

The Ohio Bureau of Workers' Compensation  
30 W. Spring Street  
Columbus, OH 43215-2256  
1-800-OHIOBWC  
www.ohiobwc.com



# EDI IMPLEMENTATION DOCUMENTATION

## Health Partnership Program *for* Managed Care Organizations and Health Care Providers

ANSI ASC X12Version 4010

**837**

Institutional  
Health Care Claim

**837**

Professional  
Health Care Claim

**835**

Health Care Claim Payment/Advice

**277**

Health Care Claim Status Notification

**997**

Functional Acknowledgment

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## **GENERAL INFORMATION**

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## **A. EDI DOCUMENTATION OVERVIEW**

These guidelines define the supported data transmission mechanisms as well as the X12 transaction sets that will be used by the Providers for the Health Partnership Program (HPP).

The minimum acceptable data transmission method is a modem connection at 28,800 baud. Other methods may be acceptable by mutual agreement between the MCO and the provider or their representative.

This document contains processing guidelines for the following ANSI ASC X12 Version 4010 transaction sets:

- 837 Health Care Claim - Institutional
- 837 Health Care Claim – Professional
- 835 Health Care Claim Payment/Advice
- 277 Health Care Claim Status Notification
- 997 Functional Acknowledgment

## **B. CONTRACT INFORMATION**

Each provider or their representative should negotiate an EDI Trading Partner Agreement with each MCO.

## **C. LIST OF CONTACTS**

The initial contact information for each MCO and billing intermediary is identified in the MCO and Billing Intermediary Contacts document found at <http://www.ohiobwc.com/provider/services> under the Electronic Billing tab. Please contact these individuals to initiate negotiations for the Trading Partner Agreement or to resolve any issues you may have regarding this process.

## **D. EDI PRODUCTION PROCESSING**

The ISA, GS, and ST control numbers for any transaction set must be unique from prior transmissions. Also the control numbers in the ISA and the corresponding IEA must match, the control numbers in the GS and the corresponding GE must match, and the control numbers in the ST and the corresponding SE must match.

**X12 837 – version 004010**  
**Health Care Claim: Institutional (for UB-92 users)**

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## **A. 837 OVERVIEW – Institutional Version (for UB-92 Users)**

Providers will use the X12 837 Health Care Claim transaction set (inbound) to submit medical bills to MCOs for review. The medical bills submitted using the institutional version should be for services billed on the UB-92. BWC's Billing and Reimbursement Manual states which provider types are eligible to bill on this form. The guidelines in the Billing and Reimbursement Manual apply to all bills submitted in the X12 837 format.

If the X12 837 meets the criteria in this implementation guide, the MCO will consider the bill for payment.

MCOs will send an X12 997 Functional Acknowledgment for each 837 received. Refer to the section on 997 Functional Acknowledgment Processing for more information.

Expectations for inbound data elements are listed alphabetically in the Business Rules Matrix. "Mandatory" means that providers must gather and transmit the data elements in the 837 transaction. "Expected" means that the providers must gather and transmit the data elements in the 837 transaction, when applicable to the bill. "Optional" means that providers should send these data elements, if available. More specific information is included in the "Notes" column.

The cross-reference to the Implementation Guide is in the column titled "Location within X12 837". This column identifies the segment that contains the data, the position of the segment in the X12 837 standard, and the position within the segment where the data element is located and the conditions needed to extract the data. Example: The data element "Admit Date" is contained in a DTP segment located at position 2/135 (in the X12 standard, Table 2/Detail, position 135). It also notes that the data element is in DTP03, the third element in the DTP segment, and contains the "Admit Date" when the DTP01 element of the DTP segment equals "435."

**B. 837 HL STRUCTURE – INST**

The following figure details the overall looping structure of the X12 837:

PROVIDER (Billing Intermediary/Pay-to Provider HL03='20')

SUBSCRIBER (Injured Worker HL03='22')

CLAIM

SERVICE LINE(S)

CLAIM

SERVICE LINE(S)

SUBSCRIBER (Injured Worker HL03='22')

CLAIM

SERVICE LINE(S)

PROVIDER (Billing Intermediary/Pay-to Provider HL03='20')

SUBSCRIBER (Injured Worker HL03='22')

CLAIM

SERVICE LINE(S)

SUBSCRIBER (Injured Worker HL03='22')

CLAIM

SERVICE LINE(S)

CLAIM

SERVICE LINE(S)

CLAIM

SERVICE LINE(S)

**C. 837 BUSINESS RULES MATRIX – INST**

<b>UB92 Form Box</b>	<b>Data Element</b>	<b>Mandatory, Expected or Optional</b>	<b>Location within X12 837 v4010 (Segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
	Billing Intermediary Name	E	NM1,2/015; NM103, when NM101='85', and NM102='2'	Name of the entity submitting the bill, if different from the trading partner identified in the transaction header.  Organizational Names larger than 35 bytes are continued in the N2 segment.
	Billing Intermediary Address	E	N3,2/025; N301, when NM101='85'	Address of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary City	E	N4,2/030; N401, when NM101='85'	City of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary State	E	N4,2/030; N402, when NM101='85'	State of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary Zip	E	N4,2/030; N403, when NM101='85'	Zip of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary ID	E	NM1,2/015; NM109 when NM101='85' and NM108='FI'	ID of the entity submitting the bill, if different from the trading partner identified in the transaction header.
1	Pay to Provider Name	M	NM1,2/015; NM103, when NM101='87' and NM102='2'	Organizational Names larger than 35 bytes are continued in the N2 segment.
1	Pay to Provider Address	M	N3,2/025; N301, when NM101='87'	
1	Pay to Provider City	M	N4,2/030; N401, when NM101='87'	
1	Pay to Provider State	M	N4,2/030; N402, when NM101='87'	
1	Pay to Provider Zip	M	N4,2/030; N403, when NM101='87'	
3	Patient control no.	M	CLM,2/130; CLM01	Use to identify the patient account number for this transaction.
4 4	Type of Bill - pos 1-2 Type of Bill - pos 3	M M	CLM,2/130; CLM05-C02301 CLM,2/130; CLM05-C02303	Used to identify the type of hospitalization service required. Data elements in this group are used to determine the 3-digit bill type defined for the UB-92 form.  Valid values are 111-114 for inpatient bills, and 131-134 for outpatient bills.

**C. 837 BUSINESS RULES MATRIX – INST**

UB92 Form Box	Data Element	Mandatory, Expected or Optional	Location within X12 837 v4010 (Segment, table/position) and Mapping Criteria	Notes
6	Beginning date of service	M	DTP,2/135; DTP03 (pos 1-8) when DTP01='472' and DTP02= 'RD8'	Used to report the service dates for this bill. This is the beginning date from the 'Statement Covers Period' field.
6	Ending date of service	M	DTP,2/135; DTP03 (pos 10-17) when DTP01='472' and DTP02= 'RD8'	Used to determine the ending date of service for this bill. This is the ending date from the 'Statement Covers Period' field.
7	Days Covered	M	QTY,2/240; QTY02 when QTY01= 'CA'	Used to identify the number of days covered on a hospital bill.
12	Injured worker's first name	M	NM1,2/015; NM104 when NM101='IL', and NM102='1'	Used to identify the injured worker.
12	Injured worker's last name	M	NM1,2/015; NM103 when NM101='IL', and NM102='1'	Used to identify the injured worker.
12	Injured worker's middle name	E	NM1,2/015; NM105 when NM101='IL', and NM102='1'	Used to identify the injured worker.
12	Injured worker's suffix	E	NM1,2/015; NM107 when NM101='IL', and NM102='1'	Used to identify the injured worker.
14	Injured worker's date of birth	M	DMG,2/032; DMG02, when DMG01='D8'	Used to identify the injured worker's date of birth.
15	Injured worker gender code	O	DMG,2/032; DMG03	Used to identify the injured worker's sex.
17	Admit date	M	DTP,2/135; DTP03 (pos 1-8) when DTP01='435'	Used to indicate the hospital admission date in CCYYMMDD. <b>Mandatory for inpatient hospital bills only.</b>
18	Admit hour	M	DTP,2/135; DTP03 (pos 9-12) when DTP01='435'	Used to determine the hospital admission time in HHMM. Only used for hospital bills. Mandatory for inpatient hospital bills only. Valid values are 0000-2359.
19	Admission type	M	CL1,2/140; CL101	Used to identify the hospital admission type. <b>Mandatory for inpatient hospital bills only.</b>
20	Admission source	M	CL1,2/140; CL102	Used to identify the referring source of admission. <b>Mandatory for inpatient hospital bills only.</b>
21	Discharge hour	M	DTP,2/135; DTP03 when DTP01='096' and DTP02='TM'	Used to determine the discharge time for a hospital stay. <b>Mandatory for inpatient hospital bills only.</b> Valid values are 0000-2359.
22	Patient status	M	CL1,2/140; CL103	Used to identify the status of the patient during the statement covers period. <b>Mandatory for inpatient hospital bills only.</b>

**C. 837 BUSINESS RULES MATRIX – INST**

<b>UB92 Form Box</b>	<b>Data Element</b>	<b>Mandatory, Expected or Optional</b>	<b>Location within X12 837 v4010 (Segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
23	Medical record number	M	REF,2/035; REF02 when REF01='EA'	Used to identify the medical record number for this bill.
24 -30	Condition codes	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BG', where nn is any HI element number 01-12. Up to 7 HI data elements may be used.	Condition codes are required on hospital bills when applicable.
32 -35 (a-b)	Occurrence codes	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BH', where nn is any HI element number 01-12. Up to 8 HI data elements may be used.	Used to identify the occurrence code. Required on hospital bills when applicable. Date of injury should be indicated using occurrence code 04. <b>Date of injury is required on all bills.</b>
32 -35 (a-b)	Occurrence date	E	HI,2/231; HIInn-C02204 when HIInn-C02201= 'BH' and HIInn-C02203='D8', where nn is any HI element number 01-12. Up to 8 HI data elements may be used.	Used to identify the date of the occurrence. When the occurrence code is 04, the date in this data element should be the date of injury. <b>Date of injury is required on all bills.</b>
36 (a-b)	Occurrence span beginning date	E	HI,2/231; HIInn-C02204 (pos 1-8) when HIInn-C02201= 'BI' and HIInn-C02203='RD8', where nn is any HI element number 01-12. Up to 2 HI data elements may be used.	Used to identify the beginning date of the occurrence. Required on hospital bills when applicable.
36 (a-b)	Occurrence span ending date	E	HI,2/231; HIInn-C02204 (pos 10-17) when HIInn-C02201= 'BI' and HIInn-C02203='RD8', where nn is any HI element number 01-12. Up to 2 HI data elements may be used.	Used to identify the ending date of the occurrence. Required on hospital bills when applicable.
36 (a-b)	Occurrence Span Code	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BI', where nn is any HI element number 01-12. Up to 2 HI data elements may be used.	
39-41 (a-d)	Value code	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BE', where nn is any HI element number 01-12. The associated amount must be in the same HI element. Up to 12 HI data elements may be used.	Used to identify the value code. Required on hospital bills when applicable.
39-41 (a-d)	Value code amount	E	HI,2/231; HIInn-C02205 when HIInn-C02201= 'BE', where nn is any HI element number 01-12. The associated code must be in the same HI element. Up to 12 HI data elements may be used.	Use to identify the value amount. Required on hospital bills when applicable.
42	Line item revenue code	M	SV2,2/375; SV201	<b>Mandatory for hospital bills only.</b>

**C. 837 BUSINESS RULES MATRIX – INST**

UB92 Form Box	Data Element	Mandatory, Expected or Optional	Location within X12 837 v4010 (Segment, table/position) and Mapping Criteria	Notes
44	Line item procedure code	M	SV2,2/375; SV202-C00302	Used to identify the line item procedure performed. Mandatory for specific revenue codes on outpatient bills only. Refer to the BWC Billing and Reimbursement Manual for list of revenue codes that require HCPCS level I, II or III codes. Data is required in this element to meet ANSI/HIPAA standars. If business rules do not require a procedure code, the following numeric value should be submitted: "00000".
44	Hospital accommodation daily rate	E	SV2,2/375; SV206	Used to identify the daily hospital room rate. Required for each line item where a revenue code in the 100-219 range is billed.
45	Line item date of service	M	DTP,2/455;DTP03 when DTP01= '472' and DTP02= 'D8'	Used to identify the line item start service date. <b>Mandatory for all outpatient hospital bills. Optional for inpatient facility bills.</b>
46	Line item units of service provided	M	SV2,2/375; SV205, when SV204='DA' or 'UN'	Used to identify the units of service provided for this line item.
47	Line item billed charges from the provider	M	SV2,2/375; SV203	Used to identify the line item charges from the provider.
51	Pay to Provider ID	M	NM1,2/015; NM109 when NM101='87' and NM108='FI'	Used to identify the provider who will receive the payment.
52	Patient medical release indicator	M	CLM,2/130; CLM09	Used to identify if injured worker has signed a medical release or not.
53	Injured Worker Benefits Assignment Indicator	M	CLM,2/130;CLM08	Used to determine if payment goes to provider or injured worker.
55	Total amount billed by provider	M	CLM,2/130; CLM02	Used to identify the total charges submitted by the provider for this bill.
60	Injured worker's SSN	E	REF,2/035; REF02 when REF01='SY'	Used to identify the injured worker's social security number for this claim.
62	Claim number	M	NM1,2/015; NM109 when NM101='IL' and NM108='MI'	Used to identify the BWC assigned claim number for this date of injury.
67	Principal diagnosis code	M	HI,2/231; HInn-C02202 when HInn-C02201= 'BK'	Used to identify the injured worker's principal diagnosis code for this service.
68 thru 75	Other diagnosis	E	HI,2/231; HInn-C02202 when HInn-C02201= 'BF', where nn is any HI element number 01-12.	Used to identify other diagnosis for injured worker.

**C. 837 BUSINESS RULES MATRIX – INST**

<b>UB92 Form Box</b>	<b>Data Element</b>	<b>Mandatory, Expected or Optional</b>	<b>Location within X12 837 v4010 (Segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
76	Admit diagnosis code	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BJ'	Used to identify the diagnosis at the time of hospital admission. <b>Mandatory for inpatient hospital bills only.</b>
80	Principal procedure code	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BR'	Used to identify the ICD-9 procedure billed on a hospital. <b>Mandatory for inpatient hospital bills only.</b>
80	Principal procedure date	O	HI,2/231; HIInn-C02204 when HIInn-C02201= 'BR' and HIInn-C02203= 'D8'	Used to identify the date the ICD-9 procedure was performed.
81 (a-e)	Other procedure codes	O	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BQ', where nn is any HI element number 01-12. Up to 5 HI data elements may be used.	Used to identify other procedures performed on the patient.
81 (a-e)	Other procedure date	O	HI,2/231; HIInn-C02204 when HIInn-C02201= 'BQ' and HIInn-C02203= 'D8', where nn is any HI element number 01-12. Up to 5 HI data elements may be used.	Used to identify other procedure dates.
82	Attending Provider Name	E	NM1, 2/250; NM103 (Last) and NM104 (First) when NM101='71'	Organizational Names larger than 35 bytes are continued in the N2 segment.
82	Attending Provider ID	E	NM1, 2/250; NM109, when NM101='71' and NM108='FI'	
83	Other Provider Name	O	NM1, 2/250; NM103 (Last) and NM104 (First) when NM101='73'	Organizational Names larger than 35 bytes are continued in the N2 segment.
83	Other Provider ID	O	NM1, 2/250; NM109, when NM101='73' and NM108='FI'	
	MCO Name	O	NM1,2/015; NM103 when NM101='PR'	Name of MCO who will receive the bill.
	MCO Number	O	NM1,2/015; NM103 when NM101='PR', and NM108='PI'	Use BWC assigned 5-digit ID number of MCO who will receive the bill.
	Service Facility Name	O	NM1,2/015; NM103, when NM101='FA' and NM102='2'	The Service Facility NM1 loop and associated segments (N2, N3 & N4) are only used when the service was rendered at a different location than what is specified on the Billing or Pay-To Provider NM1 loops. Organizational Names longer than 35 bytes are continued in the N2 segment.
	Service Facility Address	O	N3,2/025; N301, when NM101='FA'	See note pertaining to Service Facility Name.
	Service Facility City	O	N4,2/030; N401, when NM101='FA'	See note pertaining to Service Facility Name.
	Service Facility State	O	N4,2/030; N402, when NM101='FA'	See note pertaining to Service Facility Name.
	Service Facility Zip	O	N4,2/030; N403, when NM101='FA'	See note pertaining to Service Facility Name.

**D. 837 SUMMARY OF SEGMENTS USED – INST****Table 1 Header**

Pos No.	Seg ID	Name	
	ISA	Interchange Control Header	
	GS	Functional Group Header	
005	ST	Transaction Set Header	
010	BHT	Beginning of Hierarchical Transaction	(Transaction Creation Date)
015	REF	Reference Numbers	(Institutional Claim Submission Type)
020	NM1	Individual or Organizational Name	(Submitter Name)
045	PER	Administrative Communications Contact	(Submitter EDI contact)

**Table 2 Detail**

Pos No.	Seg ID	Name	
<b>001 HL</b>	<b>Hierarchical Level</b>		<b>(Billing/Pay-to Provider, HL03='20')</b>
015	NM1	Individual or Organizational Name	(Billing Intermediary Name and ID)
020	N2	Additional Name Information	(Billing Intermediary Name greater than 35 characters)
025	N3	Address Information	(Billing Intermediary Address)
030	N4	Geographic Location	(Billing Intermediary City, State, Zip)
015	NM1	Individual or Organizational Name	(Pay-to Provider Name and ID)
020	N2	Additional Name Information	(Pay-to Provider Name greater than 35 characters)
025	N3	Address Information	(Pay-to Provider Address)
030	N4	Geographic Location	(Pay-to Provider City, State, Zip)
<b>001 HL</b>	<b>Hierarchical Level</b>		<b>(Injured Worker Loop, HL03='22')</b>
005	SBR	Subscriber Information	(Payer Responsibility code, Individual Relationship code, Workers' Compensation Filing Indicator)
015	NM1	Individual or Organizational Name	(Injured Worker Name and Claim Number)
032	DMG	Demographic Information	(Injured Worker Birth Date and Gender)
035	REF	Reference Numbers	(Injured Worker SSN)
035	REF	Reference Numbers	(Medical Record Number)
015	NM1	Individual or Organizational Name	(MCO Name and MCO Number)
130	CLM	Health Claim	(Patient Account Number, Total Amount Billed by Provider, Type of Bill, Injured Worker Benefits Assignment Indicator, Patient Medical Release Indicator)
135	DTP	Date or Time or Period	(Discharge Hour)
135	DTP	Date or Time or Period	(Beginning and Ending Dates of Service)
135	DTP	Date or Time or Period	(Admit Date and Hour)
140	CL1	Claim Codes	(Admission Type, Admission Source, Patient Status)
231	HI	Health Care Information Codes	(Value Codes, Admit Diagnosis Code, Principle Diagnosis Code, Principle Procedure Code and Date, Condition Codes, Occurrence Codes, Occurrence Span, Other Diagnosis Codes, Occurrence Date, Other Procedure Date, Occurrence Span Begin & End Dates, Value Code Amount)
240	QTY	Quantity	(Covered Days)
250	NM1	Individual or Organizational Name	(Attending Provider Name and ID)
260	N2	Additional Name Information	(Attending Provider Name greater than 35 characters)

**D. 837 SUMMARY OF SEGMENTS USED – INST****Table 2 Detail**

<b>Pos No.</b>	<b>Seg ID</b>	<b>Name</b>	
250	NM1	Individual or Organizational Name	(Other Provider Name and ID)
260	N2	Additional Name Information	(Other Provider Name greater than 35 characters)
250	NM1	Individual or Organizational Name	(Other Provider Name and ID)
260	N2	Additional Name Information	(Other Provider Name greater than 35 characters)
250	NM1	Individual or Organizational Name	(Service Facility Name)
260	N2	Additional Name Information	(Service Facility Name greater than 35 characters)
265	N3	Address Information	(Service Facility Address)
270	N4	Geographic Location	(Service Facility City, State, Zip)
365	LX	Assigned Number	(Line Item Number)
375	SV2	Institutional Service	(Line Item: Revenue Code, Procedure Code, Billed Charges, Units of Service, Hospital Accommodation Daily Rate)
455	DTP	Date or Time or Period	(Line Item Date of Service)
555	SE	Transaction Set Trailer	
	GE	Functional Group Trailer	
	IEA	Interchange Control Trailer	

## **E. 837 IMPLEMENTATION GUIDE – INST**

The 837 Implementation Guide contains the detailed structure of the X12 837 document. It includes:

- a graphical depiction of the X12 837 looping structure
- all ASC X12 semantic and syntax notes
- indicators identifying mandatory and optional segments according to X12 rules
- indicators identifying mandatory, optional, and conditional data elements according to X12 rules
- indicators identifying which data elements of the used segments are used and not used
- subsets of valid code values used for ID type data elements
- notes specifying MCO's usage of the 837

The notes are included throughout the document in *italics*. These note the MCO's usage of the 837 transaction set, segments, data elements and codes. Required data elements on optional segments are only required when the segment is used.

# 837 Health Care Claim: Institutional

Functional Group ID=**HC**

## Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

## Notes:

>> *Mandatory for Institutional 837*  
 X *Not Used*

## Heading:

	<b>Pos. No.</b>	<b>Seg. ID</b>	<b>Name</b>	<b>Req. Des.</b>	<b>Max.Use</b>	<b>Loop Repeat</b>	<b>Notes and Comments</b>
>>	005	ST	Transaction Set Header	M	1		
>>	010	BHT	Beginning of Hierarchical Transaction	M	1		
>>	015	REF	Reference Identification	O	3		
LOOP ID - 1000						10	
>>	020	NM1	Individual or Organizational Name	O	1		n1
>>	045	PER	Administrative Communications Contact	O	2		

## Detail:

	<b>Pos. No.</b>	<b>Seg. ID</b>	<b>Name</b>	<b>Req. Des.</b>	<b>Max.Use</b>	<b>Loop Repeat</b>	<b>Notes and Comments</b>
LOOP ID - 2000						>1	
>>	001	HL	Hierarchical Level	M	1		
	005	SBR	Subscriber Information	O	1		
LOOP ID - 2010						10	
>>	015	NM1	Individual or Organizational Name	O	1		n2
	020	N2	Additional Name Information	O	2		
	025	N3	Address Information	O	2		
	030	N4	Geographic Location	O	1		
	032	DMG	Demographic Information	O	1		
	035	REF	Reference Identification	O	20		

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		LOOP ID - 2300		100
>>	130	CLM	Health Claim	O 1
>>	135	DTP	Date or Time or Period	O 150
>>	140	CL1	Claim Codes	O 1
>>	231	HI	Health Care Information Codes	O 25
	240	QTY	Quantity	O 10
		LOOP ID - 2310		9
	250	NM1	Individual or Organizational Name	O 1 n3
	260	N2	Additional Name Information	O 2
	265	N3	Address Information	O 2
	270	N4	Geographic Location	O 1
		LOOP ID - 2400		>1
>>	365	LX	Assigned Number	O 1 n4
>>	375	SV2	Institutional Service	O 1
>>	455	DTP	Date or Time or Period	O 15
>>	555	SE	Transaction Set Trailer	M 1

**Transaction Set Notes**

1. Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
2. 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.
3. Loop 2310 contains information about the rendering, referring, or attending provider.
4. Loop 2400 contains Service Line information.

**Segment:** **ST** Transaction Set Header  
**Position:** 005  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the start of a transaction set and to assign a control number  
**Syntax Notes:**  
**Semantic Notes:** 1 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).  
**Comments:**

**Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	
>>	ST01	143	<b>Transaction Set Identifier Code</b> Code uniquely identifying a Transaction Set 837 Health Care Claim <i>Required</i>	M ID 3/3
>>	ST02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>The ST02 value must equal the SE02 value.</i>	M AN 4/9

**Segment:** **BHT** **Beginning of Hierarchical Transaction**  
**Position:** 010  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

**Syntax Notes:****Semantic Notes:**

- 1 BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
- 2 BHT04 is the date the transaction was created within the business application system.
- 3 BHT05 is the time the transaction was created within the business application system.

**Comments:****Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>		<u>Attributes</u>
>>	<b>BHT01</b>	<b>1005</b>	<b>Hierarchical Structure Code</b>	<b>M ID 4/4</b>
			Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	
			0019 Information Source, Subscriber, Dependent	
>>	<b>BHT02</b>	<b>353</b>	<b>Transaction Set Purpose Code</b>	<b>M ID 2/2</b>
			Code identifying purpose of transaction set	
			00 Original	
>>	<b>BHT03</b>	<b>127</b>	<b>Reference Identification</b>	<b>O AN 1/30</b>
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			<i>Originator Application Transaction Identifier.</i>	
			<i>Use the reference identifier to identify the inventory file number of the transmission assigned by the submitter's system.</i>	
>>	<b>BHT04</b>	<b>373</b>	<b>Date</b>	<b>O DT 8/8</b>
			Date expressed as CCYYMMDD	
			<i>Transaction Set Creation Date.</i>	
			<i>Use this date to identify the date on which the submitter created the file.</i>	
>>	<b>BHT05</b>	<b>337</b>	<b>Time</b>	<b>O TM 4/8</b>
			Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	
			<i>Transaction Set Creation Time.</i>	
			<i>Use this time to identify the time of day that the submitter created the file.</i>	
>>	<b>BHT06</b>	<b>640</b>	<b>Transaction Type Code</b>	<b>O ID 2/2</b>
			Code specifying the type of transaction	
			CH Chargeable	

<b>Segment:</b>	<b>REF</b> Reference Identification
<b>Position:</b>	015
<b>Loop:</b>	
<b>Level:</b>	Heading
<b>Usage:</b>	Optional (Must Use)
<b>Max Use:</b>	3
<b>Purpose:</b>	To specify identifying information
<b>Syntax Notes:</b>	<ol style="list-style-type: none"> <li>1 At least one of REF02 or REF03 is required.</li> <li>2 If either C04003 or C04004 is present, then the other is required.</li> <li>3 If either C04005 or C04006 is present, then the other is required.</li> </ol>
<b>Semantic Notes:</b>	1 REF04 contains data relating to the value cited in REF02.
<b>Comments:</b>	

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
		87	Functional Category An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc	
>>	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Claim Submission Type, when REF01='87'. This element must be 'X096' to denote the X12 837 Institutional Implementation Guide is being used.</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **NM1 Individual or Organizational Name**  
**Position:** 020  
**Loop:** 1000 Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.

## Data Element Summary

	<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual 41 Submitter Entity transmitting transaction set	M ID 2/3
>>	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity 2 Non-Person Entity	M ID 1/1
>>	NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <i>Submitter Last or Organization Name</i>	O AN 1/35
X	NM104	1036	<b>Name First</b> Individual first name	O AN 1/25
X	NM105	1037	<b>Name Middle</b> Individual middle name or initial	O AN 1/25
X	NM106	1038	<b>Name Prefix</b> Prefix to individual name	O AN 1/10
X	NM107	1039	<b>Name Suffix</b> Suffix to individual name	O AN 1/10
>>	NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) 46 Electronic Transmitter Identification Number (ETIN) A unique number assigned to each transmitter and software developer	X ID 1/2
>>	NM109	67	<b>Identification Code</b> Code identifying a party or other code <i>Submitter Identifier</i>	X AN 2/80
X	NM110	706	<b>Entity Relationship Code</b> Code describing entity relationship	X ID 2/2
X	NM111	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

**Segment:** **PER Administrative Communications Contact**  
**Position:** 045  
**Loop:** 1000 Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 2  
**Purpose:** To identify a person or office to whom administrative communications should be directed  
**Syntax Notes:**

- 1 If either PER03 or PER04 is present, then the other is required.
- 2 If either PER05 or PER06 is present, then the other is required.
- 3 If either PER07 or PER08 is present, then the other is required.

**Semantic Notes:**  
**Comments:**

## Data Element Summary

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	PER01	366	<b>Contact Function Code</b> M ID 2/2
		Code identifying the major duty or responsibility of the person or group named	
		IC Information Contact	
	PER02	93	<b>Name</b> O AN 1/60
		Free-form name	
		<i>Submitter Contact Name</i>	
>>	PER03	365	<b>Communication Number Qualifier</b> X ID 2/2
		Code identifying the type of communication number	
		EM Electronic Mail	
		FX Facsimile	
		TE Telephone	
>>	PER04	364	<b>Communication Number</b> X AN 1/80
		Complete communications number including country or area code when applicable	
		<i>Complete 10 digit communications number including area code or e-mail address.</i>	
	PER05	365	<b>Communication Number Qualifier</b> X ID 2/2
		Code identifying the type of communication number	
		EM Electronic Mail	
		FX Facsimile	
		TE Telephone	
	PER06	364	<b>Communication Number</b> X AN 1/80
		Complete communications number including country or area code when applicable	
		<i>Complete 10 digit communications number including area code or e-mail address.</i>	
	PER07	365	<b>Communication Number Qualifier</b> X ID 2/2
		Code identifying the type of communication number	
		EM Electronic Mail	
		FX Facsimile	
		TE Telephone	
	PER08	364	<b>Communication Number</b> X AN 1/80
		Complete communications number including country or area code when applicable	
		<i>Complete 10 digit communications number including area code or e-mail address.</i>	

<b>X</b>	<b>PER09</b>	<b>443</b>	<b>Contact Inquiry Reference</b>	<b>O AN 1/20</b>
			Additional reference number or description to clarify a contact number	

**Segment:** **HL Hierarchical Level**  
**Position:** 001  
**Loop:** 2000 Mandatory  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments  
**Syntax Notes:**  
**Semantic Notes:**  
**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. The HL segment defines a top-down/left-right ordered structure.
- 2 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.
- 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
- 4 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.
- 5 HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	HL01	628	<b>Hierarchical ID Number</b> M AN 1/12 A unique number assigned by the sender to identify a particular data segment in a hierarchical structure
	HL02	734	<b>Hierarchical Parent ID Number</b> O AN 1/12 Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to <i>HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. This is the value of the HL01 element from the prior HL segment where HL03='20'.</i>  <i>Not used for the Billing/Pay-to Provider level, when HL03='20'.</i> <i>Required for the Injured Worker level, when HL03='22'.</i>
>>	HL03	735	<b>Hierarchical Level Code</b> M ID 1/2 Code defining the characteristic of a level in a hierarchical structure 20 Information Source Identifies the payor, maintainer, or source of the information <i>Use this code for the Billing/Pay-to Provider Level</i> 22 Subscriber Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits <i>Use this code for the Injured Worker Level</i>

>>	<b>HL04</b>	<b>736</b>	<b>Hierarchical Child Code</b>	<b>O ID 1/1</b>
			Code indicating if there are hierarchical child data segments subordinate to the level being described	
			<i>The claim loop (Loop-ID-2300) can only be used when HL04='0'.</i>	
		0	No Subordinate HL Segment in This Hierarchical Structure.	
			<i>Use this code when HL03='22'.</i>	
		1	Additional Subordinate HL Data Segment in This Hierarchical Structure.	
			<i>Use this code when HL03='20'.</i>	

**Segment:** **SBR** **Subscriber Information**  
**Position:** 005  
**Loop:** 2000 Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To record information specific to the primary insured and the insurance carrier for that insured  
**Syntax Notes:**  
**Semantic Notes:**

- 1 SBR02 specifies the relationship to the person insured.
- 2 SBR03 is policy or group number.
- 3 SBR04 is plan name.
- 4 SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer; an "N" value indicates the payer is not the destination payer.

