organ Donor	
			40	Cadaver Donor	
			53	Life Partner	
			G8	Other Relationship	

OTHER SUBSCRIBE							• • • • •		
SITUATIONAL	UATIONAL SBR03	127		dentification rmation as defined for a particular		AN or as s	1/50 pecified		
			semantic: SBR	03 is policy or group number.					
			for the non- iteration of l	LE: Required when the subscr destination payer identified in Loop ID-2320 shows a group etation guide, do not send.	n Loop ID-233	0B of	this		
			IMPLEMENTATION	N NAME: Insured Group or Polic	y Number				
			unique subs	he number uniquely identifyin scriber number is submitted i n of Loop ID-2320.					
SITUATIONAL	ONAL SBR04	93	Name Free-form nam	ne	O 1	AN	1/60		
				04 is plan name.					
				LE: Required when SBR03 is r ilable. If not required by this i					
			IMPLEMENTATION	N NAME: Other Insured Group N	ame				
NOT USED	SBR05	1336	Insurance T	ype Code	O 1	ID	1/3		
NOT USED	SBR06	1143	Coordinatio	n of Benefits Code	01	ID	1/1		
NOT USED	SBR07	1073	Yes/No Con	dition or Response Code	01	ID	1/1		
NOT USED	SBR08	584	Employmen	t Status Code	01	ID	2/2		
SITUATIONAL	SBR09	1032	Claim Filing Code identifyir	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 Progra	ms				
			12	Preferred Provider Organi	zation (PPO)				
			13	Point of Service (POS)					
			14	Exclusive Provider Organ	ization (EPO)				
			15	Indemnity Insurance					
			16	Health Maintenance Orga Risk	nization (HMC) Med	icare		
			17	Dental Maintenance Orga	nization				
			AM	Automobile Medical					
			BL	Blue Cross/Blue Shield					
			СН	Champus					
			CI	Commercial Insurance Co).				
			DS	Disability					
			FI	Federal Employees Progra					
			НМ	Health Maintenance Organ	nization				

LM	Liability Medical
MA	Medicare Part A
	Medicale Fait A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
	Use code OF when submitting Medicare Part D claims.
Т٧	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	Use Code ZZ when Type of Insurance is not known.

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

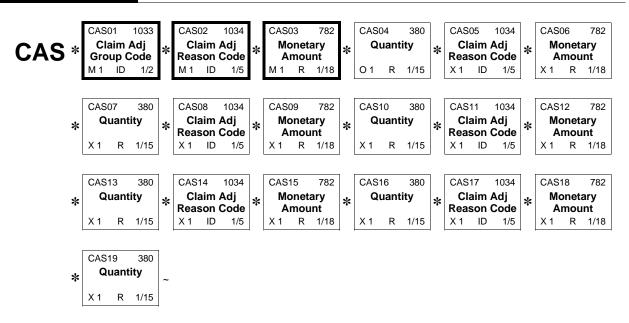
Usage: SITUATIONAL

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



005010X223 • 837 • 2320 • CAS CLAIM LEVEL ADJUSTMENTS

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIB	JTES
REQUIRED	CAS01	CAS01 1033	Claim Adjustment Group Code Code identifying the general category of payment adjustment CODE DEFINITION	M 1 nt	ID	1/2
			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 ma	M 1 .de	ID	1/5
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
			See CODE SOURCE 139: Claim Adjustment Reason	on Co	de	
REQUIRED	QUIRED CAS03	S03 782	Monetary Amount Monetary amount	M 1	R	1/18
			SEMANTIC: CAS03 is the amount of adjustment.			
			IMPLEMENTATION NAME: Adjustment Amount			
SITUATIONAL	TIONAL CAS04	CAS04 380	Quantity Numeric value of quantity	01	R	1/15
		SEMANTIC: CAS04 is the units of service being adjusted.				
			SITUATIONAL RULE: Required when the number of serv adjusted. If not required by this implementation g			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL	CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was ma	X 1 de	ID	1/5
			syntax: L050607, C0605, C0705			
			SITUATIONAL RULE: Required when it is necessary to re non-zero adjustment, beyond what has already be this claim for the Claim Adjustment Group Code r If not required by this implementation guide, do n	en s eport	upplie ted in	d, to
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
SITUATIONAL	L CAS06 78	782	Monetary Amount Monetary amount	X 1	R	1/18
			syntax: L050607, C0605			
			SEMANTIC: CAS06 is the amount of the adjustment.			
			SITUATIONAL RULE: <i>Required when CAS05 is present. In this implementation guide, do not send.</i>	f not	requii	red by
			IMPLEMENTATION NAME: Adjustment Amount			
			•			

ASC X12N • INSURA ECHNICAL REPORT				IM LEVEL		320 • CAS STMENTS
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 prese units of service adjustment. If not required by guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL CAS08	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment wa	X1 s made	ID	1/5	
			syntax: L080910, C0908, C1008			
			SITUATIONAL RULE: Required when it is necessary non-zero adjustment, beyond what has alread this claim for the Claim Adjustment Group Co If not required by this implementation guide,	ly been s de repor	upplie ted in	ed, to
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
SITUATIONAL	TUATIONAL CAS09	09 782	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 prese this implementation guide, do not send.	nt. If not	requii	red by
			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 prese units of service adjustment. If not required by guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL	CAS11	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment wa	X1 s made	ID	1/5
			syntax: L111213, C1211, C1311			
			SITUATIONAL RULE: Required when it is necessary non-zero adjustment, beyond what has alread this claim for the Claim Adjustment Group Co If not required by this implementation guide,	ly been s de repor	upplie ted in	ed, to
			IMPLEMENTATION NAME: Adjustment Reason Code			

005010X223 • 837 • 232 CLAIM LEVEL ADJUST			ASC X12N • INSU TECH	JRANCE S		
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 this implementation guide, do not send.	nt. If not	requi	red by
			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: <i>Required when CAS11 is presenunits of service adjustment. If not required by guide, do not send.</i>			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL CAS14	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was	X1 s made	ID	1/5	
		syntax: L141516, C1514, C1614				
		SITUATIONAL RULE: Required when it is necessary to non-zero adjustment, beyond what has alread this claim for the Claim Adjustment Group Co If not required by this implementation guide, o	y been s de repor	uppli ted in	ed, to	
			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 this implementation guide, do not send.	nt. If not	requi	red by
			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 presen units of service adjustment. If not required by guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE		005010X223 • 8 CLAIM LEVEL		
SITUATIONAL	CAS17	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustm	X 1 ent was made	ID	1/5
			syntax: L171819, C1817, C1917			
			SITUATIONAL RULE: Required when it is necess non-zero adjustment, beyond what has a this claim for the Claim Adjustment Grou If not required by this implementation ge	already been s up Code repor	uppli ted in	ed, to
			IMPLEMENTATION NAME: Adjustment Reason C	ode		
			code source 139: Claim Adjustment Reason Cod	de		
SITUATIONAL	ATIONAL CAS18 782	Monetary Amount Monetary amount	X 1	R	1/18	
			syntax: L171819, C1817			
			SEMANTIC: CAS18 is the amount of the adjustmer	nt.		
			SITUATIONAL RULE: <i>Required when CAS17 is this implementation guide, do not send.</i>	present. If not	requ	ired by
			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 ad	justed.		
			SITUATIONAL RULE: <i>Required when CAS17 is units of service adjustment. If not requir guide, do not send.</i>			
			IMPLEMENTATION NAME: Adjustment Quantity			

SEGMENT DETAIL									
			OORDIN PAID AN	IATION OF BENEF 10UNT	TTS (CO	B)		
X12 Segment Na	me: Mon	etary Am	ount Informati	on					
X12 Purpe	ose: To in	ndicate th	e total moneta	ry amount					
Lo	oop: 232	0 — ОТН	ER SUBSCRI	BER INFORMATION					
Segment Rep	eat: 1								
Usa	age: SITU	JATIONA	L						
Situational R	Loo OR Req pay	Required when the claim has been adjudicated by the payer identified in Loop ID-2330B of this loop. DR 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 Exam	ple: AMT	F*D*411	~						
DIAGRAM									
	1 522 unt Qual code ID 1/3		t [*] Flag C						
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	ITES		
REQUIRED	AMT01	522	Amount Qual Code to qualify a CODE		M 1	ID	1/3		
			D	Payor Amount Paid					
REQUIRED	AMT02	782	Monetary Am Monetary amou		M 1	R	1/18		
			IMPLEMENTATION I	NAME: Payer Paid Amount					
			It is acceptab	le to show "0" as the amount pa	id.				
			When Loop II agency actua	D-2010AC is present, this is the a lly paid.	amount th	ne Med	licaid		
NOT USED	AMT03	478	Credit/Debit F	ilag Code	01	ID	1/1		

SEGMENT DETAIL								
	AMT - R	EMAINING PATIENT LIABIL	ITY					
X12 Segment Name:	Monetary Am	ount Information						
X12 Purpose:	To indicate th	o indicate the total monetary amount						
Loop:	2320 — OTH	320 — OTHER SUBSCRIBER INFORMATION						
Segment Repeat:	1							
Usage:	SITUATIONA	L						
Situational Rule:	iteration of L level informa OR Required wh iteration of L received a pa ability to rep	en the Other Payer identified in Loop ID-2330 oop ID-2320) has adjudicated this claim and ation only. en the Other Payer identified in Loop ID-2330 oop ID-2320) has adjudicated this claim and aper remittance advice and the provider does ort line item information. ed by this implementation guide, do not send	provie DB (of the pr s not l	ded c this rovide	er			
TR3 Notes: 1. In the judgment of the provider, this is the remaining amount to I paid after adjudication by the Other Payer identified in Loop ID-2 of this iteration of Loop ID-2320.								
	in Payer 3. This seg	ment is only used in provider submitted clain -to-Payer Coordination of Benefits (COB). ment is not used if the line level (Loop ID-24 Liability AMT segment is used for this Other I	30) Re	emain				
TR3 Example:	AMT*EAF*7	/5~						
DIAGRAM								
AMT * Amount Qu Code	AMT02 Monetal Amoun 1/3 M 1 R	t Tlag Code						
USAGE R	EF. DATA ES. <u>ELEMENT</u>	NAME		ATTRIB	JTES			
REQUIRED AMTO	01 522	Amount Qualifier Code Code to qualify amount	M 1	ID	1/3			
REQUIRED AMTO	02 782	CODE DEFINITION EAF Amount Owed Monetary Amount Monetary amount	M 1	R	1/18			
NOT USED AMTO	03 478	Credit/Debit Flag Code	01	ID	1/1			

SEGMENT DETAIL							
		OORDINATION OF BENEFIT	⁻ S (CO	B)		
X12 Segment Name:	Monetary Am	ount Information					
X12 Purpose:	To indicate the	e total monetary amount					
Loop:	2320 — OTH	ER SUBSCRIBER INFORMATION					
Segment Repeat:	1						
Usage:	SITUATIONA	L					
Situational Rule:	providers to	en the destination payer's cost avoidance po bypass claim submission to the otherwise p Loop ID-2330B. If not required by this implem	rior pa	ayer			
TR3 Notes:	the total payer pa	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*27	3~					
DIAGRAM							
AMT * Amount Q		t [*] Flag Code ~					
	EF. DATA ES. ELEMENT	NAME		ATTRIBU			
REQUIRED AMT		Amount Qualifier Code	M 1	ID	1/3		
		Code to qualify amount					
REQUIRED AMT	02 782	A8 Noncovered Charges - Actual Monetary Amount Monetary amount	M 1	R	1/18		
		IMPLEMENTATION NAME: Non-Covered Charge Amount					
NOT USED AMT	03 478	Credit/Debit Flag Code	01	ID	1/1		

SEGMENT DETAIL							
			HER INSU	JRANCE COVERA	GE		
X12 Segment	Name: Oth	er Health	Insurance Info	rmation			
X12 Pu	rpose: To a	specify inf	ormation assoc	ciated with other health insuran	ice cove	rage	
	Loop: 232	0 — ОТН		BER INFORMATION			
Segment R	epeat: 1						
ι	Jsage: REG	QUIRED					
TR3	Notes: 1.			ned in the OI segment applie 330B in this iteration of Loop	-	-	ayer
TR3 Exa	ample: OI*	**Y*B*	*Y~				
DIAGRAM							
	Claim File	Claim Cu	bmt _* Yes/No C	1073 Cond ode 1/1 * Ol04 1351 Patient Sig Source Code 0 1 ID 1/1 Ol05 Provid Agree C 0 1 ID 1/1	ler Fode *	Ol06 Releas Info Co O 1 ID	~
	REF.	DATA					
	DES.			diastar Cada			
NOT USED	Ol01 Ol02	1032 1383	Claim Filing Ir	sion Reason Code	01	ID ID	1/2 2/2
REQUIRED	0103	1073	Yes/No Condi	tion or Response Code	01	ID	1/1
			SEMANTIC: OI03 is insured or author an "N" value india IMPLEMENTATION N	a Yes or No condition or response is the assignment of benefits indicator. rized person authorizes benefits to be cates benefits have not been assigned IMME: Benefits Assignment Certifi swalk from CLM08 when doing (assigned t I to the pro ication In	o the pro vider.	ovider;
			This element a	answers the question whether o e plan to remit payment directly	r not the		
			CODE	DEFINITION	•		
			N	No			
			W	Not Applicable			
				Use code 'W' when the patient benefits.	refuses	to assi	gn
			Y	Yes			
NOT USED	OI04	1351		ure Source Code	01	ID	1/1
NOT USED	OI05	1360	Provider Agre	ement Code	01	ID	1/1

005010X223 • 837 • 2320 • OI
OTHER INSURANCE COVERAGE INFORMATION

REQUIRED	OI06	1363	Code indicating	Formation CodeO 1ID1/1whether the provider has on file a signed statement by the patient elease of medical data to other organizations1/1
			This is a cros	swalk from CLM09 when doing COB.
			The Release c carried in this	of Information response is limited to the information sclaim.
			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 Medic claims	are inpatient
Loop:	2320 — OTHER SUBSCRIBER INFORMATION	
Segment Repeat:	1	
Usage:	SITUATIONAL	
Situational Rule:	Required when inpatient adjudication information is report remittance advice. OR Required when it is necessary to report remark codes. If not required by this implementation guide, do not send.	ted in the
TR3 Example:	MIA*1***3568.98*MA01**********************	5~
DIAGRAM		
MIA01 3 Quantity	80 * MIA02 782 MIA03 380 MIA04 782 MIA05 127 * Monetary Amount * Quantity * Monetary Amount * Reference Ident	MIA06 782 MOnetary Amount
M 1 R 1/	15 O1 R 1/18 O1 R 1/15 O1 R 1/18 O1 AN 1/50	O 1 R 1/18
MIA07 7 ★ Monetary Amount O 1 R 1/	Amount Amount Amount Amount Amount	* Monetary Amount
* Monetary Amount	82 MIA14 782 MIA15 380 MIA16 782 MIA17 782 Monetary Amount Quantity * Monetary Mon	* Monetary Amount
MIA19 7 Monetary Amount O 1 R 1/	↑ Ident ↑ Ident ↑	* Monetary Amount ~
ELEMENT DETAIL		
USAGE D	EF. DATA S. ELEMENT NAME	ATTRIBUTES
REQUIRED MIA0	·	M 1 R 1/15
	Numeric value of quantity	
	SEMANTIC: MIA01 is the covered days.	
NOT USED MIA0	IMPLEMENTATION NAME: Covered Days or Visits Count 2 782 Monetary Amount	O 1 R 1/18

SITUATIONAL	MIA03	380	Quantity	0.4	_			
		380	Numeric value of quantity	01	R	1/15		
			SEMANTIC: MIA03 is the lifetime psychiatric days.					
			SITUATIONAL RULE: Required when returned in the r not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Lifetime Psychiatric Days Co	ount				
SITUATIONAL	MIA04	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA04 is the Diagnosis Related Group (DRG)	amount.				
			SITUATIONAL RULE: <i>Required when returned in the r</i> not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim DRG Amount					
SITUATIONAL	TIONAL MIA05	127	Reference Identification Reference information as defined for a particular Transa by the Reference Identification Qualifier		AN or as s	1/50 becified		
			SEMANTIC: MIA05 is the Claim Payment Remark Code. See Code Source 411.					
			SITUATIONAL RULE: Required when returned in the r not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim Payment Remark Code	e				
SITUATIONAL	MIA06	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA06 is the disproportionate share amount.					
			SITUATIONAL RULE: Required when returned in the r not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim Disproportionate Shar	e Amou	nt			
SITUATIONAL	MIA07	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA07 is the Medicare Secondary Payer (MSF) pass-th	rough a	amount.		
			SITUATIONAL RULE: Required when returned in the r not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim MSP Pass-through Am	nount				
SITUATIONAL	MIA08	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA08 is the total Prospective Payment System	m (PPS) c	apital a	amount.		
		SITUATIONAL RULE: Required when returned in the range of			rice. If			
			not required by the implementation galac, ac					

ASC X12N • INSURAL TECHNICAL REPORT			INPATIENT	005010X223 • 8 ADJUDICATION			
SITUATIONAL	MIA09	782	Monetary Amount Monetary amount	01	R	1/18	
			SEMANTIC: MIA09 is the Prospective Payment Syst specific portion, Diagnosis Related Group (DRG)		al, feder	ral	
			SITUATIONAL RULE: Required when returned in not required by this implementation guid			vice. If	
			IMPLEMENTATION NAME: PPS-Capital FSP DRG	Amount			
SITUATIONAL	MIA10	782	Monetary Amount Monetary amount	01	R	1/18	
			SEMANTIC: MIA10 is the Prospective Payment Syst specific portion, Diagnosis Related Group (DRG),		al, hosp	ital	
			SITUATIONAL RULE: Required when returned in not required by this implementation guid			rice. If	
			IMPLEMENTATION NAME: PPS-Capital HSP DRG	Amount			
SITUATIONAL	IONAL MIA11	11 782	Monetary Amount Monetary amount	01	R	1/18	
			SEMANTIC: MIA11 is the Prospective Payment Syst disproportionate share, hospital Diagnosis Relate			t.	
					SITUATIONAL RULE: Required when returned in not required by this implementation guid		
			IMPLEMENTATION NAME: PPS-Capital DSH DRG	Amount			
SITUATIONAL	MIA12	782	Monetary Amount Monetary amount	01	R	1/18	
			SEMANTIC: MIA12 is the old capital amount.				
			SITUATIONAL RULE: Required when returned in not required by this implementation guid			rice. If	
			IMPLEMENTATION NAME: Old Capital Amount				
SITUATIONAL	MIA13	782	Monetary Amount Monetary amount	01	R	1/18	
			SEMANTIC: MIA13 is the Prospective Payment Syst medical education claim amount.	em (PPS) capita	al indire	ct	
			SITUATIONAL RULE: Required when returned in not required by this implementation guid			vice. If	
			IMPLEMENTATION NAME: PPS-Capital IME amoun	nt			
SITUATIONAL	MIA14 7	782	Monetary Amount Monetary amount	01	R	1/18	
			SEMANTIC: MIA14 is hospital specific Diagnosis Re	lated Group (DR	(G) Am	ount.	
			SITUATIONAL RULE: Required when returned in not required by this implementation guid			rice. If	
			IMPLEMENTATION NAME: PPS-Operating Hospita		• •		

005010X223 • 837 • 2320 • MIA INPATIENT ADJUDICATION INFORMATION			ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3					
SITUATIONAL	MIA15	380	Quantity Numeric value of quantity	01	R	1/15		
			SEMANTIC: MIA15 is the cost report days.					
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Cost Report Day Count					
SITUATIONAL	MIA16	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA16 is the federal specific Diagnosis Relat	ed Group (DRG) a	amount.		
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: PPS-Operating Federal Spe	cific DRG	6 Amo	unt		
SITUATIONAL	MIA17	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA17 is the Prospective Payment System (F amount.	PPS) Capita	al Outli	er		
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim PPS Capital Outlier A	mount				
SITUATIONAL	MIA18	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA18 is the indirect teaching amount.					
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim Indirect Teaching Am	ount				
SITUATIONAL	MIA19	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA19 is the professional component amoun	t billed but	not pay	/able.		
		SITUATIONAL RULE: Required when returned in the remittance advice. In not required by this implementation guide, do not send.						
			IMPLEMENTATION NAME: Non-Payable Professional C Amount	Compone	nt Bill	ed		
SITUATIONAL	MIA20 127	127	Reference Identification Reference information as defined for a particular Trans by the Reference Identification Qualifier	O 1 action Set		1/50 pecified		
			SEMANTIC: MIA20 is the Claim Payment Remark Code.	See Code S	Source	411.		
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim Payment Remark Cod	le				

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			0050 [.] INPATIENT ADJU			320 • MIA RMATION		
SITUATIONAL MIA21 127	127	Reference Identification Reference information as defined for a particular Transa by the Reference Identification Qualifier		AN or as s	1/50 Decified			
			SEMANTIC: MIA21 is the Claim Payment Remark Code.	See Code	Source	411.		
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
		IMPLEMENTATION NAME: Claim Payment Remark Cod	le					
SITUATIONAL MIA22	127	Reference Identification Reference information as defined for a particular Transa by the Reference Identification Qualifier	O 1 action Set	AN or as s	1/50 Decified			
			SEMANTIC: MIA22 is the Claim Payment Remark Code.	See Code	Source	411.		
		SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If			
			IMPLEMENTATION NAME: Claim Payment Remark Cod	le				
SITUATIONAL	MIA23	127	Reference Identification Reference information as defined for a particular Transa by the Reference Identification Qualifier	O 1 action Set	AN or as s	1/50 Decified		
			SEMANTIC: MIA23 is the Claim Payment Remark Code. See Code Source 411.					
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: Claim Payment Remark Cod	le				
SITUATIONAL	MIA24	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MIA24 is the capital exception amount.					
			SITUATIONAL RULE: Required when returned in the not required by this implementation guide, do			rice. If		
			IMPLEMENTATION NAME: PPS-Capital Exception Amo	unt				

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:	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							
MOA * Percent	27 e * MOA08 782 Monetary Amount * MOA09 782 Monetary Amount ~						
R	EF. DATA ES. <u>element</u> <u>Name</u> <u>Attributes</u>						
SITUATIONAL MOA	Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%) SEMANTIC: MOA01 is the reimbursement rate. SITUATIONAL RULE: <i>Required when returned in the remittance advice. If</i>						
	not required by this implementation guide, do not send.						

	T • TYPE 3		Con An	ENT ADJUDICATION						
SITUATIONAL	MOA02	782	Monetary Amount Monetary amount	0 1	R	1/18				
			SEMANTIC: MOA02 is the claim Health Care Fi Procedural Coding System (HCPCS) payable		on Com	nmon				
			SITUATIONAL RULE: Required when returned not required by this implementation g			rice. If				
			IMPLEMENTATION NAME: HCPCS Payable An	nount						
SITUATIONAL	NAL MOA03	127	Reference Identification Reference information as defined for a partic by the Reference Identification Qualifier	01 ular Transaction Set		1/50 becified				
			SEMANTIC: MOA03 is the Claim Payment Rem	ark Code. See Code	Source	e 411.				
			SITUATIONAL RULE: Required when returne not required by this implementation g			rice. If				
			IMPLEMENTATION NAME: Claim Payment Ren	nark Code						
SITUATIONAL MOA04 12		127	Reference IdentificationO 1 AN 1/Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier							
			SEMANTIC: MOA04 is the Claim Payment Remark Code. See Code Source 411.							
		SITUATIONAL RULE: Required when returned not required by this implementation g			rice. If					
			IMPLEMENTATION NAME: Claim Payment Rer	IMPLEMENTATION NAME: Claim Payment Remark Code						
SITUATIONAL	- MOA05 127	MOA05 127	Reference Identification Reference information as defined for a partic by the Reference Identification Qualifier	01 ular Transaction Set		1/50 becified				
			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 O 1 AN 1 Reference information as defined for a particular Transaction Set or as species by the Reference Identification Qualifier							
			SEMANTIC: MOA06 is the Claim Payment Rem	ark Code. See Code	Source	e 411.				
			SITUATIONAL RULE: Required when returne not required by this implementation g			rice. If				
			IMPLEMENTATION NAME: Claim Payment Rer	mark Code						
SITUATIONAL	MOA07	127	Reference Identification Reference information as defined for a partic by the Reference Identification Qualifier		AN or as sp	1/50 becified				
			SEMANTIC: MOA07 is the Claim Payment Rem	nark Code. See Code	Source	e 411.				
			SITUATIONAL RULE: Required when returne not required by this implementation g			rice. If				
			IMPLEMENTATION NAME: Claim Payment Rer							

SITUATIONAL MOA08	MOA08	782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MOA08 is the End Stage Renal Disease (ESRD) payme	nt amo	unt.		
			SITUATIONAL RULE: Required when returned in the rel not required by this implementation guide, do no			ice. If		
		IMPLEMENTATION NAME: End Stage Renal Disease Payment Amount						
SITUATIONAL MOA0	MOA09	09 782	Monetary Amount Monetary amount	01	R	1/18		
			SEMANTIC: MOA09 is the professional component amount b	oilled but	i not pa	yable.		
			SITUATIONAL RULE: Required when returned in the remittance advice. If not required by this implementation guide, do not send.					
			IMPLEMENTATION NAME: Non-Payable Professional Con Amount	nponei	nt Bille	ed		

OEGMENT DETAIE								
	NM1 - OTHER SUBSCRIBER NAME							
X12 Segment Name:	Individual or Organizational Name							
X12 Purpose:	o supply the full name of an individual or organizational entity							
X12 Set Notes:	 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								
NM1 * Entity ID	98 NM102 1065 NM103 1035 NM104 1036 NM105 1037 NM106 1038 * Entity Type * Name Last/ * Name * Name * Name							

NM1 * * * * * Code Qualifier Org Name First Prefix Middle ID 2/3 M1 ID 1/1 X 1 AN 1/60 O 1 AN 1/35 O 1 AN 1/25 O 1 AN 1/10 M 1 NM107 1039 NM108 66 NM109 67 NM110 706 NM111 98 NM112 1035 Name ID Code ID Entity Entity ID Name Last/ * * * * * * ~ Qualifier Code Relat Code Org Name Suffix Code O 1 AN 1/10 X1 ID 1/2 X 1 AN 2/80 X 1 ID 2/2 01 ID 2/3 O 1 AN 1/60

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBUTE	S		
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location individual			ID perty or an	2/3		
			CODE	DEFINITION					
			IL	Insured or Subscriber					
REQUIRED	NM102	1065	Entity Type Qu Code qualifying t		M 1	ID	1/1		
			SEMANTIC: NM102	2 qualifies NM103.					
			CODE	DEFINITION					
			1	Person					
			2	Non-Person Entity					
REQUIRED	NM103	1035		Organization Name me or organizational name	X 1	AN	1/60		
			syntax: C1203						
			IMPLEMENTATION N	AME: Other Insured Last Name					
SITUATIONAL	- NM104 1036		Name First Individual first na	me	01	AN	1/35		
				Required when NM102 = 1 (person) ne. If not required by this implemen		-			
			IMPLEMENTATION N	AME: Other Insured First Name					
SITUATIONAL	NM105	1037	Name Middle Individual middle	name or initial	01	AN	1/25		
			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 N	AME: Other Insured Middle Name					
NOT USED	NM106	1038	Name Prefix		01	AN	1/10		
SITUATIONAL	NM107	1039	Name Suffix Suffix to individua	al name	01	AN	1/10		
			suffix of the p	Required when NM102 = 1 (person) erson is needed to identify the indiv is implementation guide, do not ser	vidua		ne		
			IMPLEMENTATION N	AME: Other Insured Name Suffix					

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

REQUIRED	NM108	66		Code Qualifier ng the system/method of code structure u	X 1 used for lo	ID dentifica	1/2 ation
			CODE	DEFINITION			
			II	Standard Unique Health Identifi in the United States	er for ea	ach Ind	lividual
				Required if the HIPAA Individua mandated use. If not required, instead.			ifier is
			МІ	Member Identification Number			
				The code MI is intended to be the identification number as assign example, Insured's ID, Subscrib Insurance Claim Number (HIC), MI is also intended to be used in the Indian Health Service/Contra (IHS/CHS) Fiscal Intermediary for	ed by th ber's ID, etc.) n claims act Heal	he paye Health s subm	er. (For initiated to vices
				reporting the Tribe Residency C State). In the event that a Social (SSN) is also available on an IH SSN in REF02.	ode (Tr Securi	ibe Co ty Num	unty Iber
				When sending the Social Secur Member ID, it must be a string of numbers with no separators. For "111002222" would be valid, wh 2222" would be invalid.	of exactl	y nine ple, se	nding
REQUIRED	NM109	67	Identification Code identifying	Code a party or other code	X 1	AN	2/80
			SYNTAX: P0809				
			IMPLEMENTATION I	NAME: Other Insured Identifier			
NOT USED	NM110	706	Entity Relatio	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifi	er Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	Organization Name	01	AN	1/60