**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed from segment usage since the SBR segment is not used at HL03=20 level. SBR is still a "Must Use" segment when HL03=22.*

**Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>		<u>Attributes</u>
>>	<b>SBR01</b>	<b>1138</b>	<b>Payer Responsibility Sequence Number Code</b>	<b>M ID 1/1</b>
			Code identifying the insurance carrier's level of responsibility for a payment of a claim	
		P	Primary	
>>	<b>SBR02</b>	<b>1069</b>	<b>Individual Relationship Code</b>	<b>O ID 2/2</b>
			Code indicating the relationship between two individuals or entities	
			<i>Patient's Relationship to Insured.</i>	
		18	Self	
			<i>This code must be used, since the patient (injured worker) is always the same person as the subscriber (insured) for Workers Compensation claims.</i>	
X	<b>SBR03</b>	<b>127</b>	<b>Reference Identification</b>	<b>O AN 1/30</b>
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
X	<b>SBR04</b>	<b>93</b>	<b>Name</b>	<b>O AN 1/60</b>
			Free-form name	
X	<b>SBR05</b>	<b>1336</b>	<b>Insurance Type Code</b>	<b>O ID 1/3</b>
			Code identifying the type of insurance policy within a specific insurance program	
X	<b>SBR06</b>	<b>1143</b>	<b>Coordination of Benefits Code</b>	<b>O ID 1/1</b>
			Code identifying whether there is a coordination of benefits	
X	<b>SBR07</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O ID 1/1</b>
			Code indicating a Yes or No condition or response	
X	<b>SBR08</b>	<b>584</b>	<b>Employment Status Code</b>	<b>O ID 2/2</b>
			Code showing the general employment status of an employee/claimant	
>>	<b>SBR09</b>	<b>1032</b>	<b>Claim Filing Indicator Code</b>	<b>O ID 1/2</b>
			Code identifying type of claim	
		WC	Workers' Compensation Health Claim	

**Segment:** **NM1 Individual or Organizational Name**  
**Position:** 015  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.  
**Notes:** *This segment is used in the Billing/Pay-To Provider Level, when HL03='20'.*  
*This segment is used in the Injured Worker/MCO Level, when HL03='22'.*

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	NM101	98	<b>Entity Identifier Code</b> <b>M ID 2/3</b>
			Code identifying an organizational entity, a physical location, property or an individual <i>The entity identifier code in NM101 applies to all segments in Loop ID-2010.</i>
		85	Billing Provider
		87	Pay-to Provider
		IL	Insured or Subscriber <i>Use this code for the Injured Worker.</i>
		PR	Payer <i>Use this code to identify the MCO.</i>
>>	NM102	1065	<b>Entity Type Qualifier</b> <b>M ID 1/1</b>
			Code qualifying the type of entity
		1	Person <i>Use this code when NM101='IL'.</i>
		2	Non-Person Entity <i>Use this code when NM101='85', '87', or 'PR'.</i>
	NM103	1035	<b>Name Last or Organization Name</b> <b>O AN 1/35</b>
			Individual last name or organizational name <i>Billing Intermediary Organization Name, when NM101='85', and NM102='2'.</i> <i>Pay-To Provider Organization Name, when NM101='87', and NM102='2'.</i> <i>Injured Worker Last Name, when NM101='IL', and NM102='1'.</i> <i>MCO Name, when NM101='PR' and NM102='2'.</i> <i>If Billing Intermediary Organization Name and/or Pay-To Provider Organization Name are longer than 35 bytes the name is continued in the N2 segment.</i>
			UB-92 Form Location 1, Line 1, when NM101='87'.
			UB-92 Form Location 12, when NM101='IL'.
	NM104	1036	<b>Name First</b> <b>O AN 1/25</b>
			Individual first name <i>Injured Worker First Name, when NM101='IL', and NM102='1'.</i>
			UB-92 Form Location 12, when NM101='IL'.
	NM105	1037	<b>Name Middle</b> <b>O AN 1/25</b>
			Individual middle name or initial <i>Injured Worker Middle Initial, when NM101='IL', and NM102='1'.</i>
			UB-92 Form Location 12, when NM101='IL'.

X	NM106	1038	<b>Name Prefix</b> Prefix to individual name	O AN 1/10
	NM107	1039	<b>Name Suffix</b> Suffix to individual name <i>Injured Worker Name Suffix, when NM101='IL', and NM102='I'.</i> UB-92 Form Location 12, when NM101='IL'.	O AN 1/10
>>	NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number <i>Use this code when NM101='85' or '87'.</i> MI Member Identification Number <i>Use this code when NM101='IL'.</i> PI Payor Identification <i>Use this code for MCO Number.</i>	X ID 1/2
>>	NM109	67	<b>Identification Code</b> Code identifying a party or other code <i>Billing Intermediary ID, when NM101='85' and NM108='FI'.</i> <i>Pay-To Provider ID, when NM101='87' and NM108='FI'.</i> <i>Claim Number, when NM101='IL' and NM108='MI'.</i> <i>MCO Number, when NM101='PR' and NM108='PI'.</i> UB-92 Form Location 51a, when NM101='87' and NM108='FI'. UB-92 Form Location 62, when NM101='IL' and NM108='MI'.	X AN 2/80
X	NM110	706	<b>Entity Relationship Code</b> Code describing entity relationship	X ID 2/2
X	NM111	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

**Segment:** **N2 Additional Name Information**  
**Position:** 020  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify additional names or those longer than 35 characters in length  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *Use when names are longer than 35 bytes for:  
 Billing Provider (when NM101=85)  
 Pay-To Provider (when NM101=87)*

**Data Element Summary**

	<b>Ref.</b>	<b>Data</b>	<b>Name</b>	<b>Attributes</b>
	<b>Des.</b>	<b>Element</b>	<b>Name</b>	
>>	N201	93	Name Free-form name <i>Contains additional name text as an extension of the value in NM103 when the name is longer than 35 bytes.</i>	M AN 1/60
X	N202	93	Name Free-form name	O AN 1/60

**Segment:** **N3** **Address Information**  
**Position:** 025  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Billing/Pay-to Provider Level, when HL03='20'.*

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	N301	166	<b>Address Information</b> Address information <i>Billing Intermediary Address Line, when NM101='85'.</i> <i>Pay-To Provider Address Line, when NM101='87'.</i> UB-92 Form Location 1, Line 2, when NM101='87'	M AN 1/55
X	N302	166	<b>Address Information</b> Address information	O AN 1/55

**Segment:** **N4 Geographic Location**  
**Position:** 030  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify the geographic place of the named party  
**Syntax Notes:** 1 If N406 is present, then N405 is required.  
**Semantic Notes:**  
**Comments:** 1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.  
 2 N402 is required only if city name (N401) is in the U.S. or Canada.  
**Notes:** *This segment is only used in the Billing/Pay-to Provider Level, when HL03='20'.*  
 HCFA 1500 Form Location 33, when NM101='85'.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
N401	19	<b>City Name</b> Free-form text for city name <i>Billing Intermediary City Name, when NM101='85'.</i> <i>Pay-To Provider City Name, when NM101='87'.</i> UB-92 Form Location 1, Line 3, when NM101='87'.	O AN 2/30
N402	156	<b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <i>Billing Intermediary State Code, when NM101='85'.</i> <i>Pay-To Provider State Code, when NM101='87'.</i> UB-92 Form Location 1, Line 3, when NM101='87'.	O ID 2/2
N403	116	<b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <i>Billing Intermediary Zip Code, when NM101='85'.</i> <i>Pay-To Provider Zip Code, when NM101='87'.</i> UB-92 Form Location 1, Line 3, when NM101='87'.	O ID 3/15
X	N404	26 <b>Country Code</b> Code identifying the country	O ID 2/3
X	N405	309 <b>Location Qualifier</b> Code identifying type of location	X ID 1/2
X	N406	310 <b>Location Identifier</b> Code which identifies a specific location	O AN 1/30

**Segment:** **DMG Demographic Information**  
**Position:** 032  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply demographic information  
**Syntax Notes:** 1 If either DMG01 or DMG02 is present, then the other is required.  
**Semantic Notes:** 1 DMG02 is the date of birth.  
 2 DMG07 is the country of citizenship.  
 3 DMG09 is the age in years.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>		<u>Attributes</u>
DMG01	1250	<b>Date Time Period Format Qualifier</b>		<b>X ID 2/3</b>
		Code indicating the date format, time format, or date and time format		
		D8 Date Expressed in Format CCYYMMDD		
DMG02	1251	<b>Date Time Period</b>		<b>X AN 1/35</b>
		Expression of a date, a time, or range of dates, times or dates and times		
		<i>Injured Worker Birth Date.</i>		
		UB-92 Form Location 14.		
DMG03	1068	<b>Gender Code</b>		<b>O ID 1/1</b>
		Code indicating the sex of the individual		
		<i>Injured Worker Gender Code.</i>		
		UB-92 Form Location 15.		
		F Female		
		M Male		
		U Unknown		
X	DMG04	1067	<b>Marital Status Code</b>	<b>O ID 1/1</b>
			Code defining the marital status of a person	
X	DMG05	1109	<b>Race or Ethnicity Code</b>	<b>O ID 1/1</b>
			Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes	
X	DMG06	1066	<b>Citizenship Status Code</b>	<b>O ID 1/2</b>
			Code indicating citizenship status	
X	DMG07	26	<b>Country Code</b>	<b>O ID 2/3</b>
			Code identifying the country	
X	DMG08	659	<b>Basis of Verification Code</b>	<b>O ID 1/2</b>
			Code indicating the basis of verification	
X	DMG09	380	<b>Quantity</b>	<b>O R 1/15</b>
			Numeric value of quantity	

<b>Segment:</b>	<b>REF</b> Reference Identification
<b>Position:</b>	035
<b>Loop:</b>	2010 Optional (Must Use)
<b>Level:</b>	Detail
<b>Usage:</b>	Optional
<b>Max Use:</b>	20
<b>Purpose:</b>	To specify identifying information
<b>Syntax Notes:</b>	<ol style="list-style-type: none"> <li>1 At least one of REF02 or REF03 is required.</li> <li>2 If either C04003 or C04004 is present, then the other is required.</li> <li>3 If either C04005 or C04006 is present, then the other is required.</li> </ol>
<b>Semantic Notes:</b>	1 REF04 contains data relating to the value cited in REF02.
<b>Comments:</b>	
<b>Notes:</b>	<i>This segment is only used in the Injured Worker Level, when HL03='22'.</i>

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification EA Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records SY Social Security Number	M ID 2/3
>>	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Medical Record Number, when REF01='EA'.</i> <i>Injured Worker SSN, when REF01='SY'.</i> UB-92 Form Location 23, when REF01='EA'. UB-92 Form Location 60, when REF01='SY'.	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **CLM Health Claim**

**Position:** 130

**Loop:** 2300 Optional (Must Use)

**Level:** Detail

**Usage:** Optional (Must Use)

**Max Use:** 1

**Purpose:** To specify basic data about the claim

**Syntax Notes:**

**Semantic Notes:**

- 1 CLM02 is the total amount of all submitted charges of service segments for this claim.
- 2 CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
- 3 CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.
- 4 CLM13 is CHAMPUS nonavailability indicator. A "Y" value indicates a statement of non-availability is on file; an "N" value indicates statement of nonavailability is not on file or not necessary.
- 5 CLM15 is charges itemized by service indicator. A "Y" value indicates charges are itemized by service; an "N" value indicates charges are summarized by service.
- 6 CLM18 is explanation of benefit (EOB) indicator. A "Y" value indicates that a paper EOB is requested; an "N" value indicates that no paper EOB is requested.

**Comments:**

**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed from segment usage since the CLM segment is not used at HL03=20 level. CLM is still a "Must Use" segment when HL03=22.*

**Data Element Summary**

Ref.	Data	Name	Attributes
Des.	Element		
>>	CLM01	<b>1028 Claim Submitter's Identifier</b> Identifier used to track a claim from creation by the health care provider through payment <i>Patient Control Number.</i> UB-92 Form Location 3.	<b>M AN 1/38</b>
>>	CLM02	<b>782 Monetary Amount</b> Monetary amount <i>Total Amount Billed by Provider.</i> <i>Use this element for the total of the line item charges.</i> UB-92 Form Location 55a.	<b>O R 1/18</b>
X	CLM03	<b>1032 Claim Filing Indicator Code</b> Code identifying type of claim	<b>O ID 1/2</b>
X	CLM04	<b>1343 Non-Institutional Claim Type Code</b> Code identifying the type of provider or claim	<b>O ID 1/2</b>
>>	CLM05	<b>C023 Health Care Service Location Information</b> To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered <i>Type of Bill. Valid values are 111-114 for inpatient bills and 131-134 for outpatient bills.</i> UB-92 Form Location 4.	<b>O</b>

>>	<b>C02301</b>	<b>1331</b>	<b>Facility Code Value</b>	<b>M AN 1/2</b>
			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 <i>Facility Type Code.</i>	
			UB-92 Form Location 4, Positions 1-2.	
>>	<b>C02302</b>	<b>1332</b>	<b>Facility Code Qualifier</b>	<b>O ID 1/2</b>
			Code identifying the type of facility referenced	
			A Uniform Billing Claim Form Bill Type	
>>	<b>C02303</b>	<b>1325</b>	<b>Claim Frequency Type Code</b>	<b>O ID 1/1</b>
			Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type <i>Claim Frequency Code.</i>	
			UB-92 Form Location 4, Position 3.	
X	<b>CLM06</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O ID 1/1</b>
			Code indicating a Yes or No condition or response	
X	<b>CLM07</b>	<b>1359</b>	<b>Provider Accept Assignment Code</b>	<b>O ID 1/1</b>
			Code indicating whether the provider accepts assignment	
>>	<b>CLM08</b>	<b>1073</b>	<b>Yes/No Condition or Res ponse Code</b>	<b>O ID 1/1</b>
			Code indicating a Yes or No condition or response <i>Injured Worker Benefits Assignment Indicator.</i>	
			UB-92 Form Location 53a.	
			N No	
				<i>Use this value to indicate that benefits have not been assigned to the provider.</i>
			Y Yes	
				<i>Use this value to indicate injured worker or authorized person authorizes benefits to be assigned to the provider.</i>
	<b>CLM09</b>	<b>1363</b>	<b>Release of Information Code</b>	<b>O ID 1/1</b>
			Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations <i>Patient Medical Release Indicator</i>	
			UB-92 Form Location 52a.	
			M	The Provider has Limited or Restricted Ability to Release Data Related to a Claim UB-92 Code 'R'.
			N	No, Provider is Not Allowed to Release Data UB-92 Code 'N'.
			Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim UB-92 Code 'Y'.
X	<b>CLM10</b>	<b>1351</b>	<b>Patient Signature Source Code</b>	<b>O ID 1/1</b>
			Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider	
X	<b>CLM11</b>	<b>C024</b>	<b>Related Causes Information</b>	<b>O</b>
			To identify one or more related causes and associated state or country information	
X	<b>C02401</b>	<b>1362</b>	<b>Related-Causes Code</b>	<b>M ID 2/3</b>
			Code identifying an accompanying cause of an illness, injury or an accident	
X	<b>C02402</b>	<b>1362</b>	<b>Related-Causes Code</b>	<b>O ID 2/3</b>
			Code identifying an accompanying cause of an illness, injury or an accident	

X	<b>C02403</b>	<b>1362</b>	<b>Related-Causes Code</b> Code identifying an accompanying cause of an illness, injury or an accident	<b>O ID 2/3</b>
X	<b>C02404</b>	<b>156</b>	<b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency	<b>O ID 2/2</b>
X	<b>C02405</b>	<b>26</b>	<b>Country Code</b> Code identifying the country	<b>O ID 2/3</b>
X	<b>CLM12</b>	<b>1366</b>	<b>Special Program Code</b> Code indicating the Special Program under which the services rendered to the patient were performed	<b>O ID 2/3</b>
X	<b>CLM13</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	<b>O ID 1/1</b>
X	<b>CLM14</b>	<b>1338</b>	<b>Level of Service Code</b> Code specifying the level of service rendered	<b>O ID 1/3</b>
X	<b>CLM15</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	<b>O ID 1/1</b>
X	<b>CLM16</b>	<b>1360</b>	<b>Provider Agreement Code</b> Code indicating the type of agreement under which the provider is submitting this claim	<b>O ID 1/1</b>
X	<b>CLM17</b>	<b>1029</b>	<b>Claim Status Code</b> Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization	<b>O ID 1/2</b>
X	<b>CLM18</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	<b>O ID 1/1</b>
X	<b>CLM19</b>	<b>1383</b>	<b>Claim Submission Reason Code</b> Code identifying reason for claim submission	<b>O ID 2/2</b>
X	<b>CLM20</b>	<b>1514</b>	<b>Delay Reason Code</b> Code indicating the reason why a request was delayed	<b>O ID 1/2</b>

**Segment:** **DTP** **Date or Time or Period**  
**Position:** 135  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 150  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	<b>DTP01</b>	<b>374</b> <b>Date/Time Qualifier</b>	<b>M ID 3/3</b>
		Code specifying type of date or time, or both date and time	
		096 Discharge	
		435 Admission	
		Date of entrance to a health care establishment	
		472 Service	
		Begin and end dates of the service being rendered	
>>	<b>DTP02</b>	<b>1250</b> <b>Date Time Period Format Qualifier</b>	<b>M ID 2/3</b>
		Code indicating the date format, time format, or date and time format	
		DT Date and Time Expressed in Format CCYYMMDDHHMM <i>Use this code when DTP01='435'.</i>	
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date <i>Use this code when DTP01='472'.</i>	
		TM Time Expressed in Format HHMM Time expressed in the format HHMM where HH is the numerical expression of hours in the day based on a twenty-four hour clock and MM is the numerical expression of minutes within an hour <i>Use this code when DTP01='096'.</i>	
>>	<b>DTP03</b>	<b>1251</b> <b>Date Time Period</b>	<b>M AN 1/35</b>
		Expression of a date, a time, or range of dates, times or dates and times <i>Discharge Hour, when DTP01='096'.</i> <i>Admission Date and Hour, when DTP01='435'.</i> <i>Beginning and Ending Dates from the 'Statement Covers Period' field, when DTP01='472'.</i>	
		UB-92 Form Location 21, when DTP01='096'.	
		UB-92 Form Location 17 & 18, when DTP01='435'.	
		UB-92 Form Location 6, when DTP01='472'.	

**Segment:** **CL1 Claim Codes**  
**Position:** 140  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply information specific to hospital claims  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed from CL103 since this element is only available to BWC on Inpatient bills. CL103 is an "Optional" element when processing an Outpatient bill.*

#### Data Element Summary

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>		
>>	CL101	<b>1315 Admission Type Code</b> Code indicating the priority of this admission <i>Admission Type</i> <i>Valid values are '1'=emergency, '2'=urgent, '3'=elective.</i> UB-92 Form Location 19.	<b>O ID 1/1</b>
>>	CL102	<b>1314 Admission Source Code</b> Code indicating the source of this admission <i>Admission Source</i> <i>Valid values are '1'=physician referral, '2'=clinic referral, '3'=HMO referral, '4'=transfer from hospital, '5'=transfer from nursing facility, '6'=transfer from other health care facility, '7'=emergency room, '8'=court/law enforcement, '9'=information not available.</i> UB-92 Form Location 20.	<b>O ID 1/1</b>
	CL103	<b>1352 Patient Status Code</b> Code indicating patient status as of the "statement covers through date" <i>Patient Status</i> <i>Valid values are '01'=routine discharge, '02'=discharge/transfer to another acute care facility, '03'=discharge/transfer to skilled nursing facility, '04'=discharge/transfer to another intermediate care facility, '05'=discharge/transfer to another institution for inpatient or outpatient care, '06'=discharge/transfer to a home health care facility, '07'=left against medical advice or discontinued care, '20'=expired, '30'=still a patient or expected to return for outpatient service.</i> UB-92 Form Location 22.	<b>O ID 1/2</b>
X	CL104	<b>1345 Nursing Home Residential Status Code</b> Code specifying the status of a nursing home resident at the time of service	<b>O ID 1/1</b>

**Segment:** **HI** **Health Care Information Codes**  
**Position:** 231  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 25  
**Purpose:** To supply information related to the delivery of health care  
**Syntax Notes:**

- 1 If either C02203 or C02204 is present, then the other is required.
- 2 If either C02203 or C02204 is present, then the other is required.
- 3 If either C02203 or C02204 is present, then the other is required.
- 4 If either C02203 or C02204 is present, then the other is required.
- 5 If either C02203 or C02204 is present, then the other is required.
- 6 If either C02203 or C02204 is present, then the other is required.
- 7 If either C02203 or C02204 is present, then the other is required.
- 8 If either C02203 or C02204 is present, then the other is required.
- 9 If either C02203 or C02204 is present, then the other is required.
- 10 If either C02203 or C02204 is present, then the other is required.
- 11 If either C02203 or C02204 is present, then the other is required.
- 12 If either C02203 or C02204 is present, then the other is required.

**Semantic Notes:**

**Comments:**

**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Two data elements are mandatory: Principal Diagnosis, and Admit Diagnosis Code (on Inpatient Bills only.)*

*Three data elements are expected when applicable: Principal Procedure Code, Value Code and Value Amount.*

*Note: The "Must Use" designation was removed from HI02 since this element is only available to BWC on Inpatient bills. HI02 is an "Optional" element when processing an Outpatient bill.*

Do NOT create additional HI segments unless all of the elements on the first/prior HI segment are used. Populate the HI elements in order HI01 - HI12, and only leave unused elements at the end of the last HI segment.

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	HI01	C022	Health Care Code Information M
			To send health care codes and their associated dates, amounts and quantities <i>Diagnosis Code</i>
>>	C02201	1270	Code List Qualifier Code M ID 1/3
			Code identifying a specific industry code list
		BE	Value
		BF	Diagnosis
		BG	Condition
		BH	Occurrence
		BI	Occurrence Span
		BJ	Admitting Diagnosis
		BK	Principal Diagnosis
		BO	Health Care Financing Administration Common Procedural Coding System
		BP	Health Care Financing Administration Common Procedural Coding System Principal Procedure

			BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure	
			BR	International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>		<b>M AN 1/30</b>
				Code indicating a code from a specific industry code list	
				<i>Principle Diagnosis, when HInn-C02201='BK'. One occurrence only must be used.</i>	
				<i>Admit Diagnosis, when HInn-C02201='BJ'. One occurrence only must be used.</i>	
				<i>Principle Procedure Code, when HInn-C02201='BR' or 'BP'. One occurrence only must be used.</i>	
				<i>Value Code, when HInn-C02201='BE'. Up to 12 occurrences may be used.</i>	
				<i>Other Diagnosis Codes, when HInn-C02201='BF'. Up to 8 data elements may be used.</i>	
				<i>Condition Codes, when HInn-C02201='BG'. Up to 7 data elements may be used.</i>	
				<i>Occurrence Codes, when HInn-C02201='BH'. Up to 8 data elements may be used.</i>	
				<i>Occurrence Span Code, when HInn-C02201='BI'. Up to 2 data elements may be used.</i>	
				<i>Other Procedure Codes, when HInn-C02201='BQ' or 'BO'. Up to 5 data elements may be used.</i>	
				UB-92 Form Location 67, when HI01 -C02201='BK'.	
				UB-92 Form Location 39-41 (a-d), when HInn-C02201='BE'.	
				UB-92 Form Location 68-75, when HInn-C02201='BF'.	
				UB-92 Form Location 24-30, when HInn-C02201='BG'.	
				UB-92 Form Location 32-35 (a-b), when HI01 -C02201='BH'.	
				UB-92 Form Location 36, when HInn-C02201='BI'.	
				UB-92 Form Location 76, when HInn-C02201='BJ'.	
				UB-92 Form Location 80, when HInn-C02201='BR' or 'BP'.	
				UB-92 Form Location 81 (a-e), when HInn-C02201='BQ' or 'BO'.	
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>		<b>X ID 2/3</b>
				Code indicating the date format, time format, or date and time format	
			D8	Date Expressed in Format CCYYMMDD <i>Use this code when HInn-C02201='BR', HInn-C02201='BP', HInn-C02201='BH', HInn-C02201='BQ', or HInn-C02201='BO'.</i>	
			RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date <i>Use this code when HInn-C02201='BI'.</i>	

	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X</b>	<b>AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times <i>Principle Procedure Date, when HInn-C02201='BR' or 'BP'. One occurrence only must be used.</i> <i>Occurrence Date when HInn-C02201='BH' and HInn-C02202='D8'. Up to 8 data elements may be used.</i> <i>Other Procedure Date when HInn-C02201='BQ' or 'BO' and HInn-C02202='D8'. Up to 5 data elements may be used.</i> <i>Occurrence Span Begin Date (pos 1-8) when HInn-C02201='BI' and HInn-C02202='RD8'. Up to 2 data elements may be used.</i> <i>Occurrence Span End Date (pos 10-17) when HInn-C02201='BI' and HInn-C02202='RD8'. Up to 2 data elements may be used.</i>		
			UB-92 Form Location 80, when HInn-C02201='BR' or 'BP' and HInn-C02202='D8'. UB-92 Form Location 32-35 (a-b), when HInn-C02201='BH' and HInn-C02202='D8'. UB-92 Form Location 81 (a-e), when HInn-C02201='BQ' or 'BO' and HInn-C02202='D8'. UB-92 Form Location 36 (a-b), when HInn-C02201='BI' and HInn-C02202='RD8'		
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O</b>	<b>R 1/18</b>
			Monetary amount <i>Value Code Amount, when HInn-C02201='BE'.</i>		
			UB-92 Form Location 39-41 (a-d), when HInn-C02201='BE'.		
<b>X</b>	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O</b>	<b>R 1/15</b>
			Numeric value of quantity		
<b>X</b>	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O</b>	<b>AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm		
	<b>HI02</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>	
			To send health care codes and their associated dates, amounts and quantities		
<b>&gt;&gt;</b>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M</b>	<b>ID 1/3</b>
			Code identifying a specific industry code list		
<b>&gt;&gt;</b>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X</b>	<b>ID 2/3</b>
			Code indicating the date format, time format, or date and time format		
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X</b>	<b>AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times		
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O</b>	<b>R 1/18</b>
			Monetary amount		
<b>X</b>	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O</b>	<b>R 1/15</b>
			Numeric value of quantity		
<b>X</b>	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O</b>	<b>AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm		

	<b>HI03</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>	
			To send health care codes and their associated dates, amounts and quantities		
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M</b>	<b>ID 1/3</b>
			Code identifying a specific industry code list		
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X</b>	<b>ID 2/3</b>
			Code indicating the date format, time format, or date and time format		
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X</b>	<b>AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times		
			UB-92 Form Location 80.		
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O</b>	<b>R 1/18</b>
			Monetary amount		
X	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O</b>	<b>R 1/15</b>
			Numeric value of quantity		
X	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O</b>	<b>AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm		
	<b>HI04</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>	
			To send health care codes and their associated dates, amounts and quantities		
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M</b>	<b>ID 1/3</b>
			Code identifying a specific industry code list		
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X</b>	<b>ID 2/3</b>
			Code indicating the date format, time format, or date and time format		
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X</b>	<b>AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times		
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O</b>	<b>R 1/18</b>
			Monetary amount		
X	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O</b>	<b>R 1/15</b>
			Numeric value of quantity		
X	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O</b>	<b>AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm		
	<b>HI05</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>	
			To send health care codes and their associated dates, amounts and quantities		
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M</b>	<b>ID 1/3</b>
			Code identifying a specific industry code list		
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X</b>	<b>ID 2/3</b>
			Code indicating the date format, time format, or date and time format		
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X</b>	<b>AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times		
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O</b>	<b>R 1/18</b>
			Monetary amount		
X	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O</b>	<b>R 1/15</b>
			Numeric value of quantity		

X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
	HI06	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
>>	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
>>	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
	HI07	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
>>	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
>>	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
	HI08	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
>>	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
>>	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30

	<b>HI09</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M ID 1/3</b>
			Code identifying a specific industry code list	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M AN 1/30</b>
			Code indicating a code from a specific industry code list	
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>
			Code indicating the date format, time format, or date and time format	
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times	
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O R 1/18</b>
			Monetary amount	
<b>X</b>	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O R 1/15</b>
			Numeric value of quantity	
<b>X</b>	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm	
	<b>HI10</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M ID 1/3</b>
			Code identifying a specific industry code list	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M AN 1/30</b>
			Code indicating a code from a specific industry code list	
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>
			Code indicating the date format, time format, or date and time format	
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times	
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O R 1/18</b>
			Monetary amount	
<b>X</b>	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O R 1/15</b>
			Numeric value of quantity	
<b>X</b>	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm	
	<b>HI11</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M ID 1/3</b>
			Code identifying a specific industry code list	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M AN 1/30</b>
			Code indicating a code from a specific industry code list	
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>
			Code indicating the date format, time format, or date and time format	
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times	
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O R 1/18</b>
			Monetary amount	
<b>X</b>	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O R 1/15</b>
			Numeric value of quantity	
<b>X</b>	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm	

	<b>HI12</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	<b>M ID 1/3</b>
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b> Code indicating a code from a specific industry code list	<b>M AN 1/30</b>
	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	<b>X ID 2/3</b>
	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	<b>X AN 1/35</b>
	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b> Monetary amount	<b>O R 1/18</b>
<b>X</b>	<b>C02206</b>	<b>380</b>	<b>Quantity</b> Numeric value of quantity	<b>O R 1/15</b>
<b>X</b>	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	<b>O AN 1/30</b>

**Segment:** **QTY** Quantity  
**Position:** 240  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 10  
**Purpose:** To specify quantity information  
**Syntax Notes:** 1 At least one of QTY02 or QTY04 is required.  
 2 Only one of QTY02 or QTY04 may be present.  
**Semantic Notes:** 1 QTY04 is used when the quantity is non-numeric.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	QTY01	673	<b>Quantity Qualifier</b> Code specifying the type of quantity CA Covered - Actual Days covered on this service	M ID 2/2
>>	QTY02	380	<b>Quantity</b> Numeric value of quantity <i>Days Covered, when QTY01='CA'.</i> UB-92 Form Location 7, when QTY01='CA'.	X R 1/15
	QTY03	C001	<b>Composite Unit of Measure</b> To identify a composite unit of measure (See Figures Appendix for examples of use)	O
>>	C00101	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken DA Days	M ID 2/2
X	C00102	1018	<b>Exponent</b> Power to which a unit is raised	O R 1/15
X	C00103	649	<b>Multiplier</b> Value to be used as a multiplier to obtain a new value	O R 1/10
X	C00104	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	O ID 2/2
X	C00105	1018	<b>Exponent</b> Power to which a unit is raised	O R 1/15
X	C00106	649	<b>Multiplier</b> Value to be used as a multiplier to obtain a new value	O R 1/10
X	C00107	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	O ID 2/2
X	C00108	1018	<b>Exponent</b> Power to which a unit is raised	O R 1/15
X	C00109	649	<b>Multiplier</b> Value to be used as a multiplier to obtain a new value	O R 1/10
X	C00110	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	O ID 2/2
X	C00111	1018	<b>Exponent</b> Power to which a unit is raised	O R 1/15

X	C00112	649	<b>Multiplier</b> Value to be used as a multiplier to obtain a new value	O R 1/10
X	C00113	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	O ID 2/2
X	C00114	1018	<b>Exponent</b> Power to which a unit is raised	O R 1/15
X	C00115	649	<b>Multiplier</b> Value to be used as a multiplier to obtain a new value	O R 1/10
X	QTY04	61	<b>Free-Form Message</b> Free-form information	X AN 1/30

**Segment:** **NM1** Individual or Organizational Name  
**Position:** 250  
**Loop:** 2310 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*The Service Facility NM1 loop is Optional.*

*This NM1 may be used when the service was rendered at a different location (Place of Service) than what is specified in the Billing or Pay-To Provider NM1 loops.*

**Data Element Summary**

Ref.	Data	Name	Attributes
Des.	Element		
>>	NM101	98 <b>Entity Identifier Code</b>	M ID 2/3
		Code identifying an organizational entity, a physical location, property or an individual	
		71 Attending Physician	
		Physician present when medical services are performed	
		73 Other Physician	
		Physician not one of the other specified choices	
		FA Facility	
		<i>Use this code for Service Facility</i>	
>>	NM102	1065 <b>Entity Type Qualifier</b>	M ID 1/1
		Code qualifying the type of entity	
		1 Person	
		2 Non-Person Entity	
		<i>Use this code for Service Facility</i>	
	NM103	1035 <b>Name Last or Organization Name</b>	O AN 1/35
		Individual last name or organizational name	
		<i>Attending Provider Last Name, when NM101='71'.</i>	
		<i>Other Provider Last Name, when NM101='73'.</i>	
		<i>Service Facility Name, when NM101='FA'.</i>	
		<i>Note: Any name value longer than 35 bytes is continued in N2 segment.</i>	
		UB-92 Form Location 82 line b, when NM101='71'.	
		UB-92 Form Location 83 line b, when NM101='73'.	
	NM104	1036 <b>Name First</b>	O AN 1/25
		Individual first name	
		<i>Attending Provider First Name, when NM101='71'.</i>	
		<i>Other Provider First Name, when NM101='73'.</i>	
		UB-92 Form Location 82 line b, when NM101='71'.	
		UB-92 Form Location 83 line b, when NM101='73'.	
X	NM105	1037 <b>Name Middle</b>	O AN 1/25
		Individual middle name or initial	
X	NM106	1038 <b>Name Prefix</b>	O AN 1/10
		Prefix to individual name	
X	NM107	1039 <b>Name Suffix</b>	O AN 1/10
		Suffix to individual name	

>>	<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number	<b>X ID 1/2</b>
>>	<b>NM109</b>	<b>67</b>	<b>Identification Code</b> Code identifying a party or other code <i>Attending Provider ID, when NM101='71'.</i> <i>Other Provider ID, when NM101='73'.</i> UB-92 Form Location 82 line a, when NM101='71'. UB-92 Form Location 83 line a, when NM101='73'.	<b>X AN 2/80</b>
<b>X</b>	<b>NM110</b>	<b>706</b>	<b>Entity Relationship Code</b> Code describing entity relationship	<b>X ID 2/2</b>
<b>X</b>	<b>NM111</b>	<b>98</b>	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	<b>O ID 2/3</b>

**Segment:** **N2 Additional Name Information**  
**Position:** 260  
**Loop:** 2310 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify additional names or those longer than 35 characters in length  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *Use when names are longer than 35 bytes for:  
 Attending Physician (when NM101=71)  
 Other Physician (when NM101=73)  
 Service Facility (when NM101=FA)*

**Data Element Summary**

	<b>Ref. Des.</b>	<b>Data Element</b>	<b>Name</b>	<b>Attributes</b>
>>	N201	93	<b>Name</b> Free-form name <i>Additional Name text as an extension of the value in NM103 when the Attending/Other Physician or Service facility name(s) are longer than 35 bytes.</i>	<b>M AN 1/60</b>
X	N202	93	<b>Name</b> Free-form name	<b>O AN 1/60</b>

**Segment:** **N3** **Address Information**  
**Position:** 265  
**Loop:** 2310 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	N301	166	<b>Address Information</b> Address information <i>Service Facility Address</i>	M AN 1/55
X	N302	166	<b>Address Information</b> Address information	O AN 1/55

- Segment:** **N4 Geographic Location**  
**Position:** 270  
**Loop:** 2310 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify the geographic place of the named party  
**Syntax Notes:** 1 If N406 is present, then N405 is required.  
**Semantic Notes:**  
**Comments:** 1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.  
 2 N402 is required only if city name (N401) is in the U.S. or Canada.  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

<b>Ref.</b>	<b>Data</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element Name</b>	
N401	19 <b>City Name</b> Free-form text for city name <i>Service Facility City</i>	O AN 2/30
N402	156 <b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <i>Service Facility State</i>	O ID 2/2
N403	116 <b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <i>Service Facility Postal Zip Code</i>	O ID 3/15
X N404	26 <b>Country Code</b> Code identifying the country	O ID 2/3
X N405	309 <b>Location Qualifier</b> Code identifying type of location	X ID 1/2
X N406	310 <b>Location Identifier</b> Code which identifies a specific location	O AN 1/30

**Segment:** **LX** Assigned Number  
**Position:** 365  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To reference a line number in a transaction set  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.  
 The service line loop (LoopID-2400) begins with the LX segment, and is required when Loop-ID2400 is used.*

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>> LX01	554	Assigned Number	M N0 1/6
		Number assigned for differentiation within a transaction set	
		<i>Service Line Number.</i>	
		<i>The service line number is incremented by 1 for each service line</i>	

**Segment:** **SV2 Institutional Service**  
**Position:** 375  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify the claim service detail for a Health Care institution  
**Syntax Notes:** 1 At least one of SV201 or SV202 is required.  
 2 If either SV204 or SV205 is present, then the other is required.  
**Semantic Notes:** 1 SV201 is the revenue code.  
 2 SV203 is a submitted charge amount.  
 3 SV207 is a noncovered charge amount.  
 4 SV208 is the detail service line indicator. A "Y" value indicates a detail service line; an "N" value indicates a summary service line.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	SV201	234 <b>Product/Service ID</b>	X AN 1/48
		Identifying number for a product or service <i>Line Item Revenue Code.</i>	
		UB-92 Form Location 42.	
>>	SV202	C003 <b>Composite Medical Procedure Identifier</b>	X
		To identify a medical procedure by its standardized codes and applicable modifiers <i>Line Item Procedure Code.</i>	
		<i>Required for all Outpatient claims.</i>	
		UB-92 Form Location 44 (HCPCS)	
>>	C00301	235 <b>Product/Service ID Qualifier</b>	M ID 2/2
		Code identifying the type/source of the descriptive number used in Product/Service ID (234)	
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments	
>>	C00302	234 <b>Product/Service ID</b>	M AN 1/48
		Identifying number for a product or service <i>HCPCS Procedure Code. Refer to BWC's Billing and Reimbursement Manual for list of revenue codes that require HCPCS level I, II of III codes.</i>	
		UB-92 Form Location 44 (HCPCS).	
X	C00303	1339 <b>Procedure Modifier</b>	O AN 2/2
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00304	1339 <b>Procedure Modifier</b>	O AN 2/2
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00305	1339 <b>Procedure Modifier</b>	O AN 2/2
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00306	1339 <b>Procedure Modifier</b>	O AN 2/2
		This identifies special circumstances related to the performance of the service, as defined by trading partners	

X	C00307	352	<b>Description</b> A free-form description to clarify the related data elements and their content	O AN 1/80
>>	SV203	782	<b>Monetary Amount</b> Monetary amount <i>Line Item Billed Charges from the Provider.</i>	O R 1/18
			UB-92 Form Location 47.	
>>	SV204	355	<b>Unit or Basis for Measurement Code</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken DA Days UN Unit	X ID 2/2
>>	SV205	380	<b>Quantity</b> Numeric value of quantity <i>Line Item Units of Service Provided.</i>	X R 1/15
			UB-92 Form Location 46.	
	SV206	1371	<b>Unit Rate</b> The rate per unit of associate revenue for hospital accommodation <i>Hospital Accommodation Daily Rate.</i>	O R 1/10
			UB-92 Form Location 44 (Rates).	
X	SV207	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	SV208	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1
X	SV209	1345	<b>Nursing Home Residential Status Code</b> Code specifying the status of a nursing home resident at the time of service	O ID 1/1
X	SV210	1337	<b>Level of Care Code</b> Code specifying the level of care provided by a nursing home facility	O ID 1/1

**Segment:** **DTP** **Date or Time or Period**  
**Position:** 455  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 15  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
>> DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time 472 Service Begin and end dates of the service being rendered	<b>M ID 3/3</b>
>> DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format D8 Date Expressed in Format CCYYMMDD	<b>M ID 2/3</b>
>> DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <i>Line Item Date of Service</i>	<b>M AN 1/35</b>

UB-92 Form Location 45

**Segment:** **SE** Transaction Set Trailer  
**Position:** 555  
**Loop:**  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

**Syntax Notes:**

**Semantic Notes:**

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

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>		<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	SE01	96	<b>Number of Included Segments</b> Total number of segments included in a transaction set including ST and SE segments	M N0 1/10
>>	SE02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>The SE02 value must equal the ST02 value.</i>	M AN 4/9

**X12 837 – version 004010**  
**Health Care Claim: Professional**  
**(for HCFA-1500 and C-19 users)**

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## A. 837 OVERVIEW – Professional Version

Providers will use the X12 837 Health Care Claim transaction set (inbound) to submit medical bills to MCOs for review. The medical bills submitted using the institutional version should be for professional services billed on the HCFA-1500 or C-19. BWC's Billing and Reimbursement Manual states which provider types are eligible to bill on these forms. **Dental services may not be billed in the X12 837 format at this time.** The guidelines in the Billing and Reimbursement Manual apply to all bills submitted in the X12 837 format.

If the X12 837 meets the criteria in this implementation guide, the MCO will consider the bill for payment.

MCOs will send an X12 997 Functional Acknowledgment for each 837 received. Refer to the section on 997 Functional Acknowledgment Processing for more information.

Expectations for inbound data elements are listed alphabetically in the Business Rules Matrix. "Mandatory" means that providers must gather and transmit the data elements in the 837 transaction. "Expected" means that the providers must gather and transmit the data elements in the 837 transaction, when applicable to the bill. "Optional" means that providers should send these data elements, if available. More specific information is included in the "Notes" column.

The cross-reference to the Implementation Guide is in the column titled "Location within X12 837". This column identifies the segment that contains the data, the position of the segment in the X12 837 standard, and the position within the segment where the data element is located and the conditions needed to extract the data. Example: The data element "Admit Date" is contained in a DTP segment located at position 2/135 (in the X12 standard, Table 2/Detail, position 135). It also notes that the data element is in DTP03, the third element in the DTP segment, and contains the "Admit Date" when the DTP01 element of the DTP segment equals "435."

**B. 837 HL STRUCTURE – PROF**

The following figure details the overall looping structure of the X12 837:

PROVIDER (Billing/Pay-to Provider HL03='20')

    SUBSCRIBER (Injured Worker HL03='22')

        CLAIM

            SERVICE LINE(S)

        CLAIM

            SERVICE LINE(S)

    SUBSCRIBER (Injured Worker HL03='22')

        CLAIM

            SERVICE LINE(S)

PROVIDER (Billing/Pay-to Provider HL03='20')

    SUBSCRIBER (Injured Worker HL03='22')

        CLAIM

            SERVICE LINE(S)

    SUBSCRIBER (Injured Worker HL03='22')

        CLAIM

            SERVICE LINE(S)

        CLAIM

            SERVICE LINE(S)

        CLAIM

            SERVICE LINE(S)

**C. 837 BUSINESS RULES MATRIX – PROF**

HCFA Form Box	Data Element	Mandatory, Expected, or Optional	Location within X12 837 (Segment, table/position) and Mapping Criteria	Notes
01A	Claim number	M	NM1,2/015; NM109 when NM101='IL' and NM108 = 'MI'.	Used to identify the BWC assigned claim number for this date of injury.
02	Injured worker's first name	M	NM1, 2/015; NM104 when NM101='IL', and NM102='1'	Used to identify the injured worker.
02	Injured worker's last name	M	NM1, 2/015; NM103 when NM101='IL', and NM102='1'	Used to identify the injured worker.
02	Injured worker's middle name	E	NM1, 2/015; NM105 when NM101='IL', and NM102='1'	Used to identify the injured worker.
02	Injured worker's suffix	E	NM1, 2/015; NM107 when NM101='IL', and NM102='1'	Used to identify the injured worker.
03	Injured worker gender code	O	DMG,2/032;DMG03	Used to identify the injured worker's sex.
03	Injured worker's date of birth	M	DMG,2/032; DMG02, DMG01='D8'	Used to identify the injured worker's date of birth.
11	Injured worker's SSN	E	REF,2/035; REF02, when REF01='SY'	Used to identify the injured worker's social security number for this claim.
12	Patient medical release indicator	M	CLM,2/130; CLM09	Used to identify if injured worker has signed a medical release or not.
13	Injured Worker Benefits Assignment Indicator	M	CLM,2/130;CLM08	Used to determine if payment goes to provider or injured worker.
21	Diagnosis or Nature of Illness or Injury	E	HI,2/231; HIInn-C02202 when HIInn-C02201= 'BF', where nn=01-04.	Used to identify diagnosis for injured worker.
24D	Line item procedure code	M	SV1,2/370; SV101-C00302	Used to identify the line item procedure performed.
24G	Line item units of service provided	M	SV1,2/370; SV104, SV103='MJ' or 'UN'	Used to identify the units of service provided for this line item.
24F	Line item billed charges from the provider	M	SV1,2/370; SV102	Used to identify the line item charges from the provider.
24E	Line item diagnosis for DOS	M	SV1,2/370; SV107-C00401	A pointer to one of the four diagnosis codes on the HI segment that is used to identify the line item diagnosis for each procedure/ service performed. <b>Mandatory of non-facility bills only.</b> Valid values are 1, 2 ,3 or 4.

**C. 837 BUSINESS RULES MATRIX – PROF**

HCFA Form Box	Data Element	Mandatory, Expected, or Optional	Location within X12 837 (Segment, table/position) and Mapping Criteria	Notes
24A	Line item beginning / ending date of service	M	DTP,2/455;DTP03 when DTP01= '472' and DTP02='D8' or DTP02='RD8'	Used to identify the line item beginning and ending service dates. <b>Mandatory for all non-facility bills.</b> BWC requires the beginning and ending dates to be the same.
24B	Facility type code	M	SV1,2/370;SV105	Used to identify medical facility where service was performed. Use HCFA standard place of service codes.
24C	Service type code	O	SV1,2/370;SV106	Used to identify type of service.
24D	Line item procedure modifier1	O	SV1,2/370;SV101-C00303	Use only BWC's valid modifiers. See BWC Provider Billing & Reimbursement Manual.
24D	Line item procedure modifier2	O	SV1,2/370;SV101-C00304	none
24D	Line item procedure modifier3	O	SV1,2/370;SV101-C00305	none
24D	Line item procedure modifier4	O	SV1,2/370;SV101-C00306	none
25	Servicing provider ID	M	NM1,2/250;NM109 when NM101= '82', and NM108='FI'	Used to identify the servicing provider if different from pay-to provider. Use 11-digit BWC identification number. This provider may NOT be a group provider (BWC provider type 12.)
	Servicing provider organization name	M	NM1,2/250;NM103 when NM101= '82', and NM102='2'	Used to identify the servicing provider if different from pay-to provider.  Organizational Names larger than 35 bytes are continued in the N2 segment.
	Servicing provider last name	M	NM1,2/250;NM103 when NM101= '82', and NM102='1'	Used to identify the servicing provider if different from pay-to provider.  Last Names larger than 35 bytes are continued in the N2 segment.
	Servicing provider first name	M	NM1,2/250;NM104 when NM101= '82', and NM102='1'	Used to identify the servicing provider if different from pay-to provider.
	Servicing provider middle name	E	NM1,2/250;NM105 when NM101= '82', and NM102='1'	Used to identify the servicing provider if different from pay-to provider.
	Servicing provider name suffix	E	NM1,2/250;NM107 when NM101= '82', and NM102='1'	Used to identify the servicing provider if different from pay-to provider.

**C. 837 BUSINESS RULES MATRIX – PROF**

HCFA Form Box	Data Element	Mandatory, Expected, or Optional	Location within X12 837 (Segment, table/position) and Mapping Criteria	Notes
	Servicing provider address	M	N3,2/265;N301	Used to identify the servicing provider if different from pay-to provider.
	Servicing provider city	M	N4,2/270;N401	Used to identify the servicing provider if different from pay-to provider.
	Servicing provider state	M	N4,2/270;N402	Used to identify the servicing provider if different from pay-to provider.
	Servicing provider zip	M	N4,2/270;N403	Used to identify the servicing provider if different from pay-to provider.
26	Patient account number	M	CLM,2/130; CLM01	Use to identify the patient account number for this transaction.
28 - 30	Total amount billed by provider	M	CLM,2/130; CLM02	Used to identify the total charges submitted by the provider for this bill.
33	Pay-to Provider Name	M	NM1,2/015; NM103, when NM101='87' and NM102='2' or NM1,2/015; NM103, NM104, NM105, and NM107 when NM101='87' and NM102='1'	Organizational or Last Names larger than 35 bytes are continued in the N2 segment.
33	Pay-to Provider Address	M	N3,2/025; N301, when NM101='87'	
33	Pay-to Provider City	M	N4,2/030; N401, when NM101='87'	
33	Pay-to Provider State	M	N4,2/030; N402, when NM101='87'	
33	Pay-to Provider Zip	M	N4,2/030; N403, when NM101='87'	
33	Pay-to Provider ID	M	NM1,2/015; N109, when NM101='87' and NM108='FI'	Used to identify the provider who will receive the payment.
	Billing Intermediary Name	E	NM1,2/015; NM103, when NM101='85' and NM102='2' or NM1,2/015; NM103, NM104, NM105, and NM107 when NM101='85' and NM102='1'	Name of the entity submitting the bill, if different from the trading partner identified in the transaction header. Organizational or Last Names larger than 35 bytes are continued in the N2 segment.
	Billing Intermediary Address	E	N3,2/025; N301, when NM101='85'	Address of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary City	E	N4,2/030; N401, when NM101='85'	City of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary State	E	N4,2/030; N402, when NM101='85'	State of the entity submitting the bill, if different from the trading partner identified in the transaction header.

**C. 837 BUSINESS RULES MATRIX – PROF**

HCFA Form Box	Data Element	Mandatory, Expected, or Optional	Location within X12 837 (Segment, table/position) and Mapping Criteria	Notes
	Billing Intermediary Zip	E	N4,2/030; N403, when NM101='85'	Zip of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	Billing Intermediary ID	E	NM1,2/015; N109, when NM101='85' and NM108='FI'	BWC provider id of the entity submitting the bill, if different from the trading partner identified in the transaction header.
	MCO Name	O	NM1,2/015; NM103 when NM101='PR'	Name of MCO who will receive the bill.
	MCO Number	O	NM1,2/015; NM103 when NM101='PR', and NM108='PI'	Use BWC assigned 5-digit ID number of MCO who will receive the bill.
32	Service Facility Name	O	NM1,2/015; NM103, when NM101='FA' and NM102='2'	The Service Facility NM1 loop and associated segments (N2, N3 & N4) are only used when the service was rendered at a different location than what is specified on the Billing or Pay-To Provider NM1 loops. Organizational Names longer than 35 bytes are continued in the N2 segment.
32	Service Facility Address	O	N3,2/025; N301, when NM101='FA'	See note pertaining to Service Facility Name.
32	Service Facility City	O	N4,2/030; N401, when NM101='FA'	See note pertaining to Service Facility Name.
32	Service Facility State	O	N4,2/030; N402, when NM101='FA'	See note pertaining to Service Facility Name.
32	Service Facility Zip	O	N4,2/030; N403, when NM101='FA'	See note pertaining to Service Facility Name.

**D. 837 SUMMARY OF SEGMENTS USED – PROF****Table 1 Header**

Pos No.	Seg ID	Name	
	ISA	Interchange Control Header	
	GS	Functional Group Header	
005	ST	Transaction Set Header	
010	BHT	Beginning of Hierarchical Transaction	(Transaction Creation Date)
015	REF	Reference Numbers	(Professional Claim Submission Type)
020	NM1	Individual or Organizational Name	(Submitter Name)
045	PER	Administrative Communications Contact	(Submitter EDI contact)

**Table 2 Detail**

Pos No.	Seg ID	Name	
<b>001</b>	<b>HL</b>	<b>Hierarchical Level</b>	<b>(Billing/Pay-to Provider, HL03='20')</b>
015	NM1	Individual or Organizational Name	(Billing Intermediary Name and ID)
020	N2	Additional Name Information	(Billing Intermediary Name greater than 35 characters)
025	N3	Address Information	(Billing Intermediary Address)
030	N4	Geographic Location	(Billing Intermediary City, State, Zip)
015	NM1	Individual or Organizational Name	(Pay-to Provider Name and ID)
020	N2	Additional Name Information	(Pay-to Provider Name greater than 35 characters)
025	N3	Address Information	(Pay-to Provider Address)
030	N4	Geographic Location	(Pay-to Provider City, State, Zip)
<b>001</b>	<b>HL</b>	<b>Hierarchical Level</b>	<b>(Injured Worker Loop, HL03='22')</b>
005	SBR	Subscriber Information	(Payer Responsibility code, Individual Relationship Code, Workers' Compensation Filing Indicator)
015	NM1	Individual or Organizational Name	(Injured Worker Name and Claim Number)
032	DMG	Demographic Information	(Injured Worker Birth Date and Gender)
035	REF	Reference Numbers	(Injured Worker SSN)
015	NM1	Individual or Organizational Name	(MCO Name and MCO Number)
130	CLM	Health Claim	(Patient Account Number, Total Amount Billed by Provider, Facility Type Code, Injured Worker Benefits Assignment Indicator, Patient Medical Release Indicator)
231	HI	Health Care Information Codes	(Diagnosis Codes)
250	NM1	Individual or Organizational Name	(Servicing Provider Name and ID)
260	N2	Additional Name Information	(Servicing Provider Name greater than 35 characters)
265	N3	Address Information	(Servicing Provider Address)
270	N4	Geographic Location	(Servicing Provider City, State, Zip)
250	NM1	Individual or Organizational Name	(Service Facility Name)
260	N2	Additional Name Information	(Service Facility Name greater than 35 characters)
265	N3	Address Information	(Service Facility Address)
270	N4	Geographic Location	(Service Facility City, State, Zip)
365	LX	Assigned Number	(Line Item Number)
375	SV1	Professional Service	(Line Item: Facility Type Code, Service Type Code, Procedure Code, Procedure modifiers 1-4, Diagnosis Code, Billed Charges, Units of Service)
455	DTP	Date or Time or Period	(Line Item Dates of Service)

**D. 837 SUMMARY OF SEGMENTS USED – PROF**

555	SE	Transaction Set Trailer
	GE	Functional Group Trailer
	IEA	Interchange Control Trailer

## **E. 837 IMPLEMENTATION GUIDE – PROF**

The 837 Implementation Guide contains the detailed structure of the X12 837 document. It includes:

- a graphical depiction of the X12 837 looping structure
- all ASC X12 semantic and syntax notes
- indicators identifying mandatory and optional segments according to X12 rules
- indicators identifying mandatory, optional, and conditional data elements according to X12 rules
- indicators identifying which data elements of the used segments are used and not used
- subsets of valid code values used for ID type data elements
- notes specifying MCO's usage of the 837

The notes are included throughout the document in *italics*. These notes the MCO's usage of the 837 transaction set, segments, data elements and codes. Required data elements on optional segments are only required when the segment is used.

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# 837 Health Care Claim: Professional

Functional Group ID=**HC**

## Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

## Notes:

>> *Mandatory for Professional 837*  
 X *Not Used*

## Heading:

	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
>>	005	ST	Transaction Set Header	M	1		
>>	010	BHT	Beginning of Hierarchical Transaction	M	1		
>>	015	REF	Reference Identification	O	3		
LOOP ID - 1000						10	
>>	020	NM1	Individual or Organizational Name	O	1		n1
>>	045	PER	Administrative Communications Contact	O	2		

## Detail:

	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
LOOP ID - 2000						>1	
>>	001	HL	Hierarchical Level	M	1		
	005	SBR	Subscriber Information	O	1		
LOOP ID - 2010						10	
>>	015	NM1	Individual or Organizational Name	O	1		n2
	020	N2	Additional Name Information	O	2		
	025	N3	Address Information	O	2		
	030	N4	Geographic Location	O	1		
	032	DMG	Demographic Information	O	1		
	035	REF	Reference Identification	O	20		

		LOOP ID - 2300		100
>>	130	CLM	Health Claim	O 1
	231	HI	Health Care Information Codes	O 25
		LOOP ID - 2310		9
>>	250	NM1	Individual or Organizational Name	O 1 n3
	260	N2	Additional Name Information	O 2
	265	N3	Address Information	O 2
	270	N4	Geographic Location	O 1
		LOOP ID - 2400		>1
>>	365	LX	Assigned Number	O 1 n4
>>	370	SV1	Professional Service	O 1
>>	455	DTP	Date or Time or Period	O 15
>>	555	SE	Transaction Set Trailer	M 1

**Transaction Set Notes**

1. Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
2. 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.
3. Loop 2310 contains information about the rendering, referring, or attending provider.
4. Loop 2400 contains Service Line information.

**Segment:** **ST** Transaction Set Header  
**Position:** 005  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the start of a transaction set and to assign a control number  
**Syntax Notes:**  
**Semantic Notes:** 1 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).  
**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	ST01	143	<b>Transaction Set Identifier Code</b> Code uniquely identifying a Transaction Set 837 Health Care Claim <b>M ID 3/3</b>
>>	ST02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>The Transaction Set Control Numbers in ST02 and SE02 must be identical.</i> <b>M AN 4/9</b>

**Segment:** **BHT** **Beginning of Hierarchical Transaction**  
**Position:** 010  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

**Syntax Notes:****Semantic Notes:**

- 1 BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
- 2 BHT04 is the date the transaction was created within the business application system.
- 3 BHT05 is the time the transaction was created within the business application system.

**Comments:****Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>		<u>Attributes</u>
>>	<b>BHT01</b>	<b>1005</b>	<b>Hierarchical Structure Code</b>	<b>M ID 4/4</b>
			Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	
			0019 Information Source, Subscriber, Dependent	
>>	<b>BHT02</b>	<b>353</b>	<b>Transaction Set Purpose Code</b>	<b>M ID 2/2</b>
			Code identifying purpose of transaction set	
			00 Original	
>>	<b>BHT03</b>	<b>127</b>	<b>Reference Identification</b>	<b>O AN 1/30</b>
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
			<i>Originator Application Transaction Identifier.</i>	
			<i>The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number. It may or may not be identical to the number in the ST02.</i>	
>>	<b>BHT04</b>	<b>373</b>	<b>Date</b>	<b>O DT 8/8</b>
			Date expressed as CCYYMMDD	
			<i>Identifies the date that the submitter created the file.</i>	
>>	<b>BHT05</b>	<b>337</b>	<b>Time</b>	<b>O TM 4/8</b>
			Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	
			<i>Use this time to identify the time of day that the submitter created the file.</i>	
>>	<b>BHT06</b>	<b>640</b>	<b>Transaction Type Code</b>	<b>O ID 2/2</b>
			Code specifying the type of transaction	
			CH Chargeable	

**Segment:** **REF** Reference Identification  
**Position:** 015  
**Loop:**  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 3  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

- 1 REF04 contains data relating to the value cited in REF02.

**Comments:**

## Data Element Summary

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
		87	Functional Category An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc	
>>	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Claim Submission Type, when REF01='87'. This element must be 'X098' to denote the X12 837 Professional Implementation Guide is being used.</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **NM1 Individual or Organizational Name**  
**Position:** 020  
**Loop:** 1000 Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual 41 Submitter Entity transmitting transaction set	M ID 2/3
>>	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity 1 Person 2 Non-Person Entity	M ID 1/1
>>	NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <i>Submitter Last or Organization Name</i>	O AN 1/35
	NM104	1036	<b>Name First</b> Individual first name <i>Submitter First Name</i> <i>Required if NM102='I'.</i>	O AN 1/25
	NM105	1037	<b>Name Middle</b> Individual middle name or initial <i>Submitter Middle Name</i> <i>Required if NM102='I' and the middle name/initial of the person is known.</i>	O AN 1/25
X	NM106	1038	<b>Name Prefix</b> Prefix to individual name	O AN 1/10
X	NM107	1039	<b>Name Suffix</b> Suffix to individual name	O AN 1/10
>>	NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) 46 Electronic Transmitter Identification Number (ETIN) A unique number assigned to each transmitter and software developer	X ID 1/2
>>	NM109	67	<b>Identification Code</b> Code identifying a party or other code <i>Submitter Identifier</i>	X AN 2/80
X	NM110	706	<b>Entity Relationship Code</b> Code describing entity relationship	X ID 2/2
X	NM111	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	O ID 2/3

**Segment:** **PER Administrative Communications Contact**  
**Position:** 045  
**Loop:** 1000 Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 2  
**Purpose:** To identify a person or office to whom administrative communications should be directed  
**Syntax Notes:** 1 If either PER03 or PER04 is present, then the other is required.  
 2 If either PER05 or PER06 is present, then the other is required.  
 3 If either PER07 or PER08 is present, then the other is required.  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	PER01	366 <b>Contact Function Code</b>	M ID 2/2
		Code identifying the major duty or responsibility of the person or group named IC Information Contact	
>>	PER02	93 <b>Name</b>	O AN 1/60
		Free-form name <i>Submitter Contact Name</i>	
>>	PER03	365 <b>Communication Number Qualifier</b>	X ID 2/2
		Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	
>>	PER04	364 <b>Communication Number</b>	X AN 1/80
		Complete communications number including country or area code when applicable <i>10 digit communications number including area code or e-mail address.</i>	
	PER05	365 <b>Communication Number Qualifier</b>	X ID 2/2
		Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	
	PER06	364 <b>Communication Number</b>	X AN 1/80
		Complete communications number including country or area code when applicable <i>10 digit communications number including area code or e-mail address.</i>	
	PER07	365 <b>Communication Number Qualifier</b>	X ID 2/2
		Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	
	PER08	364 <b>Communication Number</b>	X AN 1/80
		Complete communications number including country or area code when applicable <i>10 digit communications number including area code or e-mail address.</i>	
X	PER09	443 <b>Contact Inquiry Reference</b>	O AN 1/20
		Additional reference number or description to clarify a contact number	

**Segment:** **HL** Hierarchical Level  
**Position:** 001  
**Loop:** 2000 Mandatory  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments  
**Syntax Notes:**  
**Semantic Notes:**  
**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. The HL segment defines a top-down/left-right ordered structure.
- 2 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.
- 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
- 4 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.
- 5 HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	HL01	628 Hierarchical ID Number	M AN 1/12
		A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	
	HL02	734 Hierarchical Parent ID Number	O AN 1/12
		Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to <i>HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate. This is the value of the HL01 element from the prior HL segment where HL03='20'.</i>	
		<i>Not used for the Billing/Pay-to Provider level, when HL03='20'.</i> <i>Required for the Injured Worker level, when HL03='22'.</i>	
>>	HL03	735 Hierarchical Level Code	M ID 1/2
		Code defining the characteristic of a level in a hierarchical structure	
		20	Information Source Identifies the payor, maintainer, or source of the information <i>Use this code for the Billing/Pay-to Provider Level.</i>
		22	Subscriber Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits <i>Use this code for the Injured Worker Level.</i>

>>	<b>HL04</b>	<b>736</b>	<b>Hierarchical Child Code</b>	<b>O ID 1/1</b>
			Code indicating if there are hierarchical child data segments subordinate to the level being described	
			<i>The claim loop (Loop-ID-2300) can only be used when HL04='0'.</i>	
		0	No Subordinate HL Segment in This Hierarchical Structure. <i>Use this code when HL03='22'.</i>	
		1	Additional Subordinate HL Data Segment in This Hierarchical Structure. <i>Use this code when HL03='20'.</i>	

**Segment:** **SBR** **Subscriber Information**  
**Position:** 005  
**Loop:** 2000 Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To record information specific to the primary insured and the insurance carrier for that insured  
**Syntax Notes:**  
**Semantic Notes:**

- 1 SBR02 specifies the relationship to the person insured.
- 2 SBR03 is policy or group number.
- 3 SBR04 is plan name.
- 4 SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer; an "N" value indicates the payer is not the destination payer.

**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed from segment usage since the SBR segment is not used at HL03=20 level. SBR is still a "Must Use" segment when HL03=22.*

#### Data Element Summary

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	
>>	SBR01	1138	<b>Payer Responsibility Sequence Number Code</b>	<b>M ID 1/1</b>
			Code identifying the insurance carrier's level of responsibility for a payment of a claim	
		P	Primary	
>>	SBR02	1069	<b>Individual Relationship Code</b>	<b>O ID 2/2</b>
			Code indicating the relationship between two individuals or entities	
			<i>Patient's Relationship to Insured.</i>	
		18	Self	
			<i>This code must be used, since the patient (injured worker) is always the same person as the subscriber (insured) for Workers Compensation claims.</i>	
X	SBR03	127	<b>Reference Identification</b>	<b>O AN 1/30</b>
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	
X	SBR04	93	<b>Name</b>	<b>O AN 1/60</b>
			Free-form name	
X	SBR05	1336	<b>Insurance Type Code</b>	<b>O ID 1/3</b>
			Code identifying the type of insurance policy within a specific insurance program	
X	SBR06	1143	<b>Coordination of Benefits Code</b>	<b>O ID 1/1</b>
			Code identifying whether there is a coordination of benefits	
X	SBR07	1073	<b>Yes/No Condition or Response Code</b>	<b>O ID 1/1</b>
			Code indicating a Yes or No condition or response	
X	SBR08	584	<b>Employment Status Code</b>	<b>O ID 2/2</b>
			Code showing the general employment status of an employee/claimant	
>>	SBR09	1032	<b>Claim Filing Indicator Code</b>	<b>O ID 1/2</b>
			Code identifying type of claim	
		WC	Workers' Compensation Health Claim	

**Segment:** **NM1** Individual or Organizational Name  
**Position:** 015  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.  
**Notes:** This segment is used in the Billing/Pay-to Provider Level, when HL03='20'.  
 This segment is used in the Injured Worker/MCO Level, when HL03='22'.