SEGMENT DETAIL										
	-	_	HER SUBSCRIBER ADD	RESS						
X12 Segment Na	ame: Party	/ Locatio	n							
X12 Purp	ose: To s	o specify the location of the named party								
L	oop: 2330	30A — OTHER SUBSCRIBER NAME								
Segment Rep	peat: 1									
Us	age: SITU	JATIONA	۱L							
Situational F	-	equired when the information is available. If not required by this aplementation guide, do not send.								
TR3 Exan	nple: N3*	N3*123 MAIN STREET~								
DIAGRAM										
	ddress rmation AN 1/55	Addres Informat O 1 AN	ion ~							
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES				
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	01	AN	1/55				
			SITUATIONAL RULE: Required when there is a se required by this implementation guide, do		ss line.	lf not				
			IMPLEMENTATION NAME: Other Insured Address	Line						



X12 Segment Name: Geographic Location **X12 Purpose:** To specify the geographic place of the named party 1. E0207 X12 Syntax: 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 N401 N402 156 N403 116 N404 N405 309 N406 310 19 26 City State or Postal Country Location **Location** N4 * * * * * * **Prov Code** Name **Qualifier Identifier** Code Code AN 2/30 Χ1 ID 2/2 01 ID 3/15 X 1 ID 2/3 X 1 ID 1/2 01 AN 1/30 O 1 N407 1715 **Country Sub** * Code Χ1 ID 1/3 ELEMENT DETAIL DATA ELEMENT REF. DES. USAGE NAME ATTRIBUTES REQUIRED N401 19 O1 AN 2/30 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

005010X223 • 837 • 2330A •	N4
OTHER SUBSCRIBER CITY, S	STATE, ZIP CODE

SITUATIONAL	N402	156	State or Province CodeX 1ID2/2Code (Standard State/Province) as defined by appropriate government agency					
			syntax: E0207					
			COMMENT: N402 is required only if city name (N401) is in th	e U.S. (or Canad	da.		
			SITUATIONAL RULE: Required when the address is in t America, including its territories, or Canada. If n implementation guide, do not send.					
			IMPLEMENTATION NAME: Other Insured State Code					
			CODE SOURCE 22: States and Provinces					
SITUATIONAL	TIONAL N403 1	116	Postal Code Code defining international postal zone code excluding pu (zip code for United States)	O 1 nctuatio	ID on and b	3/15 lanks		
			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	SITUATIONAL N404 26	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 ISC) 3166				
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2		
NOT USED	N406	310	Location Identifier	01	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	of ISO	3166			

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 REF01 128 REF02 127 REF03 352 REF04 C040 Reference Reference **Description** Reference **REF*** * * **Ident Qual** Ident **Identifier** ID 2/3 AN 1/50 AN 1/80 M 1 X 1 01 ELEMENT DETAIL REF. DATA ELEMENT USAGI NAME ATTRIBUTES REQUIRED REF01 128 **Reference Identification Qualifier** ID 2/3 M 1 Code qualifying the Reference Identification CODE DEFINITION SY **Social Security Number** The Social Security Number must be a string of exactly nine numbers with no separators. For example, sending "111002222" would be valid, while sending "111-00-2222" would be invalid. REQUIRED REF02 127 **Reference Identification** X1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SYNTAX: R0203 IMPLEMENTATION NAME: Other Insured Additional Identifier NOT USED REF03 352 1/80 Description X1 AN NOT USED **REFERENCE IDENTIFIER** REF04 C040 01

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 NM101 NM102 NM103 1035 NM104 1036 NM105 1037 NM106 1038 98 1065 Entity Type Entity ID Name Last/ Name Name Name NM1 * * * * Code Qualifier Org Name First Middle Prefix ID 2/3 M 1 ID 1/1 X 1 AN 1/60 01 AN 1/35 01 AN 1/25 01 AN 1/10 M 1 NM107 1039 NM108 NM109 NM110 NM111 98 NM112 1035 66 67 706 ID Code ID Entity Entity ID Name Last/ Name * * * * * Org Name **Suffix** Qualifier Code Relat Code Code O 1 AN 1/10 ID 1/2X 1 AN 2/80 X 1 ID 2/2 O 1 ID 2/3 01 AN 1/60 ELEMENT DETAIL DATA LEMENT REF. USAGE NAME ATTRIBUTES REQUIRED NM101 98 ID **Entity Identifier Code** M 1 2/3 Code identifying an organizational entity, a physical location, property or an individual CODE DEFINITION PR Payer REQUIRED NM102 ID 1/1 1065 **Entity Type Qualifier** M 1 Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103. CODE DEFINITION 2 **Non-Person Entity**

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2330B • NM1 OTHER PAYER NAME				
REQUIRED	NM103	1035		r Organization Name ame or organizational name	X 1	AN	1/60
			syntax: C1203				
			IMPLEMENTATION	NAME: Other Payer Last or O	ganization Na	ime	
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle		01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	AN	1/10
REQUIRED	NM108	66	Code designatin Code (67)	Code Qualifier ng the system/method of code str	X 1 ucture used for I	ID dentifica	1/2 ation
			syntax: P0809				
				e mandated implementatio Identifier (National Plan ID			
				nandated implementation dan the second se	-		phase-
			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 Ser	vices	PlanID
				code source 540: Centers for PlanID	Medicare and Me	edicaid	Services
REQUIRED	NM109	67	Identification Code identifying		X 1	AN	2/80
			SYNTAX: P0809				
			IMPLEMENTATION	NAME: Other Payer Primary Id	dentifier		
			identifier sen	g Line Adjudication Informa t in SVD01 (Payer Identifier Information) must match th) of Loop ID-24		
NOT USED	NM110	706	Entity Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	^r Organization Name	O 1	AN	1/60

	N3 - OTH	HER PAYER ADDRESS							
X12 Segment Name:	Party Location	1							
X12 Purpose:	To specify the	o specify the location of the named party							
Loop:	2330B — OTI	HER PAYER NAME							
Segment Repeat:	1								
Usage:	SITUATIONA	L							
Situational Rule:	for the claim	equired when the payer address is available and the submitter intends or the claim to be printed on paper at the next EDI location (for example, a earinghouse). If not required by this implementation guide, do not send.							
TR3 Example:	N3*123 MAIN	STREET~							
DIAGRAM									
N301 166 Address Information M 1 AN 1/55 N302 166 Address Information O 1 AN 1/55									
ELEMENT DETAIL									
	EF. DATA ES. ELEMENT	NAME		ATTRIBUT	TES				
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	01	AN	1/55				
		SITUATIONAL RULE: Required when there is a second a required by this implementation guide, do not set		s line.	lf not				
		IMPLEMENTATION NAME: Other Payer Address Line							

SEGMENT DETAIL								
	N4 - OTH	HER PAYER CITY, STATE, Z						
X12 Segment Name:								
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	2. C0605 If N406 is present, then N405 is required.						
	3. C0704							
Loop:		HER PAYER NAME						
Segment Repeat:	1							
	REQUIRED							
•								
-	N4*KANSAS	CITY*MO*64108~						
DIAGRAM								
N401 City Name O 1 AN 2	* State or Prov Cod		* Location Identifier					
* Country St Code	(15) ub 1/3							
ELEMENT DETAIL								
USAGE R	EF. DATA ES. ELEMENT	NAME	ATTRIBUTES					
REQUIRED N401	19	City Name	O 1 AN 2/30					
		Free-form text for city name	405 101400 1					
		COMMENT : A combination of either N401 through N404, or N- adequate to specify a location.	405 and N406 may be					
		IMPLEMENTATION NAME: Other Payer City Name						
SITUATIONAL N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate g	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 America, including its territories, or Canada. If no implementation guide, do not send.						
		IMPLEMENTATION NAME: Other Payer State Code						
		CODE SOURCE 22: States and Provinces						

SITUATIONAL	ATIONAL N403 116		Postal CodeO 1ID3/15Code defining international postal zone code excluding punctuation and blanks (zip code for United States)					
		SITUATIONAL RULE: Required when the address is in America, including its territories, or Canada, or exists for the country in N404. If not required by implementation guide, do not send.	when a					
			IMPLEMENTATION NAME: Other Payer Postal Zone or Z	P Cod	e			
			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 ou States of America. If not required by this impler not send.						
			CODE SOURCE 5: Countries, Currencies and Funds					
			Use the alpha-2 country codes from Part 1 of IS	O 3166	j.			
NOT USED	N405	309	Location Qualifier	X 1	ID	1/2		
NOT USED	N406	310	Location Identifier	01	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									
X12 Segment Name		DTP - CLAIM CHECK OR REMITTANCE DATE							
X12 Purpose	: To specify a	To specify any or all of a date, a time, or a time period							
Loop	: 2330B — O	2330B — OTHER PAYER NAME							
Segment Repeat	: 1	1							
. .									
Usage	: SITUATION	AL							
Situational Rule	adjudicated	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*[08*20040203~							
DIAGRAM									
DTP * Date/Tin Qualifit M 1 ID	ne er 3/3 * Date T Format M 1 ID	Qual [*] Perio 2/3 M 1 AN	d ~		ATTRIBUT	FS			
REQUIRED DTF		Date/Time Qua	alifior	М 1	ID	3/3			
DI	-01 - 574		type of date or time, or both date and time		U	3/3			
		IMPLEMENTATION N	IAME: Date Time Qualifier						
		CODE	DEFINITION						
		573	Date Claim Paid						
REQUIRED DTF	902 1250		iod Format Qualifier the date format, time format, or date and tir	M 1 ne forr	ID nat	2/3			
			2 is the date or time or period format that wi	II appe	ear in DT	P03.			
			Definition	MDD					
REQUIRED DTF	203 1251	D8 Date Time Per	Date Expressed in Format CCYYM iod	MDD M1	AN	1/35			
			date, a time, or range of dates, times or dat						
		IMPLEMENTATION N	IAME: Adjudication or Payment Date						

SEGMENT DETAIL										
	REF - O		YER SECONDARY							
X12 Segment Name:	Reference Infe	Reference Information								
X12 Purpose:	To specify ide	To specify identifying information								
X12 Syntax:	1. R0203 At least o									
Loop:	2330B — OTI		IAME							
Segment Repeat:	2									
	SITUATIONA	L								
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*987	765~								
DIAGRAM										
REF * Reference Ident Qua	e _* Reference	* .	↑ Identifier							
	EF. DATA ES. ELEMENT	NAME			ATTRIBL	UTES				
REQUIRED REFO	01 128		ntification Qualifier he Reference Identification DEFINITION Payer Identification Number Employer's Identification Number The Employer's Identification Number string of exactly nine numbers with For example, "001122333" would sending "001-12-2333" or "00-112 invalid.	nber n th no s be val	separa id, wh	ators. nile				
		FY	Claim Office Number							
		NF	National Association of Insurance (NAIC) Code	e Com	missio	oners				
			CODE SOURCE 245: National Association o Commissioners (NAIC) Code	f Insura	ince					

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2330B • REF OTHER PAYER SECONDARY IDENTIFIER				
REQUIRED	REF02	127	Reference IdentificationX 1AN1/50Reference information as defined for a particular Transaction Set or as specified by the Reference Identification QualifierSYNTAX: R0203				
			IMPLEMENTATION NAME: Other Payer Secondary Identif	ier			
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01			

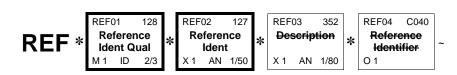
SEGMENT DETAIL **REF - OTHER PAYER PRIOR** AUTHORIZATION NUMBER X12 Segment Name: Reference Information X12 Purpose: To specify identifying information 1. R0203 X12 Syntax: At least one of REF02 or REF03 is required. Loop: 2330B - OTHER PAYER NAME Segment Repeat: 1 **Usage: SITUATIONAL** Situational 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 REF01 128 REF02 127 REF03 352 REF04 C040 Reference Reference **Description** Reference **REF*** * * **Ident Qual** Ident **Identifier** ID 2/3 AN 1/50 AN 1/80 VI 1 1 X 1 01 ELEMENT DETAIL REF. DATA USAGI NAME ATTRIBUTES REQUIRED REF01 128 **Reference Identification Qualifier** ID 2/3 M 1 Code qualifying the Reference Identification CODE DEFINITION G1 **Prior Authorization Number** REQUIRED REF02 127 **Reference Identification** 1/50 X1 AN 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 NOT USED REF03 352 Description 1/80 X 1 AN NOT USED **REFERENCE IDENTIFIER** REF04 C040 01

SEGMENT DETAIL									
	RE	F - 0	THER PA	YER REFERRAL N	IUM	BEF	र		
X12 Segment Na	me: Refe	Reference Information							
X12 Purpo	ose: To s	: To specify identifying information							
X12 Syn		1. R0203							
		At least one of REF02 or REF03 is required.							
		2330B — OTHER PAYER NAME							
Segment Rep	eat: 1								
Usa	age: SITU	JATIONA	\L						
Situational R	num	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 Exam	ple: REF	*9F*123	345~						
DIAGRAM									
	1 128 erence nt Qual ID 2/3	REF02 Reference Ident X 1 AN	* .	352 tion * REF04 C040 Reference Identifier 0 1					
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	ITES		
REQUIRED	REF01	128	Reference Ide	ntification Qualifier he Reference Identification	M 1	ID	2/3		
			CODE	DEFINITION					
			9F	Referral Number					
REQUIRED	REF02	127		ntification nation as defined for a particular Transac e Identification Qualifier		AN or as sp	1/50 becified		
			syntax: R0203						
			IMPLEMENTATION N Number	AME: Other Payer Prior Authorization	on or R	eferra			
NOT USED	REF03	352	Description		X 1	AN	1/80		
NOT USED	REF04	C040	REFERENCE I	DENTIFIER	01				

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



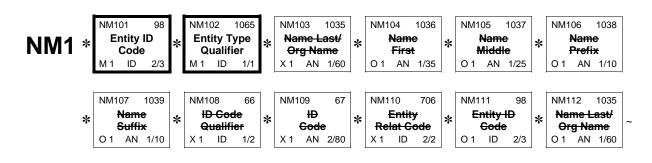
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification		M 1	ID	2/3
			CODE	DEFINITION			
			Т4	Signal Code			
REQUIRED	REF02	127		entification nation as defined for a particular Transact e Identification Qualifier	X 1 on Set		1/50 becified
			IMPLEMENTATION NAME: Other Payer Claim Adjustment Indicator				
			Only allowed	value is "Y".			
NOT USED	REF03	352	Description		X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE	IDENTIFIER	01		

REF - OTHER PAYER CLAIM CONTROL NUMBER

X12 Segment N	ame: Refe	erence Inf	formation					
X12 Purj	oose: To s	pecify ide	entifying information					
X12 Sy		R0203 At least c	one of REF02 or REF03 is required.					
L	_oop: 233	0В — ОТ	HER PAYER NAME					
Segment Re	peat: 1							
U	sage: SITU	JATIONA	AL					
Situational	Nun OR Req	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 Exar	mple: REF	*F8*R5	55588~					
DIAGRAM								
	o1 128 eference ent Qual ID 2/3	REF02 Referen Ident X 1 AN	* * Identifier ~					
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES		
USAGE			Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ATTRIBU ID	<u>тез</u> 2/3		
	DES.	ELEMENT	Reference Identification Qualifier Code qualifying the Reference Identification CODE DEFINITION	 M 1				
	DES.	ELEMENT	Reference Identification Qualifier Code qualifying the Reference Identification	Contr ified in pically	ID ol Nun this it	2/3 hber eration		
	DES.	ELEMENT	Reference Identification Qualifier Code qualifying the Reference Identification CODE DEFINITION F8 Original Reference Number This is the payer's internal Claim for this claim for the payer ident of Loop ID-2330. This value is ty	i Contr ified in pically nly. X 1	ID ol Nun this it used	2/3 hber eration in 1/50		
REQUIRED	REF01	<u>ELEMENT</u> 128	Reference Identification Qualifier Code qualifying the Reference Identification CODE DEFINITION F8 Original Reference Number This is the payer's internal Claim for this claim for the payer ident of Loop ID-2330. This value is ty payer-to-payer COB situations o Reference Identification Reference for a particular Transact	i Contr ified in pically nly. X 1	ID ol Nun this it used	2/3 hber eration in 1/50		
REQUIRED	REF01	<u>ELEMENT</u> 128	Reference Identification Qualifier Code qualifying the Reference Identification CODE DEFINITION F8 Original Reference Number This is the payer's internal Claim for this claim for the payer ident of Loop ID-2330. This value is ty payer-to-payer COB situations o Reference Identification Reference Identification Reference Identification Reference Identification Qualifier	i Contr ified in pically nly. X 1 tion Set	ID ol Nun this it used AN or as sp	2/3 hber eration in 1/50		
REQUIRED	REF01	<u>ELEMENT</u> 128	Reference Identification Qualifier Code qualifying the Reference Identification CODE DEFINITION F8 Original Reference Number This is the payer's internal Claim for this claim for the payer ident of Loop ID-2330. This value is ty payer-to-payer COB situations o Reference Identification Reference Identification Reference Identification Reference Identification Qualifier SYNTAX: R0203	i Contr ified in pically nly. X 1 tion Set	ID ol Nun this it used i AN or as sp	2/3 hber eration in 1/50		

	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:	 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



SEGMENT DETAIL

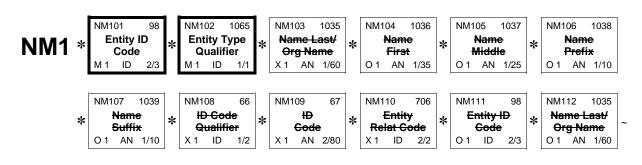
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	JTES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical loca individual		M 1 location, prop	ID erty or	2/3 an
			CODE	DEFINITION			
			71	Attending Physician			
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1
			SEMANTIC: NM10	02 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
NOT USED	NM103	1035	Name Last of	r Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle		01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	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 Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	r Organization Name	01	AN	1/60

SEGMENT DETAIL								
			YER ATTENDING F	PROVIDER				
X12 Segment Name:	Reference Info	Reference Information						
X12 Purpose:	To specify ide	To specify identifying information						
X12 Syntax:	1. R0203							
			r REF03 is required.					
Loop:	2330C — OTI	HER PAYER A	ATTENDING PROVIDER					
Segment Repeat:	4							
Usage:	REQUIRED							
TR3 Notes:	1. Non-dest	tination (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*123	345~						
DIAGRAM								
REF * Reference Ident Qua	e _* Referenc	*	352 tion ★ ReF04 C040 Reference Identifier ~ 0 1 ~					
	EF. DATA ES. ELEMENT	NAME		ATTRIBUTES				
REQUIRED REFO	128	Reference Ide	ntification Qualifier he Reference Identification	M 1 ID 2/3				
		CODE	DEFINITION					
		0B	State License Number					
		1G	Provider UPIN Number UPINs must be formatted as eithe	xr X00000 or				
			XXX999.	A 299999 01				
		G2	Provider Commercial Number					
			This code designates a proprietat for the non-destination payer iden Payer Name Loop ID-2330B for th ID-2320. This is true regardless of payer is Medicare, Medicaid, a Blu Shield plan, a commercial plan, o plan.	ntified in the Other is iteration of Loop f whether that ue Cross Blue				
		LU	Location Number					

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2330C • REF OTHER PAYER ATTENDING PROVIDER SECONDARY IDENTIFICATION				
REQUIRED REF02 127		127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier SYNTAX: R0203		AN or as s	1/50 pecified	
			IMPLEMENTATION NAME: Other Payer Attending Provide	er Sec	ondar	y	
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01			

	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:	 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

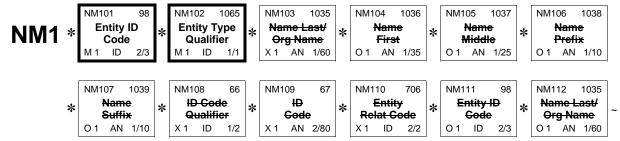


USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	ITES
REQUIRED	NM101	98	Entity Identif Code identifying individual	ier Code g an organizational entity, a physical	M 1 location, prop	ID erty or	2/3 an
			CODE	DEFINITION			
			72	Operating Physician			
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1
			SEMANTIC: NM10	02 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
NOT USED	NM103	1035	Name Last or	r Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle	1	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	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 Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	r Organization Name	01	AN	1/60

SEGMENT DETAIL				
			YER OPERATING ONDARY IDENTIF	
X12 Segment Name:	Reference Infe	ormation		
X12 Purpose:	To specify ide	ntifying inform	ation	
X12 Syntax:	1. R0203			
			or REF03 is required.	
Loop:	2330D — OTI	HER PAYER (OPERATING PHYSICIAN	
Segment Repeat:	4			
Usage:	REQUIRED			
TR3 Notes:	1. Non-dest	tination (COB) payer's provider identification	on number(s).
		swalking CO ing COB in th	B Data Elements section for r e 837.	nore information
TR3 Example:	REF*G2*123	345~		
DIAGRAM				
REF * Reference Ident Qua	e 🐰 Referenc	*	352 tion 1/80 REF04 C040 Reference Identifier ○ 1 ○	
	EF. DATA ES. ELEMENT	NAME		ATTRIBUTES
REQUIRED REFO			ntification Qualifier	M 1 ID 2/3
		Code qualifying t	he Reference Identification	
		CODE	DEFINITION	
		0B	State License Number	
		1G	Provider UPIN Number UPINs must be formatted as eit	bor X00000 or
			XXX999.	11el 799999 01
		G2	Provider Commercial Number	
			This code designates a proprie for the non-destination payer ic Payer Name Loop ID-2330B for ID-2320. This is true regardless payer is Medicare, Medicaid, a Shield plan, a commercial plan plan.	dentified in the Other this iteration of Loop of whether that Blue Cross Blue
		LU	Location Number	

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X2 OTHER PAYER OPERATING PHYSICIAN SECON			30D • REF FICATION
REQUIRED REF02 127		127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier SYNTAX: R0203		AN or as s	1/50 pecified
			IMPLEMENTATION NAME: Other Payer Operating Provide	er Sec	ondar	y
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

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: 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



USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	ITES
REQUIRED	NM101	98	Entity Identif Code identifying individual	ier Code g an organizational entity, a physical locatio	M 1 n, prop	ID berty or a	2/3 an
			CODE	DEFINITION			
			ZZ	Mutually Defined			
				ZZ is used to indicate Other Operation	ating	Physic	ian.
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1
			SEMANTIC: NM10	02 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
NOT USED	NM103	1035	Name Last of	r Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle		01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	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 Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	•	r Organization Name	01	AN	1/60

SEGMENT DETAIL				
			AYER OTHER OPER ONDARY IDENTIFIC	
X12 Segment Name:	Reference Inf	ormation		
X12 Purpose:	To specify ide	entifying inform	ation	
X12 Syntax:	1. R0203 At least o	ne of REF02 o	or REF03 is required.	
Loop:	2330E — OTI	HER PAYER O	OTHER OPERATING PHYSICIA	N
Segment Repeat:	4			
Usage:	REQUIRED			
TR3 Notes:	1. Non-dest	tination (COB) payer's provider identification	n number(s).
		swalking CO ing COB in th	B Data Elements section for mo ne 837.	ore information
TR3 Example:	REF*G2*123	345~		
DIAGRAM				
REF * Reference Ident Qua	e _* Reference	* .	352 tion 1/80 REF04 C040 Reference Identifier O 1	
	EF. DATA ES. ELEMENT	NAME		ATTRIBUTES
REQUIRED REFO			ntification Qualifier	M 1 ID 2/3
		Code qualifying	the Reference Identification	
		CODE	DEFINITION	
		0B	State License Number	
		1G	Provider UPIN Number UPINs must be formatted as eith	
			XXX999.	ei 799999 Ol
		G2	Provider Commercial Number	
			This code designates a proprieta for the non-destination payer ide Payer Name Loop ID-2330B for th ID-2320. This is true regardless of payer is Medicare, Medicaid, a B Shield plan, a commercial plan, of plan.	entified in the Other his iteration of Loop of whether that lue Cross Blue
		LU	Location Number	

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			0050102 OTHER PAYER OTHER OPERATING PHYSICIAN SECO			30E • REF FICATION
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transa by the Reference Identification Qualifier SYNTAX: R0203	X 1 ction Set	AN or as s	1/50 pecified
			IMPLEMENTATION NAME: Other Payer Other Operating Secondary Identifier	Physic	ian	
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

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: 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

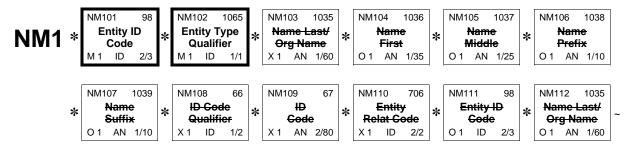
NM101 NM102 NM103 1035 NM104 1036 NM105 1037 NM106 1038 98 1065 Entity ID Entity Type Name Last/ Name Name Name NM1 * * * * Qualifier Middle **Prefix** Code Org Name First ID 2/3 ID 1/1 AN 1/60 01 AN 1/35 01 AN 1/25 01 AN 1/10 M 1 M 1 X 1 NM110 NM107 1039 NM108 66 NM109 67 706 98 NM112 1035 NM111 Name ID Code **ID** Entity Entity ID Name Last/ * * * * * * **Qualifier** Code Relat Code Suffix Code Org Name X 1 AN 2/80 O 1 AN 1/10 Χ1 ID 1/2 Χ1 ID 2/2 O 1 ID 2/3 O 1 AN 1/60

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	TES
REQUIRED	NM101	98	Entity Identi Code identifyin individual	fier Code g an organizational entity, a physica	M 1 I location, prop	ID erty or	2/3 an
			CODE	DEFINITION			
			77	Service Location			
REQUIRED	NM102	1065	Entity Type Code qualifying	Qualifier g the type of entity	M 1	ID	1/1
			SEMANTIC: NM1	02 qualifies NM103.			
			CODE	DEFINITION			
			2	Non-Person Entity			
NOT USED	NM103	1035	Name Last o	or Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle	9	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	AN	1/10
NOT USED	NM108	66	Identificatio	n Code Qualifier	X 1	ID	1/2
NOT USED	NM109	67	Identification	n Code	X 1	AN	2/80
NOT USED	NM110	706	Entity Relati	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identi	fier Code	01	ID	2/3
NOT USED	NM112	1035	-	or Organization Name	01	AN	1/60

SEGMENT DETAIL		
		THER PAYER SERVICE FACILITY
X12 Segment Name:	Reference Inf	formation
X12 Purpose:	To specify ide	entifying information
X12 Syntax:	1. R0203	
		one of REF02 or REF03 is required.
Loop:	2330F — OTI	HER PAYER SERVICE FACILITY LOCATION
Segment Repeat:	3	
Usage:	REQUIRED	
TR3 Notes:	1. Non-des	stination (COB) payer's provider identification number(s).
		sswalking COB Data Elements section for more information lling COB in the 837.
TR3 Example:	REF*G2*12	345~
DIAGRAM		
REF * Reference Ident Qua	A	t 🔭 Identifier
	EF. DATA ES. ELEMENT	NAME ATTRIBUTES
REQUIRED REFO		Reference Identification Qualifier M 1 ID 2/3
		Code qualifying the Reference Identification
		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.
REQUIRED		LU Location Number
REQUIRED REFO	2 127	Reference IdentificationX 1AN1/50Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
		syntax: R0203
		IMPLEMENTATION NAME: Other Payer Service Facility Location Identifier

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2330F • REF OTHER PAYER SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION				
NOT USED	REF03	352	Description	X 1	AN	1/80	
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01			

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:	 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	



USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	ITES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical loca individual		M 1 ocation, prop	ID erty or a	2/3 an
			CODE	DEFINITION			
			82	Rendering Provider			
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1
			SEMANTIC: NM10	2 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
NOT USED	NM103	1035	Name Last or	Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle		01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	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 Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identifi	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last or	Organization Name	01	AN	1/60