**Data Element Summary**

Ref.	Data		Attributes
Des.	Element	Name	
>>	NM101	98	<b>Entity Identifier Code</b> M ID 2/3
		Code identifying an organizational entity, a physical location, property or an individual <i>The entity identifier code in NM101 applies to all segments in Loop ID-2010.</i>	
		85 Billing Provider	
		87 Pay-to Provider	
		IL Insured or Subscriber <i>Use this code for Injured Worker.</i>	
		PR Payer <i>Use this code to identify the MCO.</i>	
>>	NM102	1065	<b>Entity Type Qualifier</b> M ID 1/1
		Code qualifying the type of entity	
		1 Person	
		2 Non-Person Entity	
	NM103	1035	<b>Name Last or Organization Name</b> O AN 1/35
		Individual last name or organizational name <i>Billing Intermediary Organization Name, when NM101='85', and NM102='2'.          Billing Intermediary Last Name, when NM101='85' and NM102='1'.          Pay-to Provider Organization Name, when NM101='87', and NM102='2'.          Pay-to Provider Last Name, when NM101='87', and NM102='1'.          Injured Worker Last Name, when NM101='IL', and NM102='1'.          If Billing Intermediary Organization Name and/or Pay-To Provider Organization Name is longer than 35 bytes it is continued in N2 segment.          MCO Name, when NM101='PR' and NM102='2'</i>	
		HCFA 1500 Form Location 33, when NM101='87'. HCFA 1500 Form Location 2, when NM101='IL'.	
	NM104	1036	<b>Name First</b> O AN 1/25
		Individual first name <i>Billing Intermediary First Name, when NM101='85'.          Pay-to Provider First Name, when NM101='87'.          Injured Worker First Name, when NM101='IL'.          Required when NM102='1'.</i>	
		HCFA 1500 Form Location 33, when NM101='87'. HCFA 1500 Form Location 2, when NM101='IL'.	

	NM105	1037	<b>Name Middle</b> Individual middle name or initial <i>Billing Intermediary Middle Name, when NM101='85'.</i> <i>Pay-to Provider Middle Name, when NM101='87'.</i> <i>Injured Worker Middle Name, when NM101='IL'.</i> <i>Required if NM102='I', and the middle name/initial is known.</i> HCFA 1500 Form Location 33, when NM101='87'. HCFA 1500 Form Location 2, when NM101='IL'.	O	AN 1/25
X	NM106	1038	<b>Name Prefix</b> Prefix to individual name	O	AN 1/10
	NM107	1039	<b>Name Suffix</b> Suffix to individual name <i>Billing Intermediary Name Suffix, when NM101='85'.</i> <i>Pay-to Provider Name Suffix, when NM101='87'.</i> <i>Injured Worker Name Suffix, when NM101='IL'.</i> <i>Required if known.</i> HCFA 1500 Form Location 33, when NM101='87'. HCFA 1500 Form Location 2, when NM101='IL'.	O	AN 1/10
>>	NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number <i>Use this code when NM101='85' or '87'</i> MI Member Identification Number <i>Use this code when NM101='IL'.</i> PI Payor Identification <i>Use this code for MCO Number.</i>	X	ID 1/2
>>	NM109	67	<b>Identification Code</b> Code identifying a party or other code <i>Billing Intermediary ID, when NM101='85' and NM108='FI'.</i> <i>Pay-to Provider ID, when NM101='87' and NM108='FI'.</i> <i>Claim Number, when NM101='IL' and NM108='MI'</i> <i>MCO Number, when NM101='PR' and NM108='PI'</i> HCFA 1500 Form Location 1A, when NM101='IL' and NM108='MI'. HCFA 1500 Form Location 33, when NM101='87' and NM108='FI'.	X	AN 2/80
X	NM110	706	<b>Entity Relationship Code</b> Code describing entity relationship	X	ID 2/2
X	NM111	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	O	ID 2/3

**Segment:** **N2 Additional Name Information**  
**Position:** 020  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify additional names or those longer than 35 characters in length  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *Use when names are longer than 35 bytes for:  
 Billing Provider (NM101=85)  
 Pay-To Provider (NM101=87)*

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	N201	93 Name Free-form name	M AN 1/60
		<i>Contains additional name text as an extension of the value in NM103 when the name(s) are longer than 35 bytes.</i>	
X	N202	93 Name Free-form name	O AN 1/60

**Segment:** **N3** **Address Information**  
**Position:** 025  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Billing/Pay-to Provider Level, when HL03='20'.*

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	N301	166	<b>Address Information</b> Address information <i>Billing Intermediary Address, when NM101='85'.</i> <i>Pay-to Provider Address, when NM101='87'.</i> HCFA 1500 Form Location 33, when NM101='87'.	M AN 1/55
X	N302	166	<b>Address Information</b> Address information	O AN 1/55

<b>Segment:</b>	<b>N4 Geographic Location</b>
<b>Position:</b>	030
<b>Loop:</b>	2010 Optional (Must Use)
<b>Level:</b>	Detail
<b>Usage:</b>	Optional
<b>Max Use:</b>	1
<b>Purpose:</b>	To specify the geographic place of the named party
<b>Syntax Notes:</b>	1 If N406 is present, then N405 is required.
<b>Semantic Notes:</b>	
<b>Comments:</b>	1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. 2 N402 is required only if city name (N401) is in the U.S. or Canada.
<b>Notes:</b>	<i>This segment is only used in the Billing/Pay-to Provider Level, when HL03='20'.</i> HCFA 1500 Form Location 33, when NM101='85'.

**Data Element Summary**

<b>Ref.</b>	<b>Data</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element Name</b>	
<b>N401</b>	<b>19 City Name</b> Free-form text for city name <i>Billing Intermediary City, when NM101='85'.</i> <i>Pay-to Intermediary City, when NM101='87'.</i> HCFA 1500 Form Location 33, when NM101='87'.	<b>O AN 2/30</b>
<b>N402</b>	<b>156 State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <i>Billing Intermediary State, when NM101='85'.</i> <i>Pay-to Provider State, when NM101='87'.</i> HCFA 1500 Form Location 33, when NM101='87'.	<b>O ID 2/2</b>
<b>N403</b>	<b>116 Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <i>Billing Intermediary Zip Code, when NM101='85'.</i> <i>Pay-to Provider Zip Code, when NM101='87'.</i> HCFA 1500 Form Location 33, when NM101='87'.	<b>O ID 3/15</b>
<b>X N404</b>	<b>26 Country Code</b> Code identifying the country	<b>O ID 2/3</b>
<b>X N405</b>	<b>309 Location Qualifier</b> Code identifying type of location	<b>X ID 1/2</b>
<b>X N406</b>	<b>310 Location Identifier</b> Code which identifies a specific location	<b>O AN 1/30</b>

**Segment:** **DMG Demographic Information**  
**Position:** 032  
**Loop:** 2010 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply demographic information  
**Syntax Notes:** 1 If either DMG01 or DMG02 is present, then the other is required.  
**Semantic Notes:** 1 DMG02 is the date of birth.  
 2 DMG07 is the country of citizenship.  
 3 DMG09 is the age in years.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

<b>Ref.</b>	<b>Data</b>	<b>Name</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element</b>		
DMG01	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format D8 Date Expressed in Format CCYYMMDD	X ID 2/3
DMG02	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <i>Injured Worker Birth Date</i>	X AN 1/35
DMG03	1068	<b>Gender Code</b> Code indicating the sex of the individual <i>Injured Worker Gender Code</i> HCFA 1500 Form Location 3 F Female M Male U Unknown	O ID 1/1
X	DMG04	1067 <b>Marital Status Code</b> Code defining the marital status of a person	O ID 1/1
X	DMG05	1109 <b>Race or Ethnicity Code</b> Code indicating the racial or ethnic background of a person; it is normally self-reported; Under certain circumstances this information is collected for United States Government statistical purposes	O ID 1/1
X	DMG06	1066 <b>Citizenship Status Code</b> Code indicating citizenship status	O ID 1/2
X	DMG07	26 <b>Country Code</b> Code identifying the country	O ID 2/3
X	DMG08	659 <b>Basis of Verification Code</b> Code indicating the basis of verification	O ID 1/2
X	DMG09	380 <b>Quantity</b> Numeric value of quantity	O R 1/15

<b>Segment:</b>	<b>REF</b> Reference Identification
<b>Position:</b>	035
<b>Loop:</b>	2010 Optional (Must Use)
<b>Level:</b>	Detail
<b>Usage:</b>	Optional
<b>Max Use:</b>	20
<b>Purpose:</b>	To specify identifying information
<b>Syntax Notes:</b>	<ol style="list-style-type: none"> <li>1 At least one of REF02 or REF03 is required.</li> <li>2 If either C04003 or C04004 is present, then the other is required.</li> <li>3 If either C04005 or C04006 is present, then the other is required.</li> </ol>
<b>Semantic Notes:</b>	1 REF04 contains data relating to the value cited in REF02.
<b>Comments:</b>	
<b>Notes:</b>	<i>This segment is only used in the Injured Worker Level, when HL03='22'.</i>

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>		<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification SY Social Security Number	M ID 2/3
>>	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Injured Worker SSN</i> HCFA 1500 Form Location 11	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **CLM Health Claim**  
**Position:** 130  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify basic data about the claim

**Syntax Notes:**  
**Semantic Notes:**

- 1 CLM02 is the total amount of all submitted charges of service segments for this claim.
- 2 CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
- 3 CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.
- 4 CLM13 is CHAMPUS nonavailability indicator. A "Y" value indicates a statement of non-availability is on file; an "N" value indicates statement of nonavailability is not on file or not necessary.
- 5 CLM15 is charges itemized by service indicator. A "Y" value indicates charges are itemized by service; an "N" value indicates charges are summarized by service.
- 6 CLM18 is explanation of benefit (EOB) indicator. A "Y" value indicates that a paper EOB is requested; an "N" value indicates that no paper EOB is requested.

**Comments:**

**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed from segment usage since the CLM segment is not used at HL03=20. CLM is still a "Must Use" segment when HL03=22.*

**Data Element Summary**

Ref.	Des.	Data Element	Name	Attributes
>>	CLM01	1028	<b>Claim Submitter's Identifier</b> Identifier used to track a claim from creation by the health care provider through payment <i>Patient Account Number</i> HCFA 1500 Form Location 26	M AN 1/38
>>	CLM02	782	<b>Monetary Amount</b> Monetary amount <i>Total Amount Billed by Provider.</i> HCFA 1500 Form Location 28	O R 1/18
X	CLM03	1032	<b>Claim Filing Indicator Code</b> Code identifying type of claim	O ID 1/2
X	CLM04	1343	<b>Non-Institutional Claim Type Code</b> Code identifying the type of provider or claim	O ID 1/2
X	CLM05	C023	<b>Health Care Service Location Information</b> To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered	O
X	C02301	1331	<b>Facility Code Value</b> Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	M AN 1/2
X	C02302	1332	<b>Facility Code Qualifier</b> Code identifying the type of facility referenced	O ID 1/2
X	C02303	1325	<b>Claim Frequency Type Code</b> Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type	O ID 1/1

X	CLM06	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1
X	CLM07	1359	<b>Provider Accept Assignment Code</b> Code indicating whether the provider accepts assignment	O ID 1/1
>>	CLM08	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response <i>Injured Worker Benefits Assignment Indicator.</i>	O ID 1/1
HCFA 1500 Form Location 13				
		N	No <i>Use this value to indicate that benefits have not been assigned to the provider.</i>	
		Y	Yes <i>Use this value to indicate injured worker or authorized person authorizes benefits to be assigned to the provider.</i>	
	CLM09	1363	<b>Release of Information Code</b> Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations <i>Patient Medical Release Indicator.</i>	O ID 1/1
HCFA 1500 Form Location 12				
		A	Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization	
		I	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes	
		M	The Provider has Limited or Restricted Ability to Release Data Related to a Claim	
		N	No, Provider is Not Allowed to Release Data	
		O	On file at Payor or at Plan Sponsor	
		Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim	
X	CLM10	1351	<b>Patient Signature Source Code</b> Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider	O ID 1/1
X	CLM11	C024	<b>Related Causes Information</b> To identify one or more related causes and associated state or country information	O
X	C02401	1362	<b>Related-Causes Code</b> Code identifying an accompanying cause of an illness, injury or an accident	M ID 2/3
X	C02402	1362	<b>Related-Causes Code</b> Code identifying an accompanying cause of an illness, injury or an accident	O ID 2/3
X	C02403	1362	<b>Related-Causes Code</b> Code identifying an accompanying cause of an illness, injury or an accident	O ID 2/3
X	C02404	156	<b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency	O ID 2/2
X	C02405	26	<b>Country Code</b> Code identifying the country	O ID 2/3
X	CLM12	1366	<b>Special Program Code</b> Code indicating the Special Program under which the services rendered to the patient were performed	O ID 2/3
X	CLM13	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1

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X	CLM14	1338	<b>Level of Service Code</b> Code specifying the level of service rendered	O ID 1/3
X	CLM15	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1
X	CLM16	1360	<b>Provider Agreement Code</b> Code indicating the type of agreement under which the provider is submitting this claim	O ID 1/1
X	CLM17	1029	<b>Claim Status Code</b> Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization	O ID 1/2
X	CLM18	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1
X	CLM19	1383	<b>Claim Submission Reason Code</b> Code identifying reason for claim submission	O ID 2/2
X	CLM20	1514	<b>Delay Reason Code</b> Code indicating the reason why a request was delayed	O ID 1/2

**Segment:** **HI** Health Care Information Codes  
**Position:** 231  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 25  
**Purpose:** To supply information related to the delivery of health care  
**Syntax Notes:**

- 1 If either C02203 or C02204 is present, then the other is required.
- 2 If either C02203 or C02204 is present, then the other is required.
- 3 If either C02203 or C02204 is present, then the other is required.
- 4 If either C02203 or C02204 is present, then the other is required.
- 5 If either C02203 or C02204 is present, then the other is required.
- 6 If either C02203 or C02204 is present, then the other is required.
- 7 If either C02203 or C02204 is present, then the other is required.
- 8 If either C02203 or C02204 is present, then the other is required.
- 9 If either C02203 or C02204 is present, then the other is required.
- 10 If either C02203 or C02204 is present, then the other is required.
- 11 If either C02203 or C02204 is present, then the other is required.
- 12 If either C02203 or C02204 is present, then the other is required.

**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

Ref.	Data			Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>		
>>	HI01	C022	<b>Health Care Code Information</b>	M
			To send health care codes and their associated dates, amounts and quantities <i>Diagnosis Code</i>	
>>	C02201	1270	<b>Code List Qualifier Code</b>	M ID 1/3
			Code identifying a specific industry code list BF Diagnosis	
>>	C02202	1271	<b>Industry Code</b>	M AN 1/30
			Code indicating a code from a specific industry code list <i>ICD-9 Diagnosis Code</i> HCFA 1500 Form Location 21	
X	C02203	1250	<b>Date Time Period Format Qualifier</b>	X ID 2/3
			Code indicating the date format, time format, or date and time format	
X	C02204	1251	<b>Date Time Period</b>	X AN 1/35
			Expression of a date, a time, or range of dates, times or dates and times	
X	C02205	782	<b>Monetary Amount</b>	O R 1/18
			Monetary amount	
X	C02206	380	<b>Quantity</b>	O R 1/15
			Numeric value of quantity	
X	C02207	799	<b>Version Identifier</b>	O AN 1/30
			Revision level of a particular format, program, technique or algorithm	

	<b>HI02</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities <i>Diagnosis Code</i>	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M ID 1/3</b>
			Code identifying a specific industry code list BF Diagnosis	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M AN 1/30</b>
			Code indicating a code from a specific industry code list <i>ICD-9 Diagnosis Code</i> HCFA 1500 Form Location 21	
X	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>
			Code indicating the date format, time format, or date and time format	
X	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times	
X	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O R 1/18</b>
			Monetary amount	
X	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O R 1/15</b>
			Numeric value of quantity	
X	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm	
	<b>HI03</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities <i>Diagnosis Code</i>	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M ID 1/3</b>
			Code identifying a specific industry code list BF Diagnosis	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M AN 1/30</b>
			Code indicating a code from a specific industry code list <i>ICD-9 Diagnosis Code</i> HCFA 1500 Form Location 21	
X	<b>C02203</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>
			Code indicating the date format, time format, or date and time format	
X	<b>C02204</b>	<b>1251</b>	<b>Date Time Period</b>	<b>X AN 1/35</b>
			Expression of a date, a time, or range of dates, times or dates and times	
X	<b>C02205</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O R 1/18</b>
			Monetary amount	
X	<b>C02206</b>	<b>380</b>	<b>Quantity</b>	<b>O R 1/15</b>
			Numeric value of quantity	
X	<b>C02207</b>	<b>799</b>	<b>Version Identifier</b>	<b>O AN 1/30</b>
			Revision level of a particular format, program, technique or algorithm	
	<b>HI04</b>	<b>C022</b>	<b>Health Care Code Information</b>	<b>O</b>
			To send health care codes and their associated dates, amounts and quantities <i>Diagnosis Code</i>	
>>	<b>C02201</b>	<b>1270</b>	<b>Code List Qualifier Code</b>	<b>M ID 1/3</b>
			Code identifying a specific industry code list BF Diagnosis	
>>	<b>C02202</b>	<b>1271</b>	<b>Industry Code</b>	<b>M AN 1/30</b>
			Code indicating a code from a specific industry code list <i>ICD-9 Diagnosis Code</i> HCFA 1500 Form Location 21	

X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI05	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI06	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI07	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35

X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI08	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI09	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI10	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15

X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI11	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30
X	HI12	C022	<b>Health Care Code Information</b> To send health care codes and their associated dates, amounts and quantities	O
X	C02201	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list	M ID 1/3
X	C02202	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list	M AN 1/30
X	C02203	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	X ID 2/3
X	C02204	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	X AN 1/35
X	C02205	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	C02206	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	C02207	799	<b>Version Identifier</b> Revision level of a particular format, program, technique or algorithm	O AN 1/30

**Segment:** **NM1 Individual or Organizational Name**  
**Position:** 250  
**Loop:** 2310 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*The Service Facility NM1 loop is Optional.*

*This NM1 may be used when the service was rendered at a different location (Place of Service) than what is specified in the Billing or Pay-To Provider NM1 loops.*

*Note: The "Must Use" designation was removed from NM104 since this element is not used at HL03=20 level. NM104 is still a "Must Use" element when HL03=22.*

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	NM101	98	<b>Entity Identifier Code</b> M ID 2/3
		Code identifying an organizational entity, a physical location, property or an individual	
		82 Rendering Provider	
		<i>Use this code for Servicing Provider.</i>	
		FA Facility	
		<i>Use this code for Service Facility</i>	
>>	NM102	1065	<b>Entity Type Qualifier</b> M ID 1/1
		Code qualifying the type of entity	
		1 Person	
		2 Non-Person Entity	
		<i>Use this code for Service Facility</i>	
>>	NM103	1035	<b>Name Last or Organization Name</b> O AN 1/35
		Individual last name or organizational name	
		<i>Servicing Provider Last Name or Service Facility Name.</i>	
		<i>Note: Any name value longer than 35 bytes is continued in the N2 segment.</i>	
		HCFA 1500 Form Location 33, when NM101='82'	
		HCFA 1500 Form Location 32, when NM101='FA'	
	NM104	1036	<b>Name First</b> O AN 1/25
		Individual first name	
		<i>Servicing Provider First Name</i>	
		HCFA 1500 Form Location 33	
	NM105	1037	<b>Name Middle</b> O AN 1/25
		Individual middle name or initial	
		<i>Servicing Provider Middle Name/Initial. Required if known.</i>	
		HCFA 1500 Form Location 33	
X	NM106	1038	<b>Name Prefix</b> O AN 1/10
		Prefix to individual name	

	<b>NM107</b>	<b>1039</b>	<b>Name Suffix</b> Suffix to individual name <i>Servicing Provider Name Suffix. Required if known.</i>	<b>O AN 1/10</b>
>>	<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number <i>Use this code for Servicing Provider ID</i>	<b>X ID 1/2</b>
>>	<b>NM109</b>	<b>67</b>	<b>Identification Code</b> Code identifying a party or other code <i>Servicing Provider ID</i> HCFA 1500 Form Location 25, when NM101='82'	<b>X AN 2/80</b>
<b>X</b>	<b>NM110</b>	<b>706</b>	<b>Entity Relationship Code</b> Code describing entity relationship	<b>X ID 2/2</b>
<b>X</b>	<b>NM111</b>	<b>98</b>	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	<b>O ID 2/3</b>

**Segment:** **N2 Additional Name Information**  
**Position:** 260  
**Loop:** 2310 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify additional names or those longer than 35 characters in length  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *Use when names are longer than 35 bytes for:  
 Servicing Provider (when NM101=82)  
 Service Facility (when NM101=FA)*

**Data Element Summary**

	<b>Ref.</b>	<b>Data</b>		<b>Attributes</b>
	<b>Des.</b>	<b>Element</b>	<b>Name</b>	
>>	N201	93	<b>Name</b> Free-form name  <i>Contains additional name text as an extension of the value in NM103 when the Servicing Provider or Service Facility names are longer than 35 bytes.</i>	<b>M AN 1/60</b>
X	N202	93	<b>Name</b> Free-form name	<b>O AN 1/60</b>

**Segment:** **N3** **Address Information**  
**Position:** 265  
**Loop:** 2310 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed since the N3 segment is not used at HL03=20 level. The N3 segment is still a "Must Use" segment when HL03=22.*

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	N301	166	<b>Address Information</b> Address information <i>Servicing Provider or Service Facility Address</i> HCFA 1500 Form Location 33, when NM101='82' HCFA 1500 Form Location 32, when NM101='FA'	<b>M AN 1/55</b>
X	N302	166	<b>Address Information</b> Address information	<b>O AN 1/55</b>

- Segment:** **N4 Geographic Location**  
**Position:** 270  
**Loop:** 2310 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify the geographic place of the named party  
**Syntax Notes:** 1 If N406 is present, then N405 is required.  
**Semantic Notes:**  
**Comments:** 1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.  
 2 N402 is required only if city name (N401) is in the U.S. or Canada.  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

*Note: The "Must Use" designation was removed since the N3 segment is not used at HL03=20 level. The N3 segment is still a "Must Use" segment when HL03=22.*

**Data Element Summary**

<b>Ref.</b>	<b>Data</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element Name</b>	
>>	<b>N401</b> 19 <b>City Name</b> Free-form text for city name <i>Servicing Provider or Service Facility City</i> HCFA 1500 Form Location 33, when NM101='82' HCFA 1500 Form Location 32, when NM101='FA'	<b>O AN 2/30</b>
>>	<b>N402</b> 156 <b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <i>Servicing Provider or Service Facility State</i> HCFA 1500 Form Location 33, when NM101='82' HCFA 1500 Form Location 32, when NM101='FA'	<b>O ID 2/2</b>
>>	<b>N403</b> 116 <b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <i>Servicing Provider or Service Facility Postal Zip Code</i> HCFA 1500 Form Location 33, when NM101='82' HCFA 1500 Form Location 32, when NM101='FA'	<b>O ID 3/15</b>
X	<b>N404</b> 26 <b>Country Code</b> Code identifying the country	<b>O ID 2/3</b>
X	<b>N405</b> 309 <b>Location Qualifier</b> Code identifying type of location	<b>X ID 1/2</b>
X	<b>N406</b> 310 <b>Location Identifier</b> Code which identifies a specific location	<b>O AN 1/30</b>

**Segment:** **LX** Assigned Number  
**Position:** 365  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To reference a line number in a transaction set  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
>> LX01	<u>Element</u> 554	<u>Assigned Number</u> Number assigned for differentiation within a transaction set <i>Service Line Number</i> <i>The service line number is incremented by 1 for each service line</i>	M N0 1/6

- Segment:** **SV1 Professional Service**
- Position:** 370
- Loop:** 2400 Optional (Must Use)
- Level:** Detail
- Usage:** Optional (Must Use)
- Max Use:** 1
- Purpose:** To specify the claim service detail for a Health Care professional
- Syntax Notes:** 1 If either SV103 or SV104 is present, then the other is required.
- Semantic Notes:**
- 1 SV102 is the submitted charge amount.
  - 2 SV105 is the place of service.
  - 3 SV108 is the independent lab charges.
  - 4 SV109 is the emergency-related indicator; a "Y" value indicates service provided was emergency related; an "N" value indicates service provided was not emergency related.
  - 5 SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement.
  - 6 SV112 is the family planning involvement indicator. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement.
  - 7 SV117 is the health care manpower shortage area (HMSA) facility identification.
  - 8 SV118 is the health care manpower shortage area (HMSA) zip code.
  - 9 SV119 is a noncovered charge amount.
- Comments:** 1 If SV113 is equal to "L" or "N", then SV114 is required.
- Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
>>	<b>SV101</b>	<b>C003 Composite Medical Procedure Identifier</b>	<b>M</b>
		To identify a medical procedure by its standardized codes and applicable modifiers <i>Line Item Procedure Code</i>	
>>	<b>C00301</b>	<b>235 Product/Service ID Qualifier</b>	<b>M ID 2/2</b>
		Code identifying the type/source of the descriptive number used in Product/Service ID (234) HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments <i>Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under 'HC'.</i>	
>>	<b>C00302</b>	<b>234 Product/Service ID</b>	<b>M AN 1/48</b>
		Identifying number for a product or service <i>Procedure Code</i> HCFA 1500 Form Location 24D	
	<b>C00303</b>	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners <i>Procedure Modifier 1</i> HCFA 1500 Form Location 24D	
	<b>C00304</b>	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners <i>Procedure Modifier 2</i> HCFA 1500 Form Location 24D	

	<b>C00305</b>	<b>1339</b>	<b>Procedure Modifier</b>	<b>O AN 2/2</b>
			This identifies special circumstances related to the performance of the service, as defined by trading partners <i>Procedure Modifier 3</i>	
			HCFA 1500 Form Location 24D	
	<b>C00306</b>	<b>1339</b>	<b>Procedure Modifier</b>	<b>O AN 2/2</b>
			This identifies special circumstances related to the performance of the service, as defined by trading partners <i>Procedure Modifier 4</i>	
			HCFA 1500 Form Location 24D	
<b>X</b>	<b>C00307</b>	<b>352</b>	<b>Description</b>	<b>O AN 1/80</b>
			A free-form description to clarify the related data elements and their content	
<b>&gt;&gt;</b>	<b>SV102</b>	<b>782</b>	<b>Monetary Amount</b>	<b>O R 1/18</b>
			Monetary amount <i>Line Item Billed Charges from the Provider.</i>	
			HCFA 1500 Form Location 24F	
<b>&gt;&gt;</b>	<b>SV103</b>	<b>355</b>	<b>Unit or Basis for Measurement Code</b>	<b>X ID 2/2</b>
			Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	
			MJ Minutes	
			UN Unit	
<b>&gt;&gt;</b>	<b>SV104</b>	<b>380</b>	<b>Quantity</b>	<b>X R 1/15</b>
			Numeric value of quantity <i>Line Item Units of Service Provided.</i> <i>If a decimal is needed to report units, include it in this element.</i>	
			HCFA 1500 Form Location 24G	
	<b>SV105</b>	<b>1331</b>	<b>Facility Code Value</b>	<b>O AN 1/2</b>
			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 <i>Facility Type Code.</i> <i>Use HCFA standard Place of Service codes.</i>	
			HCFA 1500 Form Location 24B	
	<b>SV106</b>	<b>1365</b>	<b>Service Type Code</b>	<b>O ID 1/2</b>
			Code identifying the classification of service	
			HCFA 1500 Form Location 24C	
			1 Medical Care	
			2 Surgical	
			3 Consultation	
			4 Diagnostic X-Ray	
			5 Diagnostic Lab	
			6 Radiation Therapy	
			7 Anesthesia	
			8 Surgical Assistance	
			9 Other Medical	
			10 Blood Charges	
			11 Used Durable Medical Equipment	
			12 Durable Medical Equipment Purchase	
			13 Ambulatory Service Center Facility	
			14 Renal Supplies in the Home	
			15 Alternate Method Dialysis	
			16 Chronic Renal Disease (CRD) Equipment	

			17	Pre-Admission Testing	
			18	Durable Medical Equipment Rental	
			19	Pneumonia Vaccine	
			20	Second Surgical Opinion	
			21	Third Surgical Opinion	
			22	Social Work	
			33	Chiropractic	
			42	Home Health Care	
			45	Hospice	
			46	Respite Care	
			50	Hospital - Outpatient	
			59	Licensed Ambulance	
			64	Acupuncture	
			66	Pathology	
			67	Smoking Cessation	
			68	Well Baby Care	
			69	Maternity	
			76	Dialysis	
			78	Chemotherapy	
			79	Allergy Testing	
			80	Immunizations	
			A4	Psychiatric	
			AE	Physical Medicine	
			AF	Speech Therapy	
			AG	Skilled Nursing Care	
			AL	Vision (Optometry)	
			AM	Frames	
			AO	Lenses	
>>	SV107	C004		<b>Composite Diagnosis Code Pointer</b>	<b>O</b>
				To identify one or more diagnosis code pointers	
>>	C00401	1328		<b>Diagnosis Code Pointer</b>	<b>M N0 1/2</b>
				A pointer to the claim diagnosis code in the order of importance to this service	
				<i>Line Item Diagnosis Pointer. A pointer to one of the four diagnosis codes on the HI segment that is used to identify the line item diagnosis for each procedure/ service performed. Valid values are 1, 2, 3 or 4.</i>	
				HCFA 1500 Form Location 24E related back to Diagnosis Code Pointer from HCFA 1500 Form Location 21	
X	C00402	1328		<b>Diagnosis Code Pointer</b>	<b>O N0 1/2</b>
				A pointer to the claim diagnosis code in the order of importance to this service	
X	C00403	1328		<b>Diagnosis Code Pointer</b>	<b>O N0 1/2</b>
				A pointer to the claim diagnosis code in the order of importance to this service	
X	C00404	1328		<b>Diagnosis Code Pointer</b>	<b>O N0 1/2</b>
				A pointer to the claim diagnosis code in the order of importance to this service	
X	SV108	782		<b>Monetary Amount</b>	<b>O R 1/18</b>
				Monetary amount	
X	SV109	1073		<b>Yes/No Condition or Response Code</b>	<b>O ID 1/1</b>
				Code indicating a Yes or No condition or response	
X	SV110	1340		<b>Multiple Procedure Code</b>	<b>O ID 1/2</b>
				Code indicating proper adjudication and payment determination in cases involving multiple surgical procedures during the same surgical session	

X	SV111	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1
X	SV112	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1
X	SV113	1364	<b>Review Code</b> Code identifying extenuating circumstances or justifications which might assist any review of the medical necessity for this service	O ID 1/2
X	SV114	1341	<b>National or Local Assigned Review Value</b> Value assigned by national or local organizations for various healthcare data elements	O AN 1/2
X	SV115	1327	<b>Copay Status Code</b> Code indicating whether or not co-payment requirements were met on a line by line basis	O ID 1/1
X	SV116	1334	<b>Health Care Professional Shortage Area Code</b> Code identifying the Health Care Professional Shortage Area Code (HPSA)	O ID 1/1
X	SV117	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30
X	SV118	116	<b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)	O ID 3/15
X	SV119	782	<b>Monetary Amount</b> Monetary amount	O R 1/18
X	SV120	1337	<b>Level of Care Code</b> Code specifying the level of care provided by a nursing home facility	O ID 1/1
X	SV121	1360	<b>Provider Agreement Code</b> Code indicating the type of agreement under which the provider is submitting this claim	O ID 1/1

**Segment:** **DTP** **Date or Time or Period**  
**Position:** 455  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 15  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:** *This segment is only used in the Injured Worker Level, when HL03='22'.*

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
>> DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time 472 Service Begin and end dates of the service being rendered	<b>M ID 3/3</b>
>> DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date	<b>M ID 2/3</b>
>> DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <i>Line Item Beginning/ Ending Dates of Service.</i> <i>BWC requires the beginning and ending dates to be the same.</i> HCFA 1500 Form Location 24A	<b>M AN 1/35</b>

**Segment:** **SE** Transaction Set Trailer  
**Position:** 555  
**Loop:**  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

**Syntax Notes:**

**Semantic Notes:**

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

**Data Element Summary**

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
>>	SE01	96	<b>Number of Included Segments</b> Total number of segments included in a transaction set including ST and SE segments	M N0 1/10
>>	SE02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <i>The Transaction Set Control Numbers in ST02 and SE02 must be identical.</i>	M AN 4/9

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**X12 835 – version 004010**  
**Health Care Claim Payment/Advice**

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## A. 835 OVERVIEW

Managed Care Organizations (MCOs) will send the X12 835 Health Care Claim Payment/Advice transaction set ("Provider 835") to Healthcare Providers as a remittance advice. Healthcare Providers will use this remittance advice to reconcile medical bills.

This Provider 835 was developed utilizing the Health Insurance Portability and Accountability Act (HIPAA) transaction & code set standards. HIPAA's regulations define covered entities as health plans, healthcare clearinghouses and healthcare providers. BWC, its MCOs and self-insuring employers' workers' compensation programs are **not** considered covered entities under HIPAA. However, this transaction was developed to be as "HIPAA friendly" as possible. Due to the nature of workers' compensation in Ohio, there are some data elements that deviate from HIPAA. These deviations are noted in the 835 Data Dictionary. Please refer to [www.ohiobwc.com](http://www.ohiobwc.com) for more information related to HIPAA and BWC (hint: Search BWC's web-site for "HIPAA" and all related articles will be listed.)

Healthcare Providers are expected to send an X12 997 Functional Acknowledgment for each 835 received. Refer to the section on 997 Functional Acknowledgment Processing for more information.

Expectations for data elements are listed in the Business Rules Matrix. "Required" means that MCOs must transmit the data element in every 835 transaction. "Situational" means that the MCOs must transmit the data element in the 835 transaction when applicable to the situation specified. The Data Dictionary explains the data element with more specific detail.

The cross-reference to the Implementation Guide is in the column titled "Location within X12 835". This column identifies the segment that contains the data, the position of the segment in the X12 835 standard, and the position within the segment where the data element is located and the conditions needed to extract the data. Example: The data element "BWC Claim Number" is contained in a CLP segment located at position 2/010 (in the X12 standard, Table 2/Detail, position 010). It also notes that the data element is in CLP07, the seventh element in the CLP segment.

**B. 835 BUSINESS RULES MATRIX**

**Required:** Required data elements must be sent to the Healthcare Provider on all 835 transmissions.

**Situational:** Situational data elements must be sent to the Healthcare Provider under the following circumstances:

- **Situation 1:** these data elements must be provided when ACH
- **Situation 2:** these data elements must be provided when CHK
- **Situation 3:** these data elements must be provided when NON (informational-only remittance advice)
- **Situation 4:** these data elements must be provided when the Receiver is other than the Pay-To-Provider
- **Situation 5:** these data elements must be provided if available
- **Situation 6:** these data elements must be provided if applicable
- **Situation 7:** these data elements must be provided when the bill is an inpatient, institutional bill
- **Situation 8:** these data elements must be provided when the bill is an outpatient, institutional bill
- **Situation 9:** these data elements must be provided when the bill is a professional bill

<b>L N</b>	<b>Data Element</b>	<b>Required or Situational</b>	<b>Location within X12 148 (HL value, segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
1	Pay-To-Provider Total Paid Amount	R	BPR, 1/020, BPR02	
2	Pay-To-Provider Payment Method	R	BPR, 1/020, BPR04	Indicates method of payment either ACH, CHK or NON. Refer to 835 Data Dictionary for definitions.
3	MCO Routing Number	S1	BPR, 1/020, BPR07 when BPR04="ACH"	
4	MCO Financial Institutions Account Number	S1	BPR, 1/020, BPR09 when BPR04="ACH"	
5	MCO Federal Tax ID	R	BPR, 1/020, BPR10 when BPR04="ACH" and TRN, 1/040, TRN03	
6	Pay-To-Provider Routing Number	S1	BPR, 1/020, BPR13 when BPR04="ACH"	
7	Pay-To-Provider Financial Institution Account Number	S1	BPR, 1/020, BPR15 when BPR04="ACH"	
8	EFT Settlement Date	S1	BPR, 1/020, BPR16 when BPR04="ACH"	
9	Check Issued Date	S2	BPR, 1/020, BPR16 when BPR04="CHK"	
10	Remittance Advice Date	S3	BPR, 1/020, BPR16 when BPR04="NON"	
11	Check Number	S2	TRN, 1/040, TRN02 when BPR04="CHK"	
12	EFT Trace Number	S1	TRN, 1/040, TRN02 when BPR04="ACH"	
13	Remittance Advice Number	S3	TRN, 1/040, TRN02 when BPR04="NON"	
14	Receiver ID	S4	REF, 1/060, REF02 when REF01='EV'	
15	Adjudication Date	S5	DTM, 1/070, DTM02 when DTM01='405'	
16	MCO Number	R	N1, 1/Loop 1000A/080, N104 when N101='PR' and N103='PI'	
17	MCO Name	R	N1, 1/Loop 1000A/080, N102 when N101='PR'	
18	MCO Mailing Address – Line 1	R	N3, 1/Loop 1000A/100, N301 when N101='PR'	
19	MCO Mailing Address – Line 2	S5	N3, 1/Loop 1000A/100, N302 when N101='PR'	

**B. 835 BUSINESS RULES MATRIX**

<b>L N</b>	<b>Data Element</b>	<b>Required or Situational</b>	<b>Location within X12 148 (HL value, segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
20	MCO City	R	N4, 1/Loop 1000A/110, N401 when N101='PR'	
21	MCO State	R	N4, 1/Loop 1000A/110, N402 when N101='PR'	
22	MCO Zip	R	N4, 1/Loop 1000A/110, N403 when N101='PR'	
23	Originating MCO Number	S6	REF, 1/Loop 1000A/120, REF02 when REF01='EO'	Only populated in Merger & Acquisition situations, when the financially responsible MCO is different than the original submitting MCO.
24	MCO Contact Name	R	PER, 1/Loop 1000A/130, PER02 when PER01='CX'	
25	MCO Electronic Mail	R	PER, 1/Loop 1000A/130, contained in <ul style="list-style-type: none"> <li>• PER04 when PER03='EM' or</li> <li>• PER06 when PER05='EM'</li> </ul>	
26	MCO Facsimile Number	R	PER, 1/Loop 1000A/130, contained in <ul style="list-style-type: none"> <li>• PER04 when PER03='FX' or</li> <li>• PER06 when PER05='FX'</li> </ul>	
27	MCO Telephone Number	R	PER, 1/Loop 1000A/130, contained in <ul style="list-style-type: none"> <li>• PER04 when PER03='TE' or</li> <li>• PER06 when PER05='TE'</li> </ul>	
28	MCO Telephone Extension Number	S5	PER, 1/Loop 1000A/130, contained in <ul style="list-style-type: none"> <li>• PER06 when PER05='EX' or</li> <li>• PER08 when PER07='EX'</li> </ul>	
29	Pay-To-Provider Name	R	N1, 1/Loop 1000B/080, N102 when N101='PE'	
30	Pay-To-Provider BWC ID	R	N1, 1/Loop 1000B/080, N104 when N101='PE' and N103='FI'	
31	Pay-To-Provider Mailing Address – Line 1	R	N3,1/Loop 1000B/080, N301 when N101='PE'	
32	Pay-To-Provider Mailing Address – Line 2	S5	N3, 1/Loop 1000B/080, N302 when N101='PE'	
33	Pay-To-Provider City	S6	N4, 1/Loop 1000B/080, N401 when N101='PE'	
34	Pay-To-Provider State	S6	N4, 1/Loop 1000B/080, N402 when N101='PE'	
35	Pay-To-Provider Zip	S6	N4, 1/Loop 1000B/080, N403 when N101='PE'	
36	Pay-To-Provider Country Code	S6	N4, 1/Loop 1000B/080, N404 when N101='PE'	
37	Servicing Provider BWC ID	S6	TS3, 2/Loop 2000/005, TS301	
38	Servicing Provider Facility Type Code	S6	TS3, 2/Loop 2000/005, TS302	
39	Servicing Provider Fiscal Period Date	S6	TS3, 2/Loop 2000/005, TS303	
40	Servicing Provider Summary Total Bill Count	S6	TS3, 2/Loop 2000/005, TS304	
41	Servicing Provider Summary Provider Charges	S6	TS3, 2/Loop 2000/005, TS305	

**B. 835 BUSINESS RULES MATRIX**

<b>L N</b>	<b>Data Element</b>	<b>Required or Situational</b>	<b>Location within X12 148 (HL value, segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
42	Servicing Provider Summary BWC Allowed Charges	S6	TS3, 2/Loop 2000/005, TS306	
43	Servicing Provider Summary Paid Charges	S6	TS3, 2/Loop 2000/005, TS309	
44	Servicing Provider Summary Interest Amount	S6	TS3, 2/Loop 2000/005, TS310	
45	Servicing Provider Summary MCO Allowed Charges	S6	TS3, 2/Loop 2000/005, TS311	
46	Patient Account Number	R	CLP, 2/Loop 2100/010, CLP01	
47	Bill Payment Status Code	R	CLP, 2/Loop 2100/010, CLP02	
48	Bill Total Provider Charges	R	CLP, 2/Loop 2100/010, CLP03	
49	Bill Total Paid Amount	R	CLP, 2/Loop 2100/010, CLP04	
50	BWC Claim Number	R	CLP, 2/Loop 2100/010, CLP07 when CLP06='WC'	
51	Bill Institutional Type	S7 or S8	CLP, 2/Loop 2100/010, CLP08-CLP09	For Institutional Bills: <ul style="list-style-type: none"> <li>• Apply Situation 7 or 8.</li> <li>• CLP08 contains positions 1 &amp; 2 of the place of service.</li> <li>• CLP09 contains position 3 of the place of service.</li> </ul> For Professional Bills: <ul style="list-style-type: none"> <li>• CLP08 can contain the first line item's place of service.</li> </ul>
52	Bill Adjustment Group Code	S6	CAS, 2/Loop 2100/020, CAS01	
53	Bill EOB Code	S6	CAS, 2/Loop 2100/020, CAS02	
54	Bill Adjusted Amount	S6	CAS, 2/Loop 2100/020, CAS03	
55	Injured Worker Name – Last	R	NM1, 2/Loop 2100/030, NM103 when NM101='QC' and NM102='1'	
56	Injured Worker Name – First	R	NM1, 2/Loop 2100/030, NM104 when NM101='QC' and NM102='1'	
57	Injured Worker Name – Middle Initial	S5	NM1, 2/Loop 2100/030, NM105 when NM101='QC' and NM102='1'	
58	Injured Worker – Suffix	S5	NM1, 2/Loop 2100/030, NM107 when NM101='QC' and NM102='1'	
59	Injured Worker Social Security Number	S5	NM1, 2/Loop 2100/030, NM109 when NM101='QC' and NM102='1' and NM108='34'	
60	Servicing Provider Organization Name	S6	NM1, 2/Loop 2100/030, NM103 when NM101='82' and NM102='2'	Either Servicing Provider Organization Name or Servicing Provider Name – Last must be provided when applicable.

**B. 835 BUSINESS RULES MATRIX**

<b>L N</b>	<b>Data Element</b>	<b>Required or Situational</b>	<b>Location within X12 148 (HL value, segment, table/position and Mapping Criteria</b>	<b>Notes</b>
61	Servicing Provider Name – Last	S6	NM1, 2/Loop 2100/030, NM103 when NM101='82' and NM102='1'	Either Servicing Provider Organization Name or Servicing Provider Name – Last must be provided when applicable.
62	Servicing Provider Name – First	S6	NM1, 2/Loop 2100/030, NM104 when NM101='82' and NM102='1'	
63	Servicing Provider Name – Middle Initial	S6	NM1, 2/Loop 2100/030, NM105 when NM101='82' and NM102='1'	
64	Servicing Provider Name – Suffix	S6	NM1, 2/Loop 2100/030, NM107 when NM101='82' and NM102='1'	
65	Servicing Provider BWC ID	R	NM1, 2/Loop 2100/030, NM109 when NM108='FI' and NM101='82'	
66	Submitting MCO Name	R	NM1, 2/Loop 2100/030, NM103 when NM101='TT' and NM102='2'	
67	Submitting MCO Number	R	NM1, 2/Loop 2100/030, NM109 when NM108='FI' and NM101='TT'	
68	Medical Record Number	S5	REF, 2/Loop 2100/040, REF02 when REF01='EA'	Format: 17 characters alphanumeric .
69	MCO Bill Document Number	R	REF, 2/Loop 2100/040, REF02 when REF01='1W'	
70	BWC Bill Number	S5	REF, 2/Loop 2100/040, REF02 when REF01='F8'	
71	Bill Begin Date of Service/Bill Date of Service	S7	DTM, 2/Loop 2100/050, DTM02 when DTM = '232'	
72	Bill End Date of Service	S7	DTM, 2/Loop 2100/050, DTM02 when DTM = '233'	
73	MCO Case Manager Name	S5	PER, 2/Loop 2100/060, PER02 when PER01='CX'	Recommended name format: First Last
74	MCO Case Manager Electronic Mail	S5	PER, 2/Loop 2100/060, contained in <ul style="list-style-type: none"> <li>• PER04 when PER03='EM' or</li> <li>• PER06 when PER05='EM'</li> </ul>	
75	MCO Case Manager Facsimile Number	S5	PER, 2/Loop 2100/060, contained in <ul style="list-style-type: none"> <li>• PER04 when PER03='FX' or</li> <li>• PER06 when PER05='FX'</li> </ul>	
76	MCO Case Manager Telephone Number	S5	PER, 2/Loop 2100/060, contained in <ul style="list-style-type: none"> <li>• PER04 when PER03='TE' or</li> <li>• PER06 when PER05='TE'</li> </ul>	
77	MCO Case Manager Telephone Extension Number	S5	PER, 2/Loop 2100/060, contained in <ul style="list-style-type: none"> <li>• PER06 when PER05='EX' or</li> <li>• PER08 when PER07='EX'</li> </ul>	
78	Bill Total Interest Amount	S6	AMT, 2/Loop 2100/062, AMT02 when AMT01='I'	
79	Bill Total MCO Allowed Amount	S5	AMT, 2/Loop 2100/062, AMT02 when AMT01='B6'	
80	Bill Total BWC Allowed Amount	R	AMT, 2/Loop 2100/062, AMT02 when AMT01='AU'	

**B. 835 BUSINESS RULES MATRIX**

<b>L N</b>	<b>Data Element</b>	<b>Required or Situational</b>	<b>Location within X12 148 (HL value, segment, table/position) and Mapping Criteria</b>	<b>Notes</b>
81	Line Item Procedure Code	R	SVC, 2/Loop 2110/070, SVC01-2 through SVC01-6 when SVC01-1='HC' (HCPCS) or SVC01-1='NU' (Revenue Code)	
82	Line Item Provider Charges	R	SVC, 2/Loop 2110/070, SVC02	
83	Line Item Paid Amount	R	SVC, 2/Loop 2110/070, SVC03	
84	Line Item Revenue Code	S6	SVC, 2/Loop 2110/070, SVC04	
85	Line Item Units of Service	S6	SVC, 2/Loop 2110/070, SVC05	
86	Line Item Date of Service	S8 & S9	DTM, 2/Loop 2110/080, DTM02 when DTM01='472'	Recommended for use when a single date of service exists.
87	Line Item Begin Date of Service	S8 & S9	DTM, 2/Loop 2110/080, DTM02 when DTM01='150'	Recommended for use when both begin and end dates are utilized.
88	Line Item End Date of Service	S8 & S9	DTM, 2/Loop 2110/080, DTM02 when DTM01='151'	Recommended for use when both begin and end dates are available
89	Line Item Adjustment Group Code	S6	CAS, 2/Loop 2110/090, CAS01	
90	Line Item EOB Code	S6	CAS, 2/Loop 2110/090, CAS02	
91	Line Item Adjusted Amount	S6	CAS, 2/Loop 2110/090, CAS03	
92	Line Item Interest Amount	S6	AMT, 2/Loop 2110/110, AMT02 when AMT01='I'	
93	Line Item MCO Allowed Amount	S5	AMT, 2/Loop 2110/100, AMT02, when AMT01='B6'	
94	Line Item BWC Allowed Amount	R	AMT, 2/Loop 2110/100, AMT02 when AMT01='AU'	
95	Adjusted Pay-To-Provider BWC ID	S6	PLB, 3/ 010, PLB01	
96	Adjusted Pay-To-Provider Fiscal Period	S6	PLB, 3/ 010, PLB02	
97	Adjusted Pay-To-Provider Adjustment Group Code	S6	PLB, 3/ 010, PLB03-2	
98	Adjusted Pay-To-Provider Adjustment Amount	S6	PLB, 3/010, PLB04	
99	Line Number: BWC	S5	REF, 2/Loop 2110/100, REF02 when REF01='83'	Line number assigned by BWC's system.
100	Line Number: MCO	S5	REF, 2/Loop 2110/100, REF02 when REF01='FJ'	Line number assigned by the MCO's system.
101	Line Number: Provider	S5	REF, 2/Loop 2110/100, REF02 when REF01='6R'	Line number assigned by the Healthcare Provider's system. Recommended for use. If the MCO & BWC line numbers are known, they should also be sent.

**C. 835 SUMMARY OF SEGMENTS USED****Table 1 Header**

Pos No.	Seg ID	Name	
	ISA	Interchange Control Header	
	GS	Functional Group Header	
010	ST	Transaction Set Header	
<b>Payment Header</b>			
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(Pay-To-Provider Total Paid Amount)
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(Pay-To-Provider Payment Method)
<b>Payment Header: Sender/MCO</b>			
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(MCO Routing Number)
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(MCO Financial Institutions Account Number)
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(MCO Federal Tax ID)
<b>Payment Header: Receiver/Provider</b>			
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(Pay-To-Provider Routing Number)
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(Pay-To-Provider Financial Institution Account Number)
<b>Payment Header</b>			
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(EFT Settlement Date)
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(Check Issued Date)
020	BPR	Beginning Segment for Payment Order/ Remittance Advice	(Remittance Advice Date)
040	TRN	Trace	(Check Number)
040	TRN	Trace	(EFT Trace Number)
040	TRN	Trace	(Remittance Advice Number)
040	TRN	Trace	(MCO Federal Tax ID)
060	REF	Reference Identification	(Receiver ID)
070	DTM	Date/Time Reference	(Adjudication Date)
<b>Payer MCO</b>			
080	N1	Name	(MCO Number, MCO Name)
100	N3	Address Information	(MCO Mailing Address – Line 1 & Line 2)
110	N4	Geographic Location	(MCO City, State, Zip)
120	REF	Reference Identification	(Originating MCO Number)
130	PER	Administrative Communications Contact	(MCO Contact Name, MCO Electronic Mail, MCO Facsimile Number, MCO Telephone Number, MCO Telephone Extension Number)
<b>Pay-To-Provider</b>			
080	N1	Name	(Pay-To-Provider Name, Pay-To-Provider BWC ID)
100	N3	Address Information	(Pay-To-Provider Mailing Address – Line 1 & Line 2)
110	N4	Geographic Location	(Pay-To-Provider City, State, Zip, Country Code)

**C. 835 SUMMARY OF SEGMENTS USED****Table 2 Detail**

<b>Pos No.</b>	<b>Seg ID</b>	<b>Name</b>	
<b>Service Provider Summary</b>			
005	TS3	Transaction Statistics	(Servicing Provider BWC ID, Servicing Provider Facility Type Code, Servicing Provider Fiscal Period Date, Servicing Provider Summary Total Bill Count, Servicing Provider Summary Provider Charges, Servicing Provider BWC Allowed Charges, Servicing Provider Summary Paid Charges, Servicing Provider Summary Interest Amount, Servicing Provider Summary MCO Allowed Charges)
<b>Bill Level Summary</b>			
010	CLP	Claim Level Data	(Patient Account Number, Bill Payment Status Code, Bill Total Provider Charges, Bill Total Paid Amount, BWC Claim Number, Bill Institutional Type)
020	CAS	Claims Adjustment	(Bill Adjustment Group Code, Bill EOB Code, Bill Adjusted Amount)
030	NM1	Individual or Organizational Name	(Injured Worker Name – Last, First, Middle Initial, Suffix, Injured Worker Social Security Number)
030	NM1	Individual or Organizational Name	(Servicing Provider Organization Name, Servicing Provider Name – Last, First, Middle Initial, Suffix, Servicing Provider BWC ID)
030	NM1	Individual or Organizational Name	(Submitting MCO Name, Submitting MCO Number)
040	REF	Reference Identification	(Medical Record Number)
040	REF	Reference Identification	(MCO Bill Document Number)
040	REF	Reference Identification	(BWC Bill Number)
050	DTM	Date/Time Reference	(Bill Begin Date of Service/Bill Date of Service)
050	DTM	Date/Time Reference	(Bill End Date of Service)
060	PER	Administrative Communications Contact	(MCO Case Manager Name, MCO Case Manager Electronic Mail, MCO Case Manager Facsimile Number, MCO Case Manager Telephone Number, MCO Case Manager Telephone Extension Number)
062	AMT	Monetary Amount	(Bill Total Interest Amount)
062	AMT	Monetary Amount	(Bill Total MCO Allowed Amount)
062	AMT	Monetary Amount	(Bill Total BWC Allowed Amount)
<b>Line Item Level</b>			
070	SVC	Service Information	(Line Item Procedure Code, Line Item Provider Charges, Line Item Paid Amount, Line Item Units of Service, Line Item Revenue Code)
080	DTM	Date/Time Reference	(Line Item Date of Service)
080	DTM	Date/Time Reference	(Line Item Begin Date of Service)
080	DTM	Date/Time Reference	(Line Item End Date of Service)
090	CAS	Claims Adjustment	(Line Item Adjustment Group Code, Line Item EOB Code, Line Item Adjusted Amount)

## C. 835 SUMMARY OF SEGMENTS USED

**Table 2 Detail - continued**

Pos No.	Seg ID	Name	
100	REF	Reference Identification	(Line Item Numbers: Provider, BWC, MCO)
110	AMT	Monetary Amount	(Line Item Interest Amount)
110	AMT	Monetary Amount	(Line Item MCO Allowed Amount)
110	AMT	Monetary Amount	(Line Item BWC Allowed Amount)

**Table 3 Summary**

Pos No.	Seg ID	Name	
010	PLB	Provider Level Adjustment	(Adjusted Pay-To-Provider BWC ID, Adjusted Pay-To-Provider Fiscal Period, Adjusted Pay-To-Provider Adjustment Group Code, Adjusted Pay-To-Provider Adjustment Amount)
030	SE	Transaction Set Trailer	
	GE	Functional Group Trailer	
	IEA	Interchange Control Trailer	

## **D. 835 IMPLEMENTATION GUIDE**

The 835 Implementation Guide contains the detailed structure of the X12 835 document. It includes:

- a graphical depiction of the X12 837 looping structure
- all ASC X12 semantic and syntax notes
- indicators identifying mandatory and optional segments according to X12 rules
- indicators identifying mandatory, optional, and conditional data elements according to X12 rules
- indicators identifying which data elements of the used segments are used and not used
- subsets of valid code values used for ID type data elements
- notes specifying MCO's and Healthcare Provider's usage of the 835

The notes are included throughout the document in *italics*. These note the MCO's usage of the 835 transaction set, segments, data elements and codes. Required data elements on optional segments are only required when the segment is used.

# 835 Health Care Claim Payment/Advice

Functional Group ID=**HP**

## Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

## Notes:

The column left of the name for each segment and element denote the usage of that segment or element. The notations are defined as follows:

>> mandatory according to X12 rules

X not used.

## Heading:

	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
>>	010	ST	Transaction Set Header	M	1		
>>	020	BPR	Beginning Segment for Payment Order/Remittance Advice	M	1		
	040	TRN	Trace	O	1		c1
	060	REF	Reference Identification	O	>1		
	070	DTM	Date/Time Reference	O	>1		
LOOP ID - 1000A						200	
	080	N1	Name	O	1		c2
	100	N3	Address Information	O	>1		
	110	N4	Geographic Location	O	1		
	120	REF	Reference Identification	O	>1		
	130	PER	Administrative Communications Contact	O	>1		
LOOP ID - 1000B						200	
	080	N1	Name	O	1		
	100	N3	Address Information	O	>1		
	110	N4	Geographic Location	O	1		

## Detail:

	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
LOOP ID - 2000						>1	
	003	LX	Assigned Number	O	1		n1
	005	TS3	Transaction Statistics	O	1		
LOOP ID - 2100						>1	
>>	010	CLP	Claim Level Data	M	1		
	020	CAS	Claims Adjustment	O	99		n2
>>	030	NM1	Individual or Organizational Name	M	9		
	040	REF	Reference Identification	O	99		
	050	DTM	Date/Time Reference	O	9		
	060	PER	Administrative Communications Contact	O	3		
	062	AMT	Monetary Amount	O	20		

		LOOP ID - 2110			999
070	SVC	Service Information	O	1	
080	DTM	Date/Time Reference	O	9	n3
090	CAS	Claims Adjustment	O	99	n4
100	REF	Reference Identification	O	99	
110	AMT	Monetary Amount	O	20	

**Summary:**

<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
010	PLB	Provider Level Adjustment	O	>1		
>> 020	SE	Transaction Set Trailer	M	1		

**Transaction Set Notes**

1. The LX segment is used to provide a looping structure and logical grouping of claim payment information.
2. The CAS segment is used to reflect changes to amounts within Table 2.
3. The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.
4. The CAS segment is used to reflect changes to amounts within Table 2.

**Transaction Set Comments**

1. The TRN segment is used to uniquely identify a claim payment and advice.
2. The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

**Segment:** **ST** Transaction Set Header  
**Position:** 010  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the start of a transaction set and to assign a control number  
**Syntax Notes:**  
**Semantic Notes:** 1 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).  
**Comments:**

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	ST01	143	<b>Transaction Set Identifier Code</b> Code uniquely identifying a Transaction Set 835 Health Care Claim Payment/Advice <b>M ID 3/3</b>
>>	ST02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>M AN 4/9</b>

**Segment:** **BPR** Beginning Segment for Payment Order/Remittance Advice  
**Position:** 020  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur

- Syntax Notes:**
- 1 If either BPR06 or BPR07 is present, then the other is required.
  - 2 If BPR08 is present, then BPR09 is required.
  - 3 If either BPR12 or BPR13 is present, then the other is required.
  - 4 If BPR14 is present, then BPR15 is required.
  - 5 If either BPR18 or BPR19 is present, then the other is required.
  - 6 If BPR20 is present, then BPR21 is required.

- Semantic Notes:**
- 1 BPR02 specifies the payment amount.
  - 2 When using this transaction set to initiate a payment, all or some of BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used. BPR06 and BPR07 relate to the originating depository financial institution (ODFI).
  - 3 BPR08 is a code identifying the type of bank account or other financial asset.
  - 4 BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.
  - 5 BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).
  - 6 BPR14 is a code identifying the type of bank account or other financial asset.
  - 7 BPR15 is the account number of the receiving company to be debited or credited with the payment order.
  - 8 BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).
  - 9 BPR17 is a code identifying the business reason for this payment.
  - 10 BPR18, BPR19, BPR20 and BPR21, if used, identify a third bank identification number and account to be used for return items only.
  - 11 BPR20 is a code identifying the type of bank account or other financial asset.

**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	<b>BPR01</b>	<b>305</b>	<b>Transaction Handling Code</b> <b>M ID 1/2</b>
		Code designating the action to be taken by all parties	
		C Payment Accompanies Remittance Advice	
		I Remittance Information Only	
	<b>BPR02</b>	<b>782</b>	<b>Monetary Amount</b> <b>O R 1/18</b>
		Monetary amount	
		<i>Pay-To-Provider Total Paid Amount</i>	
>>	<b>BPR03</b>	<b>478</b>	<b>Credit/Debit Flag Code</b> <b>M ID 1/1</b>
		Code indicating whether amount is a credit or debit	
		C Credit	
	<b>BPR04</b>	<b>591</b>	<b>Payment Method Code</b> <b>O ID 3/3</b>
		Code identifying the method for the movement of payment instructions	
		<i>Pay-To-Provider Payment Method</i>	
		ACH Automated Clearing House (ACH)	
		<i>Indicates that funds are transferred electronically via ACH</i>	
		<i>When ACH is used, BPR05 through BPR10 and BPR12</i>	
		<i>through BPR15 are required.</i>	
		CHK Check	
		<i>Indicates the Pay-To-Provider receives a paper check</i>	

		NON	Non-Payment Data <i>Indicates Remittance information only</i>	
	<b>BPR05</b>	<b>812</b>	<b>Payment Format Code</b> Code identifying the payment format to be used <i>BPR05 is only used and required when BPR04=ACH</i>	<b>O ID 1/10</b>
		CCP	Cash Concentration/Disbursement plus Addenda (CCD+) (ACH)	
		CTX	Corporate Trade Exchange (CTX) (ACH)	
	<b>BPR06</b>	<b>506</b>	<b>(DFI) ID Number Qualifier</b> Code identifying the type of identification number of Depository Financial Institution (DFI) <i>BPR06 is only used and required when BPR04=ACH</i>	<b>X ID 2/2</b>
		01	ABA Transit Routing Number Including Check Digits (9 digits)	
	<b>BPR07</b>	<b>507</b>	<b>(DFI) Identification Number</b> Depository Financial Institution (DFI) identification number <i>MCO Routing Number is only used and required when BPR04=ACH and BPR06=01</i>	<b>X AN 3/12</b>
	<b>BPR08</b>	<b>569</b>	<b>Account Number Qualifier</b> Code indicating the type of account <i>BPR08 is only used and required when BPR04=ACH and BPR06=01</i>	<b>O ID 1/3</b>
		DA	Demand Deposit	
	<b>BPR09</b>	<b>508</b>	<b>Account Number</b> Account number assigned <i>MCO Financial Institutions Account Number is only used and required when BPR04=ACH and BPR06=01</i>	<b>X AN 1/35</b>
	<b>BPR10</b>	<b>509</b>	<b>Originating Company Identifier</b> A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9 <i>MCO Federal Tax ID (must be identical to TRN03)</i>	<b>O AN 10/10</b>
<b>X</b>	<b>BPR11</b>	<b>510</b>	<b>Originating Company Supplemental Code</b> A code defined between the originating company and the originating depository financial institution (ODFI) that uniquely identifies the company initiating the transfer instructions	<b>O AN 9/9</b>
	<b>BPR12</b>	<b>506</b>	<b>(DFI) ID Number Qualifier</b> Code identifying the type of identification number of Depository Financial Institution (DFI) <i>BPR12 is only used and required when BPR04=ACH</i>	<b>X ID 2/2</b>
		01	ABA Transit Routing Number Including Check Digits (9 digits)	
	<b>BPR13</b>	<b>507</b>	<b>(DFI) Identification Number</b> Depository Financial Institution (DFI) identification number <i>Pay-To-Provider Routing Number is only used and required when BPR04=ACH and BPR12=01</i>	<b>X AN 3/12</b>
	<b>BPR14</b>	<b>569</b>	<b>Account Number Qualifier</b> Code indicating the type of account <i>BPR14 is only used and required when BPR04=ACH and BPR12=01</i>	<b>O ID 1/3</b>
		DA	Demand Deposit	
		SG	Savings	
	<b>BPR15</b>	<b>508</b>	<b>Account Number</b> Account number assigned <i>Pay-To-Provider Financial Institution Account Number is only used and required when BPR04=ACH and BPR12=01</i>	<b>X AN 1/35</b>

	<b>BPR16</b>	<b>373</b>	<b>Date</b> Date expressed as CCYYMMDD <i>EFT Settlement Date (BPR04=ACH)</i> <i>Check Issued Date (BPR04=CHK)</i> <i>Remittance Advice Date (BPR04=NON)</i>	<b>O DT 8/8</b>
<b>X</b>	<b>BPR17</b>	<b>1048</b>	<b>Business Function Code</b> Code identifying the business reason for this payment Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 1/3</b>
<b>X</b>	<b>BPR18</b>	<b>506</b>	<b>(DFI) ID Number Qualifier</b> Code identifying the type of identification number of Depository Financial Institution (DFI) Refer to 004010 Data Element Dictionary for acceptable code values.	<b>X ID 2/2</b>
<b>X</b>	<b>BPR19</b>	<b>507</b>	<b>(DFI) Identification Number</b> Depository Financial Institution (DFI) identification number	<b>X AN 3/12</b>
<b>X</b>	<b>BPR20</b>	<b>569</b>	<b>Account Number Qualifier</b> Code indicating the type of account Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 1/3</b>
<b>X</b>	<b>BPR21</b>	<b>508</b>	<b>Account Number</b> Account number assigned	<b>X AN 1/35</b>

**Segment:** **TRN** Trace  
**Position:** 040  
**Loop:**  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To uniquely identify a transaction to an application  
**Syntax Notes:**  
**Semantic Notes:**

- 1 TRN02 provides unique identification for the transaction.
- 2 TRN03 identifies an organization.
- 3 TRN04 identifies a further subdivision within the organization.