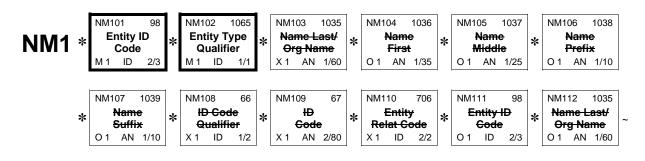
SEGMENT DETAIL				
			AYER RENDERING F	PROVIDER
X12 Segment Name:	Reference Inf	ormation		
X12 Purpose:	To specify ide	ntifying inform	ation	
X12 Syntax:	1. R0203			
			or REF03 is required.	
Loop:	2330G — OT	HER PAYER F	RENDERING PROVIDER NAME	
Segment Repeat:	4			
Usage:	REQUIRED			
TR3 Notes:	1. Non-dest	tination (COB) payer's provider identification	number(s).
		swalking CO ing COB in th	B Data Elements section for mo e 837.	re information
TR3 Example:	REF*G2*123	345~		
DIAGRAM				
REF * Reference Ident Qua	e _* Referenc	* .	352 tion 1/80 REF04 C040 Reference Identifier 0 1 ~	
	EF. DATA ES. ELEMENT	NAME		ATTRIBUTES
REQUIRED REFO	1 128		ntification Qualifier the Reference Identification	M 1 ID 2/3
		CODE	DEFINITION	
		0B	State License Number	
		1G	Provider UPIN Number	
			UPINs must be formatted as eithe XXX999.	r X99999 or
		G2	Provider Commercial Number	
			This code designates a proprietar for the non-destination payer ider Payer Name Loop ID-2330B for th ID-2320. This is true regardless of payer is Medicare, Medicaid, a Blu Shield plan, a commercial plan, or plan.	tified in the Other is iteration of Loop whether that ue Cross Blue
		LU	Location Number	

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X2 OTHER PAYER RENDERING PROVIDER SECON			BOG • REF
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier SYNTAX: R0203		AN or as s	1/50 pecified
			IMPLEMENTATION NAME: Other Payer Rendering Provid	ler Sec	ondar	У
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

	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:	 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~

IR3 Example: NINITADINAL

DIAGRAM



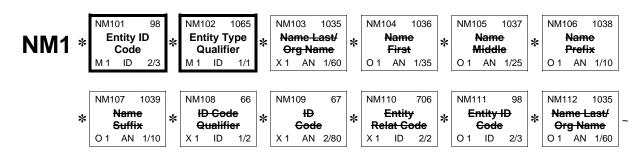
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	ITES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical loca individual		M 1 al location, prop	ID erty or	2/3 an
			CODE	DEFINITION			
			DN	Referring Provider			
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1
			SEMANTIC: NM10	02 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
NOT USED	NM103	1035	Name Last of	r Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle	1	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	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 Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last o	r Organization Name	O 1	AN	1/60

SEGMENT DETAIL						
			AYER REFERRING F	PRO	VIDE	R
X12 Segment Name:	Reference Infe	ormation				
X12 Purpose:	To specify ide	entifying inform	ation			
X12 Syntax:	1. R0203 At least o	ne of REF02 c	or REF03 is required.			
Loop:	2330H — OTI	HER PAYER F	REFERRING PROVIDER			
Segment Repeat:	3					
Usage:	REQUIRED					
TR3 Notes:	1. Non-dest	tination (COB) payer's provider identification	numb	er(s).	
		sswalking CO ing COB in th	B Data Elements section for mo e 837.	ore info	ormation	n
TR3 Example:	REF*G2*123	345~				
DIAGRAM						
ELEMENT DETAIL		* .	tion * Reference Identifier ~ 1/80 O 1		ATTRIBUTES	
REQUIRED REFO			ntification Qualifier	M 1		2/3
	-	Code qualifying t	the Reference Identification			
		CODE	DEFINITION			
		0B	State License Number			
		1G	Provider UPIN Number	1/222	••	
			UPINs must be formatted as eithe XXX999.	er X999	99 or	
		G2	Provider Commercial Number			
			This code designates a proprietar for the non-destination payer ider Payer Name Loop ID-2330B for th ID-2320. This is true regardless of payer is Medicare, Medicaid, a Blu Shield plan, a commercial plan, o plan.	ntified i is itera wheth ue Cros	in the Oth tion of Lo er that ss Blue	her oop

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X2 OTHER PAYER REFERRING PROVIDER SECON			
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transacti by the Reference Identification Qualifier SYNTAX: R0203		AN or as sp	1/50 Decified
			IMPLEMENTATION NAME: Other Payer Referring Provide	r Iden	tifier	
NOT USED	REF03	352	Description	X 1	AN	1/80
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01		

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:	 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
-	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
-	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
-	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.

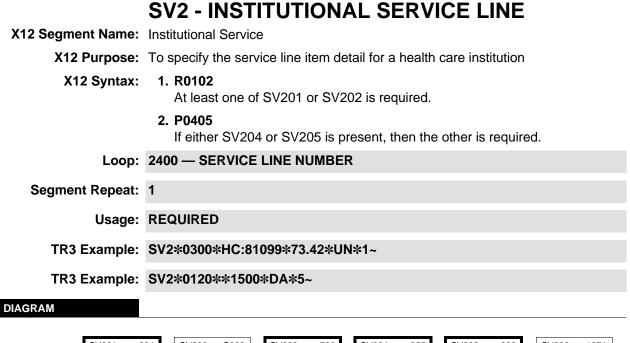
DIAGRAM

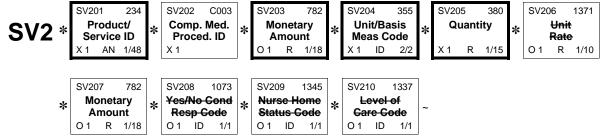


USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	ITES
REQUIRED	NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical locat individual		M 1 al location, prop	ID erty or	2/3 an
			CODE	DEFINITION			
			85	Billing Provider			
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1
			SEMANTIC: NM10	02 qualifies NM103.			
			CODE	DEFINITION			
			2	Non-Person Entity			
NOT USED	NM103	1035	Name Last o	r Organization Name	X 1	AN	1/60
NOT USED	NM104	1036	Name First		01	AN	1/35
NOT USED	NM105	1037	Name Middle	•	01	AN	1/25
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
NOT USED	NM107	1039	Name Suffix		01	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 Relation	onship Code	X 1	ID	2/2
NOT USED	NM111	98	Entity Identif	ier Code	01	ID	2/3
NOT USED	NM112	1035	Name Last o	r Organization Name	O 1	AN	1/60

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 1. See Crosswalking COB Data Elements section for more information TR3 Notes: on handling COB in the 837. TR3 Example: REF*G2*12345~ DIAGRAM REF04 RFF03 RFF01 REF02 352 128 127 C040 Reference Reference **Description** Reference * * REF * **Ident Qual** Ident **Identifier** 01 M 1 ID 2/3 AN 1/50 X 1 AN 1/80 ELEMENT DETAIL DATA ELEMENT NAME REF. USAGE ATTRIBUTES REQUIRED REF01 128 **Reference Identification Qualifier** ID 2/3 M 1 Code qualifying the Reference Identification DEFINITION CODE 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** X1 AN 1/50 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier **SYNTAX:** R0203 IMPLEMENTATION NAME: Other Payer Billing Provider Identifier NOT USED REF03 352 Description X 1 AN 1/80 NOT USED **REFERENCE IDENTIFIER** REF04 C040 01

SEGMENT DETAIL									
	LX - SERVICE LI	NE NUMBER							
X12 Segment Name:	Transaction Set Line Numbe	r							
X12 Purpose:	To reference a line number i	o reference a line number in a transaction set							
X12 Set Notes:	1. Loop 2400 contains Ser	vice Line information.							
Loop:	2400 — SERVICE LINE NU	MBER Loop Repeat:	999						
Segment Repeat:	1								
Usage:	REQUIRED								
TR3 Notes:	1. The LX functions as a	line counter.							
	2. The Service Line LX set by one for each addition	-	th one and is incremented laim.						
	3. LX01 is used to indica Adjudication loop. See bundling and unbundl	Section 1.4.1.2 for mo							
TR3 Example:	_X*1~								
DIAGRAM									
LX * Assigned Number	4 5								
ELEMENT DETAIL									
USAGE R	. DATA . <u>ELEMENT NAME</u>		ATTRIBUTES						
REQUIRED LX01	554 Assigned Num Number assigned	ber I for differentiation within a tra	M 1 NO 1/6 Insaction set						





ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	ITES
REQUIRED	SV201	234	Product/Service ID Identifying number for a product or service	X 1	AN	1/48
			syntax: R0102			
			SEMANTIC: SV201 is the revenue code.			
			IMPLEMENTATION NAME: Service Line Revenue Code			
			See Code Source 132: National Uniform Billing C Codes.	commi	ttee (N	IUBC)

SITUATIONAL	SV202	C003	COMPOSITE MEDICAL PROCEDURE X 1 IDENTIFIER X 1 To identify a medical procedure by its standardized codes and applicable modifiers X 1							
				SITUATIONAL RULE: Required for outpatient claims when an appropried of the service line item. HCPCS or HIPPS code exists for this service line item. OR Required for inpatient claims when an appropriate HCPCS (dru 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	l	235	Code id	ct/Service ID Qualifier lentifying the type/source of the descriptive t/Service ID (234)	M ID 2/2 e number used in				
				SEMANTI						
				IMPLEME	INTATION NAME: Product or Service ID G	Qualifier				
			C	ODE	DEFINITION					
			ER		Jurisdiction Specific Procedure a	nd Supply Codes				
							This code set is not allowed for us the time of this writing. The qualif used:			
									If a new rule names the Jurisdictic Procedure and Supply Codes as a set under HIPAA,	•
							OR The Secretary grants an exception set as a pilot project as allowed u OR			
					For claims which are not covered	under HIPAA.				
			нс		code source 576: Workers Compensation and Supply Codes Health Care Financing Administra Procedural Coding System (HCPC	tion Common				
					Because the AMA's CPT codes ar HCPCS codes, they are reported					
			HP		code source 130: Healthcare Common F System Health Insurance Prospective Pay (HIPPS) Skilled Nursing Facility R	vment System				
					CODE SOURCE 716: Health Insurance Pros System (HIPPS) Rate Code for Skilled N					

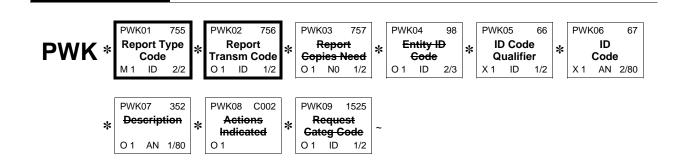
	IV	Home Infusion EDI Coalition (HIEC) Product/Service Code
		This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used: If a new rule names the Home Infusion EDI Coalition (HIEC) Product/Service Codes as an allowable code set under HIPAA, OR The Secretary 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.
	WK	code source 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List 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.
REQUIRED SV202 - 2	234	CODE SOURCE 843: Advanced Billing Concepts (ABC) Codes 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.

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

SITUATIONAL	SV202 - 5	1339	Procedure Modifier C This identifies special circumstances related to the perservice, as defined by trading partners		-	2/2 of the		
			SEMANTIC: C003-05 modifies the value in C003-02 and C003-08					
			SITUATIONAL RULE: Required when a third modified improves the reporting accuracy of the assoc procedure code. If not required by this imple guide, do not send.	ciated	1			
SITUATIONAL	SV202 - 6	1339	Procedure Modifier C This identifies special circumstances related to the perservice, as defined by trading partners		-	2/2 of the		
			SEMANTIC: C003-06 modifies the value in C003-02 and C003-08					
			SITUATIONAL RULE: Required when a fourth modia improves the reporting accuracy of the asso procedure code. If not required by this imple guide, do not send.	ciated	1			
SITUATIONAL	SV202 - 7	352	Description C A free-form description to clarify the related data elem content			1/80 eir		
			SEMANTIC: C003-07 is the description of the procedure identified	in C00	3-02			
			SITUATIONAL RULE: Required when, in the judgme submitter, the Procedure Code does not def describe the service/product/supply and Loo not used. OR Required when SV202-2 is a non-specific Pr Non-specific codes may include in their des such as: Not Otherwise Classified (NOC); Un Unspecified; Unclassified; Other; Miscelland Prescription Drug, Generic; or Prescription I Name. If not required by this implementation guide	nitive op ID-2 ocedu cripto listea ous; Drug, l	ly 2410 re C rs te ; Brai	code. erms nd		
NOT USED	SV202 - 8	234	Product/Service ID C	A (1	1/48		
REQUIRED	SV203 782		ary Amount O	1 R		1/18		
		SEMANTIC: SV203 is the submitted service line item amount.						
			IMPLEMENTATION NAME: Line Item Charge Amount					
		inclus	s the total charge amount for this service line. ive of the provider's base charge and any app nts reported within this line's AMT segments.					
		Zero "	0" is an acceptable value for this element.					

005010X223 • 837 • 2400 • SV2 INSTITUTIONAL SERVICE LINE								
JIRED SV204 355		Code specifyin	g the units in which a value is being	X 1 expressed, or	ID manne	2/2 r in which		
		SYNTAX : P0405						
		CODE	DEFINITION					
		DA	Days					
		UN	Unit					
SV205	380	Quantity Numeric value	of quantity	X 1	R	1/15		
		syntax: P0405						
		IMPLEMENTATION NAME: Service Unit Count						
		When a deci	mal is used, the maximum nu	-				
SV206	1371	Unit Rate		01	R	1/10		
SV207	782			01	R	1/18		
		semantic: SV2	07 is a non-covered service amount					
		covered cha	rge amount. If not required th	-				
		IMPLEMENTATION Amount	I NAME: Line Item Denied Charg	e or Non-Cov	vered	Charge		
SV208	1073	Yes/No Con	dition or Response Code	01	ID	1/1		
SV209	1345	Nursing Hor	ne Residential Status Code	01	ID	1/1		
SV210	1337	Level of Car	e Code	01	ID	1/1		
	SV204 SV204 SV205 SV205 SV206 SV207 SV208 SV208 SV209	SV204 355 SV205 380 SV206 1371 SV207 782 SV208 1073 SV209 1345	SV204 355 Unit or Basis Code specifyin a measurement SYNTAX: P0405 SV205 380 CODE DA UN SV205 380 Quantity Numeric value SYNTAX: P0405 SV206 1371 Unit Rate SV206 1371 Unit Rate SV207 782 Monetary Ar Monetary amon SEMANTIC: SV20 SITUATIONAL RUL covered cha do not send. IMPLEMENTATION Amount SV208 1073 Yes/No Cond Nursing Hon	SV204 355 Unit or Basis for Measurement Code Code specifying the units in which a value is being a measurement has been taken SV204 355 Unit of Days SV104 DA Days DA Days DA DA Days UN UN Unit Unit SV205 380 Quantity Numeric value of quantity syntax: P0405 IMPLEMENTATION NAME: Service Unit Count The maximum length for this field is 8 dig When a decimal is used, the maximum nu the right of the decimal is three. SV206 1371 Unit Rate SV207 782 Monetary Amount Monetary amount SEMANTIC: SV207 is a non-covered service amount STUATIONAL RULE: Required if needed to repoin covered charge amount. If not required the do not send. IMPLEMENTATION NAME: Line Item Denied Charg Amount SV208 1073 Yes/No Condition or Response Code SV209 1345 Nursing Home Residential Status Code	SV204 355 Unit or Basis for Measurement Code X 1 SV204 355 Unit or Basis for Measurement Code X 1 Code specifying the units in which a value is being expressed, or a measurement has been taken SYNTAX: P0405 DA Days UN UN Unit SV205 380 Quantity SV1 Vuneric value of quantity X 1 Numeric value of quantity SYNTAX: P0405 IMPLEMENTATION NAME: Service Unit Count The maximum length for this field is 8 digits excluding When a decimal is used, the maximum number of digit the right of the decimal is three. 0 1 SV206 1371 Unit Rate 0 1 SV207 782 Monetary Amount Monetary amount 0 1 SEMANTIC: SV207 SITUATION LRULE: Required if needed to report line specific covered charge amount. If not required this implement do not send. IMPLEMENTATION NAME: Line Item Denied Charge or Non-Cov Amount SV208 1073 Yes/No Condition or Response Code 0 1 SV209 1345 Nursing Home Residential Status Code 0 1	SV204 355 Unit or Basis for Measurement Code X 1 ID Code specifying the units in which a value is being expressed, or manne a measurement has been taken SYNTAX: P0405 CODE DEFINITION DA Days UN Unit SV205 380 Quantity X 1 R Numeric value of quantity SYNTAX: P0405 X 1 R SV205 380 Quantity X 1 R Numeric value of quantity SYNTAX: P0405 IMPLEMENTATION NAME: Service Unit Count The maximum length for this field is 8 digits excluding the d When a decimal is used, the maximum number of digits allor the right of the decimal is three. SV206 1371 Unit Rate 0 1 R SV207 782 Monetary Amount Monetary amount semantic: SV/207 is a non-covered service amount. SITUATIONAL RULE: Required if needed to report line specific non-covered charge amount. If not required this implementation do not send. IMPLEMENTATION NAME: Line Item Denied Charge or Non-Covered Amount SV208 1073 Yes/No Condition or Response Code 0 1 ID SV209 1345 Nursing Home Residential Status Code 0 1 ID		

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:	 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

005010X223 • 837 • 2400 • PWK LINE SUPPLEMENTAL INFORMATION

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	
REQUIRED	PWK01	755	Report Type Code M 1 ID		
				ing the title or contents of a document, report or supporting item	
				N 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	
			ВТ	Blanket Test Results	
			СВ	Chiropractic Justification	
			СК	Consent Form(s)	
			СТ	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 on Medicare Secondary Payor)	
			НС	Health Certificate	
			HR	Health Clinic Records	
			15	Immunization Record	

IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
МТ	Models
NN	Nursing Notes
ОВ	Operative Note
oc	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
ОХ	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
РО	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
ХР	Photographs
Report Transr	mission Code 0 1 ID 1/2

REQUIRED

PWK02 756

Report Transmission CodeO 1ID1/2Code defining timing, transmission method or format by which reports are to be
sent

IMPLEMENTATION NAME: Attachment Transmission Code

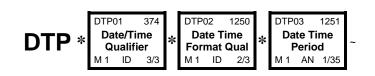
CODE	DEFINITION
AA	Available on Request at Provider Site
	This means that the additional information is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.
вм	By Mail
EL	Electronically Only
	Indicates that the attachment is being 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.

005010X223 • 837 • 2400 • PWK LINE SUPPLEMENTAL INFORMATION

			FX	By Fax				
NOT USED	PWK03	757	Report Copies	s Needed	01	N0	1/2	
NOT USED	PWK04	98	Entity Identifi	er Code	01	ID	2/3	
SITUATIONAL	PWK05	66		Code Qualifier g the system/method of code structure us	X1 ed for le	ID dentifica	1/2 tion	
			syntax: P0506					
			соммент: PWK0 number.	5 and PWK06 may be used to identify the	addres	see by a	code	
			SITUATIONAL RULE: Required when PWK02 = "BM", "EL", "EM", "FX" of "FT". If not required by this implementation guide, do not send.					
			CODE	DEFINITION				
			AC	Attachment Control Number				
SITUATIONAL	PWK06	67	Identification Code identifying	Code a party or other code	X 1	AN	2/80	
			syntax: P0506					
			SITUATIONAL RULE: Required when PWK02 = "BM", "EL", "EM", "FX" or "FT". If not required by this implementation guide, do not send.					
				NAME: Attachment Control Number				
				ed to identify the attached electroni n PWK06 is carried in the TRN of th			ition.	
			For the purpo is 50.	ese of this implementation, the max	imum	field le	ength	
NOT USED	PWK07	352	Description		01	AN	1/80	
NOT USED	PWK08	C002	ACTIONS IND	ICATED	01			
NOT USED	PWK09	1525	Request Cate	gory Code	01	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			ATTRIBU	TES	
REQUIRED	DTP01	374	Date/Time Qua Code specifying	alifier type of date or time, or both date and time	M 1	ID	3/3	
				IAME: Date Time Qualifier				
			CODE	DEFINITION				
			472	Service				
REQUIRED	DTP02	1250		riod Format Qualifier the date format, time format, or date and time	M1 me forr	ID mat	2/3	
			SEMANTIC: DTP02	2 is the date or time or period format that w	ill appe	ear in D	TP03.	
			RD8 is required only when the "To and From" dates are different However, at the discretion of the submitter, RD8 can also be us when the "To and From" dates are the same.					
			CODE	DEFINITION				
			D8	Date Expressed in Format CCYYN	IMDD			
			RD8	Range of Dates Expressed in Forr CCYYMMDD	nat C	CYYMI	MDD-	
REQUIRED	DTP03	1251	Date Time Per Expression of a c	iod date, a time, or range of dates, times or da	M 1 tes and	AN d times	1/35	
				IAME: Service Date				

	REF - LINE ITEM CONTROL NUMBER									
X12 Segment Name:	Reference Information									
X12 Purpose:	o 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										
REF * Reference Ident Qua										

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	JTES
REQUIRED	REF01	128	Reference lo Code qualifying	M 1	ID	2/3	
			CODE	DEFINITION			
			6R	Provider Control Number			

005010X223 • 837 • 2400 • REF LINE ITEM CONTROL NUMBER			ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3					
REQUIRED	REF02	127	Reference Identification Reference information as defined for a particular Transac by the Reference Identification Qualifier	X 1 ction Set		1/50 pecified		
			syntax: R0203					
			IMPLEMENTATION NAME: Line Item Control Number					
			The maximum number of characters to be supp '30'. A submitter may submit fewer characters of their needs. However, the HIPAA maximum req supported by any receiving system is '30'. Cha are not required to be stored nor returned by an system.	depend uireme racters	ling up nt to b beyor	oon e nd 30		
NOT USED	REF03	352	Description	X 1	AN	1/80		
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01				

REF - REPRICED LINE ITEM REFERENCE
NUMBER

X12 Segment Na	me: Refe	rence Inf	ormation							
X12 Purpo	se: To sp	ecify ide	ntifying inform	ation						
X12 Synt		1. R0203 At least one of REF02 or REF03 is required.								
Lo	op: 2400	— SERV	VICE LINE NU	MBER						
Segment Repo	eat: 1									
Usa	ige: SITU	ATIONA	L							
Situational R	ident orga	ifying no	umber on the . This segmen	(pricing) organization needs to service line in their submissior it is not completed by providers ide, do not send.	n to th	neir pa	-			
TR3 Exam	ple: REF*	k9B*444	444~							
DIAGRAM										
KEF * Iden	erence *	REF02 Reference Ident X 1 AN	*	352 tion 1/80 REF04 C040 Reference Identifier O 1 ∼						
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES			
REQUIRED	REF01	128		ntification Qualifier he Reference Identification	M 1	ID	2/3			
			CODE	DEFINITION						
			9B	Repriced Line Item Reference Nu	mber					
REQUIRED	REF02	127		ntification nation as defined for a particular Transacti e Identification Qualifier	X 1 on Set		1/50 ecified			
			syntax: R0203							
			IMPLEMENTATION N	AME: Repriced Line Item Reference	Numb	er				
NOT USED	REF03	352	Description		X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE I	DENTIFIER	01					

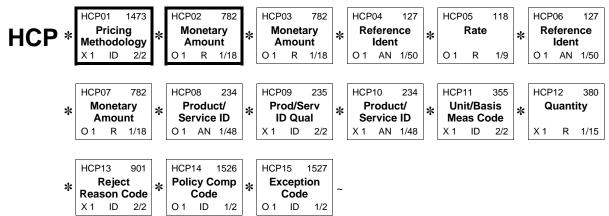
SEGMENT DETAIL								
			DJUSTED REPRICED LINE I ENCE NUMBER	TEI	Ν			
X12 Segment N	ame: Ref	erence Inf	formation					
X12 Purp	bose: To s	specify ide	entifying information					
X12 Sy	ntax: 1.	R0203 At least c	one of REF02 or REF03 is required.					
L	.oop: 240	0 — SER	VICE LINE NUMBER					
Segment Re	peat: 1							
U	sage: SIT	UATIONA	AL					
Situational	ider pay	ntifying n er organi	en a repricing (pricing) organization needs to number on an adjusted service line in their su ization. This segment is not completed by pro this implementation guide, do not send.	bmis	sion to			
TR3 Exar	nple: REF	-*9D*44	4444~					
DIAGRAM								
REF01 128 Reference Reference Ident Reference M1 ID 2/3 X1 AN 1/50								
ELEMENT DETAIL								
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES		
REQUIRED	REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M 1	ID	2/3		
			CODE DEFINITION					
REQUIRED	REF02	127	9D Adjusted Repriced Line Item Reference Identification		Numb AN	er 1/50		
	KEI UZ	121	Reference information as defined for a particular Transact by the Reference Identification Qualifier					
			syntax: R0203					
			IMPLEMENTATION NAME: Adjusted Repriced Line Item R	Refere	nce Nu	mber		
NOT USED	REF03	352	Description	X 1	AN	1/80		
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01				

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. 1. When reporting the Service Tax Amount (AMT02), the amount TR3 Notes: 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 AMT03 AMT01 522 AMT02 782 478 Amount Qual **Gred/Debit** Monetary AMT * * Code Amount Flag Code ID 1/3R 1/18 01 ID 1/1 M 1 М 1 ELEMENT DETAIL REF. DATA ELEMENT USAGE NAME ATTRIBUTES REQUIRED **AMT01** 522 Amount Qualifier Code M 1 ID 1/3 Code to qualify amount DEFINITION CODE GT Goods and Services Tax REQUIRED AMT02 782 **Monetary Amount** M 1 R 1/18 Monetary amount IMPLEMENTATION NAME: Service Tax Amount NOT USED **AMT03** 478 01 ID **Credit/Debit Flag Code** 1/1

	AMT - F	ACILITY TAX AMOUNT				
X12 Segment Name:	Monetary Amo	ount Information				
X12 Purpose:	To indicate the	indicate the total monetary amount				
Loop:	2400 — SER	VICE LINE NUMBER				
Segment Repeat:	1					
Usage:	SITUATIONA	L				
Situational Rule:	reported in S	en a facility tax or surcharge applies to the s V201 and the submitter is required to report er. If not required by this implementation gui	that i	nf <mark>or</mark> m	ation	
TR3 Notes:	in the Lir	porting the Facility Tax Amount (AMT02), the ne Item Charge Amount (SV203) for this serv he amount reported in the Facility Tax Amou	ice lin		-	
TR3 Example:	AMT*N8*22	~				
DIAGRAM						
AMT * Amount Qu Code		t [*] Flag Code [~]				
USAGE R	EF. DATA ES. ELEMENT	NAME		ATTRIB	JTES	
REQUIRED AMT	01 522	Amount Qualifier Code Code to qualify amount	M 1	ID	1/3	
REQUIRED AMT	02 782	CODE DEFINITION N8 Miscellaneous Taxes Monetary Amount Monetary amount	M 1	R	1/18	
		IMPLEMENTATION NAME: Facility Tax Amount				
NOT USED AMT	03 478	Credit/Debit Flag Code	01	ID	1/1	

SEGMENT DETAIL									
		HIRD PARTY ORGANIZATIO	N NOTES						
X12 Segment Name:	Note/Special	Instruction							
X12 Purpose:		b transmit information in a free-form format, if necessary, for comment or ecial instruction							
X12 Comments:	X12 stan NTE segi	segment permits free-form information/data white dard implementations, is not machine processible ment should therefore be avoided, if at all possible d environment.	e. The use of the						
Loop:	2400 — SER	VICE LINE NUMBER							
Segment Repeat:	1								
Usage:	SITUATIONA	L							
Situational Rule:	to the payer.	Required when the TPO/repricer needs to forward additional information o the payer. This segment is not completed by providers. If not required by this implementation guide, do not send.							
TR3 Example:	NTE*TPO*s claim~	tate regulation 123 was applied during the pr	icing of this						
DIAGRAM									
NTE * Note Ref		~							
ELEMENT DETAIL									
	EF. DATA ES. ELEMENT	NAME	ATTRIBUTES						
REQUIRED NTEO	91 363	Note Reference Code Code identifying the functional area or purpose for which the code CODE DEFINITION	O 1 ID 3/3 ne note applies						
REQUIRED NTEC	2 352	TPO Third Party Organization Notes Description A free-form description to clarify the related data elements	M 1 AN 1/80 and their content						
		IMPLEMENTATION NAME: Line Note Text							