**Comments:**

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	TRN01	481	<b>Trace Type Code</b> Code identifying which transaction is being referenced 1 Current Transaction Trace Numbers <b>M ID 1/2</b>
>>	TRN02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>EFT Trace Number (BPR04=ACH)</i> <i>Check Number (BPR04=CHK)</i> <i>Remittance Advice Number (BPR04=NON)</i> <b>M AN 1/30</b>
	TRN03	509	<b>Originating Company Identifier</b> A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9 <i>MCO Federal Tax ID (must be identical to BPR10)</i> <b>O AN 10/10</b>
X	TRN04	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>O AN 1/30</b>

**Segment:** **REF** Reference Identification  
**Position:** 060  
**Loop:**  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** >1  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

- 1 REF04 contains data relating to the value cited in REF02.

**Comments:**

## Data Element Summary

	<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification EV Receiver Identification Number A unique number identifying the organization/site location designated to receive the current transmitted transaction set <i>Receiver ID</i>	M ID 2/3
	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Receiver ID (REF01=EV)</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **DTM** Date/Time Reference  
**Position:** 070  
**Loop:**  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** >1  
**Purpose:** To specify pertinent dates and times  
**Syntax Notes:**

- 1 At least one of DTM02 DTM03 or DTM05 is required.
- 2 If DTM04 is present, then DTM03 is required.
- 3 If either DTM05 or DTM06 is present, then the other is required.

**Semantic Notes:**  
**Comments:**

## Data Element Summary

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	DTM01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time 405 Production Used to identify dates and times that operations or processes were performed <i>Adjudication Date</i> <b>M ID 3/3</b>
	DTM02	373	<b>Date</b> Date expressed as CCYYMMDD <i>Adjudication Date (DTM01=405)</i> <b>X DT 8/8</b>
X	DTM03	337	<b>Time</b> Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) <b>X TM 4/8</b>
X	DTM04	623	<b>Time Code</b> Code identifying the time. In accordance with International Standards Organization standard 8601, time can be specified by a + or - and an indication in hours in relation to Universal Time Coordinate (UTC) time; since + is a restricted character, + and - are substituted by P and M in the codes that follow Refer to 004010 Data Element Dictionary for acceptable code values. <b>O ID 2/2</b>
X	DTM05	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format Refer to 004010 Data Element Dictionary for acceptable code values. <b>X ID 2/3</b>
X	DTM06	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X AN 1/35</b>

- Segment:** **N1** Name
- Position:** 080
- Loop:** 1000A Optional
- Level:** Heading
- Usage:** Optional
- Max Use:** 1
- Purpose:** To identify a party by type of organization, name, and code
- Syntax Notes:**
- 1 At least one of N102 or N103 is required.
  - 2 If either N103 or N104 is present, then the other is required.
- Semantic Notes:**
- Comments:**
- 1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
  - 2 N105 and N106 further define the type of entity in N101.

**Data Element Summary**

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>		
>>	<b>N101</b>	<b>98 Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual PR Payer <i>MCO Demographic Information</i>	<b>M ID 2/3</b>
	<b>N102</b>	<b>93 Name</b> Free-form name <i>MCO Name (N101=PR)</i>	<b>X AN 1/60</b>
	<b>N103</b>	<b>66 Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) PI Payor Identification	<b>X ID 1/2</b>
	<b>N104</b>	<b>67 Identification Code</b> Code identifying a party or other code <i>MCO Number (N101=PR and N103=PI)</i>	<b>X AN 2/80</b>
<b>X</b>	<b>N105</b>	<b>706 Entity Relationship Code</b> Code describing entity relationship Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 2/2</b>
<b>X</b>	<b>N106</b>	<b>98 Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 2/3</b>

**Segment:** **N3** **Address Information**  
**Position:** 100  
**Loop:** 1000A Optional  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** >1  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

	<b>Ref.</b>	<b>Data</b>	<b>Name</b>	<b>Attributes</b>
	<b>Des.</b>	<b>Element</b>		
>>	N301	166	<b>Address Information</b> Address information <i>MCO Mailing Address - Line 1 (N101=PR)</i>	M AN 1/55
	N302	166	<b>Address Information</b> Address information <i>MCO Mailing Address - Line 2 (N101=PR)</i>	O AN 1/55

**Segment:** **N4 Geographic Location**  
**Position:** 110  
**Loop:** 1000A Optional  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify the geographic place of the named party  
**Syntax Notes:** 1 If N406 is present, then N405 is required.  
**Semantic Notes:**  
**Comments:** 1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.  
 2 N402 is required only if city name (N401) is in the U.S. or Canada.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
N401	19		<b>City Name</b> Free-form text for city name <i>MCO City (N101=PR)</i>	O AN 2/30
N402	156		<b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <i>MCO State (N101=PR)</i>	O ID 2/2
N403	116		<b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <i>MCO Zip (N101=PR)</i>	O ID 3/15
X	N404	26	<b>Country Code</b> Code identifying the country	O ID 2/3
X	N405	309	<b>Location Qualifier</b> Code identifying type of location Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 1/2
X	N406	310	<b>Location Identifier</b> Code which identifies a specific location	O AN 1/30

<b>Segment:</b>	<b>REF</b> Reference Identification
<b>Position:</b>	120
<b>Loop:</b>	1000A Optional
<b>Level:</b>	Heading
<b>Usage:</b>	Optional
<b>Max Use:</b>	>1
<b>Purpose:</b>	To specify identifying information
<b>Syntax Notes:</b>	<ol style="list-style-type: none"> <li>1 At least one of REF02 or REF03 is required.</li> <li>2 If either C04003 or C04004 is present, then the other is required.</li> <li>3 If either C04005 or C04006 is present, then the other is required.</li> </ol>
<b>Semantic Notes:</b>	1 REF04 contains data relating to the value cited in REF02.
<b>Comments:</b>	

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification <i>Originating MCO Number</i> EO Submitter Identification Number A unique number identifying the submitter of the transaction set	M ID 2/3
	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Originating MCO Number (REF01=EO)</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **PER Administrative Communications Contact**  
**Position:** 130  
**Loop:** 1000A Optional  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** >1  
**Purpose:** To identify a person or office to whom administrative communications should be directed  
**Syntax Notes:**

- 1 If either PER03 or PER04 is present, then the other is required.
- 2 If either PER05 or PER06 is present, then the other is required.
- 3 If either PER07 or PER08 is present, then the other is required.

**Semantic Notes:**  
**Comments:**

## Data Element Summary

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>> PER01	366	<b>Contact Function Code</b> Code identifying the major duty or responsibility of the person or group named CX Payers Claim Office Location responsible for paying bills related to medical care received <i>MCO Contact Information</i>	M ID 2/2
PER02	93	<b>Name</b> Free-form name <i>MCO Contact Name (PER01=CX)</i> <i>format: First Last</i>	O AN 1/60
PER03	365	<b>Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	X ID 2/2
PER04	364	<b>Communication Number</b> Complete communications number including country or area code when applicable <i>MCO Electronic Mail (PER03=EM)</i> <i>MCO Facsimile Number (PER03=FX)</i> <i>MCO Telephone Number (PER03=TE)</i>	X AN 1/80
PER05	365	<b>Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone	X ID 2/2
PER06	364	<b>Communication Number</b> Complete communications number including country or area code when applicable <i>MCO Electronic Mail (PER05=EM)</i> <i>MCO Telephone Extension Number (PER05=EX)</i> <i>MCO Facsimile Number (PER05=FX)</i> <i>MCO Telephone Number (PER05=TE)</i>	X AN 1/80
PER07	365	<b>Communication Number Qualifier</b> Code identifying the type of communication number EX Telephone Extension	X ID 2/2
PER08	364	<b>Communication Number</b> Complete communications number including country or area code when applicable <i>MCO Telephone Extension Number (PER07=EX)</i>	X AN 1/80

<b>X</b>	<b>PER09</b>	<b>443</b>	<b>Contact Inquiry Reference</b>	<b>O AN 1/20</b>
			Additional reference number or description to clarify a contact number	

- Segment:** **N1** Name
- Position:** 080
- Loop:** 1000B Optional
- Level:** Heading
- Usage:** Optional
- Max Use:** 1
- Purpose:** To identify a party by type of organization, name, and code
- Syntax Notes:**
- 1 At least one of N102 or N103 is required.
  - 2 If either N103 or N104 is present, then the other is required.
- Semantic Notes:**
- Comments:**
- 1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
  - 2 N105 and N106 further define the type of entity in N101.

**Data Element Summary**

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>		
>>	<b>N101</b>	<b>98 Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual PE Payee <i>Pay-To-Provider Information</i>	<b>M ID 2/3</b>
	<b>N102</b>	<b>93 Name</b> Free-form name <i>Pay-To-Provider Name (N101=PE)</i>	<b>X AN 1/60</b>
	<b>N103</b>	<b>66 Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) FI Federal Taxpayer's Identification Number	<b>X ID 1/2</b>
	<b>N104</b>	<b>67 Identification Code</b> Code identifying a party or other code <i>Pay-To-Provider BWC ID (N101=PE and N103=FI)</i>	<b>X AN 2/80</b>
<b>X</b>	<b>N105</b>	<b>706 Entity Relationship Code</b> Code describing entity relationship Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 2/2</b>
<b>X</b>	<b>N106</b>	<b>98 Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 2/3</b>

**Segment:** **N3** **Address Information**  
**Position:** 100  
**Loop:** 1000B Optional  
**Level:** Heading  
**Usage:** Optional  
**Max Use:** >1  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

<b>Ref.</b>	<b>Data</b>	<b>Name</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element</b>		
>> N301	166	<b>Address Information</b> Address information <i>Pay-To-Provider Mailing Address - Line 1 (N101=PE)</i>	<b>M AN 1/55</b>
N302	166	<b>Address Information</b> Address information <i>Pay-To-Provider Mailing Address - Line 2 (N101=PE)</i>	<b>O AN 1/55</b>

<b>Segment:</b>	<b>N4 Geographic Location</b>
<b>Position:</b>	110
<b>Loop:</b>	1000B Optional
<b>Level:</b>	Heading
<b>Usage:</b>	Optional
<b>Max Use:</b>	1
<b>Purpose:</b>	To specify the geographic place of the named party
<b>Syntax Notes:</b>	1 If N406 is present, then N405 is required.
<b>Semantic Notes:</b>	
<b>Comments:</b>	1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location. 2 N402 is required only if city name (N401) is in the U.S. or Canada.

## Data Element Summary

<b>Ref.</b>	<b>Data</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element Name</b>	
N401	19 <b>City Name</b> Free-form text for city name <i>Pay-To-Provider City (N101=PE)</i>	O AN 2/30
N402	156 <b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <i>Pay-To-Provider State (N101=PE)</i>	O ID 2/2
N403	116 <b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <i>Pay-To-Provider Zip (N101=PE)</i>	O ID 3/15
N404	26 <b>Country Code</b> Code identifying the country <i>Pay-To-Provider Country Code (N101=PE)</i> <i>Required when address is outside the USA</i>	O ID 2/3
X	N405 309 <b>Location Qualifier</b> Code identifying type of location Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 1/2
X	N406 310 <b>Location Identifier</b> Code which identifies a specific location	O AN 1/30

**Segment:** **LX** Assigned Number  
**Position:** 003  
**Loop:** 2000 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To reference a line number in a transaction set  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
>> LX01	554	Assigned Number	M N0 1/6
		Number assigned for differentiation within a transaction set	

**Segment:** **TS3** **Transaction Statistics**  
**Position:** 005  
**Loop:** 2000 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply provider-level control information  
**Syntax Notes:**  
**Semantic Notes:**

- 1 TS301 is the provider number.
- 2 TS303 is the last day of the provider's fiscal year.
- 3 TS304 is the total number of claims.
- 4 TS305 is the total of reported charges.
- 5 TS306 is the total of covered charges.
- 6 TS307 is the total of noncovered charges.
- 7 TS308 is the total of denied charges.
- 8 TS309 is the total provider payment.
- 9 TS310 is the total amount of interest paid.
- 10 TS311 is the total contractual adjustment.
- 11 TS312 is the total Gramm-Rudman Reduction.
- 12 TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
- 13 TS314 is the total blood deductible amount in dollars.
- 14 TS315 is the summary of non-lab charges.
- 15 TS316 is the total coinsurance amount.
- 16 TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
- 17 TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
- 18 TS319 is the total deductible amount.
- 19 TS320 is the total professional component amount.
- 20 TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
- 21 TS322 is the total patient reimbursement.
- 22 TS323 is the total periodic interim payment (PIP) number of claims.
- 23 TS324 is total periodic interim payment (PIP) adjustment.

**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	TS301	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Servicing Provider BWC ID</i> M AN 1/30
>>	TS302	1331	<b>Facility Code Value</b> 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 <i>Servicing Provider Facility Type Code</i> M AN 1/2
>>	TS303	373	<b>Date</b> Date expressed as CCYYMMDD <i>Servicing Provider Fiscal Period Date</i> <i>Default to 12/31 of the current year</i> M DT 8/8
>>	TS304	380	<b>Quantity</b> Numeric value of quantity <i>Servicing Provider Summary Total Bill Count</i> M R 1/15
>>	TS305	782	<b>Monetary Amount</b> Monetary amount <i>Servicing Provider Summary Provider Charges</i> M R 1/18

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	TS306	782	<b>Monetary Amount</b> Monetary amount <i>Servicing Provider Summary BWC Allowed Charges</i>	O	R 1/18
X	TS307	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS308	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
	TS309	782	<b>Monetary Amount</b> Monetary amount <i>Servicing Provider Summary Paid Charges</i>	O	R 1/18
	TS310	782	<b>Monetary Amount</b> Monetary amount <i>Servicing Provider Summary Interest Amount</i>	O	R 1/18
	TS311	782	<b>Monetary Amount</b> Monetary amount <i>Servicing Provider Summary MCO Allowed Charges</i>	O	R 1/18
X	TS312	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS313	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS314	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS315	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS316	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS317	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS318	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS319	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS320	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS321	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS322	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18
X	TS323	380	<b>Quantity</b> Numeric value of quantity	O	R 1/15
X	TS324	782	<b>Monetary Amount</b> Monetary amount	O	R 1/18

**Segment:** **CLP** Claim Level Data  
**Position:** 010  
**Loop:** 2100 Mandatory  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To supply information common to all services of a claim  
**Syntax Notes:**  
**Semantic Notes:**

- 1 CLP03 is the amount of submitted charges this claim.
- 2 CLP04 is the amount paid this claim.
- 3 CLP05 is the patient responsibility amount.
- 4 CLP07 is the payer's internal control number.
- 5 CLP12 is the diagnosis -related group (DRG) weight.
- 6 CLP13 is the discharge fraction.

**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	CLP01	1028	<b>Claim Submitter's Identifier</b> M AN 1/38
		Identifier used to track a claim from creation by the health care provider through payment <i>Patient Account Number</i>	
>>	CLP02	1029	<b>Claim Status Code</b> M ID 1/2
		Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization <i>Bill Payment Status Code</i>	
		1 Processed as Primary	
		2 Processed as Secondary	
		3 Processed as Tertiary	
		4 Denied	
		5 Pended	
		10 Received, but not in process	
		13 Suspended	
		15 Suspended - investigation with field	
		16 Suspended - return with material	
		17 Suspended - review pending	
		19 Processed as Primary, Forwarded to Additional Payer(s)	
		20 Processed as Secondary, Forwarded to Additional Payer(s)	
		21 Processed as Tertiary, Forwarded to Additional Payer(s)	
		22 Reversal of Previous Payment	
		23 Not Our Claim, Forwarded to Additional Payer(s)	
		25 Predetermination Pricing Only - No Payment	
		27 Reviewed	
>>	CLP03	782	<b>Monetary Amount</b> M R 1/18
		Monetary amount <i>Bill Total Provider Charges</i>	
>>	CLP04	782	<b>Monetary Amount</b> M R 1/18
		Monetary amount <i>Bill Total Paid Amount</i>	
X	CLP05	782	<b>Monetary Amount</b> O R 1/18
		Monetary amount	
	CLP06	1032	<b>Claim Filing Indicator Code</b> O ID 1/2
		Code identifying type of claim WC Workers' Compensation Health Claim	

	<b>CLP07</b>	<b>127</b>	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>BWC Claim Number</i>	<b>O AN 1/30</b>
	<b>CLP08</b>	<b>1331</b>	<b>Facility Code Value</b> 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 <i>For an Institutional Bill, CLP08 contains the first and second position of the place of service, reference the Bill Institutional Type (the third position is contained in CLP09).</i>  <i>For a Professional Bill, use the first line item's place of service.</i>	<b>O AN 1/2</b>
	<b>CLP09</b>	<b>1325</b>	<b>Claim Frequency Type Code</b> Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type <i>For an Institutional Bill, CLP09 contains the third position of the place of service, reference the Bill Institutional Type (the first and second positions are contained in CLP09).</i>  <i>For a Professional Bill, CLP09 is not used.</i>	<b>O ID 1/1</b>
<b>X</b>	<b>CLP10</b>	<b>1352</b>	<b>Patient Status Code</b> Code indicating patient status as of the "statement covers through date"	<b>O ID 1/2</b>
<b>X</b>	<b>CLP11</b>	<b>1354</b>	<b>Diagnosis Related Group (DRG) Code</b> Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems	<b>O ID 1/4</b>
<b>X</b>	<b>CLP12</b>	<b>380</b>	<b>Quantity</b> Numeric value of quantity	<b>O R 1/15</b>
<b>X</b>	<b>CLP13</b>	<b>954</b>	<b>Percent</b> Percentage expressed as a decimal	<b>O R 1/10</b>

**Segment:** **CAS** Claims Adjustment

**Position:** 020

**Loop:** 2100 Mandatory

**Level:** Detail

**Usage:** Optional

**Max Use:** 99

**Purpose:** To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

- Syntax Notes:**
- 1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
  - 2 If CAS06 is present, then CAS05 is required.
  - 3 If CAS07 is present, then CAS05 is required.
  - 4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
  - 5 If CAS09 is present, then CAS08 is required.
  - 6 If CAS10 is present, then CAS08 is required.
  - 7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
  - 8 If CAS12 is present, then CAS11 is required.
  - 9 If CAS13 is present, then CAS11 is required.
  - 10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
  - 11 If CAS15 is present, then CAS14 is required.
  - 12 If CAS16 is present, then CAS14 is required.
  - 13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
  - 14 If CAS18 is present, then CAS17 is required.
  - 15 If CAS19 is present, then CAS17 is required.

- Semantic Notes:**
- 1 CAS03 is the amount of adjustment.
  - 2 CAS04 is the units of service being adjusted.
  - 3 CAS06 is the amount of the adjustment.
  - 4 CAS07 is the units of service being adjusted.
  - 5 CAS09 is the amount of the adjustment.
  - 6 CAS10 is the units of service being adjusted.
  - 7 CAS12 is the amount of the adjustment.
  - 8 CAS13 is the units of service being adjusted.
  - 9 CAS15 is the amount of the adjustment.
  - 10 CAS16 is the units of service being adjusted.
  - 11 CAS18 is the amount of the adjustment.
  - 12 CAS19 is the units of service being adjusted.

- 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.
  - 2 When the submitted charges are paid in full, the value for CAS03 should be zero.

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	CAS01	1033	<b>Claim Adjustment Group Code</b> M ID 1/2
			Code identifying the general category of payment adjustment <i>Bill Adjustment Group Code.</i>
		CO	Contractual Obligations
			<i>Mergers and Acquisitions</i>
		CR	Correction and Reversals
		OA	Other adjustments
			<i>Regular Bills</i>
>>	CAS02	1034	<b>Claim Adjustment Reason Code</b> M ID 1/5
			Code identifying the detailed reason the adjustment was made <i>Bill EOB Code</i>
>>	CAS03	782	<b>Monetary Amount</b> M R 1/18
			Monetary amount <i>Bill Adjusted Amount</i>

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X	CAS04	380	<b>Quantity</b> Numeric value of quantity	O	R 1/15
X	CAS05	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS06	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS07	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS08	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS09	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS10	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS11	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS12	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS13	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS14	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS15	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS16	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS17	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS18	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS19	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15

**Segment:** **NM1** Individual or Organizational Name  
**Position:** 030  
**Loop:** 2100 Mandatory  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 9  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element Name</u>	
>>	NM101	98 <b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual 82 Rendering Provider <i>Servicing Provider</i> QC Patient Individual receiving medical care <i>Injured Worker</i> TT Transfer To <i>Submitting MCO</i>	M ID 2/3
>>	NM102	1065 <b>Entity Type Qualifier</b> Code qualifying the type of entity 1 Person 2 Non-Person Entity	M ID 1/1
	NM103	1035 <b>Name Last or Organization Name</b> Individual last name or organizational name <i>Injured Worker Name - Last (NM101=QC and NM102=1)</i> <i>Servicing Provider Organizational Name (NM101=82 and NM102=2)</i> <i>Servicing Provider Name - Last (NM101=82 and NM102=1)</i> <i>Submitting MCO Name (NM101=TT and NM102=2)</i>	O AN 1/35
	NM104	1036 <b>Name First</b> Individual first name <i>Injured Workers Name - First (NM101=QC and NM102=1)</i> <i>Servicing Providers Name - First (NM101=82 and NM102=1)</i>	O AN 1/25
	NM105	1037 <b>Name Middle</b> Individual middle name or initial <i>Injured Worker Name - Middle Initial (NM101=QC and NM102=1)</i> <i>Servicing Provider Name - Middle Initial (NM101=82 and NM102=1)</i>	O AN 1/25
X	NM106	1038 <b>Name Prefix</b> Prefix to individual name	O AN 1/10
	NM107	1039 <b>Name Suffix</b> Suffix to individual name <i>Injured Worker Name - Suffix (NM101=QC and NM102=1)</i> <i>Servicing Provider Name - Suffix (NM101=82 and NM102=1)</i>	O AN 1/10
	NM108	66 <b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) 34 Social Security Number <i>Injured Worker Social Security Number</i> FI Federal Taxpayer's Identification Number <i>Servicing Provider BWC ID</i> <i>Submitting MCO Number</i>	X ID 1/2

	<b>NM109</b>	<b>67</b>	<b>Identification Code</b> Code identifying a party or other code <i>Injured Worker Social Security Number (NM101=QC and NM108=34)</i> <i>Servicing Provider BWC ID (NM101=82 and NM108=FI)</i> <i>Submitting MCO Number (NM101=TT and NM108=FI)</i>	<b>X</b>	<b>AN 2/80</b>
<b>X</b>	<b>NM110</b>	<b>706</b>	<b>Entity Relationship Code</b> Code describing entity relationship Refer to 004010 Data Element Dictionary for acceptable code values.	<b>X</b>	<b>ID 2/2</b>
<b>X</b>	<b>NM111</b>	<b>98</b>	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O</b>	<b>ID 2/3</b>

**Segment:** **REF** Reference Identification  
**Position:** 040  
**Loop:** 2100 Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 99  
**Purpose:** To specify identifying information  
**Syntax Notes:**  
 1 At least one of REF02 or REF03 is required.  
 2 If either C04003 or C04004 is present, then the other is required.  
 3 If either C04005 or C04006 is present, then the other is required.  
**Semantic Notes:**  
 1 REF04 contains data relating to the value cited in REF02.  
**Comments:**

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
			1W Member Identification Number Unique identification number assigned to each member under a subscriber's contract <i>MCO Bill Document Number</i>	
			EA Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records <i>Medical Record Number</i>	
			F8 Original Reference Number <i>BWC Bill Number</i>	
	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>MCO Bill Document Number (REF01=1W)</i> <i>Medical Record Number (REF01=EA)</i> <i>BWC Bill Number (REF01=F8)</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3

<b>X</b>	<b>C04006</b>	<b>127</b>	<b>Reference Identification</b>	<b>X AN 1/30</b>
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	

**Segment:** **DTM** Date/Time Reference  
**Position:** 050  
**Loop:** 2100 Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 9  
**Purpose:** To specify pertinent dates and times  
**Syntax Notes:**  
**1** At least one of DTM02 DTM03 or DTM05 is required.  
**2** If DTM04 is present, then DTM03 is required.  
**3** If either DTM05 or DTM06 is present, then the other is required.  
**Semantic Notes:**  
**Comments:**

## Data Element Summary

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	DTM01	374	<b>Date/Time Qualifier</b> M ID 3/3
			Code specifying type of date or time, or both date and time
		232	Claim Statement Period Start <i>Bill Begin Date of Service/Bill Date of Service</i>
		233	Claim Statement Period End <i>Bill End Date of Service</i>
	DTM02	373	<b>Date</b> X DT 8/8
			Date expressed as CCYYMMDD <i>Bill Begin Date of Service/Bill Date of Service (DTM01=232)</i> <i>Bill End Date of Service (DTM01=233)</i>
X	DTM03	337	<b>Time</b> X TM 4/8
			Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)
X	DTM04	623	<b>Time Code</b> O ID 2/2
			Code identifying the time. In accordance with International Standards Organization standard 8601, time can be specified by a + or - and an indication in hours in relation to Universal Time Coordinate (UTC) time; since + is a restricted character, + and - are substituted by P and M in the codes that follow Refer to 004010 Data Element Dictionary for acceptable code values.
X	DTM05	1250	<b>Date Time Period Format Qualifier</b> X ID 2/3
			Code indicating the date format, time format, or date and time format Refer to 004010 Data Element Dictionary for acceptable code values.
X	DTM06	1251	<b>Date Time Period</b> X AN 1/35
			Expression of a date, a time, or range of dates, times or dates and times

**Segment:** **PER Administrative Communications Contact**  
**Position:** 060  
**Loop:** 2100 Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 3  
**Purpose:** To identify a person or office to whom administrative communications should be directed  
**Syntax Notes:** 1 If either PER03 or PER04 is present, then the other is required.  
 2 If either PER05 or PER06 is present, then the other is required.  
 3 If either PER07 or PER08 is present, then the other is required.  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>> PER01	366	<b>Contact Function Code</b> Code identifying the major duty or responsibility of the person or group named CX Payers Claim Office Location responsible for paying bills related to medical care received <i>MCO Case Manager Contact Information</i>	M ID 2/2
PER02	93	<b>Name</b> Free-form name <i>MCO Case Manager Name (PER01=CX)</i>	O AN 1/60
PER03	365	<b>Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	X ID 2/2
PER04	364	<b>Communication Number</b> Complete communications number including country or area code when applicable <i>MCO Case Manager Electronic Mail (PER03=EM)</i> <i>MCO Case Manager Facsimile Number (PER03=FX)</i> <i>MCO Case Manager Telephone Number (PER03=TE)</i>	X AN 1/80
PER05	365	<b>Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone	X ID 2/2
PER06	364	<b>Communication Number</b> Complete communications number including country or area code when applicable <i>MCO Case Manager Electronic Mail (PER05=EM)</i> <i>MCO Case Manager Telephone Extension Number (PER05=EX)</i> <i>MCO Case Manager Facsimile Number (PER05=FX)</i> <i>MCO Case Manager Telephone Number (PER05=TE)</i>	X AN 1/80
PER07	365	<b>Communication Number Qualifier</b> Code identifying the type of communication number EX Telephone Extension	X ID 2/2
PER08	364	<b>Communication Number</b> Complete communications number including country or area code when applicable <i>MCO Case Manager Telephone Extension Number (PER07=EX)</i>	X AN 1/80

<b>X</b>	<b>PER09</b>	<b>443</b>	<b>Contact Inquiry Reference</b>	<b>O AN 1/20</b>
			Additional reference number or description to clarify a contact number	

**Segment:** **AMT** Monetary Amount  
**Position:** 062  
**Loop:** 2100 Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 20  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	AMT01	522	<b>Amount Qualifier Code</b> Code to qualify amount	<b>M ID 1/3</b>
			AU Coverage Amount The dollar amount of property coverage provided by a specific policy contract <i>Bill Total BWC Allowed</i>	
			B6 Allowed - Actual Amount considered for payment under the provisions of the contract <i>Bill Total MCO Allowed Amount</i>	
			I Interest <i>Bill Total Interest Amount</i>	
>>	AMT02	782	<b>Monetary Amount</b> Monetary amount <i>Bill Total Interest Amount (AMT01=I)</i> <i>Bill Total MCO Allowed Amount (AMT01=B6)</i> <i>Bill Total BWC Allowed Amount (AMT01=AU)</i>	<b>M R 1/18</b>
X	AMT03	478	<b>Credit/Debit Flag Code</b> Code indicating whether amount is a credit or debit Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 1/1</b>

**Segment:** **SVC** **Service Information**  
**Position:** 070  
**Loop:** 2110 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply payment and control information to a provider for a particular service  
**Syntax Notes:**  
**Semantic Notes:**

- 1 SVC01 is the medical procedure upon which adjudication is based.
- 2 SVC02 is the submitted service charge.
- 3 SVC03 is the amount paid this service.
- 4 SVC04 is the National Uniform Billing Committee Revenue Code.
- 5 SVC05 is the paid units of service.
- 6 SVC06 is the original submitted medical procedure.
- 7 SVC07 is the original submitted units of service.

**Comments:**

- 1 For Medicare Part A claims, SVC01 would be the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Code (see code source 130) and SVC04 would be the Revenue Code (see code source 132).