SEGMENT DETAIL	
	HCP - LINE PRICING/REPRICING INFORMATION
X12 Segment Name:	Health Care Pricing
X12 Purpose:	To specify pricing or repricing information about a health care claim or line item
X12 Syntax:	1. R0113 At least one of HCP01 or HCP13 is required.
	2. P0910 If either HCP09 or HCP10 is present, then the other is required.
	3. P1112 If either HCP11 or HCP12 is present, then the other is required.
Loop:	2400 — SERVICE LINE NUMBER
Segment Repeat:	1
Usage:	SITUATIONAL
Situational Rule:	Required when this information is deemed necessary by the repricer. The segment is not completed by providers. The information is completed by repricers only. If not required by this implementation guide, do not send.
TR3 Notes:	1. This information is specific to the destination payer reported in Loop ID-2010BB.
	2. For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.
TR3 Example:	HCP*03*100*10*RPO12345~
DIAGRAM	
HCP01 14	HCP02 782 HCP03 782 HCP04 127 HCP05 118 HCP06 127



ELEMENT DETAIL							
USAGE	REF. DES.	DATA ELEMENT	NAME		<u> </u>	ATTRIBL	JTES
REQUIRED	HCP01	1473	Pricing Meth Code specifyir priced or reprice	ng pricing methodology at which the claim or	X 1 line iter	ID m has t	2/2 been
			syntax: R0113	3			
			Specific cod	le use is determined by Trading Partr	ner Ag	reeme	ent due
			to the variar	nces in contracting policies in the ind	lustry.		
			CODE	DEFINITION			
			00	Zero Pricing (Not Covered Under	Contra	act)	
			01	Priced as Billed at 100%			
			02	Priced at the Standard Fee Sched	ule		
			03	Priced at a Contractual Percentag	e		
			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 Au Monetary amo		01	R	1/18
			SEMANTIC: HCF	02 is the allowed amount.			
SITUATIONAL	HCP03	782	Monetary Au Monetary amo		01	R	1/18
			SEMANTIC: HCF	203 is the savings amount.			
			by the reprie	LE: Required when this information is cer. The segment is not completed by is completed by repricers only. If not tion guide, do not send.	/ prov	iders.	The
			This informa Loop ID-201	ation is specific to the destination pages 0BB.	yer re	ported	l in

SITUATIONAL	HCP04	127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier	O1 ion Set		1/50 becified
			SEMANTIC: HCP04 is the repricing organization identification	n numbe	er.	
			SITUATIONAL RULE: Required when this information is by the repricer. The segment is not completed b information is completed by repricers only. If no implementation guide, do not send.	y prov	iders.	The
			This information is specific to the destination pa Loop ID-2010BB.	ayer re	oorted	l in
SITUATIONAL	HCP05	118	Rate Rate expressed in the standard monetary denomination for	O1 or the cu	R rrency :	1/9 specified
			SEMANTIC: HCP05 is the pricing rate associated with per die	em or fla	at rate r	epricing.
			SITUATIONAL RULE: Required when this information is by the repricer. The segment is not completed b information is completed by repricers only. If no implementation guide, do not send.	y prov	iders.	The
			This information is specific to the destination pa Loop ID-2010BB.	ayer re	ported	l in
SITUATIONAL	ITUATIONAL HCP06	127	Reference Identification Reference information as defined for a particular Transact by the Reference Identification Qualifier	O1 ion Set		1/50 becified
			SEMANTIC: HCP06 is the approved DRG code.			
			Соммент : HCP06, HCP07, HCP08, HCP10, and HCP12 a different values from the original submitted values.	re fields	that wi	ll contain
			SITUATIONAL RULE: Required when this information is by the repricer. The segment is not completed b information is completed by repricers only. If no implementation guide, do not send.	y prov	iders.	The
			This information is specific to the destination pa Loop ID-2010BB.	ayer re	ported	lin
SITUATIONAL	HCP07	782	Monetary Amount Monetary amount	01	R	1/18
			SEMANTIC: HCP07 is the approved DRG amount.			
			SITUATIONAL RULE: Required when this information is by the repricer. The segment is not completed b information is completed by repricers only. If no implementation guide, do not send.	y prov	iders.	The
			This information is specific to the destination pa Loop ID-2010BB.	ayer re	ported	l in

SITUATIONAL	HCP08	234	Product/Servi Identifying numb	ce ID er for a product or service	01	AN	1/48				
			SEMANTIC: HCP08	3 is the approved revenue code.							
			by the reprice information is	Required when this information is r. The segment is not completed by completed by repricers only. If not on guide, do not send.	y prov	viders.	The				
			IMPLEMENTATION N	AME: Product or Service ID							
			This informati Loop ID-2010	on is specific to the destination pa 3B.	yer re	ported	in				
SITUATIONAL	HCP09	235	Product/Servi Code identifying Product/Service	the type/source of the descriptive number	X1 used i	ID n	2/2				
			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 a	nd Su	ipply C	odes				
				This code set is not allowed for us the time of this writing. The qualif used:							
				If a new rule names the Jurisdiction Procedure and Supply Codes as a set under HIPAA, OR	-		code				
				The Secretary grants an exception set as a pilot project as allowed u OR	nder	the law	',				
				For claims which are not covered code source 576: Workers Compensation							
			нс	and Supply Codes Health Care Financing Administra Procedural Coding System (HCPC	ation (Commo					
				Because the AMA's CPT codes ar HCPCS codes, they are reported			1				
			HP	CODE SOURCE 130: Healthcare Common F System Health Insurance Prospective Pay (HIPPS) Skilled Nursing Facility R	Proced ment ate C	ural Coc Systei ode	m				
				CODE SOURCE 716: Health Insurance Pros System (HIPPS) Rate Code for Skilled N							

		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.			
		WK	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List 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.			
SITUATIONAL HCP10	10 234		code source 843: Advanced Billing Concepts (ABC) Codes ce ID X 1 AN 1/48 er for a product or service			
		SYNTAX: P0910) is the energy of precedure code			
) 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 N	IAME: Repriced Approved HCPCS Code			
		This informati Loop ID-2010	on is specific to the destination payer reported in BB.			

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						
			by the reprice information is	Required when this information is r. The segment is not completed by completed by repricers only. If no on guide, do not send.	y providers. The	ry			
			CODE	DEFINITION					
			DA	Days					
			UN	Unit					
SITUATIONAL	HCP12	380	Quantity Numeric value of	f quantity	X 1 R 1/15	;			
			syntax: P1112						
			SEMANTIC: HCP12	2 is the approved service units or inpatient	days.				
			by the reprice information is	Required when this information is r. The segment is not completed by completed by repricers only. If no on guide, do not send.	y providers. The	ry			
			This informati Loop ID-2010	on is specific to the destination pa 3B.	yer reported in				
			When a decim	a length for this field is 8 digits excl al is used, the maximum number o e decimal is three.					
SITUATIONAL	HCP13	901	Reject Reasor Code assigned b	1 Code by issuer to identify reason for rejection	X 1 ID 2/2				
			syntax: R0113						
			SEMANTIC: HCP13	3 is the rejection message returned from th	ne third party				
			by the reprice information is	Required when this information is r. The segment is not completed by completed by repricers only. If no on guide, do not send.	y providers. The	ry			
			This informati Loop ID-2010	on is specific to the destination pa 3B.	yer reported in				
			CODE	DEFINITION					
			T1	Cannot Identify Provider as TPO (Organization) Participant	(Third Party				
			T2	Cannot Identify Payer as TPO (Th Organization) Participant	ird Party				
			ТЗ	Cannot Identify Insured as TPO (1 Organization) Participant	Third Party				
			Т4	Payer Name or Identifier Missing					
			Т5	Certification Information Missing					
			Т6	Claim does not contain enough ir pricing	nformation for re-				

SITUATIONAL	HCP14	1526	Policy Comp Code specifying	liance Code O 1 ID 1/2 g policy compliance
			by the repric information i	E: Required when this information is deemed necessary er. The segment is not completed by providers. The is completed by repricers only. If not required by this ion guide, do not send.
			This information Loop ID-2010	tion is specific to the destination payer reported in BB.
			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)
SITUATIONAL HCP15			4	Not Followed Other (Non-Compliance Other)
		5	Emergency Admit to Non-Network Hospital	
	HCP15	HCP15 1527	Exception Co Code specifying care services	ode O 1 ID 1/2 g the exception reason for consideration of out-of-network health
			SEMANTIC: HCP1	15 is the exception reason generated by a third party organization.
			by the repric information i	E: Required when this information is deemed necessary er. The segment is not completed by providers. The is completed by repricers only. If not required by this ion guide, do not send.
			This information Loop ID-2010	tion is specific to the destination payer reported in)BB.
			CODE	DEFINITION
			CODE 1	DEFINITION Non-Network Professional Provider in Network Hospital
				Non-Network Professional Provider in Network

- Services or Specialist not in Network
- **Out-of-Service Area**
- **State Mandates**
- Other

5

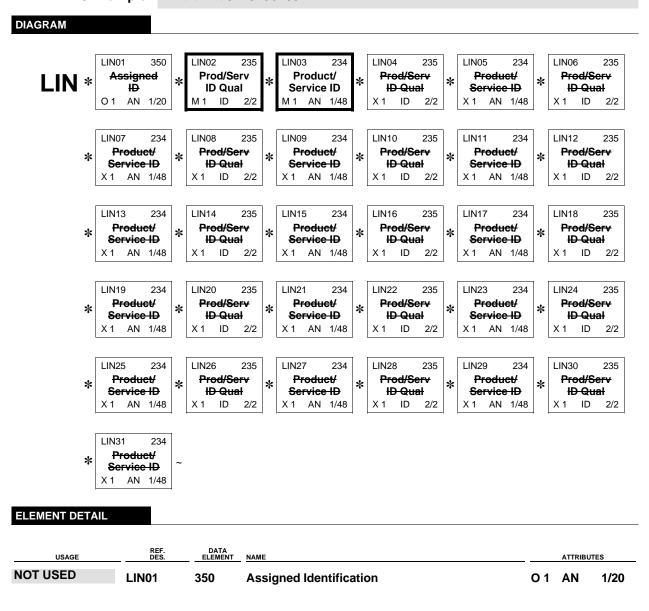
SEGMENT DETAIL	
	LIN - DRUG IDENTIFICATION
X12 Segment Name:	Item Identification
X12 Purpose:	To specify basic item identification data
X12 Set Notes:	1. Loop 2410 contains compound drug components, quantities and prices.
X12 Syntax:	1. P0405 If either LIN04 or LIN05 is present, then the other is required.
	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

	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:	 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~



ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

REQUIRED	LIN02	235		ce ID Qualifier the type/source of the descriptive number ID (234)	M 1 used ir	וD	2/2
				through LIN31 provide for fifteen different xample: Case, Color, Drawing No., U.P.C			
				NAME: Product or Service ID Qualifier	•		
			CODE	DEFINITION			
			N4	National Drug Code in 5-4-2 Form	at		
REQUIRED	LIN03	234	Product/Servi	CODE SOURCE 240: National Drug Code b Ce ID her for a product or service	y Forma M 1		1/48
				NAME: National Drug Code			
NOT USED	LIN04	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN05	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN06	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN07	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN08	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN09	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN10	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN11	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN12	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN13	234	Product/Servi	ce ID	X 1	AN	1/48
NOT USED	LIN14	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN15	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN16	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN17	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN18	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN19	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN20	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN21	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN22	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN23	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN24	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN25	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN26	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN27	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN28	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN29	234	Product/Servi	ice ID	X 1	AN	1/48
NOT USED	LIN30	235	Product/Servi	ce ID Qualifier	X 1	ID	2/2
NOT USED	LIN31	234	Product/Servi	ice 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 CTP01 CTP02 236 CTP03 212 CTP04 CTP05 CTP06 687 380 C001 648 Composite Class of Price ID Quantity Price Mult CTP * Unit * * * * * Trade Code Code Price Unit of Mea **Qualifier** 01 ID X1 ID 3/3 Χ1 R 1/17 R 1/15 01 ID 3/3 2/2 X 1 X 1

				_			_				_				_			
	CTPO)7	649		CTP08	3 782		CTP)9	639		CTP1	10	499		CTP	11	289
*	Mu	ıltip	lier	*	۸	netary nount	*	Dri	sis l ce C	odo	*		nditi /alue		*	with	i lt Pr uanti	
	X 1	R	1/10		01	R 1/18		01	ID	2/2		01	AN	1/10		01	N0	1/2

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIB	UTES
NOT USED	CTP01	687	Class of Trade Code	01	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	X 1	R	1/15
			syntax: P0405			

IMPLEMENTATION NAME: National Drug Unit Count

REQUIRED	CTP05	C001			JNIT OF MEASURE	X 1		
REQUIRED	СТР05 - 1	I	355	Code sp	Basis for Measurement Code becifying the units in which a value is bei in which a measurement has been take		ID ssed, or	2/2
				If C001- If C001-	TS: 11 is not used, its value is to be interpre 12 is not used, its value is to be interpre 14 is not used, its value is to be interpre 15 is not used, its value is to be interpre	ted as 1. ted as 1.		
				IMPLEME	NTATION NAME: Code Qualifier			
			С	ODE	DEFINITION			
			F2		International Unit			
			GR		Gram			
			ME		Milligram			
			ML		Milliliter			
			UN		Unit			
NOT USED	СТР05 - 2	2	1018	Expon	ent	0	R	1/15
NOT USED	СТР05 - 3	3	649	Multip	lier	0	R	1/10
NOT USED	CTP05 - 4	1	355	Unit or	Basis for Measurement Code	0	ID	2/2
NOT USED	CTP05 - \$	5	1018	Expon	ent	0	R	1/15
NOT USED	CTP05 - 6	6	649	Multip	lier	0	R	1/10
NOT USED	CTP05 - 7	7	355	Unit or	Basis for Measurement Code	0	ID	2/2
NOT USED	CTP05 - 8	3	1018	Expon	ent	0	R	1/15
NOT USED	CTP05 - 9	Ð	649	Multip	lier	Ο	R	1/10
NOT USED	CTP05 - 7	10	355	Unit or	Basis for Measurement Code	0	ID	2/2
NOT USED	CTP05 - 2	11	1018	Expon	ent	0	R	1/15
NOT USED	CTP05 - 7	12	649	Multip	lier	ο	R	1/10
NOT USED	CTP05 - 1	13	355	Unit or	Basis for Measurement Code	ο	ID	2/2
NOT USED	CTP05 - 7	14	1018	Expon	ent	ο	R	1/15
NOT USED	CTP05 - 7	15	649	Multip	lier	ο	R	1/10
NOT USED	CTP06	648	Price I	Multiplie	r Qualifier	01	ID	3/3
NOT USED	CTP07	649	Multip	lier		X 1	R	1/10
NOT USED	CTP08	782	Monet	ary Amo	bunt	01	R	1/18
NOT USED	CTP09	639		-	Price Code	01	ID	2/2

NOT USED

NOT USED

CTP10

CTP11

499

289

Condition Value

Multiple Price Quantity

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

1/10

1/2

O1 AN

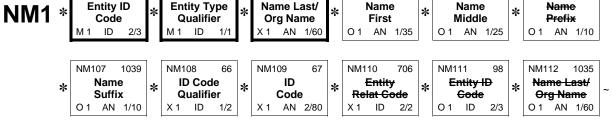
O1 N0

REF - PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER

	AC	300					
X12 Segment Na	me: Refe	erence Inf	formation				
X12 Purpo	ose: To s	pecify ide	entifying inform	ation			
X12 Synt		R0203 At least c	one of REF02 of	or REF03 is required.			
Lo	oop: 2410) — DRU	G IDENTIFICA	ATION			
Segment Repo	eat: 1						
Usa	age: SITU	JATIONA	NL				
Situational R	pres OR Req or m	scription uired wh nore drug	number. Ien the provid gs being repo	g of the drug has been done wi ed medication involves the con rted and there is no prescriptio lementation guide, do not send	npour n num	ding	
TR3 Not		the com receiving	pound will all	pound drug is being billed, the have the same prescription nu n relate all the components by	mber.	Paye	rs
		example segment provider	e, from a physi t is a "link sec assigned nur e the receiver	Irug is provided without a prese ician's office), the value provide juence number". The link seque nber that is unique to this clain to piece together the compone	ed in t ence i n. Its	his numbe ourpo	er is a
TR3 Exam	ple: REF	*XZ*12	3456~				
DIAGRAM							
KEF * Iden	I 128 Prence It Qual ID 2/3	REF02 Referen Ident X 1 AN	*	352 tion 1/80 ★ REF04 C040 Reference Identifier O 1 C 1			
USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBL	ITES
		128	Reference Ide	ntification Qualifier	M 1	ID	2/3
REQUIRED	REF01		Code qualifying	the Reference Identification			
REQUIRED	REFU1		Code qualifying	the Reference Identification			
REQUIRED	REFU1						

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2410 • REF PRESCRIPTION OR COMPOUND DRUG ASSOCIATION NUMBER						
REQUIRED	REF02	127	Reference IdentificationX 1AN1/50Reference information as defined for a particular Transaction Set or as specified by the Reference Identification QualifierSYNTAX: R0203						
			IMPLEMENTATION NAME: Prescription Number						
NOT USED	REF03	352	Description	X 1	AN	1/80			
NOT USED	REF04	C040	REFERENCE IDENTIFIER	01					

	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:	 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:	 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						
NM101	98 NM102 1065 NM103 1035 NM104 1036 NM105 1037 NM106 1038 Entity Type - Name Last/ - Name - Name - Name					



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBUTES		
REQUIRED	NM101 98		Entity Identifier Code M 1 ID 2/3 Code identifying an organizational entity, a physical location, property or an individual					
			CODE	DEFINITION				
			72	Operating Physician				
REQUIRED	NM102 10	1065	Entity Type (Code qualifying	Qualifier g the type of entity	M 1	ID	1/1	
			SEMANTIC: NM1	02 qualifies NM103.				
			CODE	DEFINITION				
			1	Person				
REQUIRED	NM103	1035		or Organization Name name or organizational name	X 1	AN	1/60	
			syntax: C1203					
			IMPLEMENTATION NAME: Operating Physician Last Name					
SITUATIONAL NM	NM104	NM104 1036	Name First Individual first r	name	01	AN	1/35	
			SITUATIONAL RULE: Required when the person has a first name. If not required by this implementation guide, do not send.					
			INAME: Operating Physician First Na	me				
SITUATIONAL	JATIONAL NM105 1037	1037	Name Middle Individual midd	e lle name or initial	01	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: Operating Physician Middle Name or Initial						
NOT USED	NM106	1038	Name Prefix		01	AN	1/10	
SITUATIONAL	NM107 1039	1039	Name Suffix Suffix to individ		01	AN	1/10	
				LE: Required when the name suffix I al. If not required by this implemen			-	
			IMPLEMENTATION	INAME: Operating Physician Name S	uffix			

IMPLEMENTATION NAME: Operating Physician Name Suffix

SITUATIONAL	NM108	66	Identification Code QualifierX 1ID1/2Code designating the system/method of code structure used for IdentificationCode (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.				
			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 CodeX 1AN2/80Code identifying a party or other codeX 1AN2/80				
			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				

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:	 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	
_	

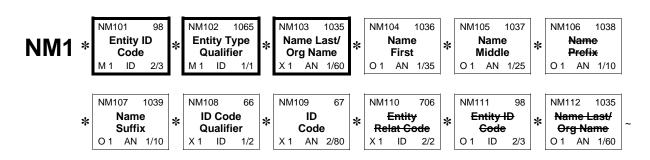
D

	REF0	1 12	3	REF	02	127	l	REF03	352]	REF04	C040]
REF *		erence nt Qual	*	Re	ferer Ident		*	Desci	ription	*	Refer Ident		~
	M 1	ID 2/	3	X 1	AN	1/50		X 1 A	N 1/80		O 1		

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES	6
REQUIRED	REF01	128		Identification Qualifier M 1 ID g the Reference Identification 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 proprietar for the destination payer identified Name loop, Loop ID-2010BB, asso claim. This is to be used by all pay Medicare, Medicaid, Blue Cross, e	d in tl ociate /ers i	ne Paye d with	er this
			LU		Location Number			
REQUIRED	REF02	127	Referen	nce inform	ntification hation as defined for a particular Transaction Identification Qualifier	X1 on Set	AN or as sp	1/50 ecified
			SYNTAX:	R0203				
			IMPLEME	NTATION N	AME: Operating Physician Secondary	y Ider	ntifier	
NOT USED	REF03	352	Descri	iption		X 1	AN	1/80
SITUATIONAL	REF04	C040	To ident	-	DENTIFIER r more reference numbers or identification Qualifier	O1 numb	ers as sp	pecified
			P0506	C04003 (or C04004 is present, then the other is req or C04006 is present, then the other is req			
					Required when the identifier repor is for a non-destination payer.	ted ir	n REFO	2 of
			Do not	-	s composite when the value report	ed in	REF01	is
			either					
REQUIRED	REF04 - 1	l	either	Refere	nce Identification Qualifier Julifying the Reference Identification	м	ID	2/3
REQUIRED	REF04 - 1	l	128	Refere Code qu	nce Identification Qualifier Julifying the Reference Identification	М	ID	2/3
REQUIRED	REF04 - 1	l	128 co	Refere	nce Identification Qualifier Jalifying the Reference Identification	М	ID	2/3
REQUIRED	REF04 - 1 REF04 - 2		128	Refere Code qu ode Refere Refere	nce Identification Qualifier Julifying the Reference Identification	м	AN	1/50
			128 	Refere Code qu ODE Refere Referen specified	nce Identification Qualifier Jalifying the Reference Identification DEFINITION Payer Identification Number nce Identification Ice information as defined for a particular 1	M	AN ction Se	1/50
			128 	Refere Code qu ODE Refere Referen specified IMPLEMEN	nce Identification Qualifier Jalifying the Reference Identification DEFINITION Payer Identification Number nce Identification ice information as defined for a particular T d by the Reference Identification Qualifier NTATION NAME: Other Payer Primary Identifier iver identifier reported in this field is sponding payer identifier reported is	M Transa entific	AN ction Se er match	1/50 t or as the
		2	128 	Refere Code qu ODE Refere Referen specified IMPLEME The pa coores NM109	nce Identification Qualifier Jalifying the Reference Identification DEFINITION Payer Identification Number nce Identification ice information as defined for a particular T d by the Reference Identification Qualifier NTATION NAME: Other Payer Primary Identifier iver identifier reported in this field is sponding payer identifier reported is	M Transa entific	AN ction Se er match	1/50 t or as the
REQUIRED	REF04 - 2	2	128 2U 127	Refere Code qu ode Refere Referen specified IMPLEMEN The pa coores NM109 Refere	nce Identification Qualifier Jalifying the Reference Identification DEFINITION Payer Identification Number nce Identification ice information as defined for a particular T d by the Reference Identification Qualifier NTATION NAME: Other Payer Primary Identifier reported in this field is sponding payer identifier reported is	M Transa entifie must n Loc	AN ction Se er match op ID-23	1/50 t or as the 330B
REQUIRED	REF04 - 2	2	128 2U 127 128	Refere Code qu ODE Referen specified IMPLEMEN The pa coores NM109 Refere Refere	nce Identification Qualifier Jalifying the Reference Identification DEFINITION Payer Identification Number nce Identification loce information as defined for a particular T d by the Reference Identification Qualifier NTATION NAME: Other Payer Primary Identifier reported in this field is apponding payer identifier reported in this field is nce Identification Qualifier	M Fransa entific must n Loc X	AN ction Se er match op ID-23	1/50 t or as the 330B 2/3

	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:	 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	



USAGE	REF. DES.	DATA ELEMENT	NAME			ATTRIBUT	ES		
REQUIRED	NM101	98	Entity Identif Code identifying individual	ier Code g an organizational entity, a physical locatior	M 1 n, prop	ID berty or a	2/3 n		
			CODE	DEFINITION					
			ZZ	Mutually Defined					
				ZZ is used to indicate Other Opera	ting	Physici	an.		
REQUIRED	NM102	1065	Entity Type C Code qualifying	Qualifier the type of entity	M 1	ID	1/1		
			SEMANTIC: NM10	02 qualifies NM103.					
			CODE	DEFINITION					
			1	Person					
REQUIRED	NM103	1035		r Organization Name name or organizational name	X 1	AN	1/60		
			syntax: C1203						
			IMPLEMENTATION	NAME: Other Operating Physician Last	Nam	ne			
SITUATIONAL	NM104	1036	Name First Individual first n	ame	01	AN	1/35		
				E: Required when the person has a fin his implementation guide, do not sen		nme. If i	not		
			IMPLEMENTATION	NAME: Other Operating Physician First	t Nan	ne			
SITUATIONAL	NM105	1037	Name Middle Individual middl	e name or initial	01	AN	1/25		
			person is ne	E: Required when the middle name or eded to identify the individual. If not i ion guide, do not send.					
			IMPLEMENTATION	NAME: Other Operating Physician Mide	dle Na	ame or	Initial		
NOT USED	NM106	1038	Name Prefix		01	AN	1/10		
SITUATIONAL	NM107	1039	Name Suffix Suffix to individ	ual name	01	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 Nam	ne Su	ffix			

SITUATIONAL	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67)
			SYNTAX: P0809 SITUATIONAL RULE: 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
SITUATIONAL	NIM400	67	CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier
ONOANONAL	NM109	67	Identification CodeX 1AN2/80Code 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
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

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:	RFF±1G±Δ12345-

TR3 Example: REF*1G*A12345~

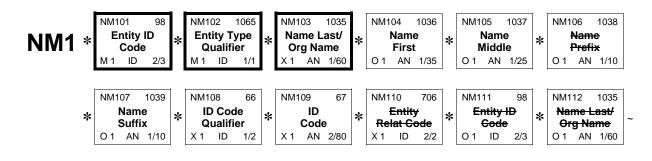
DIAGRAM

	-			-										
	REF0	1 128		REF	02	127		REF0	3	352		REF04	C040	
REF *		erence nt Qual	*	Re	eferer Iden		*	Dese	cript	lion	*	Refer Ident		~
	M 1	ID 2/3		X 1	AN	1/50		X 1	AN	1/80		O 1		

USAGE	REF. DES.	DATA	NAME	ATTRIBUTES	6
REQUIRED	REF01	128		Identification Qualifier M 1 ID g the Reference Identification ID	2/3
			CODE	DEFINITION	
			0B	State License Number	
			1G	Provider UPIN Number	
				UPINs must be formatted as either X99999 or XXX999.	