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
>>	<b>SVC01</b>	<b>C003 Composite Medical Procedure Identifier</b>	<b>M</b>
		To identify a medical procedure by its standardized codes and applicable modifiers	
		<i>Line Item Procedure Code</i>	
>>	<b>C00301</b>	<b>235 Product/Service ID Qualifier</b>	<b>M ID 2/2</b>
		Code identifying the type/source of the descriptive number used in Product/Service ID (234)	
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments	
		NU National Uniform Billing Committee (NUBC) UB92 Codes	
>>	<b>C00302</b>	<b>234 Product/Service ID</b>	<b>M AN 1/48</b>
		Identifying number for a product or service	
		<i>SVC01-2 through SVC01-6 contains HCPCS (SVC01-01=HC)</i>	
		<i>SVC01-2 through SVC01-6 contains Revenue Codes (SVC01-01=NU)</i>	
	<b>C00303</b>	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
		<i>SVC01-2 through SVC01-6 contains HCPCS (SVC01-01=HC)</i>	
		<i>SVC01-2 through SVC01-6 contains Revenue Codes (SVC01-01=NU)</i>	
	<b>C00304</b>	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
		<i>SVC01-2 through SVC01-6 contains HCPCS (SVC01-01=HC)</i>	
		<i>SVC01-2 through SVC01-6 contains Revenue Codes (SVC01-01=NU)</i>	
	<b>C00305</b>	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
		<i>SVC01-2 through SVC01-6 contains HCPCS (SVC01-01=HC)</i>	
		<i>SVC01-2 through SVC01-6 contains Revenue Codes (SVC01-01=NU)</i>	

	<b>C00306</b>	<b>1339</b>	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <i>SVC01-2 through SVC01-6 contains HCPCS (SVC01-01=HC)</i> <i>SVC01-2 through SVC01-6 contains Revenue Codes (SVC01-01=NU)</i>	<b>O AN 2/2</b>
<b>X</b>	<b>C00307</b>	<b>352</b>	<b>Description</b> A free-form description to clarify the related data elements and their content	<b>O AN 1/80</b>
<b>&gt;&gt;</b>	<b>SVC02</b>	<b>782</b>	<b>Monetary Amount</b> Monetary amount <i>Line Item Provider Charges</i>	<b>M R 1/18</b>
	<b>SVC03</b>	<b>782</b>	<b>Monetary Amount</b> Monetary amount <i>Line Item Paid Amount</i>	<b>O R 1/18</b>
	<b>SVC04</b>	<b>234</b>	<b>Product/Service ID</b> Identifying number for a product or service <i>Line Item Revenue Code</i>	<b>O AN 1/48</b>
	<b>SVC05</b>	<b>380</b>	<b>Quantity</b> Numeric value of quantity <i>Line Item Units of Service</i>	<b>O R 1/15</b>
<b>X</b>	<b>SVC06</b>	<b>C003</b>	<b>Composite Medical Procedure Identifier</b> To identify a medical procedure by its standardized codes and applicable modifiers	<b>O</b>
<b>X</b>	<b>C00301</b>	<b>235</b>	<b>Product/Service ID Qualifier</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234) Refer to 004010 Data Element Dictionary for acceptable code values.	<b>M ID 2/2</b>
<b>X</b>	<b>C00302</b>	<b>234</b>	<b>Product/Service ID</b> Identifying number for a product or service	<b>M AN 1/48</b>
<b>X</b>	<b>C00303</b>	<b>1339</b>	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	<b>O AN 2/2</b>
<b>X</b>	<b>C00304</b>	<b>1339</b>	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	<b>O AN 2/2</b>
<b>X</b>	<b>C00305</b>	<b>1339</b>	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	<b>O AN 2/2</b>
<b>X</b>	<b>C00306</b>	<b>1339</b>	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	<b>O AN 2/2</b>
<b>X</b>	<b>C00307</b>	<b>352</b>	<b>Description</b> A free-form description to clarify the related data elements and their content	<b>O AN 1/80</b>
<b>X</b>	<b>SVC07</b>	<b>380</b>	<b>Quantity</b> Numeric value of quantity	<b>O R 1/15</b>

**Segment:** **DTM** Date/Time Reference  
**Position:** 080  
**Loop:** 2110 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 9  
**Purpose:** To specify pertinent dates and times  
**Syntax Notes:**  
 1 At least one of DTM02 DTM03 or DTM05 is required.  
 2 If DTM04 is present, then DTM03 is required.  
 3 If either DTM05 or DTM06 is present, then the other is required.  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	<b>DTM01</b>	<b>374</b>	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time 150 Service Period Start <i>Line Item Begin Date of Service</i> 151 Service Period End <i>Line Item End Date of Service</i> 472 Service Begin and end dates of the service being rendered <i>Line Item Date of Service</i> <b>M ID 3/3</b>
	<b>DTM02</b>	<b>373</b>	<b>Date</b> Date expressed as CCYYMMDD <i>Line Item Date of Service (DTM01=472)</i> <i>Line Item Service Begin Date (DTM01=150)</i> <i>Line Item Service End Date (DTM01=151)</i> <b>X DT 8/8</b>
<b>X</b>	<b>DTM03</b>	<b>337</b>	<b>Time</b> Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) <b>X TM 4/8</b>
<b>X</b>	<b>DTM04</b>	<b>623</b>	<b>Time Code</b> Code identifying the time. In accordance with International Standards Organization standard 8601, time can be specified by a + or - and an indication in hours in relation to Universal Time Coordinate (UTC) time; since + is a restricted character, + and - are substituted by P and M in the codes that follow Refer to 004010 Data Element Dictionary for acceptable code values. <b>O ID 2/2</b>
<b>X</b>	<b>DTM05</b>	<b>1250</b>	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format Refer to 004010 Data Element Dictionary for acceptable code values. <b>X ID 2/3</b>
<b>X</b>	<b>DTM06</b>	<b>1251</b>	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X AN 1/35</b>

**Segment:** **CAS** Claims Adjustment

**Position:** 090

**Loop:** 2110 Optional

**Level:** Detail

**Usage:** Optional

**Max Use:** 99

**Purpose:** To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

- Syntax Notes:**
- 1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
  - 2 If CAS06 is present, then CAS05 is required.
  - 3 If CAS07 is present, then CAS05 is required.
  - 4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
  - 5 If CAS09 is present, then CAS08 is required.
  - 6 If CAS10 is present, then CAS08 is required.
  - 7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
  - 8 If CAS12 is present, then CAS11 is required.
  - 9 If CAS13 is present, then CAS11 is required.
  - 10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
  - 11 If CAS15 is present, then CAS14 is required.
  - 12 If CAS16 is present, then CAS14 is required.
  - 13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
  - 14 If CAS18 is present, then CAS17 is required.
  - 15 If CAS19 is present, then CAS17 is required.

- Semantic Notes:**
- 1 CAS03 is the amount of adjustment.
  - 2 CAS04 is the units of service being adjusted.
  - 3 CAS06 is the amount of the adjustment.
  - 4 CAS07 is the units of service being adjusted.
  - 5 CAS09 is the amount of the adjustment.
  - 6 CAS10 is the units of service being adjusted.
  - 7 CAS12 is the amount of the adjustment.
  - 8 CAS13 is the units of service being adjusted.
  - 9 CAS15 is the amount of the adjustment.
  - 10 CAS16 is the units of service being adjusted.
  - 11 CAS18 is the amount of the adjustment.
  - 12 CAS19 is the units of service being adjusted.

- 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.
  - 2 When the submitted charges are paid in full, the value for CAS03 should be zero.

**Data Element Summary**

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	CAS01	1033	<b>Claim Adjustment Group Code</b> M ID 1/2
			Code identifying the general category of payment adjustment
			<i>Line Item Adjustment Group Code</i>
		CO	Contractual Obligations
			<i>Mergers and Acquisitions</i>
		CR	Correction and Reversals
		OA	Other adjustments
			<i>Regular Bills</i>
>>	CAS02	1034	<b>Claim Adjustment Reason Code</b> M ID 1/5
			Code identifying the detailed reason the adjustment was made
			<i>Line Item EOB Code</i>
>>	CAS03	782	<b>Monetary Amount</b> M R 1/18
			Monetary amount
			<i>Line Item Adjustment Amount</i>

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X	CAS04	380	<b>Quantity</b> Numeric value of quantity	O	R 1/15
X	CAS05	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS06	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS07	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS08	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS09	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS10	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS11	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS12	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS13	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS14	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS15	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS16	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15
X	CAS17	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made	X	ID 1/5
X	CAS18	782	<b>Monetary Amount</b> Monetary amount	X	R 1/18
X	CAS19	380	<b>Quantity</b> Numeric value of quantity	X	R 1/15

**Segment:** **REF** Reference Identification  
**Position:** 100  
**Loop:** 2110 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 99  
**Purpose:** To specify identifying information  
**Syntax Notes:**  
 1 At least one of REF02 or REF03 is required.  
 2 If either C04003 or C04004 is present, then the other is required.  
 3 If either C04005 or C04006 is present, then the other is required.  
**Semantic Notes:**  
 1 REF04 contains data relating to the value cited in REF02.  
**Comments:**

**Data Element Summary**

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification 6R Provider Control Number Number assigned by information provider company for tracking and billing purposes <i>Line Number: Provider</i> 83 Extended (or Exhibit) Line Item Number (ELIN) Identifies specific line items to be delivered for a contract <i>Line Number: BWC</i> FJ Line Item Control Number A unique number assigned to each charge line used for tracking purposes <i>Line Number: MCO</i>	M ID 2/3
	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Line Number: Provider (REF01=6R)</i> <i>Line Number: BWC (REF01=83)</i> <i>Line Number: MCO (REF01=FJ)</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification Refer to 004010 Data Element Dictionary for acceptable code values.	X ID 2/3

<b>X</b>	<b>C04006</b>	<b>127</b>	<b>Reference Identification</b>	<b>X AN 1/30</b>
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	

**Segment:** **AMT** Monetary Amount  
**Position:** 110  
**Loop:** 2110 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 20  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	AMT01	522	<b>Amount Qualifier Code</b> Code to qualify amount	<b>M ID 1/3</b>
			AU Coverage Amount The dollar amount of property coverage provided by a specific policy contract <i>Line Item BWC Allowed Amount</i>	
			B6 Allowed - Actual Amount considered for payment under the provisions of the contract <i>Line Item Interest Amount</i>	
			I Interest <i>Line Item BWC Allowed Amount</i>	
>>	AMT02	782	<b>Monetary Amount</b> Monetary amount <i>Line Item Interest Amount (AMT01=I)</i> <i>Line Item MCO Allowed Amount (AMT01=B6)</i> <i>Line Item BWC Allowed Amount (AMT01=AU)</i>	<b>M R 1/18</b>
X	AMT03	478	<b>Credit/Debit Flag Code</b> Code indicating whether amount is a credit or debit Refer to 004010 Data Element Dictionary for acceptable code values.	<b>O ID 1/1</b>

**Segment:** **PLB** **Provider Level Adjustment**  
**Position:** 010  
**Loop:**  
**Level:** Summary  
**Usage:** Optional  
**Max Use:** >1  
**Purpose:** To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service

**Syntax Notes:**

- 1 If either PLB05 or PLB06 is present, then the other is required.
- 2 If either PLB07 or PLB08 is present, then the other is required.
- 3 If either PLB09 or PLB10 is present, then the other is required.
- 4 If either PLB11 or PLB12 is present, then the other is required.
- 5 If either PLB13 or PLB14 is present, then the other is required.

**Semantic Notes:**

- 1 PLB01 is the provider number assigned by the payer.
- 2 PLB02 is the last day of the provider's fiscal year.
- 3 PLB03 is the adjustment information as defined by the payer.
- 4 PLB04 is the adjustment amount.
- 5 PLB05 is the adjustment information as defined by the payer.
- 6 PLB06 is the adjustment amount.
- 7 PLB07 is adjustment information as defined by the payer.
- 8 PLB08 is the adjustment amount.
- 9 PLB09 is adjustment information as defined by the payer.
- 10 PLB10 is the adjustment amount.
- 11 PLB11 is adjustment information as defined by the payer.
- 12 PLB12 is the adjustment amount.
- 13 PLB13 is adjustment information as defined by the payer.
- 14 PLB14 is the adjustment amount.

**Comments:**

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
>>	PLB01	127 <b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Adjusted Pay-To-Provider BWC ID</i>	M AN 1/30
>>	PLB02	373 <b>Date</b> Date expressed as CCYYMMDD <i>Adjusted Pay-To-Provider Fiscal Period</i> <i>Default date of 12/31 of the current year to be used.</i>	M DT 8/8
>>	PLB03	C042 <b>Adjustment Identifier</b> To provide the category and identifying reference information for an adjustment	M
>>	C04201	426 <b>Adjustment Reason Code</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment	M ID 2/2
		50 Late Charge	
		51 Interest Penalty Charge	
		72 Authorized Return	
		90 Early Payment Allowance	
		AH Origination Fee	
		AM Applied to Borrower's Account	
		AP Acceleration of Benefits	
		B2 Rebate	
		B3 Recovery Allowance	
		BD Bad Debt Adjustment	

BN	Bonus
C5	Temporary Allowance
CR	Capitation Interest
CS	Adjustment
CT	Capitation Payment
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
FB	Forwarding Balance
FC	Fund Allocation
GO	Graduate Medical Education Passthru
IP	Incentive Premium Payment
IR	Internal Revenue Service Withholding
IS	Interim Settlement
J1	Nonreimbursable
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
LE	Levy
LS	Lump Sum
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
PI	Periodic Interim Payment
PL	Payment Final
RA	Retro-activity Adjustment
RE	Return on Equity
SL	Student Loan Repayment
TL	Third Party Liability
WO	Overpayment Recovery
WU	Unspecified Recovery
ZZ	Mutually Defined

	<b>C04202</b>	<b>127</b>	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Adjusted Pay-To-Provider Adjustment Group Code</i>	<b>O AN 1/30</b>
>>	<b>PLB04</b>	<b>782</b>	<b>Monetary Amount</b> Monetary amount <i>Adjusted Pay-To-Provider Adjustment Amount</i>	<b>M R 1/18</b>
X	<b>PLB05</b>	<b>C042</b>	<b>Adjustment Identifier</b> To provide the category and identifying reference information for an adjustment	<b>X</b>
X	<b>C04201</b>	<b>426</b>	<b>Adjustment Reason Code</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment Refer to 004010 Data Element Dictionary for acceptable code values.	<b>M ID 2/2</b>
X	<b>C04202</b>	<b>127</b>	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	<b>O AN 1/30</b>
X	<b>PLB06</b>	<b>782</b>	<b>Monetary Amount</b> Monetary amount	<b>X R 1/18</b>
X	<b>PLB07</b>	<b>C042</b>	<b>Adjustment Identifier</b> To provide the category and identifying reference information for an adjustment	<b>X</b>

X	C04201	426	<b>Adjustment Reason Code</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/2
X	C04202	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30
X	PLB08	782	<b>Monetary Amount</b> Monetary amount	X R 1/18
X	PLB09	C042	<b>Adjustment Identifier</b> To provide the category and identifying reference information for an adjustment	X
X	C04201	426	<b>Adjustment Reason Code</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/2
X	C04202	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30
X	PLB10	782	<b>Monetary Amount</b> Monetary amount	X R 1/18
X	PLB11	C042	<b>Adjustment Identifier</b> To provide the category and identifying reference information for an adjustment	X
X	C04201	426	<b>Adjustment Reason Code</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/2
X	C04202	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30
X	PLB12	782	<b>Monetary Amount</b> Monetary amount	X R 1/18
X	PLB13	C042	<b>Adjustment Identifier</b> To provide the category and identifying reference information for an adjustment	X
X	C04201	426	<b>Adjustment Reason Code</b> Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment Refer to 004010 Data Element Dictionary for acceptable code values.	M ID 2/2
X	C04202	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	O AN 1/30
X	PLB14	782	<b>Monetary Amount</b> Monetary amount	X R 1/18

**Segment:** **SE** Transaction Set Trailer  
**Position:** 020  
**Loop:**  
**Level:** Summary  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

**Syntax Notes:**

**Semantic Notes:**

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

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>		<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	SE01	96	<b>Number of Included Segments</b> Total number of segments included in a transaction set including ST and SE segments	M N0 1/10
>>	SE02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	M AN 4/9

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## **E. 835 DATA DICTIONARY**

### **1. Pay-To-Provider Total Paid Amount**

*Definition:* Total Amount distributed to the recipient of the 835 including the total of all payments for all bills, regular bills, adjustments, and interest listed on the remittance.

*Application:* The amount that matches either the check or EFT. This amount cannot be less than zero.

### **2. Pay-To-Provider Payment Method**

*Definition:* The indicator as to the method of payment the provider is receiving. The values for this data element are:

- “ACH” (Automated Clearing House): funds are transferred electronically using the Automated Clearing House. The Electronic Funds Transfer (EFT) are individual payments transferred to the recipient via the ACH. In the documentation for the Provider 835, ACH deposits are referred to as “EFT”.
- “CHK” (Check): Pay-To-Provider receives a paper check.
- “NON” (Non-Payment Data): Pay-To-Provider is receiving remittance information only.

*Application:*

- ACH: Pay-To-Provider Total Paid Amount must be greater than zero.
- CHK: Pay-To-Provider Total Paid Amount must be greater than zero.
- NON: Pay-To-Provider Total Paid Amount must be equal to zero. NON is used when either the Pay-To-Provider Total Paid amount is equal to zero, or when the provider is in an overpaid status with the originating MCO, and the payments & adjustments listed on the remittance are for informational/accounting purposes only.

### **3. MCO Routing Number**

*Definition:* When the Pay-To-Provider Payment Method is ACH (denoting EFT) this data element must contain the routing numbers of the originating MCO's bank.

### **4. MCO Financial Institutions Account Number**

*Definition:* When the Pay-To-Provider Payment Method is ACH (denoting EFT) this data element must contain the account number of the originating MCO.

### **5. MCO Federal Tax ID**

*Definition:* The Federal Tax identification number of the Financially Responsible MCO.

*Application:* The MCO's Federal Tax ID will be preceded by a “1”.

### **6. Pay-To-Provider Routing Number**

*Definition:* When the Pay-To-Provider Payment Method is ACH (denoting EFT) this data element must contain the routing numbers of the receiving Pay-To-Provider.

### **7. Pay-To-Provider Financial Institution Account Number**

*Definition:* When the Pay-To-Provider Payment Method is ACH (denoting EFT) this data element must contain the account number of the receiving Pay-To-Provider.

## E. 835 DATA DICTIONARY

### 8. EFT Settlement Date

*Definition:* This is the date that the funds are available in the receiving Pay-To-Provider's account.

*Application:*

- When the Pay-To-Provider Payment Method is ACH (denoting EFT) this date is populated, and is the "payment date" for the bills and adjustments listed on the 835.
- If the Pay-To-Provider Payment Method is CHK (denoting paper check) or NON (denoting non-payment data) this data element is not populated.

### 9. Check Issued Date

*Definition:* This is the date that the check is written, or issued from the originating MCO.

*Application:* When the Pay-To-Provider Payment Method is CHK (denoting paper check) this date is populated and is the "payment date" for the bills and adjustments listed on the 835. If the Pay-To-Provider Payment Method is ACH (denoting EFT) or NON (denoting non-payment data) this data element is not populated.

### 10. Remittance Advice Date

*Definition:* The date the remittance advice (835) is produced by the originating MCO.

*Application:*

- When the Pay-To-Provider Payment Method is NON (denoting non-payment data) this date is populated and is the "payment date" for the bills and adjustments listed on the 835. The Pay-To-Provider Total Paid Amount is equal to zero in this case. .
- If the Pay-To-Provider Payment Method is ACH (denoting EFT) or CHK (denoting paper check) this data element is not populated.

### 11. Check Number

*Definition:* The number assigned by the originating MCO that is printed on the paper check associated with this 835 remittance.

*Application:* The provider should associate the payment number (in this case the Check Number) with the Check Issued Date. The provider should use this information in the reconciliation of the 835 remittance with their patient accounts.

### 12. EFT Trace Number

*Definition:* The number assigned by the originating MCO that is associated with the Electronic Funds Transfer (EFT) associated with this 835 remittance.

*Application:* The provider should associate the payment number (in this case the EFT Trace Number) with the EFT Settlement Date. The provider should use this information in the reconciliation of the 835 remittance with their patient accounts.

### 13. Remittance Advice Number

*Definition:* The number assigned by the originating MCO that identifies the NON (denoting non-payment data) associated with this 835 remittance.

*Application:* The provider should use the Remittance Advice Number as the payment number when the Pay-To-Provider Payment Method is NON (denoting non-payment data). The provider should use this information in the reconciliation of the 835 remittance with their patient accounts.

## **E. 835 DATA DICTIONARY**

### **14. Receiver ID**

*Definition:* The identification number of a third-party billing service or intermediary receiving the 835 on behalf of a Pay-To-Provider.

*Application:* Used only when a third-party billing service or intermediary is utilized for bill processing. Only used when the receiver of the 835 is other than the Pay-To-Provider (payee).

### **15. Adjudication Date**

*Definition:* The date the bill was adjudicated.

### **16. MCO Number**

*Definition:* The 5-digit BWC assigned number that identifies the financially responsible MCO in BWC systems.

*Application:* The 5-digit MCO number that appears on both MCO and BWC generated correspondence for Workers' Compensation purposes.

*HIPAA Deviation:* BWC selected qualifier code (N103=PI) is not a valid HIPAA qualifier. HIPAA uses N103 to contain the National Provider ID, which is not yet available for use. According to HIPAA, the MCO Number should reside in a REF segment (loop 1000A/position 130). However, BWC is keeping the MCO Number on the N1 segment matching the qualifier code from the BWC Provider 837 Implementation Documentation.

### **17. MCO Name**

*Definition:* The name of the Managed Care Organization (MCO) providing services to the injured workers and employers of the state of Ohio under the Health Partnership Program.

*Application:* The entity responsible for managing and coordinating the care of the injured worker.

### **18. MCO Mailing Address - Line 1**

*Definition:* MCO Mailing Address - Line 1 (street address)

*Application:* 1<sup>st</sup> line of address (street address) of the MCO mailing address.

### **19. MCO Mailing Address - Line 2**

*Definition:* MCO Mailing Address - Line 2

*Application:* 2<sup>nd</sup> line of address of the MCO mailing address. Required if second address line exists.

### **20. MCO City**

*Definition:* MCO City

*Application:* City of the MCO mailing address.

### **21. MCO State**

*Definition:* MCO State

*Application:* State of the MCO mailing address.

## **E. 835 DATA DICTIONARY**

### **22. MCO Zip**

*Definition:* MCO Zip

*Application:* Postal zip code of the MCO mailing address.

### **23. Originating MCO Number**

*Definition:* Identifies the 5-digit MCO Number of the originating MCO (the MCO that originally submitted the bill) in the case of a merger or acquisition. The Originating MCO Number would only be used on a bill that is adjusted after the MCO merger or acquisition. If the originating and financially responsible MCO are the same MCO, this data element is not populated.

### **24. MCO Contact Name**

*Definition:* MCO Contact Name

*Application:* Identifies the MCO contact person regarding remittance.

### **25. MCO Electronic Mail**

*Definition:* MCO Electronic Mail Address

*Application:* Identifies the MCO Contact Name's electronic mail address regarding the remittance.

### **26. MCO Facsimile Number**

*Definition:* MCO Facsimile Number

*Application:* Identifies the MCO Contact Name's fax number regarding the remittance.

### **27. MCO Telephone Number**

*Definition:* MCO Telephone Number with extension

*Application:* Identifies the MCO Contact Name's telephone number regarding the remittance.

### **28. MCO Telephone Extension Number**

*Definition:* MCO Telephone Number with extension

*Application:* Identifies the MCO Contact Name's telephone number regarding the remittance.

### **29. Pay-To-Provider Name**

*Definition:* Name of the receiving Pay-To-Provider

*Application:* The name that is associated with the Pay-To-Provider BWC ID

## E. 835 DATA DICTIONARY

### 30. Pay-To-Provider BWC ID

*Definition:* The 11-digit BWC assigned identification number of the receiving Pay-To-Provider.

*Application:* Used to identify the payee of any paid amounts. The first 9-digits are the Pay-To-Provider's Tax ID, and the number used by the originating MCO in the preparation of any tax-related documents (i.e. 1099's).

*HIPAA Deviation:* Qualifier code (N103=FI) is used in HIPAA to represent the individual provider's SSN. However, BWC uses this qualifier in the Provider 837 Implementation Documentation to represent the BWC assigned provider number and BWC remain consistent with that usage.

### 31. Pay-To-Provider Mailing Address – Line 1

*Definition:* Pay-To-Provider Mailing Address - Line 1

*Application:* 1<sup>st</sup> line of address (street address) of the Pay-To-Provider's mailing address. Contains a domestic and/or foreign mailing address.

### 32. Pay-To-Provider Mailing Address - Line 2

*Definition:* Pay-To-Provider Mailing Address - Line 2

*Application:* 2<sup>nd</sup> line of address of the Pay-To-Provider's mailing address. Contains a domestic and/or foreign mailing address. Optional if second domestic line of address does not exist.

- When foreign addresses are used (those other than U.S.A. or Canada), Line 2 contains the information that would be equivalent to the U.S.A. City State & Zip information. The Pay-To-Provider City, State and Zip will not be populated in this case. The Pay-To-Provider City, State and Zip elements are only used when the address is in the U.S.A. or Canada.

### 33. Pay-To-Provider City

*Definition:* Pay-To-Provider City

*Application:* City of the Pay-To-Provider mailing address. This data element is required only when city name is in the U.S.A. or Canada.

### 34. Pay-To-Provider State

*Definition:* Pay-To-Provider State

*Application:* State of the Pay-To-Provider's mailing address. This data element is required only when State or Province is in the U.S.A. or Canada.

### 35. Pay-To-Provider Zip

*Definition:* Pay-To-Provider Zip

*Application:* Zip Code of the Pay-To-Provider's mailing address. This data element is required only when Zip Code is in the U.S.A.

### 36. Pay-To-Provider Country Code

*Definition:* Pay-To-Provider Country Code

*Application:* Country Code of the Pay-To-Provider's mailing address. This data element is required only if other than U.S.A. If the Pay-To-Provider's mailing address is foreign (other than U.S.A. or Canada), the Pay-To-Provider City, State and Zip will not be populated.

## E. 835 DATA DICTIONARY

### 37. Servicing Provider BWC ID

*Definition:* The BWC assigned 11-digit identification number of the provider that rendered services to the injured workers being reported on this remittance advice.

*Application:* Multiple Servicing Provider ID numbers may appear on the 835, when a Pay-To-Provider has multiple service providers performing service, and billing under the same Pay-To-Provider number.

### 38. Servicing Provider Facility Type Code

*Definition:*

- On Institutional bills, the Place of Service is the first two positions of the UB Type of Bill code.
- On Professional bills, the Place of Service is from the first line of the first bill.

### 39. Servicing Provider Fiscal Period Date

*Definition:* Fiscal Period Date

*Application:* default 12/31 of current year (HIPAA required).

### 40. Servicing Provider Summary Total Bill Count

*Definition:* A count of the total number of bills for this Servicing Provider at the summary level.

### 41. Servicing Provider Summary Provider Charges

*Definition:* Sum of Bill Total Provider Charges for all bills listed for this Servicing Provider.

*Application:* Since the Service Provider Summary level is a summation by Servicing Provider, the sum total of all Servicing Provider Summary Provider Charges should be equal to the sum of all Bill Total Provider Charges listed on the 835.

### 42. Servicing Provider Summary BWC Allowed Charges

*Definition:* Sum of Bill Total BWC Allowed Amounts for all bills listed for this Servicing Provider.

*Application:* Since the Service Provider Summary level is a summation by Servicing Provider, the sum total of all Servicing Provider Summary BWC Allowed Charges should be equal to the sum of all Bill Total BWC Allowed Amounts listed on the 835 for all Servicing Providers. This amount may be positive, negative or zero and excludes interest

- If the sum for all Servicing Providers is greater than zero, this will match the Pay-To-Provider Total Paid Amount.
- If the sum is negative, the Pay-To-Provider Total Paid Amount will be zero and the Pay-To-Provider will be in an overpaid status. In this case, the 835 communicates remittance information only.

### 43. Servicing Provider Summary Paid Charges

*Definition:* Sum of Bill Total BWC Paid Amounts for all bills listed for this Servicing Provider.

*Application:* Since the Service Provider Summary level is a summation by Servicing Provider, the sum total of all Servicing Provider Summary BWC Paid Charges should be equal to the sum of all Bill Total BWC Paid Amounts listed on the 835 for all Servicing Providers. This amount may be positive, negative or zero and includes interest.

- If the sum for all Servicing Providers is greater than zero, this will match the Pay-To-Provider Total Paid Amount.
- If the sum is negative, the Pay-To-Provider Total Paid Amount will be zero and the Pay-To-Provider will be in an overpaid status. In this case, the 835 communicates remittance information only.

## E. 835 DATA DICTIONARY

### 44. Servicing Provider Summary Interest Amount

*Definition:* Sum of Bill Total Interest Amounts for all bills listed for this Servicing Provider.

*Application:* Interest payable per Ohio Revised Code. The amount is included in the Total Amount Paid

### 45. Servicing Provider Summary MCO Allowed Charges

*Definition:* Sum of Bill Total MCO Allowed Amounts for all bills listed for this Servicing Provider.

*Application:* Since the Service Provider Summary level is a summation by Servicing Provider, the sum total of all Servicing Provider Summary MCO Allowed Charges should be equal to the sum of all Bill Total MCO Allowed Amounts listed on the 835 for all Servicing Providers.

### 46. Patient Account Number

*Definition:* The Patient Account Number assigned by the provider to identify the injured worker within the provider's system.

*Application:* Required if a Patient Account Number is submitted then the provider will receive that number back on the remittance to enable the provider to reconcile the remittance to the injured worker's account.

### 47. Bill Payment Status Code

*Definition:* Code identifying the status of an entire bill as assigned by the payer. Use HIPAA compliant qualifier code values.

### 48. Bill Total Provider Charges

*Definition:* The sum of all the provider line item charges for a specific bill.

*Application:* The total amount requested for a bill. This is the sum of the Line Item Provider Charges.

### 49. Bill Total Paid Amount

*Definition:* The sum of all the paid amounts for a specific bill including interest.

*Application:* Equation:

Bill Total Provider Charges minus Bill Adjusted Amount equals Bill Total Paid Amount

*Example 1:*

The provider charges for \$100 in services. The MCO allows \$80 and BWC will pay \$5 in interest.

- To calculate the Bill Adjusted Amount  $(100 - 80) - 5 = 15$   
The amount of the adjustment is a positive \$15.00 (see Bill Adjusted Amount)
- To calculate the Bill Total Paid Amount  $(100 - 15) = 85$
- Result: The Bill Total Paid Amount is \$85.00

*Example 2:*

The provider charges for \$100 in services. The MCO allows \$120 and BWC will pay \$5 in interest.

- To calculate the Bill Adjusted Amount  $(100 - 120) - 5 = -25$
- The amount of the adjustment is a negative \$25.00 (see Bill Adjusted Amount)
- To calculate the Bill Total Paid Amount  $(100 - -25) = 125$
- Result: The Bill Total Paid Amount is \$125.00

## E. 835 DATA DICTIONARY

### 50. BWC Claim Number

*Definition:* Identification number issued by BWC which signifies that a claim has been submitted for the payment of compensation and/or medical benefits as provided by the Workers' Compensation Act.

*Application:* The BWC Claim Number is assigned and associated with a specific Date of Injury or occupational disease, which determines the eligibility for medical payments under Ohio law. Because of the legal/medical nature of benefits provided for under Workers' Compensation in Ohio, providers request and receive reimbursement for services rendered to injured workers that are related to specific injuries or occupational diseases.

### 51. Bill Institutional Type

*Definition:* Identifies whether the hospitalization was for inpatient or outpatient services, or adjustments (i.e. Late Charges) to those services.

*Application:* Contains the 3-digit Type of Bill. This data element is only valid on Institutional bills.

### 52. Bill Adjustment Group Code

*Definition:* Bill level code identifying the general category of the payment or adjustment. This data element must be used when EOBs exist for the bill.

*Application:* Valid values:

- CO Mergers and Acquisitions
- OA Regular Bills
- CR Corrections and Reversals

### 53. Bill EOB Code

*Definition:* Explanation of Benefit (EOB) codes explain the reason a payment is reduced, denied, or other special circumstances related to a bill.

*Application:* EOBs explain the legal, medical or business reason a bill was processed the way it was. Providers should use line and bill level EOBs to account for differences between amounts billed for services and amounts allowed as payment for services. EOBs should reflect any reduction in benefits with the exception of the standard application of BWC fee schedule.

Notes:

- Providers should contact the MCO regarding any inquiries for any EOBs received. A list of BWC EOBs is available in the Provider Billing and Reimbursement Manual.
- EOBs can appear at either the Bill level or the Line level.