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3			005010X223 • 837 • 2420B • REF OTHER OPERATING PHYSICIAN SECONDARY IDENTIFICATION							
				Provider Commercial Number						
				This code designates a proprie for the destination payer ident Name loop, Loop ID-2010BB, a claim. This is to be used by all Medicare, Medicaid, Blue Cros	ified in th ssociate payers i	ne Pay d with	er this			
			LU	Location Number						
REQUIRED	REF02	127	Referer	nce Identification ce information as defined for a particular Trans reference Identification Qualifier	X 1 action Set	AN or as s	1/50 Decified			
			SYNTAX:	R0203						
			IMPLEME	NTATION NAME: Other Provider Secondary I	dentifier					
NOT USED	REF03	352	Descri	ption	X 1	AN	1/80			
SITUATIONAL	REF04	C040	To iden	ENCE IDENTIFIER ify one or more reference numbers or identificate reference Qualifier	O 1 ation numb	ers as s	pecified			
			P0506	C04003 or C04004 is present, then the other is	•					
				NAL RULE: Required when the identifier re gment is for a non-destination payer.	ported in	n REFO	12 of			
				use this composite when the value rep DB or 1G.	ported in	REF01	is			
REQUIRED	REF04 -	1	128	Reference Identification Qualifier Code qualifying the Reference Identification	М	ID	2/3			
			C	DE DEFINITION						
			2U	Payer Identification Number						
REQUIRED	REF04 - 2	2	127	Reference Identification Reference information as defined for a particul specified by the Reference Identification Qual		AN ction Se	1/50 et or as			
				IMPLEMENTATION NAME: Other Payer Primary	/ Identifie	ər				
				The payer identifier reported in this fie cooresponding payer identifier report NM109.						
NOT USED	REF04 -	3	128	Reference Identification Qualifier	Х	ID	2/3			
NOT USED	REF04 -	4	127	Reference Identification	Х	AN	1/50			
NOT USED	REF04 -	5	128	Reference Identification Qualifier	Х	ID	2/3			
NOT USED	REF04 -	6	127	Reference Identification	х	AN	1/50			

	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:	 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			ATTRIBUT	ES
REQUIRED	NM101	98			M 1 n, prop	ID berty or a	2/3
			CODE	DEFINITION			
			82	Rendering Provider			
REQUIRED	NM102	1065			M 1	ID	1/1
			CODE DEFINITION	02 qualifies NM103.			
			CODE	DEFINITION			
			1	Person			
REQUIRED	NM103	1035		-	X 1	AN	1/60
			syntax: C1203				
			IMPLEMENTATION	NAME: Rendering Provider Last Name	l		
SITUATIONAL	NM104	1036		ame	01	AN	1/35
				DEFINITION DEFINITION Rendering Provider Rualifier M 1 the type of entity 2 qualifies NM103. DEFINITION Person Corganization Name ame or organizational name NAME: Rendering Provider Last Name ame Context and the person has a first name his implementation guide, do not send. NAME: Rendering Provider First Name Context and the middle name or initial added to identify the individual. If not required on guide, do not send. NAME: Rendering Provider Middle Name or In Context and the name suffix is needed added to identify the name suffix is needed	ame. If r	ot	
			IMPLEMENTATION	NAME: Rendering Provider First Name)		
SITUATIONAL	NM105	1037			01	AN	1/25
			person is nee	eded to identify the individual. If not			
			IMPLEMENTATION	NAME: Rendering Provider Middle Nai	ne or	Initial	
NOT USED	NM106	1038	Name Prefix		01	AN	1/10
SITUATIONAL	NM107	1039		ual name	01	AN	1/10
	JATIONAL NM104 1036						
			IMPLEMENTATION	NAME: Rendering Provider Name Suff	ix		

IMPLEMENTATION NAME: Rendering Provider Name Suffix

SITUATIONAL	NM108	66	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.									
			CODE DEFINITION									
			XX Centers for Medicare and Medicaid Services National Provider Identifier									
				CODE SOURCE 537: Centers for Medicare National Provider Identifier	and Me	dicaid S	Services					
SITUATIONAL	NM109	67	Identification C Code identifying a	ode 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 OR	n date when the provider has rece	eived al	n NPI.						
			Required for providers prior to the mandated NPI implementatio 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 sei	nd.						
			IMPLEMENTATION NA	ME: Rendering Provider Identifier								
NOT USED	NM110	706	Entity Relations	ship Code	X 1	ID	2/2					
NOT USED	NM111	98	Entity Identifier	r Code	01	ID	2/3					
NOT USED	NM112	1035	Name Last or C	Organization Name	01	AN	1/60					

REF - RENDERING PROVIDER SECONDARY IDENTIFICATION

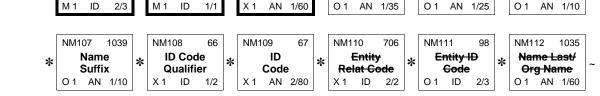
X12 Segment Name:	Reference Information
X12 Purpose:	To specify identifying information
X12 Syntax:	1. R0203 At least one of REF02 or REF03 is required.
Loop:	2420C — RENDERING PROVIDER NAME
Segment Repeat:	20
Usage:	SITUATIONAL
Situational Rule:	Required prior to the mandated HIPAA National Provider 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:	 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: DIAGRAM	REF*G2*12345~

REF *	REF01 128				REF)2	127		REF	03	352		REF04	C040
		eren nt Qu		*	Reference Ident		*	Description		*	Reference Identifier			
	M 1	ID	2/3		X 1	AN	1/50		X 1	AN	1/80		O 1	

USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES				
REQUIRED	REF01	128		Itentification Qualifier M 1 ID 2/3 g the Reference Identification	3			
			CODE	DEFINITION				
			0B	State License Number				
			1G	Provider UPIN Number				
				UPINs must be formatted as either X99999 or XXX999.				

			G2		Provider Commercial Number						
					tary provider number fied in the Payer ssociated with this payers including: s, etc.						
			LU		Location Number						
REQUIRED	REF02	127	Referer	nce inform	ntification nation as defined for a particular Transaction Identification Qualifier	X 1 AN 1/50 ction Set or as specified					
			SYNTAX:	R0203							
			IMPLEME	INTATION N	AME: Rendering Provider Secondary	ry Identifier					
NOT USED	REF03	352	Descri	iption		X 1	AN	1/80			
SITUATIONAL	REF04	C040	To iden	RENCE tify one o Reference	O 1 on numbers as specified						
			P0506 If either	C04003 C04005	uired.		2 of				
				-	is for a non-destination payer.						
				t use thi 0B or 10	s composite when the value report G.	ed in	REF01	is			
REQUIRED	REF04 - 1	l	128		nce Identification Qualifier ualifying the Reference Identification	М	ID	2/3			
			С	ODE	DEFINITION						
			2U		Payer Identification Number						
REQUIRED	REF04 - 2	2	127	Referen	nce Identification ace information as defined for a particular d by the Reference Identification Qualifier	M Fransa	AN ction Se	1/50 t or as			
				IMPLEME	NTATION NAME: Other Payer Primary Ide	entifie	ər				
					yer identifier reported in this field i sponding payer identifier reported i).						
NOT USED	REF04 - 3	3	128	Refere	nce Identification Qualifier	Х	ID	2/3			
NOT USED	REF04 - 4	Ļ	127	Refere	nce Identification	Х	AN	1/50			
NOT USED	REF04 - 5	5	128	Refere	nce Identification Qualifier	Х	ID	2/3			
NOT USED	REF04 - 6	5	127	Refere	nce 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:	 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												
NM101 Entity ID Code M 1 ID	98 NM102 1065 NM103 1035 NM104 1036 NM105 1037 NM106 1038 98 * Name Last/ Qualifier * NM107 1037 NM106 1038 2/3 M1 ID 1/1 X1 AN 1/60 O1 AN 1/25 NM105 1037 NM106 1038											



ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBUTES				
REQUIRED	NM101	98			M 1 n, prop	ID perty or a	2/3 an		
			CODE	DEFINITION					
			DN	Referring Provider					
REQUIRED	NM102	1065			M 1	ID	1/1		
			CODE DEFINITION DN Referring Provider Entity Type Qualifier Code qualifying the type of entity SEMANTIC: NM102 qualifies NM103.						
			CODE	DEFINITION					
			1	Person					
REQUIRED	NM103	1035		-	X 1	AN	1/60		
			syntax: C1203						
			IMPLEMENTATION	NAME: Referring Provider Last Name					
SITUATIONAL	NM104	1036		ame	01	AN	1/35		
						1 ID 1/ 1 ID 1/ 1 AN 1/	not		
			IMPLEMENTATION	NAME: Referring Provider First Name					
SITUATIONAL	NM105	1037			01	AN	1/25		
			person is nee	eded to identify the individual. If not					
			IMPLEMENTATION	NAME: Referring Provider Middle Nam	e or l	nitial			
NOT USED	NM106	1038			01		1/10		
SITUATIONAL	NM107	1039		ual name	01	AN	1/10		
				E: Required when the name suffix is I. If not required by this implementa			-		
			IMPLEMENTATION		x				

IMPLEMENTATION NAME: Referring Provider Name Suffix

SITUATIONAL	NM108	66	Identification Code Qualifier X 1 ID 1/2 Code designating the system/method of code structure used for Identification Code (67)									
			SYNTAX: P0809									
			SITUATIONAL RULE: 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 Medica National Provider Identifier	id Ser	vices						
SITUATIONAL	SITUATIONAL NM109 67			CODE SOURCE 537: Centers for Medicare National Provider Identifier Code a party or other code		edicaid S AN	ervices 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 I	NAME: Referring Provider Identifier								
NOT USED	NM110	706	Entity Relatio	nship Code	X 1	ID	2/2					
NOT USED	NM111	98	Entity Identifi	er Code	01	ID	2/3					
NOT USED	NM112	1035	Name Last or	Organization Name	01	AN	1/60					

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	

REF *	REF01 128		1	REF	02	127	l	REF0	3	352]	REF04	C040]
		erence nt Qual		Reference Ident		*	Description		*	Reference Identifier		~		
	M 1	ID 2/3		X 1	AN	1/50		X 1	AN	1/80		O 1		

	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES					
REQUIRED	REF01	128		Identification Qualifier M 1 ID 2/ g the Reference Identification	/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 for the destination payer identified Name loop, Loop ID-2010BB, assoc claim. This is to be used by all paye Medicare, Medicaid, Blue Cross, etc	in th iate ers i	ne Paye d with	er this
REQUIRED	REF02	127	Referen	nce Identification nce information as defined for a particular Transaction Reference Identification Qualifier	X 1 i Set	AN or as sp	1/50 becified
			SYNTAX:	R0203			
			IMPLEME	INTATION NAME: Referring Provider Secondary Id	lenti	fier	
NOT USED	REF03	352	Descri	ption	X 1	AN	1/80
SITUATIONAL	REF04	C040	To iden	RENCE IDENTIFIER tify one or more reference numbers or identification n Reference Qualifier	O 1 umb	ers as s	pecified
			P0506	C04003 or C04004 is present, then the other is requi			
				NAL RULE: Required when the identifier reporte	ed in	REFO	2 of
				t use this composite when the value reported 0B or 1G.	d in	REF01	is
REQUIRED	REF04 - 1		128	Reference Identification Qualifier Code qualifying the Reference Identification	М	ID	2/3
			C	ODE DEFINITION			
			2U	Payer Identification Number			
REQUIRED	REF04 - 2	!	127	Reference Identification Reference information as defined for a particular Tra specified by the Reference Identification Qualifier	M ansa	AN ction Se	1/50 t or as
				IMPLEMENTATION NAME: Other Payer Primary Iden	ntifie	er	
				The payer identifier reported in this field m cooresponding payer identifier reported in NM109.			
NOT USED	REF04 - 3	5	128	Reference Identification Qualifier	Х	ID	2/3
NOT USED	REF04 - 4	Ļ	127	Reference Identification	Х	AN	1/50
NOT USED	REF04 - 5	5	128	Reference Identification Qualifier	X	ID	2/3
NOT USED	REF04 - 6	i	127	Reference Identification	X	AN	1/50

SEGMENT DETAIL			
	SVD - LI	NE ADJUDICATION I	NFORMATION
X12 Segment Name:	Service Line /	Adjudication	
X12 Purpose:		rvice line adjudication information for nitial payers of a health care claim a	
X12 Set Notes:		lentifies the payer which adjudicated nust match DE 67 in the NM109 pos	
Loop:	2430 — LINE	ADJUDICATION INFORMATION	Loop Repeat: 15
Segment Repeat:	1		
Usage:	SITUATIONA	L	
Situational Rule:	identified in	en the claim has been previously Loop ID-2330B and this service lin applied to it. If not required by thi	e has payments and/or
TR3 Notes:	into (for times: or	unbundled lines: If, in the origina example) 2 additional lines, then t nce for the original adjustment to the additional unbundled lines.	he SVD for line 3 is used 3
TR3 Example:	SVD*43*55*	*HC:84550**3~	
DIAGRAM			
SVD01 ID Code M 1 AN 2/	* Monetar Amoun	t * Proced. ID * Service ID *	SVD05 380 SVD06 554 Quantity * Assigned Number O 1 R 1/15 O 1 N0 1/6
ELEMENT DETAIL			
	EF. DATA ES. ELEMENT	NAME	ATTRIBUTES
REQUIRED SVD0	67	Identification Code Code identifying a party or other code SEMANTIC: SVD01 is the payer identification of	M 1 AN 2/80
		IMPLEMENTATION NAME: Other Payer Prima	ry Identifier
		This identifier indicates the payer re- reimbursement described in this iter identifier indicates the Other Payer b Other Payer Primary Identifier (Loop	ation of the 2430 loop. The y matching the appropriate

TECHNICAL REPO					LINE ADJU	DICATIO	N INFO	кматіс
REQUIRED	SVD02	782		ary Amo ry amoun		M 1	R	1/18
			SEMANTI	c : SVD02	2 is the amount paid for this service line.			
			IMPLEME	NTATION N	AME: Service Line Paid Amount			
			Zero "	0" is an	acceptable value for this elemen	ıt.		
REQUIRED	SVD03	C003	IDENT	IFIER tify a med	MEDICAL PROCEDURE	O 1	plicable	9
			This el service		contains the procedure code that	was us	ed to	pay this
REQUIRED	SVD03 -	1	235	Code id	ct/Service ID Qualifier lentifying the type/source of the descript /Service ID (234)	M tive numb	ID er used	2/2 1 in
				SEMANTI C003-0	c: 1 qualifies C003-02 and C003-08.			
				IMPLEME	NTATION NAME: Product or Service ID	Qualifi	er	
			CC	DDE	DEFINITION			
			ER		Jurisdiction Specific Procedure	and Su	pply C	odes
					code source 576: Workers Compensa	tion Spec	ific Pro	cedure
			нс		and Supply Codes Health Care Financing Adminis			on
					Procedural Coding System (HC Because the AMA's CPT codes	•		1
					HCPCS codes, they are reporte			•
			HP		code source 130: Healthcare Commo System Health Insurance Prospective P (HIPPS) Skilled Nursing Facility	ayment	Syste	U
			IV		code source 716: Health Insurance P System (HIPPS) Rate Code for Skilled Home Infusion EDI Coalition (H Code	d Nursing	Facilitie	es
					This code set is not allowed for the time of this writing. The qua used: If a new rule names the Home I (HIEC) Product/Service Codes a	llifier ca nfusion	n only EDI C	be oalitior
					set under HIPAA, OR The Secretary grants an excep set as a pilot project as allowed OR For claims which are not cover	tion to u under t	se the	e code v,
					CODE SOURCE 513: Home Infusion EDI			

		wк	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.
REQUIRED	SVD03 - 2		CODE SOURCE 843: Advanced Billing Concepts (ABC) CodesProduct/Service IDMAN1/48Identifying number for a product or service
			SEMANTIC: If C003-08 is used, then C003-02 represents the beginning value in the range in which the code occurs.
			IMPLEMENTATION NAME: Procedure Code
SITUATIONAL	SVD03 - 3		Procedure ModifierOAN2/2This identifies special circumstances related to the performance of the service, as defined by trading partnersSEMANTIC: 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	SVD03 - 4		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 <i>improves the reporting accuracy of the associated</i> <i>procedure code. If not required by this implementation</i> <i>guide, do not send.</i>
SITUATIONAL	SVD03 - 5		Procedure ModifierOAN2/2This identifies special circumstances related to the performance of the service, as defined by trading partnersSEMANTIC: 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.

ASC X12N • INSURA TECHNICAL REPORT		MITTEE		00501 LINE ADJU			430 • SVD RMATION
SITUATIONAL	SVD03 - 6	5	1339	Procedure Modifier This identifies special circumstances related to service, as defined by trading partners SEMANTIC:	·	AN ormance	2/2 e of the
				C003-06 modifies the value in C003-02 and C0 SITUATIONAL RULE: <i>Required when a fourth</i> <i>improves the reporting accuracy of the</i> <i>procedure code. If not required by this</i> <i>guide, do not send.</i>	modifie e associ	ated	
SITUATIONAL	SVD03 - 7	7	352	Description A free-form description to clarify the related da content	O ta elemer	AN hts and	1/80 their
				SEMANTIC: C003-07 is the description of the procedure ide	entified in	C003-0)2.
				SITUATIONAL RULE: <i>Required when SVC01-7</i> 835 transaction. If not required by this guide, do not send.			
				IMPLEMENTATION NAME: Procedure Code Des	cription		
NOT USED	SVD03 - 8	3	234	Product/Service ID	ο	AN	1/48
NOT USED	SVD04	234	Produ	ct/Service ID	01	AN	1/48
REQUIRED	SVD05	380	Quant Numeri	ity c value of quantity	01	R	1/15
			SEMANT	c: SVD05 is the paid units of service.			
			IMPLEME	ENTATION NAME: Paid Service Unit Count			
				s the number of paid units from the remining are not present on the remittance and units.			
			When	aximum length for this field is 8 digits ex a decimal is used, the maximum numbe ht of the decimal is three.			
SITUATIONAL	SVD06	554		ned Number r assigned for differentiation within a transaction		N0	1/6
				ιτ: SVD06 is only used for bundling of service line ad Number of the service line into which this serv			
				DNAL RULE: Required when payer bundled t ed by this implementation guide, do not		ice lin	e. If not
			IMPLEME	ENTATION NAME: Bundled Line Number			

	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:	 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:	 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

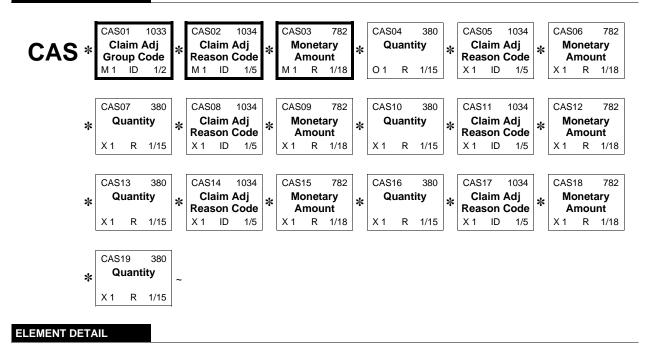
Situational Rule: Required when the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged. If not required by this implementation guide, do not send.

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



REF. DES.	DATA ELEMENT	NAME			ATTRIBU	TES
CAS01	1033	•	•	M 1 ent	ID	1/2
		CODE	DEFINITION			
		СО	Contractual Obligations			
		CR	Correction and Reversals			
		OA	Other adjustments			
		PI	Payor Initiated Reductions			
		PR	Patient Responsibility			
	CAS01	CAS01 1033	Code identifyir <u>code</u> CO CR OA PI	Code identifying the general category of payment adjustment CODE DEFINITION CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions	Code identifying the general category of payment adjustment CODE DEFINITION CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions	Code identifying the general category of payment adjustment CODE DEFINITION CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions

005010X223 • 837 • 2 LINE ADJUSTMENT	2430 • CAS		ASC X12N • INSURA TECHNIC			MMITTEE • TYPE 3
REQUIRED	CAS02	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was m	M1 ade	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	01	R	1/15
			SEMANTIC: CAS04 is the units of service being adjusted.			
			SITUATIONAL RULE: Required when the number of served adjusted. If not required by this implementation g			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL	CAS05	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment was m	X1 ade	ID	1/5
			syntax: L050607, C0605, C0705			
			SITUATIONAL RULE: Required when it is necessary to r non-zero adjustment, beyond what has already b this service line for the Claim Adjustment Group CAS01. If not required by this implementation gu	een s Code	upplie repor	ed, to ted in
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
			See CODE SOURCE 139: Claim Adjustment Reas	on Co	ode	
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. this implementation guide, do not send.	lf not	requi	red by
			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 a units of service adjustment. If not required by thi guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			

IECHNICAL REFOR	ITIFES			LIN		USINEN
SITUATIONAL	CAS08	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment v	X1 was made	ID	1/5
			syntax: L080910, C0908, C1008			
			SITUATIONAL RULE: Required when it is necessary non-zero adjustment, beyond what has alrea this service line for the Claim Adjustment G CAS01. If not required by this implementation	ady been s roup Code	upplie repo	ed, to rted in
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
			See CODE SOURCE 139: Claim Adjustment	Reason Co	ode	
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 pres this implementation guide, do not send.	ent. If not	requi	red by
			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 adjuste	d.		
			SITUATIONAL RULE: Required when CAS08 is pres units of service adjustment. If not required b guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL	CAS11	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment v	X1 was made	ID	1/5
			syntax: L111213, C1211, C1311			
			SITUATIONAL RULE: Required when it is necessary non-zero adjustment, beyond what has alrea this service line for the Claim Adjustment G CAS01. If not required by this implementation	ady been s roup Code	upplie repo	ed, to rted in
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
			See CODE SOURCE 139: Claim Adjustment	Reason Co	ode	
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 pres this implementation guide, do not send.	ent. If not	requi	red by
			IMPLEMENTATION NAME: Adjustment Amount			

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3 005010X223 • 837 • 2430 • CAS LINE ADJUSTMENT

			16			• • • • •
SITUATIONAL C	AS13	380	Quantity Numeric value of quantity	X 1	R	1/15
			syntax: L111213, C1311			
			SEMANTIC: CAS13 is the units of service being adjuste	d.		
			SITUATIONAL RULE: Required when CAS11 is pres units of service adjustment. If not required b guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL C	AS14	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment v	X1 was made	ID	1/5
			syntax: L141516, C1514, C1614			
			SITUATIONAL RULE: Required when it is necessar, non-zero adjustment, beyond what has alrea this service line for the Claim Adjustment G CAS01. If not required by this implementation	ady been s roup Code	upplie repor	ed, to ted in
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
			See CODE SOURCE 139: Claim Adjustment	Reason Co	ode	
SITUATIONAL C	AS15	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 pres this implementation guide, do not send.	sent. If not	requii	red by
			IMPLEMENTATION NAME: Adjustment Amount			
SITUATIONAL C	AS16 3	380	Quantity Numeric value of quantity	X 1	R	1/15
			syntax: L141516, C1614			
			SEMANTIC: CAS16 is the units of service being adjuste	d.		
			SITUATIONAL RULE: Required when CAS14 is pres units of service adjustment. If not required b guide, do not send.			
			IMPLEMENTATION NAME: Adjustment Quantity			
SITUATIONAL C	AS17	1034	Claim Adjustment Reason Code Code identifying the detailed reason the adjustment v SYNTAX: L171819, C1817, C1917	X 1 was made	ID	1/5
				v to roport	on od	ditional
			SITUATIONAL RULE: Required when it is necessar non-zero adjustment, beyond what has alrea this service line for the Claim Adjustment G CAS01. If not required by this implementation	ady been s roup Code	upplie repor	ed, to ted in
			IMPLEMENTATION NAME: Adjustment Reason Code			
			CODE SOURCE 139: Claim Adjustment Reason Code			
			See CODE SOURCE 139: Claim Adjustment	Reason Co	ode	

ASC X12N • INSURA TECHNICAL REPOR		MMITTEE		005010X223 • 8 LIN		430 • CAS USTMENT
SITUATIONAL	CAS18	782	Monetary Amount Monetary amount	X 1	R	1/18
			syntax: L171819, C1817			
			SEMANTIC: CAS18 is the amount of the adjustmen	ıt.		
			SITUATIONAL RULE: <i>Required when CAS17 is this implementation guide, do not send.</i>	present. If not	requi	red by
			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 adj	usted.		
			SITUATIONAL RULE: <i>Required when CAS17 is a units of service adjustment. If not requir guide, do not send.</i>			
			IMPLEMENTATION NAME: Adjustment Quantity			

SEGMENT DETAIL					
	DTP - LI	INE CHECK OR REMITTANC	E D	ATE	Ξ
X12 Segment Name:	Date or Time	or Period			
X12 Purpose:	To specify an	y 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	8*20040203~			
DIAGRAM					
DTP * Date/Tim Qualifier	*	*			
M 1 ID	REF. DATA ELEMENT	NAME		ATTRIBUT	
M 1 ID	r Format Q 3/3 M 1 ID KEF. DATA ELEMENT	2/3 M 1 AN 1/35	 M 1	ATTRIBUT	<u>TES</u>
M 1 ID ELEMENT DETAIL USAGE	r Format Q 3/3 M 1 ID KEF. DATA ELEMENT	2/3 M 1 AN 1/35 NAME Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION	- <u>M</u> 1		
ELEMENT DETAIL USAGE BEQUIRED DTPO	REF. D1 373 Format Q M 1 ID DATA ELEMENT	2/3 M 1 AN 1/35 NAME Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 573 Date Claim Paid		ID	3/3
M 1 ID ELEMENT DETAIL USAGE	REF. D1 373 Format Q M 1 ID DATA ELEMENT	2/3 M 1 AN 1/35 NAME Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION	M 1	ID	
ELEMENT DETAIL USAGE BEQUIRED DTPO	REF. D1 373 Format Q M 1 ID DATA ELEMENT	2/3 M 1 AN 1/35 NAME Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 573 Date Claim Paid Date Time Period Format Qualifier	M 1 me forr	ID ID nat	3/3 2/3
ELEMENT DETAIL USAGE E REQUIRED DTP(REF. D1 373 Format Q M 1 ID DATA ELEMENT	2/3 M 1 AN 1/35 NAME Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 573 Date Claim Paid Date Time Period Format Qualifier Code indicating the date format, time format, or date and time SEMANTIC: DTP02 is the date or time or period format that w	M 1 me forr ill appe	ID ID nat	3/3 2/3
ELEMENT DETAIL USAGE BEQUIRED DTPO	Format Q M 1 ID M 1	2/3 M 1 AN 1/35 NAME Date/Time Qualifier Code specifying type of date or time, or both date and time IMPLEMENTATION NAME: Date Time Qualifier CODE DEFINITION 573 Date Claim Paid Date Time Period Format Qualifier Code indicating the date format, time format, or date and time SEMANTIC: DTP02 is the date or time or period format that w CODE DEFINITION	M 1 me forr ill appe IMDD M 1	ID ID nat Par in DT	3/3 2/3

SEGMENT DETAIL					
	AMT - R	EMAINING PATIENT LIABIL	ITY		
X12 Segment Name:	e: Monetary Amount Information				
X12 Purpose:	To indicate the	e total monetary amount			
Loop:	2430 — LINE	ADJUDICATION INFORMATION			
Segment Repeat:	1				
Usage:	SITUATIONA	L			
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.			tion,	
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).			used	
	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*7	5~			
DIAGRAM					
AMT * Amount Qu Code		t [*] Flag Code [~]			
ELEMENT DETAIL					
	EF. DATA ES. <u>ELEMENT</u>	NAME		ATTRIBU	TES
REQUIRED AMTO		Amount Qualifier Code Code to qualify amount	M 1	ID	1/3
REQUIRED AMTO	02 782	CODE DEFINITION EAF Amount Owed Monetary Amount Monetary amount	M 1	R	1/18
		IMPLEMENTATION NAME: Remaining Patient Liability			
NOT USED AMTO	03 478	Credit/Debit Flag Code	01	ID	1/1

SEGMENT DETAIL				
	SE	E - TR	ANSACTION SET TRAILER	
X12 Segment N	lame: Trar	saction S	Set Trailer	
X12 Pur	•		e end of the transaction set and provide the cour egments (including the beginning (ST) and endin	
X12 Comm	nents: 1.	SE is the	last segment of each transaction set.	
Segment Re	epeat: 1			
U	sage: REC	UIRED		
TR3 Exa	mple: SE*	×1230*98	7654~	
DIAGRAM				
	umber of nc Segs N0 1/10	TS Conti Numbe M 1 AN		
USAGE	REF. DES.	DATA ELEMENT	NAME	ATTRIBUTES
REQUIRED	SE01	96	Number of Included Segments Total number of segments included in a transaction set inclusegments	M 1 N0 1/10 Juding ST and SE
			IMPLEMENTATION NAME: Transaction Segment Count	
REQUIRED	SE02	329	Transaction Set Control Number Identifying control number that must be unique within the tr functional group assigned by the originator for a transaction	
			The Transaction Set Control Number in ST02 and identical. The number must be unique within a sp (ISA-IEA), but can repeat in other interchanges.	

3 Examples

• Please visit http://www.wpc-edi.com/837 for additional or corrected examples.

3.1 Institutional

3.1.1 Business Scenario 1 - 837 Institutional Claim

Patient is the same person as the Subscriber. The Primary Payer is Medicare and the Secondary payer is State Teachers. The bill is a 141 Type of Bill.

PRIMARY PAYER SUBSCRIBER: John T Doe SUBSCRIBER ADDRESS: 125 City Avenue, Centerville, PA 17111 SEX: M DOB: 11/11/1926 MEDICARE INSURANCE ID#: 030005074A PAYER ID #: 00435

PATIENT: Same as Primary Subscriber

DESTINATION PAYER: Medicare B

SUBMITTER: Jones Hospital EDI#: 12345

RECEIVER: Medicare EDI #: 00120

BILLING PROVIDER: Jones Hospital NPI: 9876540809 TIN: 567891234 MEDICARE PROVIDER: #330127 ADDRESS: 225 Main Street Barkley Building, Centerville, PA 17111

ATTENDING PHYSICIAN: John J Jones UPIN #: B99937

PATIENT ACCOUNT NUMBER: 756048Q

DATE OF ADMISSION: 09/11/96 STATEMENT PERIOD DATE: 09/11/96 - 09/11/96 PLACE OF SERVICE: Inpatient Hospital Occurrence Codes and Dates: A1 11/11/26 A2 11/01/91 B1 11/11/26 B2 01/01/87 Condition Codes: 09 Value Codes: A2 \$15.31 PRINCIPAL DIAGNOSIS CODE: 366.9 SECONDARY DIAGNOSIS CODES: 401.9 794.31 NUMBER OF COVERED DAYS: 1 SERVICES: INSTITUTIONAL SERVICES RENDERED: REVENUE CODE: 0305 HCPCS Procedure Code: 85025 Unit: 1 Price \$13.39 REVENUE CODE: 0730 HCPCS Procedure Code: 93005 Unit: 1 Price: \$76.54 TOTAL CHARGES: \$89.93

SECONDARY PAYER SUBSCRIBER: Jane S Doe (wife)

SUBSCRIBER ADDRESS: 125 City Avenue, Centerville, PA 17111 SEX: F DOB: 12/11/1927 STATE TEACHERS ID#: 222004433 PAYER ID #: 1135

SEG #	LOOP SEGMENT/ELEMENT STRING
1	TRANSACTION SET HEADER ST*837*987654*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*90055555557~
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*7560480*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
48	TRAILER SE TRANSACTION SET TRAILER
48	

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*7560480*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*7560490*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*999999999999~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*OC*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~

Т

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.

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*9998	88777~
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*¥4*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
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

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*7373737377~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*OC*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 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

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

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

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

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

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

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.

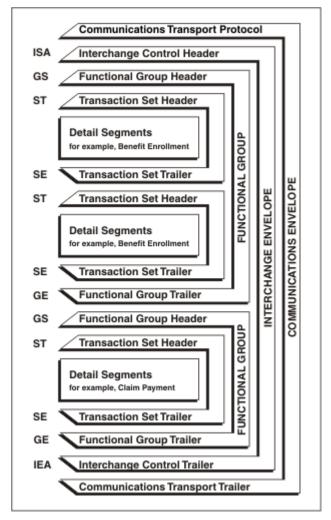
Each transaction set contains groups of logically related data in units called segments. For instance, the N4 segment used in the transaction set conveys the city, state, ZIP Code, and other geographic information. A transaction set contains multiple segments, so the addresses of the different parties, 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 - *<u>Transmission Control Schematic</u>*, 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 - <u>Basic Character Set</u>, includes those selected from the uppercase letters, digits, space, and special characters as specified below.

Table B.1 - Basic Character Set

AZ	09	!		&		()	+	*
,	-	-	/	:	;	?	=	□ (sp	ace)

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	
-------------	----------	---------------	--

az	%	~	@	[]	_	{
}	١		<	>	#	\$	

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 - <u>Base Control Set</u>.

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:

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		

Table B.3 - Base Control Set

The Group Separator (GS) may be an exception in this set because it is used in the 3780 communications protocol to indicate blank space compression.

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.

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			

Table B.4 - Extended Control Set

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.

CHARACTER	NAME	DELIMITER
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Element Separator
~	Tilde	Segment Terminator

Table B.5 - Delimiters

The delimiters above are for illustration purposes only and are not specific recommendations or requirements. Users of this implementation guide should be aware that an application system may use some valid delimiter characters within the application data. Occurrences of delimiter characters in transmitted data within a data element 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.

SYMBOL	TYPE
Nn	Numeric
R	Decimal
ID	Identifier
AN	String
DT	Date
ТМ	Time
В	Binary

Table B.6 - Data Element Types

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 1111111. 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 - <u>Reference Designator</u> and Section B.1.1.3.9 - <u>Condition Designator</u>.

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 - <u>Condition Designator</u>.

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 ea notes are detailed be	ch of the condition codes used within syntax low:			
	CONDITION CODE	DEFINITION			
	P- Paired or Multiple If any element specified in the relational condition is present, then all of the element specified must be present.				
	R- Required At least one of the elements specified in the condition must be present.				
	E- Exclusion	Not more than one of the elements specified in the condition may be present.			

C- Conditional	If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.			
L- List Conditional	If the first element specified in the condition is present, then at least one of the remaining elements must be present. However, any or all of the elements not specified as the first element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.			

DESIGNATOR DESCRIPTION

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.

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.

Tahlo	R 8 -	Data	Soamont	Requirement	Designators
labic	0.0	Dutu	ocginent	requirement	Designators

T

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 - <u>Transmission</u> <u>Control Schematic</u>.

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. 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

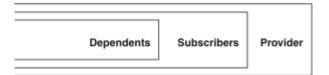
The HL segment is used in several X12 transaction sets to identify levels of detail information using a hierarchical structure, such as relating dependents to a subscriber. Hierarchical levels may differ from guide to guide.

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 third PROVIDER)

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_NM109OtherPayerPatientPrimaryIdentifier

Said in another way, ODs contain a coded component specifying a location in an implementation guide, a separator, and a name portion. For example:

837Q1_2330C_NM1	09OtherPayerPatientPrimaryIdentifier
1	
Location in the G	uide Separator Name

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.

С

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											
X12 Segment Name:	ISA - INTERCHANGE CONTROL HEADER										
X12 Purpose:	o start and identify an interchange of zero or more functional groups and terchange-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											
ISA * Author Inf Qualifier											
* Interchang ID Qual M 1 ID 2	105 ISA08 107 ISA09 108 ISA10 109 ISA11 I65 ISA12 I11 105 Interchange Interchange Interchange Interchange ISA11 I65 Repetition ISA12 I11 102 11 AN 15/15 M I DT 6/6 M I TM 4/4 M ISA11 I65 ISA12 I11 Inter Ctrl 112 ISA14 I13 ISA15 I14 ISA16 I15 I15										

1/1

*

M 1

Usage Indicator

M1 ID

*

1/1

1/1

Component Elem Sepera

9/9

*

Ack

Requested M1 ID

Inter Ctrl

Number

M 1 N0

*

ELEMENT DETAIL

USAGE	REF. DES.	DATA ELEMENT	NAME	ATT	RIBUTES			
REQUIRED	ISA01	101		Information Qualifier M 1 ID the type of information in the Authorization Information DEFINITION	_,_			
			00	No Authorization Information Present (No Meaningful Information in I02)				
			03	Additional Data Identification				
REQUIRED	ISA02	102	sender or the da	Information M 1 AN d for additional identification or authorization of the inter- ta in the interchange; the type of information is set by formation Qualifier (I01)	erchange			
REQUIRED	ISA03	103		mation Qualifier M 1 ID the type of information in the Security Information	2/2			
			CODE	DEFINITION				
			00	No Security Information Present (No Meani Information in I04)	ngful			
			01	Password				
REQUIRED	ISA04	104		identifying the security information about the interchar e interchange; the type of information is set by the Sec	ige sender			
REQUIRED	ISA05	105	sender or receiv	D Qualifier M 1 ID the system/method of code structure used to designat er ID element being qualified ies the Sender in ISA06.				
			CODE					
			01	Duns (Dun & Bradstreet)				
			14	Duns Plus Suffix				
			20	Health Industry Number (HIN)				
			27	CODE SOURCE 121: Health Industry Number Carrier Identification Number as assigned by H Care Financing Administration (HCFA)				
			28	Fiscal Intermediary Identification Number a assigned by Health Care Financing Admini (HCFA)				
			29	Medicare Provider and Supplier Identificati Number as assigned by Health Care Financ Administration (HCFA)				
			30	U.S. Federal Tax Identification Number				
			33	National Association of Insurance Commis Company Code (NAIC)	sioners			
			ZZ	Mutually Defined				
REQUIRED	ISA06	106		Sender ID M 1 AN de published by the sender for other parties to use as to them; the sender always codes this value in the ser	the receiver			

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

REQUIRED	ISA07	105	0) Qualifier he system/method of code structure u er ID element being qualified	M 1 sed to des	ID ignate th	2/2 ne
			This ID qualified	es the Receiver in ISA08.			
			CODE	DEFINITION			
			01	Duns (Dun & Bradstreet)			
			14	Duns Plus Suffix			
			20	Health Industry Number (HIN)			
			27	CODE SOURCE 121: Health Industry Nu Carrier Identification Number a Care Financing Administration	as assigr	ned by I	Health
			28	Fiscal Intermediary Identificati assigned by Health Care Finan (HCFA)	entification Number as		
			29	Medicare Provider and Supplie Number as assigned by Health Administration (HCFA)			9
			30	U.S. Federal Tax Identification	Number		
			33	National Association of Insura Company Code (NAIC)	nce Com	missio	ners
			ZZ	Mutually Defined			
REQUIRED	ISA08	107	by the sender as	eceiver ID e published by the receiver of the data their sending ID, thus other parties se to route data to them			
REQUIRED	ISA09	108	Interchange D Date of the interc		M 1	DT	6/6
			The date form	at is YYMMDD.			
REQUIRED	ISA10	109	Interchange Ti Time of the interc		M 1	тм	4/4
			The time form	at is HHMM.			
REQUIRED	ISA11	165	element; this field of a simple data e	cable; the repetition separator is a deli d provides the delimiter used to separa element or a composite data structure data element separator, component e	ate repeate this value	ed occuri e must be	ences Ə
REQUIRED	ISA12	I 11		ontrol Version Number the version number of the interchange	M 1 control se	ID gments	5/5
			CODE	DEFINITION			
			00501	Standards Approved for Public Procedures Review Board thro	-		
REQUIRED	ISA13	I12		ontrol Number r assigned by the interchange sender	•	N0	9/9
				ge Control Number, ISA13, mus erchange Trailer IEA02.	t be iden	tical to	the
			Must be a pos value in IEA02	itive unsigned number and mus	t be ider	ntical to	the

CONTROL SEGMEN	тѕ			ASC X12N • IN TE	SURANCE S		
REQUIRED	ISA14	l13	Acknowledgment Requested M 1 ID Code indicating sender's request for an interchange acknowledgment				1/1
			See Section	B.1.1.5.1 for interchange ackno	wledgment	inform	nation.
			CODE	DEFINITION			
			0	No Interchange Acknowledg	ment Reque	ested	
			1	Interchange Acknowledgmer	nt Requeste	d (TA	1)
REQUIRED	ISA15	l14	Interchange Usage Indicator M 1 ID 1/1 Code indicating whether data enclosed by this interchange envelope is test, production or information				
			CODE	DEFINITION			
			Р	Production Data			
			т	Test Data			
REQUIRED	ISA16	115	Type is not ap data element; elements withi	Element Separator plicable; the component element separ this field provides the delimiter used to n a composite data structure; this valu- separator and the segment terminator	separate con	nponen	t data

SEGMENT DETAIL								
	G	S - FU	NCTIONAL GROUP HEADER					
X12 Segment I	Name: Fui	nctional Gr	roup Header					
X12 Pui	rpose: To	To indicate the beginning of a functional group and to provide control information						
X12 Comn	nents: 1	standard	nal group of related transaction sets, within the scope of X ls, consists of a collection of similar transaction sets enclose al group header and a functional group trailer.					
Segment R	epeat: 1							
ι	Jsage: RE	QUIRED						
TR3 Exa			NDER CODE*RECEIVER 1231*0802*1*X*005010X223~					
DIAGRAM								
GS * 「	ID Code	GS02 Applicati Send's Co M 1 AN	code 🔨 Rec's Code 🌋 🕺 🔨 Nu	28 Ip Ctrl mber № 1/9				
	esponsible ency Code 1 ID 1/2	K Ver/Relea ID Cod M 1 AN	le ~					
USAGE	REF. DES.	DATA ELEMENT	_ NAME ATTRI	BUTES				
REQUIRED	GS01	479	Functional Identifier Code M 1 ID Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related transaction sets Image: Code identifying a group of application related tr	2/2				
			This is the 2-character Functional Identifier Code assigned transaction set by X12. The specific code for a transaction defined by this implementation guide is presented in sectio Version Information.	set				
REQUIRED	GS02	142	Application Sender's Code M 1 AN Code identifying party sending transmission; codes agreed to by trading	2/15 partners				
			Use this code to identify the unit sending the information.					
REQUIRED	GS03	124	Application Receiver's Code M 1 AN Code identifying party receiving transmission; codes agreed to by tradir	2/15 ig partners				
			Use this code to identify the unit receiving the information.					
REQUIRED	GS04	373	Date M 1 DT Date expressed as CCYYMMDD where CC represents the first two digi calendar year	8/8 ts of the				
			SEMANTIC: GS04 is the group date.					
			Use this date for the functional group creation date.					

CONTROL SEGMEN	TS		ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3
REQUIRED	GS05	337	TimeM 1TM4/8Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, orHHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S =integer seconds (00-59) and DD = decimal seconds; decimal seconds areexpressed 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 CodeM 1ID1/2Code 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	GS08 480	Version / Release / Industry Identifier Code M1 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	E - FU	NCTIONAL GROUP TRAILER	ł				
X12 Segment Na	ame: Fund	ctional Gr	oup Trailer					
X12 Purp	ose: To ir	o indicate the end of a functional group and to provide control information						
X12 Comme		functiona group inte	of identical data interchange control numbers in the group header and trailer is designed to maximiz egrity. The control number is the same as that us he header.	e fun	ctiona			
Segment Re	peat: 1							
Us	age: REC	UIRED						
TR3 Exan	nple: GE*	:1*1~						
DIAGRAM								
	1 97 mber of Included N0 1/6	GE02 Group C Numbe M 1 N0						
USAGE	REF. DES.	DATA ELEMENT	NAME		ATTRIBU	TES		
REQUIRED	GE01	97	Number of Transaction Sets Included Total number of transaction sets included in the functional g (transmission) group terminated by the trailer containing this			0		
REQUIRED	GE02	28	Group Control Number Assigned number originated and maintained by the sender	M 1	N0	1/9		
			SEMANTIC: The data interchange control number GE02 in this identical to the same data element in the associated functio GS06.					

SEGMENT DETAIL										
	IEA - IN	TERCHANGE CONTROL TRA		ER						
X12 Segment Name	: Interchange	erchange Control Trailer								
X12 Purpose		define the end of an interchange of zero or more functional groups and erchange-related control segments								
Segment Repea	t: 1									
Usage	REQUIRED									
TR3 Example	: IEA*1*0000	00905~								
DIAGRAM										
IEA * IEA01 Num of Funct G M 1 N0										
ELEMENT DETAIL										
USAGE	REF. DATA DES. ELEMENT	NAME		ATTRIBU	TES					
REQUIRED IEA	.01 116	Number of Included Functional Groups A count of the number of functional groups included in an i	M 1 ntercha	N0 inge	1/5					
REQUIRED IEA	.02 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.
- 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.

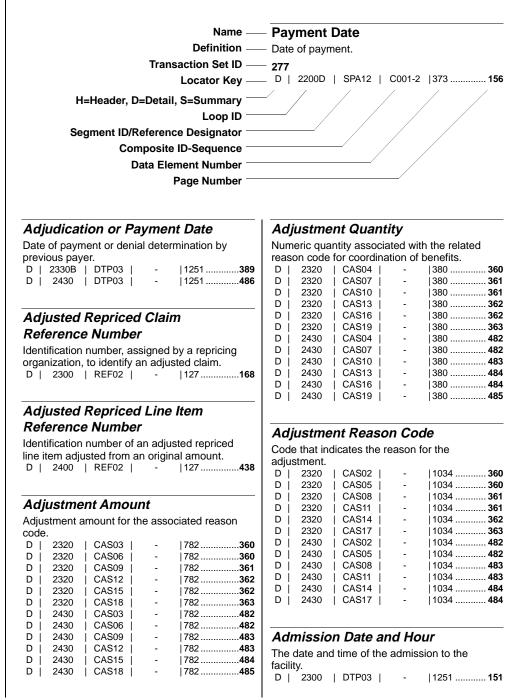
Data Element Glossary

E.1

Ε

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.



	Attending Provider Last Name
Code indicating the source of this admission.	Last Name of the provider responsible for the
D 2300 CL102 - 1314 153	care of the patient. D 2310A NM103 - 1035
Admission Type Code	
Code indicating the priority of this admission.	Attending Provider Middle
D 2300 CL101 - 1315 153	Name or Initial
	Middle name or initial of the provider
Admitting Diagnosis Code	responsible for care of the patient. D 2310A NM105 - 1037
The diagnosis code describing the patient's	
diagnosis at the time of admission.	
D 2300 HI01 C022-2 1271 188	Attending Provider Name Suffix
	Suffix to the name of the provider responsible
Amount Qualifier Code	for the care of the patient. D 2310A NM107 - 1039
Code to qualify amount.	
D 2300 AMT01 - 522 160	
D 2320 AMT01 - 522 364 D 2320 AMT01 - 522 365	Attending Provider Primary
D 2320 AMT01 - 522 366	Identifier
D 2400 AMT01 - 522 439	Primary identifier for the provider responsible t
D 2400 AMT01 - 522440	the care of the patient. D 2310A NM109 - 67
D 2430 AMT01 - 522 487	
Assistant Number	Attending Previder Cocondens
Assigned Number	Attending Provider Secondary Identifier
Number assigned for differentiation within a transaction set.	
D 2400 LX01 - 554 423	Additional identifier for the provider responsible for the care of the patient.
	D 2310A REF02 - 127
Assignment or Plan	
Participation Code	Auto Accident State or
An indication, used by a health plan, that the	Province Code
	State or Province where auto accident occurre
	State or Province where auto accident occurre
benefits.	State or Province where auto accident occurre D 2300 REF02 - 127
benefits. D 2300 CLM07 - 1359 146	State or Province where auto accident occurre D 2300 REF02 - 127
benefits. D 2300 CLM07 - 1359 146 Attachment Control Number Identification number of attachment related to	State or Province where auto accident occurre D 2300 REF02 - 127 Benefits Assignment Certification Indicator
benefits. D 2300 CLM07 - 1359 146 Attachment Control Number Identification number of attachment related to the claim. -	State or Province where auto accident occurre D 2300 REF02 - 127 Benefits Assignment Certification Indicator A code showing whether the provider has a
benefits. D 2300 CLM07 - 1359 146 Attachment Control Number Identification number of attachment related to the claim. D 2300 PWK06 - 167 157	State or Province where auto accident occurre D 2300 REF02 - 127 Benefits Assignment Certification Indicator
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073
benefits. Image: D Image: S Image: S	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 Billing Note Text
D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted.
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted.
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 Benefits Assignment Certification Indicator A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. - 1073 D 2300 CLM08 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing - - -
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 Benefits Assignment Certification Indicator A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. - 1073 D 2300 CLM08 - 1073 D 2320 Ol03 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing entity address. - -
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing entity address. D 2010AA N301 - 166
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2320 Ol03 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing entity address. D 2010AA N301 - 166
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2300 OLM08 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing entity address. D 2010AA N301 - 166
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2300 OLM08 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing entity address. D 2010AA N301 - 166 D 2010AA N302 - 166 Billing Provider City Name
benefits. D 2300 CLM07 - 1359	State or Province where auto accident occurre D 2300 REF02 - 127 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 D 2300 OLM08 - 1073 D 2300 OLM08 - 1073 D 2320 Ol03 - 1073 Billing Note Text Free-form text providing additional information about the bill or claim being submitted. D 2300 NTE02 - 352 Billing Provider Address Line Address line of the billing provider or billing entity address. D 2010AA N301 - 166

Billing Provider Contact Name Person at billing organization to contact regarding the billing transaction. D 2010AA PER02 - 93	Claim Adjustment Group Code Code identifying the general category of payment adjustment. D 2320 CAS01 - 1033
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	Claim DRG AmountTotal of Prospective Payment System operating and capital amounts for this claim.D2320MIA04-1782770
Billing Provider Organizational	Claim Disproportionate Share
Name	Amount Sum of operating capital disproportionate share
Organization name of the entity billing for services. D 2010AA NM103 - 103585	amounts for this claim. D 2320 MIA06 - 782
Billing Provider Postal Zone or ZIP Code	Claim Filing Indicator Code Code identifying type of claim or expected
Postal zone code or ZIP code for the provider or billing entity billing for services. D 2010AA N403 - 116	adjudication process. D 2000B SBR09 - 1032
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	Claim Frequency CodeCode specifying the frequency of the claim. Thisis the third position of the Uniform Billing ClaimForm Bill Type.D 2300 CLM05 C023-3 1325
made. D 2010BB REF02 - 127	Claim Identifier
Billing Provider State or Province Code	Identifies type of claims in this transaction. H BHT06 - 640 640
State or province for provider or billing entity	Claim Indirect Teaching Amount
billing for services. D 2010AA N402 - 156 89	Total of operating and capital indirect teaching amounts for this claim. D 2320 MIA18 - 782 372
Billing Provider Tax Identification Number	Claim MSP Pass-through
Tax identification number for the provider or	Amount
organization in whose name the bill is submitted and to whom payment should be made. D 2010AA REF02 - 12790	Interim cost pass-though amount used to determine Medicare Secondary Payer liability. D 2320 MIA07 - 782
Bundled Line Number	Claim Note Text
Identification of line item bundled by payer in payment of benefits. D 2430 SVD06 - 554 479	Narrative text providing additional information related to the claim. D 2300 NTE02 - 352 179
Certification Condition Code	Claim PPS Capital Amount
Applies IndicatorCode indicating whether or not the conditioncodes apply to the patient or another entity.D 2300 CRC02 - 1073	Total Prospective Payment System (PPS)capital amount payable for this claim as outputby PPS PRICER.D 2320 MIA08 - 782

Claim PPS Capital Outlier Amount D 233 Total Prospective Payment System capital day or cost outlier payable for this claim, excluding operating outlier amount. D 230 D 2320 MIA17 - 1782 372 Claim Payment Remark Code D 230 D 230 Code identifying the remark associated with the payment. 127 373 D 230 D 2320 MIA21 - 1127 373 D 230 D 2320 MIA23 - 1127 373 D 230 D 2320 MOA04 - 127 375 D 230 D 2320 MOA06 - 1127 375 D 230 D 2320 MOA06 - 1127 375 D 230 D 2300 HI01 C022-1 1270 194 D 230 D 2300 HI02 C022-1 1270 194 D 230							
Amount D 230 Total Prospective Payment System capital day or cost outilier payable for this claim, excluding operating outlier amount. D 230 D 2320 MIA17 - 1782 372 Claim Payment Remark Code Code identifying the remark associated with the payment. D 230 D 230 D 2320 MIA25 - 127 373 D 2330 D 2320 MIA25 - 127 373 D 2330 D 2320 MIA23 - 1127 373 D 2330 D 2320 MOA04 - 1127 375 D 2330 D 2320 MOA05 - 1127 375 D 2330 D 2330 MOA06 - 1127 375 D 230 D 2300 H011 C022-1 1270 184 D 230 D 2300 H012 C022-1 1270	-		S Capita	al Outlie	er		
or cost outlier payable for this claim, excluding operating outlier amount. D 230 D 2	An	nount					
operating outlier amount. D 2 330 MIA17 - 1782 372 D 2320 MIA17 - 1782 372 Claim Payment Remark Code D 230 Code identifying the remark associated with the payment. D 2320 D 2320 MIA21 - 127 373 D 2320 MIA21 - 127 373 D 2330 D 2320 MIA22 - 1127 373 D 2330 D 2320 MOA03 - 1127 375 D 2330 D 2320 MOA06 - 1127 375 D 2330 D 2330 MOA06 - 1127 375 D 2330 D 2300 HI01 C022-1 1270 184 D 2300 D 2300 HI02 C022-1 1270 196 D 230	Tota	al Prospec	tive Paym	nent Syste	m capital day	_	230
D 2320 MIA17 - 782 372 D 230 Claim Payment Remark Code Code identifying the remark associated with the payment. D 230 D<	or c	ost outlie	r payable i	for this cla	im, excluding		
	ope	0		nt.			
Claim Payment Remark Code D 230 Code identifying the remark associated with the payment. 1 230 D 230 D 2320 MIA20 - 127 370 D 230 D 2320 MIA21 - 127 373 D 230 D 2320 MIA23 - 1127 373 D 230 D 2320 MOA03 - 127 375 D 230 D 2320 MOA05 - 127 375 D 230 D 2320 MOA06 - 127 375 D 230 D 2300 MI01 CO22-1 1270 184 D 230 D 2300 HI01 CO22-1 1270 196 D 230 D 2300 HI02 CO22-1 1270 196 D 230 D 2300 HI03 CO22-1	D	2320	MIA17	-	782 372		
Claim Payment Remark Code D 230 Code identifying the remark associated with the payment. D 2320 MIA05 - 127 370 D 2320 MIA05 - 127 373 D 2330 D 2320 MIA22 - 1127 373 D 2330 D 2320 MIA23 - 1127 373 D 2330 D 2320 MOA03 - 1127 375 D 2330 D 2320 MOA041 - 1127 375 D 2330 D 2320 MOA05 - 1127 375 D 2330 D 2330 MOA07 - 1127 184 D 2300 D 2300 Hi01 C022-1 1270 184 D 230 D 2300 Hi02 C022-1 1270 186 D 230 D 2300 H						_	
Code identifying the remark associated with the payment. D 230 D 2330 D 2330 <t< td=""><td></td><td>aim Dai</td><td>mont D</td><td>omorle</td><td>Cada</td><td></td><td></td></t<>		aim Dai	mont D	omorle	Cada		
payment. D 2300 MIA05 - 127 370 D 2300 D 2320 MIA20 - 127 373 D 230 D 2320 MIA23 - 127 373 D 230 D 2320 MIA23 - 127 375 D 230 D 2320 MOA03 - 127 375 D 230 D 2320 MOA05 - 127 375 D 230 D 2320 MOA06 - 127 375 D 230 D 2320 MOA05 - 127 375 D 230 D 2300 HI01 C022-1 1270 184 D 230 D 2300 HI02 C022-1 1270 184 D 230 D 2300 HI03 C022-1 1270 128 D <		-				_	
D 2320 MIA05 - 1127 370 D 2300 D 2320 MIA21 - 127 373 D 230 D 2320 MIA22 - 127 373 D 230 D 2320 MIA23 - 127 373 D 230 D 2320 MOA03 - 127 375 D 230 D 2320 MOA06 - 127 375 D 230 D 2320 MOA06 - 127 375 D 230 D 2300 MIO1 C022-1 1270 184 D 230 D 2300 HI01 C022-1 1270 184 D 230 D 2300 HI02 C022-1 1270 194 D 230 D 2300 HI03 C022-1 1270 194 D 230 <td></td> <td></td> <td>ing the re</td> <td>mark asso</td> <td>ciated with the</td> <td></td> <td></td>			ing the re	mark asso	ciated with the		
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $					1407 070		
$\begin{array}{c c c c c c c c c c c c c c c c c c c $							
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	-						
D 2320 MIA23 - 127 373 D 230 D 2320 MOA04 - 127 375 D 230 D 2320 MOA05 - 127 375 D 230 D 2320 MOA06 - 127 375 D 230 D 2320 MOA07 - 127 375 D 230 D 2320 MOA07 - 127 375 D 230 Code List Qualifier Code D 2300 H01 C022-1 1270 184 D 230 D 230 </td <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	-						
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	D	2320	MIA23	-	127 373	D	
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	_			-		D	230
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	_			-			
D 2320 MOA07 - 127 375 D 230 Code List Qualifier Code Code identifying a specific industry code list. D 230 D 230 D 2300 HI01 C022-1 1270 184 D 230 D 2300 HI01 C022-1 1270 190 D 230 D 2300 HI02 C022-1 1270 191 D 230 D 2300 HI03 C022-1 1270 196 D 230 D 2300 HI03 C022-1 1270 196 D 230 D 2300 HI04 C022-1 1270 206 D 230 D 2300 HI06 C022-1 1270 206 D 230 D 2300 HI07 C022-1 1270 206 D 230 D 2300 HI07 C022-1 1270 216 D 230 D 2300 HI01 C022-1 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Code List Qualifier Code D 230 Code identifying a specific industry code list. D 230 D 2300 HI01 C022-1 1270 184 D 2300 HI01 C022-1 1270 184 D 2300 HI01 C022-1 1270 190 D 2300 HI03 C022-1 1270 191 D 2300 HI03 C022-1 1270 192 D 2300 HI03 C022-1 1270 194 D 230 D 2300 HI04 C022-1 1270 200 D 230 D 2300 HI05 C022-1 1270 200 D 230 D 2300 HI06 C022-1 1270 206 D 230 D 2300 HI07 C022-1 1270 206 D 230 D 2300 HI01 C022-1 1270 216 D 230 D 2300 HI01 C022-1							
Code List Qualifier Code D 2300 Code identifying a specific industry code list. D 2300 HI01 C022-1 1270 184 D 2300 HI01 C022-1 1270 184 D 230 D 2300 HI01 C022-1 1270 190 D 230 D 2300 HI02 C022-1 1270 191 D 230 D 2300 HI02 C022-1 1270 194 D 230 D 2300 HI04 C022-1 1270 194 D 230 D 2300 HI04 C022-1 1270 200 D 230 D 2300 HI06 C022-1 1270 206 D 230 D 2300 HI07 C022-1 1270 206 D 230 D 2300 HI03 C022-1 1270 216 D 230 D	_						
Code identifying a specific industry code list. D 2300 H101 C022-1 1270 184 D 230 D 2300 H101 C022-1 1270 188 D 230 D 2300 H101 C022-1 1270 190 D 230 D 2300 H102 C022-1 1270 191 D 230 D 2300 H102 C022-1 1270 194 D 230 D 2300 H103 C022-1 1270 196 D 230 D 2300 H103 C022-1 1270 200 D 230 D 2300 H106 C022-1 1270 204 D 230 D 2300 H106 C022-1 1270 204 D 230 D 2300 H106 C022-1 1270 214 D 230 D 2300 H101 C022						_	
Code identifying a specific industry code list. D 2300 Hi01 CO22-1 1270 184 D 230 D 2300 Hi01 CO22-1 1270 188 D 230 D 2300 Hi01 CO22-1 1270 190 D 230 D 2300 Hi02 CO22-1 1270 191 D 230 D 2300 Hi02 CO22-1 1270 194 D 230 D 2300 Hi03 CO22-1 1270 198 D 230 D 2300 Hi03 CO22-1 1270 200 D 230 D 2300 Hi06 CO22-1 1270 204 D 230 D 2300 Hi08 CO22-1 1270 208 D 230 D 2300 Hi10 CO22-1 1270 216 D 230 D 2300 Hi10 CO22	Со	de List	Qualifie	er Code	1	D	230
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	Coc	de identifv	ing a spec	cific indust	rv code list.		
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-		0 1			_	
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	D	2300	HI01	C022-1			
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$							
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-	•					
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	_					D	230
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	-						
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$						_	
D 2300 H105 C022-1 1270 202 D 2300 D 2300 H106 C022-1 1270 206 D 230 D 2300 H109 C022-1 1270 206 D 230 D 2300 H109 C022-1 1270 210 D 230 D 2300 H110 C022-1 1270 214 D 230 D 2300 H111 C022-1 1270 216 D 230 D 2300 H101 C022-1 1270 218 D 230 D 2300 H102 C022-1 1270 221 D 230 D 2300 H103 C022-1 1270 224 D 230 D 2300 H104 C022-1 1270 223 D 230	D	2300	HI04	C022-1	1270 200		
D 2300 H106 C022-1 1270 204 D 2300 D 2300 H107 C022-1 1270 206 D 230 D 2300 H109 C022-1 1270 208 D 230 D 2300 H110 C022-1 1270 212 D 230 D 2300 H111 C022-1 1270 216 D 230 D 2300 H111 C022-1 1270 216 D 230 D 2300 H101 C022-1 1270 218 D 230 D 2300 H103 C022-1 1270 224 D 230 D 2300 H104 C022-1 1270 227 D 230 D 2300 H105 C022-1 1270 230 D 230 D 2300 H104 C022-1 1270 233 D 230 D 230 D <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
D 2300 HI08 C022-1 1270 208 D 2300 D 2300 HI09 C022-1 1270 210 D 230 D 2300 HI10 C022-1 1270 212 D D 230 D 2300 HI11 C022-1 1270 214 D 230 D 2300 HI11 C022-1 1270 216 D 230 D 2300 HI01 C022-1 1270 221 D 230 D 2300 HI01 C022-1 1270 221 D 230 D 2300 HI03 C022-1 1270 222 D 230 D 2300 HI04 C022-1 1270 223 D 230	-						
D 2300 HI09 C022-1 1270 210 D 2300 D 2300 HI10 C022-1 1270 212 D 230 D 2300 HI11 C022-1 1270 214 D 230 D 2300 HI12 C022-1 1270 216 D 230 D 2300 HI01 C022-1 1270 218 D 230 D 2300 HI01 C022-1 1270 221 D 230 D 2300 HI02 C022-1 1270 222 D 230 D 2300 HI03 C022-1 1270 224 D 230 D 2300 HI04 C022-1 1270 228 D 230 D 2300 HI06 C022-1 1270 231 D 230 D <t< td=""><td>-</td><td></td><td></td><td></td><td></td><td>D</td><td>230</td></t<>	-					D	230
D 2300 HI10 C022-1 1270 212 D 2300 D 2300 HI11 C022-1 1270 214 D 230 D 2300 HI12 C022-1 1270 216 D 230 D 2300 HI01 C022-1 1270 218 D 230 D 2300 HI01 C022-1 1270 221 D 230 D 2300 HI03 C022-1 1270 222 D 230 D 2300 HI04 C022-1 1270 224 D 230 D 2300 HI05 C022-1 1270 228 D 230 D 2300 HI06 C022-1 1270 230 D	-						
D 2300 H 11 C022-1 1270 214 D 2300 H 12 C022-1 1270 216 D 230 D 2300 H 01 C022-1 1270 218 D 230 D 2300 H 01 C022-1 1270 221 D 230 D 2300 H 02 C022-1 1270 222 D 230 D 2300 H 03 C022-1 1270 224 D 230 D 2300 H 04 C022-1 1270 225 D 230 D 2300 H 06 C022-1 1270 231 D 230 D 2300 H 07 C022-1 1270 233 D 230 120 230 230 120 230 230 230 120 230 230 230 120 230 230 230 230 230 230 230 230 230 230						_	
D 2300 H112 C022-1 1270 216 D 2300 H101 C022-1 1270 218 D 230 D 2300 H101 C022-1 1270 221 D 230 D 2300 H102 C022-1 1270 221 D 230 D 2300 H103 C022-1 1270 224 D 230 D 2300 H104 C022-1 1270 225 D 230 D 2300 H105 C022-1 1270 228 D 230 D 2300 H106 C022-1 1270 230 D 230 D 2300 H107 C022-1 1270 231 D 230 D 2300 H109 C022-1 1270 233 D 230 D 230 D 2300 H111 C022-1 1270 234 D 230 D 2300 H103 C022-1 <td>D</td> <td>2300</td> <td> HI11</td> <td>C022-1</td> <td> 1270 214</td> <td></td> <td></td>	D	2300	HI11	C022-1	1270 214		
D 2300 H101 C022-1 1270 218 D 230 D 2300 H101 C022-1 1270 221 D 230 D 2300 H102 C022-1 1270 222 D 230 D 2300 H103 C022-1 1270 224 D 230 D 2300 H104 C022-1 1270 224 D 230 D 2300 H106 C022-1 1270 223 D 230 D 2300 H106 C022-1 1270 223 D 230 D 2300 H107 C022-1 1270 230 D 230 D 2300 H109 C022-1 1270 233 D 230 D 230 D 2300 H101 C022-1 1270 234 D 230 D 2300 H101 C022-1 1270 244 Code ider D 2300 H103 C022-1 1270 <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>_</td> <td></td>	-					_	
D 2300 HI02 C022-1 1270 222 D 2300 HI03 C022-1 1270 224 D 2300 HI04 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 HI07 C022-1 1270 231 D 2300 HI07 C022-1 1270 233 D 2300 HI09 C022-1 1270 234 D 2300 HI11 C022-1 1270 234 D 2300 HI12 C022-1 1270 243 D 2300 HI01 C022-1 1270 243 D 2300 HI01 C022-1 1270 244 D 2300 HI03 C022-1 1270 <t< td=""><td>_</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	_						
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $							
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-						
D 2300 H105 C022-1 1270 227 D 2300 H106 C022-1 1270 228 D 230 D 2300 H107 C022-1 1270 230 D 230 D 2300 H107 C022-1 1270 230 D 230 D 2300 H109 C022-1 1270 231 D 230 D 2300 H109 C022-1 1270 233 D 230 D 2300 H110 C022-1 1270 234 D 230 D 2300 H111 C022-1 1270 236 D 230 D 2300 H101 C022-1 1270 240 D 230 D 2300 H103 C022-1 1270 244 Code ider D 2300 H104 C022-1 1270 248 D 230 D 2300 H105 C022-1 1270 248 D 241 <							
D 2300 H106 C022-1 1270 228 D 2300 D 2300 H107 C022-1 1270 230 D 230 D 2300 H108 C022-1 1270 231 D 230 D 2300 H109 C022-1 1270 231 D 230 D 2300 H109 C022-1 1270 233 D 230 D 2300 H111 C022-1 1270 234 D 230 D 2300 H111 C022-1 1270 234 D 230 D 2300 H101 C022-1 1270 237 D 2300 H101 C022-1 1270 240 D 2300 H103 C022-1 1270 244 D 2300 H104 C022-1 1270 248 D 230 D 2300 H106 C022-1 1270 251 D 2300 H107 C022-1 1270 25	D	2300	HI05	C022-1	1270 227		
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-					_	
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-	•				D	230
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-					_	
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 HI01 C022-1 1270 243 D 2300 HI02 C022-1 1270 243 D 2300 HI03 C022-1 1270 244 D 2300 HI04 C022-1 1270 245 D 2300 HI05 C022-1 1270 246 D 2300 HI05 C022-1 1270 248 D 2300 HI05 C022-1 1270 250 D 2300 HI07 C022-1 1270 251 D 2300 HI08 C022-1 1270 253 D 2300 HI10 C022-1 1270 254 D 2300 HI11 C022-1 1270 <t< td=""><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	-						
D 2300 HI01 C022-1 1270 240 D 2300 HI01 C022-1 1270 243 D 2300 HI01 C022-1 1270 243 D 2300 HI02 C022-1 1270 244 D 2300 HI03 C022-1 1270 244 D 2300 HI04 C022-1 1270 246 D 230 D 2300 HI05 C022-1 1270 248 D 230 D 2300 HI06 C022-1 1270 248 D 230 D 2300 HI06 C022-1 1270 249 D 241 D 2300 HI07 C022-1 1270 250 D 241 D 2300 HI08 C022-1 1270 251 Complete D 2300 HI11 C022-1 1270 256 H 1000 D 2300 HI11 C022-1 1270 256 H	D	2300	HI11	C022-1	1270 236		230
D 2300 HI01 C022-1 1270 243 Code G D 2300 HI02 C022-1 1270 244 Code ider D 2300 HI03 C022-1 1270 244 Code ider D 2300 HI04 C022-1 1270 245 D 230 D 2300 HI04 C022-1 1270 246 D 230 D 2300 HI05 C022-1 1270 248 D 230 D 230 D 2300 HI06 C022-1 1270 248 D 230 D 2300 HI07 C022-1 1270 250 D 2300 HI07 C022-1 1270 253 D 2300 HI09 C022-1 1270 253 D 2300 HI11 C022-1 1270 254 D 2300 HI12 C022-1 1270 256 D 2300 HI12 C022-1 1270 256	-						
D 2300 HI02 C022-1 1270 244 D 2300 HI03 C022-1 1270 244 D 2300 HI03 C022-1 1270 245 D 2300 HI04 C022-1 1270 246 D 230 D 2300 HI05 C022-1 1270 248 D 230 D 2300 HI06 C022-1 1270 249 D 241 D 2300 HI07 C022-1 1270 251 D 230 D 2300 HI07 C022-1 1270 253 D 2300 HI08 C022-1 1270 253 D 2300 HI10 C022-1 1270 254 D 2300 HI11 C022-1 1270 256 D 2300 HI12 C022-1 1270 256 D 2300 HI12 C022-1 1270 256 D 2300 HI01 <	-					Co	de C
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	-	•			·		
D 2300 HI04 C022-1 1270 246 D 230 D 2300 HI05 C022-1 1270 248 D 230 D 2300 HI06 C022-1 1270 249 D 2300 D 241 D 2300 HI06 C022-1 1270 250 D 241 D 2300 HI07 C022-1 1270 250 D 241 D 2300 HI08 C022-1 1270 251 D Complete D 2300 HI10 C022-1 1270 255 Complete D 2300 H111 C022-1 1270 255 H 1000 D 2300 H112 C022-1 1270 258 H 1000 D 2300 H101 C022-1 1270 258 H 1000 D 2300 H102 C022-1 1270 258 H 1000 D 2300 H103 C022-1 <td< td=""><td>-</td><td>•</td><td></td><td></td><td>1</td><td></td><td></td></td<>	-	•			1		
D 2300 HI05 C022-1 1270 248 D 241 D 2300 HI06 C022-1 1270 249 D 241 D 2300 HI07 C022-1 1270 250 D 250 D 2300 HI08 C022-1 1270 251 D Commu D 2300 HI09 C022-1 1270 253 Complete Country of D 2300 HI10 C022-1 1270 255 Complete Country of D 2300 HI11 C022-1 1270 256 H 1000 D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI12 C022-1 1270 258 H 1000 D 2300 HI01 C022-1 1270 258 H 1000 D 2300 HI02 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 <t< td=""><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	-						
D 2300 HI07 C022-1 1270 250 D 2300 HI08 C022-1 1270 251 D 2300 HI09 C022-1 1270 253 D 2300 HI09 C022-1 1270 253 D 2300 HI10 C022-1 1270 254 D 2300 HI11 C022-1 1270 256 D 2300 HI12 C022-1 1270 256 D 2300 HI12 C022-1 1270 256 D 2300 HI01 C022-1 1270 256 D 2300 HI01 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 D 2300 HI03 C022-1 1270 260 D 2010	D	2300	HI05	C022-1		D	
D 2300 HI08 C022-1 1270 251 D 2300 HI09 C022-1 1270 253 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 256 D 2300 HI01 C022-1 1270 258 D 2300 HI02 C022-1 1270 258 D 2300 HI03 C022-1 1270 259 D 2300 HI03 C022-1 1270 259 D 2300 HI03 C022-1 1270 260 D	-	•					
D 2300 HI09 C022-1 1270 253 D 2300 HI10 C022-1 1270 254 Complete D 2300 HI11 C022-1 1270 255 Complete D 2300 HI11 C022-1 1270 255 H 1000 D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI01 C022-1 1270 258 H 1000 D 2300 HI02 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 1270 260 D 2010	-						
D 2300 HI10 C022-1 1270 254 Complete D 2300 HI11 C022-1 1270 255 country of D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI01 C022-1 1270 258 H 1000 D 2300 HI02 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 1270 260 D 2010	-					Co	mmı
D 2300 HI11 C022-1 1270 255 country of D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI01 C022-1 1270 258 H 1000 D 2300 HI02 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 1270 260 D 2010	-					Cor	nplete
D 2300 HI12 C022-1 1270 256 H 1000 D 2300 HI01 C022-1 1270 258 H 1000 D 2300 HI01 C022-1 1270 258 H 1000 D 2300 HI02 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 1270 260 D 2010							ntry o
D 2300 HI02 C022-1 1270 259 H 1000 D 2300 HI03 C022-1 1270 260 D 2010							
D 2300 HI03 C022-1 1270 260 D 2010.	-	•					
		•					
	-					_	
	-						

D	2300	HI05	C022-1	1270 262
	•	HI06		1270 263
	•	HI07		1270 264
		HI08		1270 265
		HI09		1270 266
		HI10		1270 267
		HI11		1270 268
		HI12		1270
		HI01 HI02		1270 271 1270 272
		HI02 HI03		1270 272 1270 273
		HI04		1270 273
		HI05		1270 275
		HI06		1270 276
		HI07		1270 277
		HI08		1270 278
		HI09		1270 279
D	2300	HI10	C022-1	1270 280
D	2300	HI11	C022-1	1270 281
D	2300	HI12	C022-1	1270 282
D	•	HI01		1270 284
D	2300	HI02		1270 285
		HI03		1270 286
		HI04		1270 287
		HI05		1270 287
		HI06		1270 288
		HI07		1270 289
		HI08 HI09		1270 290 1270 290
		HI109		1270 290 1270 291
		HI11		1270 291
		HI12		1270 293
		HI01		1270 294
		HI02		1270 295
		HI03		1270 296
D	2300	HI04	C022-1	1270 297
D	2300	HI05	C022-1	1270 297
D	2300	HI06	C022-1	1270 298
		HI07		1270 299
		HI08		1270 300
		HI09		1270 300
		HI10		1270 301
	•	HI11		1270 302
		HI12		1270 303
		HI01 HI02		1270 304 1270 305
		HI02 HI03		1270 305
		HI04		1270 307
		HI05		1270 307
		HI06		1270 308
D	2300	HI07	C022-1	1270 309
-		HI08		1270 309
_	2300	HI09		1270 310
_	2300	HI10	.	
D	2300	HI11	·	
D	2300	HI12	C022-1	1270 312
	de Qua		_	
		ing the typ	be of unit	or
_	asuremen			14400
D		CRC01		1136 181
D	2410	CTP05	C001-1	355 453

Communication Number

Complete communications number including country or area code when applicable

country or area code when	applic	able
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

	2010AA	PER08	-	364 93
	mmunio	cation N	lumber	
		ing the typ	e of com	munication
H H D D	1000A	PER05 PER07 PER03 PER05	- - -	365 74 365 74 365 75 365 92 365 92 365 92 365 93
Со	ondition	Code		
				n(s) relating to
D D D D D D D D D D D D D D D D	2300 2300 2300 2300 2300 2300 2300	HI01 HI02 HI03 HI04 HI05 HI06 HI07 HI08 HI09 HI10 HI11	C022-2 C022-2 C022-2 C022-2 C022-2 C022-2 C022-2 C022-2 C022-2 C022-2 C022-2 C022-2	1271 300
Со	ndition	Indicat	or	
	de indicatii 2300 2300		ition - -	1321 182 1321 182 1321 183
	ntact F	unction	Code	
იე				or responsibility
	le identify			
Coc of th H	de identifyi ne person 1000A 2010AA	or group PER01	named.	366 74 366 92
Coc of th H D	ne person 1000A	or group PER01 PER01	named.	366 74
Coc of th D D	ne person 1000A 2010AA 2010AA 	or group PER01 PER01	named.	366 74 366 92
Coc of th D Co Fixe	ne person 1000A 2010AA 2010AA	or group PER01 PER01 Amount	named. - t pertainir	366 74 366 92
Coc of th D Fixe con D	ne person 1000A 2010AA 	or group PER01 PER01 Amount	named. - t pertainir	366 74 366 92
Coc of th D Fixe con D Coc	ne person 1000A 2010AA 2010AA 2010AA 2000 2300	Armount CN102 COde ing the sp	t pertainir - ecific cont	366 74 366 92 ng to the 782 158

Percent of charges payable under the contract D | 2300 | CN103 | - |332 159

Contract Type Code

Contract Version Identifier

Identification of additional or supplementalcontract provisions, or identification of aparticular version or modification of contract.D2300CN106-I799T59

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	- 1	26	89
D	2010AB	N404	-	26	
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.

oodo idonaiyin	9 110 0	o unit		
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	3		

Currency Code

Code for country in whos	e curr	ency the ch	arges
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

ASC X12N • INSURANCE SUBCOMMITTEE
TECHNICAL REPORT • TYPE 3

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 D	TP01 -	- 374	149
D 2300 D	TP01 -	- 374	150
D 2300 D	TP01 -	- 374	151
D 2300 D	TP01 -	- 374	152
D 2330B D	TP01 -	- 374	389
D 2400 D	TP01 -	- 374	434
D 2430 D	TP01 -	- 374	486

Delay Reason Code

Code indicating the reason why a request was delayed. D | 2300 | CLM20 | - |1514 147

Demonstration Project Identifier

Description

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							
inpati	ient car	re.					
D	2300	DTP03	1	-	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.

рпу	Sical local	ion, prope	on an in	laiviauai.
Η	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	23301	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.

000	ic quaiityii	ng the typ	C OI CHILLY.	
Н	1000A	NM102	-	1065 72
н	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

-	1065	417
-	1065	421
-	1065	457
-	1065	462
-	1065	467
-	1065	472
	-	- 1065 - 1065 - 1065 - 1065 - 1065 - 1065

Exception Code

Exception code generated by the Third Party

זר	gai	nizatio	n.	

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

External Cause of Injury Code

Code	identify	/in	g the c	au	se of the	e injury.
D	2300	1	HI01		C022-2	1271 194
D	2300	1	HI02		C022-2	1271 196
D	2300	1	HI03		C022-2	1271 198
D	2300	1	HI04		C022-2	1271 200
D	2300	1	HI05		C022-2	1271 202
D	2300	1	HI06		C022-2	1271 204
D	2300	1	HI07		C022-2	1271 206
D	2300	L	HI08		C022-2	1271 208
D	2300	İ	HI09	Ì	C022-2	1271 210
D	2300	1	HI10		C022-2	1271 212
D	2300	L	HI11		C022-2	1271 214
Dİ	2300	1	HI12	Ì	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							
receiv	/er						
D	2300	I	K301		-	449	177

HCPCS Payable Amount

Amount due under Medicare HCPCS system. -|782 **375** D | 2320 | MOA02 |

Hierarchical Child Code

Code indicating if there are hierarchical child data segments subordinate to the level being described. 20004 1700

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

005010X223 • 837 HEALTH CARE CLAIM: INSTITUTIONAL

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**

-	2000/1				020
D	2000B	HL01		-	628 107
D	2000C	HL01	1	-	628 131

Hierarchical Level Code

Code defining the characteristic of a level in a hierarchical structure

			••••				
D	L	2000A		HL03	-	735	78
D		2000B		HL03	-	735	108
D	l	2000C	I.	HL03	-	735	132

Hierarchical Parent ID Number

Identification number of the next higher hierarchical data segment that the data

segn	ient be	mg	descri	bea	is sur	pordinate t	0.
D	2000B		HL02		-	734	108
D	2000C	Ι	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

Н	BHT01	-	1005 68
---	-------	---	----------------

Identification Code Qualifier

Code designating the system/method of code structure used for Identification Code (67)

Suru	cluic used			
H	1000A	NM108	-	66 72
H	1000B	NM108	-	66 77
D	2010AA	NM108	-	66 86
D	2010AC	NM108	-	66 100
D	2010BA	NM108	-	66113
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	1	-	1069	110
D	2000C	PAT01	1	-	1069	. 133
D	2320	SBR02		-	1069	. 355

Insured Group or Policy	Laboratory or Facility State or
NumberThe 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	Province CodeState 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
	Lifetime Psychiatric Days Count
Investigational Device Exemption Identifier Number or reference identifying exemption assigned to an ivestigational device referenced in the claim. D 2300 REF02 - 127	Number of lifetime psychiatric days used for this claim. D 2320 MIA03 - 380
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 - D 2310E N302 - 166	Charges related to this service. D 2400 SV203 - 782
	Line Item Denied Charge or
Laboratory or Facility City	Non-Covered Charge Amount
Name City of the laboratory or facility performing tests billed on the claim where the health care service was performed/rendered.	Line item charges denied or not covered. D 2400 SV207 - 782
D 2310E N401 - 19	Line Note Text Narrative text providing additional information related to the service line. D 2400 NTE02 - 352
Laboratory testing on the claim where the health care service was performed/rendered. D 2310E NM103 - 1035 342	Medical Record Number A unique number assigned to patient by the provider to assist in retrieval of medical records. D 2300 REF02 - 127
Laboratory or Facility Postal Zone or ZIP Code Postal ZIP or zonal code of the laboratory or	Monetary Amount
facility performing tests billed on the claim where the health care service was performed/rendered. D 2310E N403 - 116	Monetary amount. - 782 443 D 2400 HCP02 - 782 443 D 2400 HCP03 - 782 443 D 2400 HCP07 - 782 444
Laboratory or Facility Primary IdentifierIdentifierIdentification number of laboratory or other facility performing laboratory testing on the claim where the health care service was performed/rendered.D 2310E NM109 - 67	National Drug Code The national drug identification number assigned by the Federal Drug Administration (FDA). D 2410 LIN03 - 234
Laboratory or FacilitySecondary IdentifierAdditional identifier for the laboratory or facilityperforming tests billed on the claim where thehealth care service was performed/rendered.D 2310E REF02 - 127	measure as defined by the National Drug Code. D 2410 CTP04 - 380 452

005010X223 • 837 HEALTH CARE CLAIM: INSTITUTIONAL

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 23	320 MIA19	-	782	372
D 23	320 MOA09) -	782	376

Note Reference Code

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

D 230	00 NTE0	1	-	363	178
D 230	00 NTE0	1	-	363	180
D 240	00 NTE0	1	-	363	441

Occurrence Code

A code defining a significant event relating to

this b	oll that m	nay affec	ct p	ayer pro	cessing.	
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

repor	ted in t	his	comp	osi	te eleme	ent.
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.

opun	or augo				
Ď	2300	HI01	C022-2	1271 25	58
D	2300	HI02	C022-2	1271 25	59
D	2300	HI03	C022-2	1271 26	60
D	2300	HI04	C022-2	1271 26	51
D	2300	HI05	C022-2	1271 26	62
D	2300	HI06	C022-2	1271 26	53
D	2300	HI07	C022-2	1271 26	64
D	2300	HI08	C022-2	1271 26	65
D	2300	HI09	C022-2	1271 26	66
D	2300	HI10	C022-2	1271 26	67

D	2300	Ι	HI11	Ι	C022-2	1271 268
Dİ	2300	Ì	HI12	Ì	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	1	HI03		C022-4	1251 261			
D	2300	1	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		-	1036	327
D 2420A	NM104	-	1036	457

Operating Physician Last Name

Last name of the physician performing the

prin	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

perf	orming t	he princi	pal	procedu	ure.	
D	2310B	NM10	5	-	1037	327
D	2420A	NM10	5	-	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	Э.	
D 2310B NM109	-	67 328
D 2420A NM109	-	67 458

	onal id		or th		cian performing	
) 2	310B	procedu REF02 REF02	:	-	127 33 127 46	
						_
		or Appli ion Ide				
		tion num		-	ntifies a	
ansa vsterr		within the	or	iginator's	s applications	
		BHT03	;	-	127 6	9
)the	r Dia	ignosis	2			-
		osis for th		claim.		
	2300	HI01	I	C022-2	1271	
	2300 2300	HI02 HI03		C022-2 C022-2		
) j	2300	HI04	į	C022-2	1271 22	25
	2300 2300	HI05 HI06			1271 22 1271 22	
	2300	HI07	i		1271 23	
	2300	HI08	1		1271 23	
	2300 2300	HI09 HI10		C022-2 C022-2	1271 23 1271 23	
) į	2300	HI11	i	C022-2	1271 23	6
	2300	HI12		C022-2	1271 23	87
						-
Othe	r Ins	ured A	dc	litiona	1	
	r Ins tifier	ured A	dc	litiona	1	
dent umbe	t ifier er prov	viding ad			<i>I</i>	
dent umbe her i	t ifier er prov nsured	viding ad d.	diti		ntification of the	
d ent umbe her i	t ifier er prov nsured	viding ad	diti			
umbe iher i 0 2	t ifier er prov nsureo 2330A	viding ad d.	diti !	onal idei -	ntification of the	
dent umbe ther in 0 2 Dthe ddres	tifier er prov nsured 2330A r Ins ss line	viding ad d. REF02	diti 	onal ider - dress l tional ins	ntification of the 127 38 L ine	
dent umbe her in) 2 Dthe ddres divid	tifier er prov nsured 2330A er Ins ss line ual's r	viding ad d. REF02 s ured A e of the ad mailing ad	diti 	onal ider - dress l tional ins	ntification of the 127 38 Line sured	-
denti umbe her in 0 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	tifier er prov 2330A er Ins ss line ual's r 2330A	viding ad d. REF02 s ured A e of the ad mailing ad	diti 	onal ider - <i>fress I</i> tional ins ess.	ntification of the 127 38 L ine	3
dent umbe her in 0 2 Dthe ddres divid 0 2 0 2	tifier er prov 2330A er Ins ss line ual's r 2330A 2330A	viding ad d. REF02 e of the ac mailing ac N301 N302	diti 	onal iden	ntification of the 127 38 Line sured 166 38 166 38	33
dent umbe her in 0 2 0 the ddres divid 0 2 0 2 0 2 0 2	tifier er provinsured 2330A er Ins ss line ual's r 2330A 2330A 2330A	viding ad d. REF02 sured A e of the ad mailing ad N301 N302	ditid 2 ddit ddit 1 Xity	onal ider - tional ins ess. - - / Name	ntification of the 127 38 Line sured 166 38 166 38	33
denti umbe her ii) 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	tifier er provinsured 2330A er Ins 2330A 2330A 2330A 2330A 2330A 2330A 2330A 2330A 2330A	viding ad d. REF02 e of the ac mailing ac N301 N302	ditid 2 ddit ddit 1 Xity	onal ider - tional ins ess. - - / Name	ntification of the 127 38 Line sured 166 38 166 38	33
Jeni umbe her in 0 2 Othe ddivid 0 2 Othe divid 0 2 Othe divid o 2	tifier er provinsured 2330A er Ins ss line ual's r 2330A 2330A 2330A 2330A 2330A 2330A 2330A 2330A 2330A	viding ad d. REF02 a of the ac mailing ac N301 N302 cured C me of the	diti diti ddit ddit ddr l city add	onal iden	ntification of the 127 38 Line sured 166 38 166 38	33
deni umbe her iii)) 0 0 0 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 2	tifier er prov nsurec 2330A er Ins ss line ual's r 2330A 2330A er Ins ty nam ual. 2330A	viding ad d. REF02 a of the ac mailing ac N301 N302 cured C me of the	dition dition didittion didi	onal ider - tional ins ess. - - / Name ditional in	htification of the 127 38 Line sured 166 38 166 38 e nsured 19 38	33
deni umbe her ii) 2 Dthe ddres dd	tifier r provinsured r Ins ss line ual's r Ins r Ins r Ins r Ins sst p nam ual.	viding ad d. REF02 a of the ad mailing ad N301 N302 a cured C me of the N401	dition dition didittion didit	onal ider Iress I ional ins ess. - ditional in - st Nam	ntification of the 127 38 Line sured 166 38 166 38 P nsured 19 38 P	33

Name of the group or plan through which the insurance is provided to the other insured. D | 2320 | SBR04 | - |93......356

her Insured Identifier

dentification number, assigned by the third y payer, to identify the additional insured /idual. 2330A | NM109 | -|67 **379**

her Insured Last Name

last name of the additional insured /idual. 2330A | NM103 | - |1035 378

her Insured Middle Name

he middle name of th	e ado	ditiona	al insured	
ndividual.				
D 2330A NM105		-	1037	378

her Insured Name Suffix

suffix to the name of the additional insured /idual. 2330A | NM107 | - |1039 378

her Insured Postal Zone or Code

The I	The Postal ZIP code of the additional insured									
indivi	idual's n	nai	ling ad	dres	s.					
D	2330A	L	N403	1	-	116 382				

her Insured State Code

state code of the additional insured vidual's mailing address. 2330A | N402 | |156 382

her Operating Physician st Name

First Name of the individual performing a									
secondary surgical procedure or assisting the									
Operating Physician.									
D 2310C NM104	1	-	1036 332						
D 2420B NM104	1	-	1036 462						

her Operating Physician entifier

National identifier for the individual performing a							
secondary surgical procedure or assisting the							
Operating Physician.			-				
D 2310C NM109	1	-	67	333			
D 2420B NM109	Ì	-	67	463			

her Operating Physician Last Name

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

sperating i njeretarn								
D	2310C	NM103	1	-	1035	332		
D	2420B	NM103	1	-	1035	462		

Other Operating Physician	Othe
Middle Name or Initial	Phys
Middle name or initial of the individual	The no
performing a secondary surgical procedure or	the inc
assisting the Operating Physician.	proced
D 2310C NM105 - 1037	D 2
Other Operating Physician	Othe
	Code
Name Suffix	The ZI
Suffix to the name of the individual performing a secondary surgical procedure or assisting the	addres
Operating Physician.	
D 2310C NM107 - 1039	
D 2420B NM107 - 1039 462	Othe
	An ide
Other Payer Address Line	D 2 D 2
Address line of the other payer's mailing	D 2
address.	D 2 D 2
D 2330B N301 - 166	D 2
Other Dever Attending Provider	Othe
Other Payer Attending Provider	Num
Secondary Identifier	
The non-destination (COB) payer's attending provider identification.	The no author
D 2330C REF02 - 127 399	D 2
Other Payer Billing Provider	Othe
Identifier	or Re
The non-destination (COB) payer's identifier for	The no
the provider or organization in whose name the	author
bill is submitted and to whom payment should	D 2
be made. D 2330I REF02 - 127	
	Othe
	Ident
Other Payer City Name	The no
The city name of the other payer's mailing	provid
address. D 2330B N401 - 19	D 2
-	
	Othe
Other Payer Claim Adjustment	Prov
Indicator	The no
Indicates the other payer has made a previous claim adjustment to this claim.	provid
D 2330B REF02 - 127 394	D 2
Other Payer Lest er	Othe
Other Payer Last or	Ident
Organization Name	Additic
The name of the other payer organization. D 2330B NM103 - 1035	organi D 2

D | 2330B | NM103 | - |1035 385

Other Payer Operating Provider Secondary Identifier

Other Payer Other Operating Physician Secondary Identifier

Other Payer Postal Zone or ZIP Code

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							
auth	orization	n numbe					
D	2330B	REF02	2	-	127	392	

Other Payer Prior Authorization or Referral Number

ther Payer Referring Provider Ientifier

Other Payer Rendering Provider Secondary Identifier

Other Payer Secondary Identifier

Additional identifier for the other payer organization D | 2330B | REF02 | - |127......**391**

Other Payer Service Facility Location Identifier

Other Payer State Code The state or province code of the other payer's	PPS-Operating Hospital Specific DRG Amount
mailing address. D 2330B N402 - 156 387	Sum of hospital specific operating portion of DRG amount for this claim as output by PPS-PRICER.
Other Payer's Claim Control	D 2320 MIA14 - 782 371
Number	
A number assigned by the other payer to	Paid Service Unit Count
identify a claim. The number is usually referred	Units of service paid by the payer for
to as an Internal Control Number (ICN), Claim	coordination of benefits.
Control Number (CCN) or a Document Control	D 2430 SVD05 - 380 479
Number (DCN).	
D 2330B REF02 - 127	Patient Address Line
Other Provider Secondary	Address line of the street mailing address of the
Identifier	patient. D 2010CA N301 - 166 137
Additional identification number of the other provider as defined by the payer organization. D 2310C REF02 - 127	D 2010CA N302 - 166
D 2420B REF02 - 127 465	Patient Birth Date
	Date of birth of the patient.
	D 2010CA DMG02 - 1251 140
PPS-Capital DSH DRG Amount	
PPS-capital disproportionate share amount for	
this claim as output by PPS-PRICER.	Patient City Name
D 2320 MIA11 - 782 371	The city name of the patient.
	D 2010CA N401 - 19 138
PPS Capital Example Amount	
PPS-Capital Exception Amount	Patient Control Number
A per discharge payment exception paid to the	
hospital. It is a flat-rate add-on to the PPS payment.	Patient's unique alpha-numeric identification
D 2320 MIA24 - 782 373	number for this claim assigned by the provider to facilitate retrieval of individual case records
	and posting of payment.
	D 2300 CLM01 - 1028
PPS-Capital FSP DRG Amount	
PPS-capital federal portion for this claim as	
output by PPS-PRICER.	Patient First Name
D 2320 MIA09 - 782 371	The first name of the individual to whom the
	services were provided.
PPS-Capital HSP DRG Amount	D 2010CA NM104 - 1036 136
Hospital-Specific portion for PPS-capital for this claim as output by PPS-PRICER.	Patient Gender Code
D 2320 MIA10 - 782	A code indicating the sex of the patient.
	D 2010CA DMG03 - 1068
PPS-Capital IME amount	
PPS-capital indirect medical expenses for this	Patient Last Name
claim as output by PPS-PRICER.	The last name of the individual to whom the
D 2320 MIA13 - 782 371	services were provided.
	D 2010CA NM103 - 1035 136
BBC Operating Federal Specific	
PPS-Operating Federal Specific	Patient Middle Name or Initial
DRG Amount	
Sum of federal operating portion of the DRG	The middle name or initial of the individual to
amount this claim as output by PPS-PRICER.	whom the services were provided.
D 2320 MIA16 - 782 372	D 2010CA NM105 - 1037 136
	Patient Name Suffix
	Suffix to the name of the individual to whom the
	sums to the name of the individual to whom the services were provided.
	D 2010CA NM107 - 1039

Patient Postal Zone or ZIP Code	Pay-To Plan State or Province
The ZIP Code of the patient.	Code
D 2010CA N403 - 116 139	State or province code of the Pay-to Plan. D 2010AC N402 - 156
Patient Reason For Visit	
The diagnosis code describing the patient's reason for visit at the time of outpatient registration.	Pay-To Plan Tax Identification Number
D 2300 HI01 C022-2 1271	Tax identification number of the plan to whom payment should be made.D 2010AC REF02 - 127106
Patient Responsibility Amount	Pay-to Address City Name
The amount determined to be the patient's responsibility for payment. D 2300 AMT02 - 782	City name of the entity to receive payment. D 2010AB N401 - 19
Detient State Code	Pay-to Address Postal Zone or
Patient State Code	ZIP Code
The State Postal Code of the patient. D 2010CA N402 - 156 138	Postal code of the entity to receive payment (for example, ZIP code). D 2010AB N403 - 116
Patient Status Code	
A code indicating the patient's status at the date	Pay-to Address State Code
of admission, outpatient service, or start of care. D 2300 CL103 - 1352 153	State or sub-country code of the entity to receive payment. D 2010AB N402 - 156
Pay-To Address Line	
Address line of the provider to receive payment.	Pay-to Plan Secondary
D 2010AB N301 - 166	Identifier
D 2010AB N302 - 166	Additional identifier for the Pay-To Plan. D 2010AC REF02 - 127 104
Pay-To Plan Address Line	
Street address of the Pay-To Plan.	Payer Additional Identifier
D 2010AC N301 - 166101 D 2010AC N302 - 166101	Additional identifier for the payer. D 2010BB REF02 - 127128
Pay-To Plan City Name	Payer Address Line
City name of the Pay-To Plan.	Address line of the Payer's claim mailing
D 2010AC N401 - 19 102	address for this particular payer organization identification and claim office.
Pay-To Plan Organizational	D 2010BB N301 - 166
Name	D 2010BB N302 - 166 124
Organization name of the health plan that is	
seeking reimbursement (Pay-To Plan).	Payer City Name
D 2010AC NM103 - 1035 100	The City Name of the Payer's claim mailing address for this particular payer ID and claim office.
Pay-To Plan Postal Zone or ZIP Code	D 2010BB N401 - 19 125
Postal zone or ZIP code of the Pay-To Plan.	Payer Claim Control Number
D 2010AC N403 - 116 103	A number assigned by the payer to identify a claim. The number is usually referred to as an
Pay-To Plan Primary Identifier	Internal Control Number (ICN), Claim Control
Identification number for the Pay-To Plan. D 2010AC NM109 - 67	Number (CCN) or a Document Control Number (DCN). D 2300 REF02 - 127

Payer Ide Number ider D 2010BB	tifying the			123	D D D D D D	2300
Payer Na	me				DI	
Name identif D 2010BB	ying the pa			123	D D D D	2300 2300 2300 2300
Payer Pai	d Amou	int			D	
The amount D 2320	paid by the	e payer oi			D D D D D	2300 2300 2300
Payer Pos	stal Zon	e or ZIF	P Code		D	2300
The ZIP Cod address for t identification D 2010BB	e of the Pa his particu and claim N403	ayer's clai lar payer office. -	m mailing organizatio 116		Prici item D	cing M ing met has be 2300 2400
Payer Res		inty See	quence		- 1	2.00
Number C Code identify responsibility D 2000B D 2320	/ing the ins	ment of a	claim		The esta resp	ncipa diagno blished oonsible patient
Payer Sta	te Code)			D	2300
State Postal address for t identification D 2010BB	Code of th his particu and claim	e Payer's lar payor office.	organizatio	n	Cod proc	ncipa e identi luct or s 2300
Peer Rev		horizati	on			
	ew Auu	10112211	011			-
Number Authorization organization D 2300	after revie	w comple	ted.	175	Date perf	e on wh ormed. 2300
Policy Co	mnliand	e Code	`		Dri	or Au
The code tha D 2300 D 2400	-	s policy co			A nu serv auth orga	imber, o rices pro lorized anization
Prescript	ion Nun	nber			D	2300
The unique i the pharmac	dentificatio y or suppli	on number er to the p	prescription		Pro	ocedu
D 2410	REF02	- 1	127	455		e identi
					serv D	1Ce. 2300
Present o Code which whether the of adimission	provides a diagnosis	n indicatio	on as to ent at the tir		D D D D	2300 2300 2300 2300
D 2300		C022-9	1073		D D	2300 2300
D 2300 D 2300 D 2300 D 2300 D 2300 D 2300	HI02 HI03	C022-9 C022-9 C022-9 C022-9 C022-9	1073 1073 1073 1073	197 199 201	D D D D	2300 2300 2300 2300 2300

	0000		11107		0000 0	4070 007
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	İ	HI11	- İ	C022-9	1073 236
D	2300	İ	HI12	- İ	C022-9	1073 238

Methodology

ethodology at which the claim or line een priced or repriced.

	nom nao boon prioda or reprioda.								
D	2300	HCP01	-	1473	314				
D	2400	HCP01	-	1473	443				

al 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	

al Procedure Code

tifying the principal procedure, service. | HI01 | C022-2 |1271...... 240

al Procedure Date

hich the Principal Procedure was | HI01 | C022-4 |1251...... 240

uthorization Number

code or other value that indicates the rovided on this claim have been by the payee or other service on. | REF02 | -|127 **165**

ure Code

tifying the procedure, product or

servic	ce.					
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	
Dİ	2300	HI11	- İ	C022-2	1271 255	
Dİ	2300	HI12	- İ	C022-2	1271 257	

D

Dİ

2300

2300

HI05

HI06

C022-9

| 1073 **203**

C022-9 |1073...... 205

	ire Code	-	
Procedure	Code and re	elated data	
Procedu	ire Date		
Date when performed.	the health c	are proce	edure was
D 2300	HI01	C022-4	1251 243
D 2300 D 2300		C022-4	1251 245 1251 246
D 2300	HI04	C022-4	1251 247
D 2300 D 2300		C022-4	1251 248 1251 250
D 2300	HI07	C022-4	1251 251
D 2300 D 2300		C022-4	1251 252 1251 253
D 2300	HI10	C022-4	1251 255
D 2300 D 2300		C022-4 C022-4	1251 256 1251 257
Procedu	ıre Modifi	er	
	ies special c nance of the		nces related to
D 2400	SV202	C003-3	1339 426
D 2400 D 2400		C003-4 C003-5	1339 426 1339 427
D 2400	SV202	C003-6	1339 427
D 2430 D 2430		C003-3 C003-4	1339 478 1339 478
D 2430	SVD03	C003-5	1339 478
D 2430	SVD03	C003-6	1339 479
	or Servic	e ID	
Product		a product	
dentifying	number for a		123/ //5
dentifying	number for a		234 445
dentifying D 2400		-	
dentifying D 2400 Product Code ident	HCP08	ce ID Qu	u alifier of the
dentifying D 2400 Product Code ident descriptive	HCP08	ce ID Qu	ualifier
dentifying D 2400 Product Code ident descriptive 234). D 2400	HCP08	c e ID Qu pe/source ed in Prod	of the uct/Service ID 235 425
dentifying D 2400 Product Code ident descriptive 234). D 2400 D 2400	HCP08	c e ID Qu pe/source ed in Prod C003-1	ualifier of the uct/Service ID 235
dentifying D 2400 Product Code ident lescriptive 234). D 2400 D 2400 D 2410	HCP08 <i>or Servic</i> ifying the typ number use SV202 HCP09 LIN02	c e ID Qu pe/source ed in Prod C003-1	ualifier of the uct/Service ID 235
dentifying D 2400 Product	HCP08 <i>or Servic</i> ifying the typ number use SV202 HCP09 LIN02	c e ID Qu be/source ed in Prod C003-1 -	ualifier of the uct/Service ID 235
dentifying D 2400 Product 2400 Code ident descriptive 234). D 2400 D 2400 D D 2400 D D 2400 D D 2400 D D 2400 D D 2400 D D 2430 D	HCP08 or Servic ifying the typ number use SV202 HCP09 LIN02 SVD03 V Casualt	c e ID Qu be/source ed in Prod C003-1 C003-1	ualifier of the uct/Service ID 235
dentifying D 2400 Product Code ident descriptive 234). D 2400	HCP08 or Servic ifying the typ number use SV202 HCP09 LIN02 SVD03 y Casualt	Ce ID Qu be/source ed in Prod C003-1 - C003-1 y Claim	ualifier of the uct/Service ID 235 235 235 235 235 235 235 235
dentifying D 2400 Product 2400 Code ident descriptive 234). D 2400 D 2400 D D 2400 D D 2400 D D 2400 D D 2400 D D 2430 D Property Number dentification	HCP08 or Servic ifying the typ number use SV202 HCP09 LIN02 SVD03 on number for	ce ID Qu be/source ed in Prod C003-1 - C003-1 y Claim pr property	ualifier of the uct/Service ID 235 235 235 235 235 235 (1) (2) <
dentifying D 2400 Product Code ident descriptive 234). D 2400 D 2400 D 2410 D 2430 Property Number dentification associated D 2010B.	HCP08 or Servic ifying the typ number use SV202 HCP09 LIN02 SVD03 on number for	ce ID Qu be/source ed in Prod C003-1 C003-1 C003-1 y Claim pr property vices ider	ualifier of the uct/Service ID 235 235 235 235 235 235 235 235

Code identifying the type of provider. D | 2000A | PRV01 | 1221 80 D | 2310A | PRV01 | 1221 322

005010X223 • 837 HEALTH CARE CLAIM: INSTITUTIONAL

Provider Taxonomy Code						
Code designating the provider type,						
classification, and spec	cializa	tion.				
D 2000A PRV03	-	· 12	7 80			
D 2310A PRV03	-	· 12	7 322			

Quantity

lumeric value of quantity.		
D 2400 HCP12	-	380 447

Rate

Rate expressed in the standard monetary						
denoi	minatio	n for the c	urrer	ncy sp	ecified.	
D	2400	HCP05		-	118	444

Receiver Name

Na	me	e of org	ar	nization	rece	eiving	the transa	ction.
н		1000B		NM103		-	1035	

Receiver Primary Identifier

Prim	nary ident	ification n	umber for	the receiver of	of
the t	transactio	on.			
ΗI	1000B	NM109	- 1	67	. 77

Reference Identification

The identification value assigned by the sender						
for th	is parti	cular trans	actio	n.		
D	2400	HCP04		-	127	. 444
D	2400	HCP06		-	127	. 444

Reference Identification Qualifier

Code qualifying the reference identification.

COU	ie qualityli	ng the ren	erence lue	nuncation.
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 D	00000	REF01	-	128 392
י ט		REF01	-	128
	2330B	REF01	-	128 394
D	2330B	REF01	-	128
D	2330C	REF01	-	128 398
D	2330C	REF01	-	128 398
D	2330D	REF01	-	128 402
D D	2330E 2330F	REF01 REF01	-	128 406
DI	2330F	REF01	-	128 410 128 414
D D	2330G 2330H	REF01	-	128 414
DI	23301	REF01		128 418
DI	23301	REF01		128 435
	2400	REF01		128 437
	2400	REF01		128 438
	2400	REF01		128 454
DI	2420A	REF01	_	128 459
DI	2420A	REF04	C040-1	128 460
DI		REF01	-	128 464
	2420B	REF04	C040-1	128 465
DI	2420D	REF01		128 469
DI		REF04	C040-1	128 470
DI		REF01	-	128 474
DI		REF04	C040-1	128 475
Refe D	erral auth 2300	lumber orization r REF02	-	127 163
Refe D Re The D	ferring first nam ent to the 2310F	orization r REF02 Provide e of provid	e r First der who re of service	
Refe D Re The D D D Re	ferring first nam ent to the 2310F 2420D ferring identifica sician. 2310F	orization r REF02 Provide e of provider provider of NM104	er First der who re of service	Name eferred the on this claim. 1036 350 1036 472

Name or Initial

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

ASC X12N • INSURANCE SUBCOMMITTEE TECHNICAL REPORT • TYPE 3

Referring Provider Secondary

		entification patient fo			or the provider
reie	ning the j	pallent 10	1 2614	ice.	
D	2310F	REF02	1	-	127 353
D	2420D	REF02	1	-	127 475

Reimbursement Rate

Rate used when payment is based upon a					
perce	ntage	of applicable	e charge	s.	
D	2320	MOA01	-	954	374

Reject Reason Code

Code	assigr	ned by issu	ier to	ident	ify reason fo	r
reject	ion.					
D	2300	HCP13	1	-	901	317
D	2400	HCP13	1	-	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						

	2300		-	1303 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 C	ther Pa	ayer.		-	-		
D	2320	AMT02	-	782	365		
D	2430	AMT02	-	782	487		

Rendering Provider First Name

The first name of the p the service.	provid	ler wł	no performed	
D 2310D NM104 D 2420C NM104		-	1036 1036	

Rendering Provider Identifier

The identifier assigned by the Payor to the						
provider who performe	ed the	e serv	ice.			
D 2310D NM109	1	-	67	338		
D 2420C NM109	1	-	67	468		

Rendering Provider Last Name

The last name of the provi	ider v	vho perform	ed
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	Repriced Line Item Reference
Name suffix of the provider who has provided	Number
the services to the patient. D 2310D NM107 - 1039	Identification number of a line item repriced by a
D 2420C NM107 - 1039	third party or prior payer. D 2400 REF02 - 127
Rendering Provider Secondary	Repriced Saving Amount
Identifier	The amount of savings related to Third Party
Additional identifier for the provider providing	Organization claims.
care to the patient.	D 2300 HCP03 - 782 314
D 2310D REF02 - 127 340 D 2420C REF02 - 127 470	
	Repricer Received Date
	Date the claim was received by the repricer
Repriced Allowed Amount	organization.
The maximum amount determined by the	D 2300 DTP03 - 1251 152
repricer as being allowable under the provisions of the contract prior to the determination of the	
actual payment.	Repricing Organization
D 2300 HCP02 - 782 314	Identifier
	Reference or identification number of the
Repriced Approved Amount	repricing organization.
The amount allowed by the repricer for the	D 2300 HCP04 - 127 315
claim or service line net of adjustments.	
D 2300 HCP07 - 782315	Repricing Per Diem or Flat Rate
	Amount
Repriced Approved DRG Code	Amount used to determine the flat rate or per
The Diagnosis Related Group approved by the	diem price by the repricing organization.
repricer for payment for this claim	D 2300 HCP05 - 118 315
D 2300 HCP06 - 127 315	
	Service Authorization
Repriced Approved HCPCS	Exception Code
Code	Code identifying the service authorization
The HCPCS code that describes the services	exception. D 2300 REF02 - 127 161
as approved by the repricer. D 2400 HCP10 - 234 446	
	Service Date
Repriced Approved Revenue	Date of service, such as the start date of the
Code	service, the end date of the service, or the
UB92 revenue code approved by the repricer	single day date of the service.
for payment on the claim.	D 2400 DTP03 - 1251 434
D 2300 HCP08 - 234 316	
	Service Line Paid Amount
Repriced Approved Service	Amount paid by the indicated payer for a
Unit Count	service line
Number of service units approved by pricing or	D 2430 SVD02 - 782 477
repricing entity.	
D 2300 HCP12 - 380 316	Service Line Revenue Code
	UB92 Revenue Code pertaining to the service
Repriced Claim Reference	line. D 2400 SV201 - 234
Number	
Identification number, assigned by a repricing	Comise Tou Amount
organization, to identify the claim.	Service Tax Amount
D 2300 REF02 - 127 167	The amount of service tax or surcharge applicable to the reported service.
	D 2400 AMT02 - 782

	I
Service Unit Count	Subscriber First Name
The quantity of units, times, days, visits,	The first name of the insured individual or
services, or treatments for the service described by the HCPCS codes, revenue code or	subscriber to the coverage. D 2010BA NM104 - 1036113
procedure code.	
D 2400 SV205 - 380 428	Subscriber Gender Code
	Code indicating the sex of the subscriber to the
Statement From and To Date	indicated coverage or policy.
The date of the start or end of the period covered on the claim.	D 2010BA DMG03 - 1068119
D 2300 DTP03 - 1251 150	Subscriber Group Name
	Name of the group through which the coverage
Submitter Contact Name Name of the person at the submitter	is provided to the subscriber. D 2000B SBR04 - 93 110
organization to whom inquiries about the transaction should be directed.	
H 1000A PER02 - 9374	Subscriber Group or Policy Number
Submitter First Name	The identifier assigned by the health plan or
The first name of the person submitting the	administrator to identify the group through
transaction or receiving the transaction, as identified by the preceding identification code. H $1000A$ NM104 - 1036	which the coverage is provided to the subscriber. D 2000B SBR03 - 127110
	Subscriber Last Name
Submitter Identifier	The surname of the insured individual or
Code or number identifying the entity submitting the claim. H 1000A NM109 - 6772	subscriber to the coverage. D 2010BA NM103 - 1035113
	Subscriber Middle Name or
Cubmitten Leet en Onneninetien	Initial
Submitter Last or Organization Name	The middle name or initial of the subscriber to
The last name or the organizational name of the	the indicated coverage or policy.
entity submitting the transaction H 1000A NM103 - 103572	D 2010BA NM105 - 1037113
	Subscriber Name Suffix
Submitter Middle Name or Initial	Suffix of the insured individual or subscriber to
The middle name or initial of the person	the coverage.
submitting the transaction. H 1000A NM105 - 103772	D 2010BA NM107 - 1039113
	Subscriber Postal Zone or ZIP
Subcaribar Address Line	Code
Subscriber Address Line	The ZIP Code of the insured individual or
Address line of the current mailing address of the insured individual or subscriber to the	subscriber to the coverage. D 2010BA N403 - 116 117
coverage. D 2010BA N301 - 166 115	
D 2010BA N302 - 166 115	Subscriber Primary Identifier
	Primary identification number of the subscriber
Subscriber Birth Date	to the coverage.
The date of birth of the subscriber to the	D 2010BA NM109 - 67114
indicated coverage or policy. D 2010BA DMG02 - 1251 118	
	Subscriber State Code
Subaaribar City Nama	The State Postal Code of the insured individual
Subscriber City Name	or subscriber to the coverage. D 2010BA N402 - 156
The City Name of the insured individual or subscriber to the coverage.	
D 2010BA N401 - 19 116	

Subscriber Supplemental Identifier	
dentifies another or additional distinguishing code number associated with the subscriber. D 2010BA REF02 - 127	120
Terms Discount Percentage	
Discount percentage available to the payer fo payment within a specific time period. D 2300 CN105 - 338	
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 th SE segments including the ST and SE	е
segments. D SE01 - 96	488
Transaction Set Control	
Number	
The unique identification number within a	
transaction set. H ST02 - 329	
D SE02 - 329	488
Transaction Set Creation Date	
Identifies the date the submitter created the	
transaction.	60
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 th	e
physician.	
D 2300 HI01 C022-2 1271 D 2300 HI02 C022-2 1271	
D 2300 HI03 C022-2 1271	306
D 2300 HI04 C022-2 1271 D 2300 HI05 C022-2 1271	
D 2300 HI06 C022-2 1271	308

D	2300	I	HI10	Ι	C022-2	1271 311
Dİ	2300	Í.	HI11	Ì.	C022-2	1271
D	2300		HI12		C022-2	1271 312

nit or Basis for Measurement ode

de specifying the units in which a value is ing expressed, or manner in which a easurement has been taken.

D	2300	HCP11	-	355 3	316
Dİ	2400	SV204	-	355 4	128
D	2400	HCP11	-	355 4	47

alue Added Network Trace umber

ique Identification number for a transaction signed by a Value Added Network, earinghouse, or other transmission entity. | 2300 | REF02 | - |127 171

alue Code

code that identifies data of a monetary nature at is necessary for processing this claim as quired 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

alue Code Amount

nount associated with the value code ported in this composite element

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

ersion, Release, or Industry lentifier

ode indicating the version, release, b-release and industry identification of the I standard being used. | ST03 | |1705 **67** -

D

D

D |

2300

2300

2300 HI09

Т

HI07

HI08

C022-2 | 1271 309

| C022-2 |1271 309

| C022-2 |1271...... 310