*HIPAA Deviation:* BWC and MCO EOB Codes are unique to Ohio Workers' Compensation and therefore are not a part of the national standard. BWC will continue to use BWC and MCO EOBs.

## E. 835 DATA DICTIONARY

### 54. Bill Adjusted Amount

*Definition:* The Bill Adjusted Amount is the amount, including interest, by which the Bill Total Provider Charges is adjusted to arrive at the Bill Total Paid Amount.

*Application:* Equation:

(Bill Total Provider Charges minus Bill Total MCO Allowed Amount) minus  
Bill Total Interest Amount equals  
Bill Adjusted Amount.

*Example 1:*

The provider charges for \$100 in services. The MCO allows \$80 and BWC will pay \$5 in interest.

- To calculate the Bill Adjusted Amount  $(100 - 80) - 5 = 15$
- Result: The Bill Adjusted Amount is a positive \$15.00
- Note: This adjusted amount will be subtracted from the provider charges which will decrease the amount paid to the provider to \$85.00 (see Bill Total Paid Amount)

*Example 2:*

The provider charges for \$100 in services. The MCO allows \$120 and BWC will pay \$5 in interest.

- To calculate the Bill Adjusted Amount  $(100 - 120) - 5 = -25$
- Result: The Bill Adjusted Amount is a negative \$25.00
- Note: This adjusted amount will be subtracted from the provider charges which will increase the amount paid to the provider to \$125.00 (see Bill Total Paid Amount)

### 55. Injured Worker Name – Last

*Definition:* Refers to an injured worker's legal name to which all correspondence pertaining to the claim is forwarded and received.

*Application:* Used to identify the injured worker's last name.

### 56. Injured Worker Name – First

*Definition:* Refers to an injured worker's legal name to which all correspondence pertaining to the claim is forwarded and received.

*Application:* Used to identify the injured worker's first name.

### 57. Injured Worker Name – Middle Initial

*Definition:* Refers to an injured worker's legal name to which all correspondence pertaining to the claim is forwarded and received.

*Application:* Used to identify the injured worker's middle initial.

### 58. Injured Worker Name – Suffix

*Definition:* Refers to an injured worker's legal name to which all correspondence pertaining to the claim is forwarded and received.

*Application:* Used to identify the injured worker's suffix.

## **E. 835 DATA DICTIONARY**

### **59. Injured Worker Social Security Number**

*Definition:* Used to identify the injured worker's social security number.

*Application:* Injured workers' may have multiple BWC Claim Numbers. The SSN is not required for the remittance advice, but may be supplied on the remittance advice to assist the provider in reconciling the remittance with their accounts.

### **60. Servicing Provider Organization Name**

*Definition:* The provider that rendered services to the injured worker.

*Application:* Used to identify the Servicing Providers Name. Not required if the same as the Pay-To-Provider Name.

### **61. Servicing Provider Name – Last**

*Definition:* The last name of the provider that rendered services to the injured worker

*Application:* Required only if the Pay-To-Provider Name varies from the Servicing Provider Name.

### **62. Servicing Provider Name – First**

*Definition:* The first name of the provider that rendered services to the injured worker.

*Application:* Required only if the Pay-To-Provider Name varies from the Servicing Provider Name.

### **63. Servicing Provider Name – Middle Initial**

*Definition:* The middle initial of the provider that rendered services to the injured worker.

*Application:* Required only if the Pay-To-Provider Name varies from the Servicing Provider Name.

### **64. Servicing Provider Name – Suffix**

*Definition:* The suffix of the provider that rendered services to the injured worker

*Application:* Required only if the Pay-To-Provider Name varies from the Servicing Provider Name.

### **65. Servicing Provider BWC ID**

*Definition:* The BWC assigned 11-digit identification number of the provider that rendered services to the injured workers being reported on this bill.

*HIPAA Deviation:* Qualifier code (N103=FI) is used in HIPAA to represent the individual provider's SSN. However, BWC uses this qualifier in the Provider 837 Implementation Documentation to represent the BWC assigned provider number and BWC remain consistent with that usage.

### **66. Submitting MCO Name**

*Definition:* The name of the Managed Care Organization that submitted the bill.

*Application:* Normally the same MCO submits the bill that pays the bill. In the case of MCO mergers & acquisitions, a MCO may assume financial responsibility and process the adjustment or bill of an MCO that is no longer in business.

## **E. 835 DATA DICTIONARY**

### **67. Submitting MCO Number**

*Definition:* The 5-digit MCO Number of the Managed Care Organization that submitted the bill.

*Application:* Normally the same MCO submits the bill that pays the bill. In the case of MCO mergers & acquisitions, an MCO may assume financial responsibility and process the adjustment or bill of an MCO that is no longer in business.

### **68. Medical Record Number**

*Definition:* The number assigned to the patient's medical record by the provider.

*Application:* This number is typically used to retrieve the medical record. It should not be substituted for the Patient Account Number which is assigned by the provider to facilitate retrieval of the individual financial record.

### **69. MCO Bill Document Number**

*Definition:* The unique identification number assigned by the MCO to each bill received from a provider.

*Application:* The reference number that a provider may use when inquiring to the MCO about a specific bill or adjustment

### **70. BWC Bill Number**

*Definition:* The unique identification number assigned by BWC to each bill received from a MCO or adjusted in BWC's bill processing system.

*Application:* This is the reference number for a particular bill or adjustment within BWC's medical bill processing system.

### **71. Bill Begin Date of Service/Bill Date of Service**

*Definition:*

- On Institutional bills, this is the "From" date in the "Statement Covers Period".
- On Professional bills, this is the minimum date of service from the line items.

### **72. Bill End Date of Service**

*Definition:*

- On Institutional bills, this is the "To" date in the "Statement Covers Period".
- On Professional bills, this is the maximum date of service from the line items.

### **73. MCO Case Manager Name**

*Definition:* The contact name of the person assigned by the MCO to coordinate the medical management of a specific injured worker's care.

*Application:* Identifies the MCO Case Manager.

### **74. MCO Case Manager Electronic Mail**

*Definition:* Identifies the MCO Case Manager Electronic Mail Address.

## **E. 835 DATA DICTIONARY**

### **75. MCO Case Manager Facsimile Number**

*Definition:* Identifies the MCO Case Manager's Fax Number.

### **76. MCO Case Manager Telephone Number**

*Definition:* Identifies the MCO Case Manager's Telephone Number.

### **77. MCO Case Manager Telephone Extension Number**

*Definition:* Identifies the MCO Case Manager's Telephone Extension Number.

### **78. Bill Total Interest Amount**

*Definition:* The total interest being allowed for a specific bill.

*Application:* The sum of the Line Item Interest Amounts that may be payable per the Ohio Revised Code.

### **79. Bill Total MCO Allowed Amount**

*Definition:* The total amount allowed by the MCO for a specific bill.

*Application:* The sum of the Line Item MCO Allowed Amounts. This will be an optional element. If the MCO wants to communicate to the provider their pricing, they would use this element.

*HIPAA Deviation:* BWC selected qualifier code (AMT01=B6) is not a valid HIPAA qualifier at the bill level. AMT01=B6 is, however, used at the line item level. Since we will have a MCO Allowed Amount reported at the bill level, we will utilize the qualifier code for "Allowed-Actual" (AMT01=B6).

### **80. Bill Total BWC Allowed Amount**

*Definition:* The total amount allowed by BWC for a specific bill excluding interest.

*Application:* The sum of the Line Item BWC Allowed Amounts. This is the amount that should be applied to the injured workers' account for the services billed on a specific bill. Providers should use line and bill level EOBs to reconcile differences between amounts billed for services and amounts allowed

*HIPAA Deviation:* BWC selected qualifier code (AMT01=AU) is not a valid HIPAA qualifier at the bill level. AMT01=AU is, however, used at the line item level. Since we will have a BWC Allowed Amount reported at the bill level, we will utilize the qualifier code for "Coverage Amount" (AMT01=AU).

## E. 835 DATA DICTIONARY

### 81. Line Item Procedure Code

*Definition:* This is the Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) code used to define the service or procedure provided to the injured worker. Modifiers are also reported in this data element when applicable. According to the CPT 2002 manual, "a modifier provides the means by which the reporting physician can indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code."

*Application:* This is used on Professional and Institutional bills.

Professional bills:

- Line Item Procedure Code is mandatory on Professional line items.
- If any Line Item Procedure Code has a modifier, then the modified is also reported in this data element.

Institutional bills:

- Line Item Procedure Code is mandatory on Institutional bills where the billed Revenue Center Code requires it (as specified in BWC provider publications).
- If the billed Revenue Center Code does not require a CPT code, then the Line Item Procedure Code data element may contain Revenue Center Code, and therefore the Line Item Revenue Code data element would not be used in this case.
- Modifiers are not used on Institutional bills.

### 82. Line Item Provider Charges

*Definition:* The total charges for a specific line item as submitted by the provider.

*Application:* The line level of the Provider Charged amount.

### 83. Line Item Paid Amount

*Definition:* The amount paid for this line item.

*Application:* Equation:

Line Item Provider Charges minus Line Item Adjusted Amount equals Line Item Paid Amount

*Example 1:*

The provider charges for \$100 in services. The MCO allows \$80 and BWC will pay \$5 in interest.

- To calculate the Line Item Adjusted Amount  $(100 - 80) - 5 = 15$
- The amount of the adjustment is a positive \$15.00 (see Line Item Adjusted Amount)
- To calculate the Line Item Paid Amount  $(100 - 15) = 85$
- Result: The Line Item Paid Amount is \$85.00

*Example 2:*

The provider charges for \$100 in services. The MCO allows \$120 and BWC will pay \$5 in interest.

- To calculate the Line Item Adjusted Amount  $(100 - 120) - 5 = -25$
- The amount of the adjustment is a negative \$25.00 (see Line Item Adjusted Amount)
- To calculate the Line Item Paid Amount  $(100 - -25) = 125$
- Result: The Line Item Paid Amount is \$125.00

## E. 835 DATA DICTIONARY

### 84. Line Item Revenue Code

*Definition:* The 3-digit Revenue Center Code is used by the Ohio Hospital Association in describing various cost centers/services rendered to injured workers at the hospital facility on Institutional bills.

*Application:* All Institutional line items require a Line Item Revenue Code, however this data element is only used when the Revenue Code does not require a CPT code. In that case, the Revenue Code must occupy the Line Item Procedure Code data element.

### 85. Line Item Units of Service

*Definition:* A quantitative measure of services, either by number of days, increments of time, or number of supplies as determined by the Revenue or CPT or HCPCS code. This data element is used to identify the units of service provided for a specific line item.

*Application:* The line level of the Units of Service Paid. For Institutional bills, this is either the number of units paid, or the number of days paid, in the case of room accommodation charges. For Professional bills, this is the number of units paid.

### 86. Line Item Date of Service

*Definition:* The date of service for a specific line item.

*Application:* Mutually exclusive with Line Item Begin Date of Service and Line Item End Date of Service.

### 87. Line Item Begin Date of Service

*Definition:* The beginning date of service for a specific line item.

*Application:* The Line Item Begin Date of Service is required on Professional bills and on Outpatient Institutional bills. The Line Item Begin Date of Service and End Date of Service are to match, when populated.

Notes:

- Inclusive with Line Item End Date of Service.
- Mutually exclusive with Line Item Date of Service.

### 88. Line Item End Date of Service

*Definition:* The ending date of service for a specific line item.

*Application:* A Line Item End Date of Service will only be populated when the Line Item Begin Date of Service is also populated. The Line Item End Date of Service must match the Line Item Begin Date of Service, when populated.

Notes:

- Inclusive with Line Item Begin Date of Service.
- Mutually exclusive with Line Item Date of Service.

### 89. Line Item Adjustment Group Code

*Definition:* Line level code identifying the general category of the payment or adjustment.

*Application:* Indicates if the line item is an adjustment or a new bill. This code identifies the general category of payment adjustment.

Valid values:

- CO Mergers and Acquisitions
- OA Regular bills
- CR Corrections and Reversals

## E. 835 DATA DICTIONARY

### 90. Line Item EOB Code

*Definition:* Explanation of Benefit (EOB) codes explain the reason a payment is reduced, denied, or other special circumstances related to a bill.

*Application:* EOBs explain the legal, medical or business reason an bill was processed the way it was. Providers should use line and bill level EOBs to account for differences between amounts billed for services and amounts allowed as payment for services. EOBs should reflect any reduction in benefits with the exception of the standard application of BWC fee schedule.

Notes:

- Providers should contact the MCO regarding any inquiries for any EOBs received. A list of BWC EOBs is available in the Provider Billing and Reimbursement Manual.
- EOBs can appear at either the Bill level or the Line level.

*HIPAA Deviation:* BWC and MCO EOB Codes are unique to Ohio Workers' Compensation and therefore are not a part of the national standard. BWC will continue to use BWC and MCO EOBs, which is a deviation from HIPAA.

### 91. Line Item Adjusted Amount

*Definition:* The Line Item Adjusted Amount is the amount, including interest, by which the Line Item Provider Charges is adjusted to arrive at the Line Item Paid Amount.

*Application:* Equation:

(Line Item Provider Charges minus Line Item MCO Allowed Amount) minus  
Line Item Interest Amount equals  
Line Item Adjusted Amount.

*Example 1:*

The provider charges for \$100 in services. The MCO allows \$80 and BWC will pay \$5 in interest.

- To calculate the Line Item Adjusted Amount  $(100 - 80) - 5 = 15$
- Result: The Line Item Adjusted Amount is a positive \$15.00
- Note: This adjusted amount will be subtracted from the provider charges which will decrease the amount paid to the provider to \$85.00 (see Line Item Paid Amount)

*Example 2:*

The provider charges for \$100 in services. The MCO allows \$120 and BWC will pay \$5 in interest.

- To calculate the Line Item Adjusted Amount  $(100 - 120) - 5 = -25$
- Result: The Line Item Adjusted Amount is a negative \$25.00
- Note: This adjusted amount will be subtracted from the provider charges which will increase the amount paid to the provider to \$125.00 (see Line Item Paid Amount)

### 92. Line Item Interest Amount

*Definition:* The amount of interest awarded for a specific line item.

*Application:* Interest is awarded for payments not processed in a timely manner under the Ohio Revised Code and is calculated based on allowed amounts, but is not to be considered a payment for services rendered.

*HIPAA Deviation:* BWC selected qualifier code (AMT01=I) is not a valid HIPAA qualifier at the line item level. AMT01=I is, however, used at the bill level. Since we will have Interest reported at the line item level, we will utilize the qualifier code for "Interest" (AMT01=I).

## E. 835 DATA DICTIONARY

### 93. Line Item MCO Allowed Amount

*Definition:* The amount the MCO allows for a specific line item charge.

*Application:* If the Line Item MCO Allowed Amount is less than the Line Item Provider Charges, the provider should receive EOBs except in the case when the standardized fee schedule is applied.

### 94. Line Item BWC Allowed Amount

*Definition:* The amount being awarded as payment for services being billed on the line item.

*Application:* This is the amount that should be applied to the injured worker's account for the services billed on a specific line item. Providers should use line and bill level EOBs to account for differences between amounts billed for services and amounts allowed as payment for services. EOBs should reflect any reduction in benefits with the exceptions of the standard application of BWC fee schedule.

*HIPAA Deviation:* BWC selected qualifier code (AMT01=AU) is not a valid HIPAA qualifier at the line item level. AMT01=AU is, however, used at the bill level. Since we will have the BWC Allowed Amount reported at the line item level, we will utilize the qualifier code for "Coverage Amount" (AMT01=AU).

### 95. Adjusted Pay-To-Provider BWC ID

*Definition:* BWC assigned identification number of the Pay-To-Provider.

*Application:* This Pay-To-Provider ID must match the Pay-To-Provider BWC ID. The overall effect of the remittance must be evaluated. If the sum of all bills for all Servicing Providers listed on the remittance is less than zero (negative), then the Pay-To-Provider Summary level of the 835 may be used to communicate the overpayment at a summary level.

### 96. Adjusted Pay-To-Provider Fiscal Period

*Definition:* Fiscal Period Date

*Application:* Default Date 12/31/ of the current year.

### 97. Adjusted Pay-To-Provider Adjustment Group Code

*Definition:* The HIPAA compliant qualifier code indicating reason for adjustment to Pay-To-Provider bill, debit or credit memo or payment.

### 98. Adjusted Pay-To-Provider Adjustment Amount

*Definition:* Monetary amount of the overpayment.

*Application:* The overall effect of the remittance must be evaluated. If the sum of all bills for all Servicing Providers listed on the remittance is less than zero (negative), then the Pay-To-Provider Summary level of the 835 may be used to communicate the overpayment at a summary level. The amount in this data element will reflect the overpaid amount, but the Pay-To-Provider Total Paid Amount will be zero, and the Pay-To-Provider Payment Method will be NON.

Notes:

- Monetary amount for the adjustment amount for the preceding adjustment reason.

## **E. 835 DATA DICTIONARY**

### **99. Line Number: BWC**

*Definition:* Line Number assigned by BWC.

*Application:* Line numbers, coupled with the bill number uniquely identify a line item.

*HIPAA Deviation:* BWC selected qualifier code (REF01=83) is not a valid HIPAA qualifier. However, it is a valid X12 qualifier code and used for this data element.

### **100. Line Number: MCO**

*Definition:* Line Number assigned by MCO.

*Application:* MCO's have line numbers assigned to all line items within their system. The line numbers may or may not be the same as BWC line numbers, but are a different data element, as they are initiated in separate systems.

*HIPAA Deviation:* BWC selected qualifier code (REF01=FJ) is not a valid HIPAA qualifier. However, it is a valid X12 qualifier code and used for this data element.

### **101. Line Number: Provider**

*Definition:* Line Number assigned by Provider.

*Application:* At a minimum, the Provider's Line Number should be sent on the 835.

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**X12 277 – version 004010**  
**Health Care Claim Status Notification**

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## **A. 277 OVERVIEW**

Providers will use the X12 277 Health Care Claim Status Notification response transaction set (inbound) as a MCO application level acknowledgement of 837 bills received. The purpose is to inform the Provider of claims pending adjudication and to communicate problems with bills that can not be processed. Explanation of Benefits codes are contained in the 277.

Providers will send an X12 997 Functional Acknowledgment for each 277 received. Refer to the section on 997 Functional Acknowledgment Processing for more information.

The 277 Business Rules Matrix lists all of the data elements that are mapped to the X12 277 and lists the criteria for "mandatory" and "expected." "Mandatory" indicates MCO's will always send this data on the 277. "Expected" means MCO's will send this data if it was available on the 837 of which this 277 is responding. The cross-reference to the Implementation Guide is in the column titled "Location within X12 277". This column identifies the segment that contains the data, the position of the segment in the X12 277 standard, and the position within the segment where the data element is located and the conditions needed to extract the data. Example: The data element "Claim Number" is contained in a REF segment located at position 2/110 (in the X12 standard, Table 2/Detail, position 110.) It also notes that the data element is in REF02, the second element in the REF segment, and contains the "Claim Number" when the REF01 element of the REF segment equals "Y1."

## **B. 277 HL STRUCTURE**

The following figure details the overall looping structure of the X12 277:

MCO (Payer HL03='20')

- PROVIDER (Billing Provider HL03='21')
- PROVIDER OF SERVICE (Pay-To Provider HL03='19')
- SUBSCRIBER (Injured Worker HL03='22')
- CLAIM
- SERVICE LINE(S)
- PROVIDER OF SERVICE (HL03='19')
- SUBSCRIBER (Injured Worker HL03='22')
- CLAIM
- SERVICE LINE(S)
- SUBSCRIBER (Injured Worker HL03='22')
- CLAIM
- SERVICE LINE(S)
- CLAIM
- SERVICE LINE(S)

**C. 277 BUSINESS RULES MATRIX**

LN	Data Element	Mandatory, Expected, or Optional	Location within X12 824 (Segment, table/position) and Mapping Criteria	Notes
1	MCO Name	M	NM1, 2/050; NM103 when HL03=20 and NM101=PR	
2	MCO Number	M	NM1, 2/050; NM109 when HL03=20, NM101=PR and NM108=75	Use BWC assigned 5-digit ID number of MCO who will receive the bill.
3	Billing Provider Name	E	NM1, 2/050; NM103 when HL03=21 and NM101=85	Billing Intermediary (submitter).
4	Billing Provider Number	E	NM1, 2/050; NM109 when HL03=21, NM101=85 and NM108=FI	
5	Pay-To Provider Name	E	NM1, 2/050; NM103 when HL03=19 and NM101=87	
6	Pay-To Provider Number	E	NM1, 2/050; NM109 when HL03=19, NM101=87 and NM108=SV	
7	Injured Worker Name	E	NM1, 2/050; NM103, NM104, NM105, NM107 when HL03=22 and NM101=IL	Last Name, First Name, Middle Name, Suffix
8	Injured Worker SSN	E	NM1, 2/050; NM109 when HL03=22, NM101=IL and NM108=34	Identifies the claimant's social security number.
9	Claim Information Contact	M	PER, 2/080; PER02 & PER04 when HL03=20	Identifies the MCO contact person with name, telephone number, Fax number, and/or e-mail address.
10	Patient Control Number	M	TRN, 2/090; TRN02	Identifies the patient's account number for this claim. It is the Provider's patient control number from the X12 837 CLM segment, value in element CLM01. This comes from UB92 form location 3 or HCFA 1500 form location 26.  Technical Note: This element is X12 mandatory on the TRN segment. Claim level EOB's are handled in the TRN loop.
11	Billing Account Number	E	TRN, 2/090; TRN04	Identifies the billing account number for this claim.
12	Application accept/reject code	M	Claim Level: STC, 2/100; STC01-1, STC10-1 when STC10 used (optional), STC11-1 when STC11 used (optional)  Line Item Level: STC, 2/190; STC01-1, STC10-1 when STC10 used (optional), STC11-1 when STC11 used (optional)	Value "R" indicates claim or line item rejected.

**C. 277 BUSINESS RULES MATRIX**

LN	Data Element	Mandatory, Expected, or Optional	Location within X12 824 (Segment, table/position) and Mapping Criteria	Notes
13	Error Description	M	Claim Level: STC, 2/100; STC01-2, STC10-2 when STC10 used (optional), STC11-2 when STC11 used (optional)  Line Item Level: STC, 2/190; STC01-2, STC10-2 when STC10 used (optional), STC11-2 when STC11 used (optional)	Identifies the Explanation of Benefit (EOB) code.
14	Bad data copy	E	Claim Level: STC, 2/100; STC12  Line Item Level: STC,2/190; STC12	Identifies the data in error from the original transaction.
15	Claim Number	E	REF, 2/110; REF02 when REF01=Y1	Identifies the claim number assigned by BWC for this claim.
16	Medical Record Number	E	REF, 2/110; REF02 when REF01=EA	Identifies the medical record number for this claim.
17	Date of Service	E	Claim Level: DTP, 2/120; DTP03 when DTP01=472  Line Item Level: DTP, 2/210; DTP03 when DTP01=472	Identifies the Service Date. Must be in format CCYYMMDD.
18	Service Line Item Number	E	SVC, 2/180; SVC01	Identifies the line item number of which the EOB pertains.  Technical Note: This element is X12 mandatory when the EOB pertains to the Service Line Item level. The SVC segment & loop will only be used under this circumstance. Claim level EOB's are handled in the TRN loop.
19	Submitted Charge	E	SVC, 2/180; SVC02	Identifies the line item service charge monetary amount.  Technical Note: This element is X12 mandatory when the EOB pertains to the Service Line Item level. The SVC segment & loop will only be used under this circumstance. Claim level EOB's are handled in the TRN loop.

**D. 277 SUMMARY OF SEGMENTS USED****Table 1 Header**

Pos No.	Seg ID	Name
	ISA	Interchange Control Header
	GS	Functional Group Header
010	ST	Transaction Set Header
020	BHT	Beginning of Hierarchical Transaction (Transaction Date)

**Table 2 Detail**

Pos No.	Seg ID	Name	
<b>010</b>	<b>HL</b>	<b>Hierarchical Level</b>	<b>(MCO, HL03='20')</b>
050	NM1	Individual or Organizational Name	(MCO ID)
080	PER	Administrative Communications Contact	(MCO Contact Name & Number)
<b>010</b>	<b>HL</b>	<b>Hierarchical Level</b>	<b>(Billing Provider, HL03='21')</b>
050	NM1	Individual or Organizational Name	(Billing Intermediary Name & ID)
<b>010</b>	<b>HL</b>	<b>Hierarchical Level</b>	<b>(Pay-To Provider, HL03='19')</b>
050	NM1	Individual or Organizational Name	(Pay-To Provider Name & ID)
<b>010</b>	<b>HL</b>	<b>Hierarchical Level</b>	<b>(Injured Worker, HL03='22')</b>
050	NM1	Individual or Organizational Name	(Injured Worker Name & SSN)
090	TRN	Trace	(Patient Control Number, Billing Account Number)
100	STC	Status Information	(EOB Codes at Claim Level, Copy of Rejected Data)
110	REF	Reference Information	(BWC Claim Number)
110	REF	Reference Information	(Medical Record Number)
120	DTP	Date/Time Period	(Service Date or Range)
180	SVC	Service Information	(Service Line Item Number, Submitted Charges)
190	STC	Status Information	(EOB Codes at Service Line Level, Copy of Rejected Data)
210	DTP	Date/Time Period	(Line Item Service Date)

**Table 3 Summary**

Pos No.	Seg ID	Name
270	SE	Transaction Set Trailer
	GE	Functional Group Trailer
	IEA	Interchange Control Trailer

## **E. 277 IMPLEMENTATION GUIDE**

The 277 Implementation Guide contains the detailed structure of the X12 277 document. It includes:

- a graphical depiction of the X12 277 looping structure
- all ASC X12 semantic and syntax notes
- indicators identifying mandatory and optional segments according to X12 rules
- indicators identifying mandatory, optional, and conditional data elements according to X12 rules
- indicators identifying which data elements of the used segments are used and not used
- subsets of valid code values used for ID type data elements
- notes specifying MCO's and Providers usage of the 277

The notes are included throughout the document in *italics*. These note the usage of the 277 transaction set, segments, data elements and codes. Required data elements on optional segments are only required when the segment is used.

# 277 Health Care Claim Status Notification

Functional Group ID=**HN**

## Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Status Notification Transaction Set (277) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient, or authorized agent regarding the status of a health care claim or encounter or to request additional information from the provider regarding a health care claim or encounter. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, will not be used for account payment posting. The notification may be at a summary or service line detail level. The notification may be solicited or unsolicited.

## Notes:

*MCO's will follow the hierarchical structure recommended by X12. Notes within each segment explain which segments and elements are valid for each Hierarchical Level (HL).*

*The column left of each segment and element denote its usage:*

*>> indicates Mandatory*

*X indicates Not Used*

*Refer to the Business Rules Matrix for:*

*- a cross reference of data elements to the 277 Implementation Guide*

*- a list of data elements including Mandatory and Expected designations*

## Heading:

	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
>>	010	ST	Transaction Set Header	M	1		
>>	020	BHT	Beginning of Hierarchical Transaction	M	1		

## Detail:

	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>Req. Des.</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
			LOOP ID - 2000			>1	
>>	010	HL	Hierarchical Level	M	1		
			LOOP ID - 2100			>1	
>>	050	NM1	Individual or Organizational Name	O	1		
>>	080	PER	Administrative Communications Contact	O	1		
			LOOP ID - 2200			>1	
>>	090	TRN	Trace	O	1		
>>	100	STC	Status Information	M	>1		
	110	REF	Reference Identification	O	3		
	120	DTP	Date or Time or Period	O	2		
			LOOP ID - 2220			>1	
	180	SVC	Service Information	O	1		
>>	190	STC	Status Information	M	>1		
	210	DTP	Date or Time or Period	O	1		
>>	270	SE	Transaction Set Trailer	M	1		

**Segment:** **ST** Transaction Set Header  
**Position:** 010  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the start of a transaction set and to assign a control number  
**Syntax Notes:**  
**Semantic Notes:** 1 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).  
**Comments:**

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	ST01	143	<b>Transaction Set Identifier Code</b> Code uniquely identifying a Transaction Set M ID 3/3
		277	Health Care Claim Status Notification
>>	ST02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set M AN 4/9

**Segment:** **BHT** **Beginning of Hierarchical Transaction**  
**Position:** 020  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

**Syntax Notes:****Semantic Notes:**

- 1 BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system.
- 2 BHT04 is the date the transaction was created within the business application system.
- 3 BHT05 is the time the transaction was created within the business application system.

**Comments:****Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>		<u>Attributes</u>
>>	<b>BHT01</b>	<b>1005</b>	<b>Hierarchical Structure Code</b> Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set 0010 Information Source, Information Receiver, Provider of Service, Subscriber, Dependent	<b>M ID 4/4</b>
>>	<b>BHT02</b>	<b>353</b>	<b>Transaction Set Purpose Code</b> Code identifying purpose of transaction set 08 Status	<b>M ID 2/2</b>
>>	<b>BHT03</b>	<b>127</b>	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Originator Application Transaction Identifier.</i> <i>The Interchange Control Number of the Provider's 837 which serves as an inventory file number of the 837/277 transmission (the ISA/GS/ST control numbers of the Provider's 837 of which this 277 pertains.)</i>	<b>O AN 1/30</b>
>>	<b>BHT04</b>	<b>373</b>	<b>Date</b> Date expressed as CCYYMMDD <i>Transaction Set Creation Date</i>	<b>O DT 8/8</b>
X	<b>BHT05</b>	<b>337</b>	<b>Time</b> Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)	<b>O TM 4/8</b>
>>	<b>BHT06</b>	<b>640</b>	<b>Transaction Type Code</b> Code specifying the type of transaction TH Receipt Acknowledgment Advice <i>Used when the function of this claim status notification is to provide information about a submitted bill.</i>	<b>O ID 2/2</b>

- Segment:** **HL Hierarchical Level**
- Position:** 010
- Loop:** 2000 Mandatory
- Level:** Detail
- Usage:** Mandatory
- Max Use:** 1
- Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments
- Syntax Notes:**
- Semantic Notes:**
- 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. The HL segment defines a top-down/left-right ordered structure.
  - 2 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.
  - 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
  - 4 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.
  - 5 HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u> <u>Name</u>	
>>	<b>HL01</b> <b>628</b> <b>Hierarchical ID Number</b>	<b>M AN 1/12</b>
	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure	
>>	<b>HL02</b> <b>734</b> <b>Hierarchical Parent ID Number</b>	<b>O AN 1/12</b>
	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to	
>>	<b>HL03</b> <b>735</b> <b>Hierarchical Level Code</b>	<b>M ID 1/2</b>
	Code defining the characteristic of a level in a hierarchical structure	
	19	Provider of Service <i>Pay-To Provider Level</i>
	20	Information Source Identifies the payor, maintainer, or source of the information <i>MCO Level</i>
	21	Information Receiver Identifies the provider or party(ies) who are the recipient(s) of the information <i>Billing Provider Level</i>
	22	Subscriber Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits <i>Injured Worker Level</i>
>>	<b>HL04</b> <b>736</b> <b>Hierarchical Child Code</b>	<b>O ID 1/1</b>
	Code indicating if there are hierarchical child data segments subordinate to the level being described Refer to 004010 Data Element Dictionary for acceptable code values.	

**Segment:** **NM1** **Individual or Organizational Name**  
**Position:** 050  
**Loop:** 2100 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
 2 If NM111 is present, then NM110 is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:** 1 NM110 and NM111 further define the type of entity in NM101.

## Data Element Summary

	<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>		
>>	NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual 85 Billing Provider <i>Indicates Billing Provider Level</i> 87 Pay-to Provider <i>Indicates Pay-To Provider Level</i> IL Insured or Subscriber <i>Indicates Injured Worker Level</i> PR Payer <i>Indicates MCO Level</i>	<b>M ID 2/3</b>
>>	NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity 1 Person 2 Non-Person Entity	<b>M ID 1/1</b>
>>	NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <i>Contains MCO Organizational Name when: HL03=20, NM101=PR, and NM102=2</i>  <i>Contains Billing Provider Organizational Name when: HL03=21, NM101=85, and NM102=2</i>  <i>Contains Pay-To Provider Organizational Name when: HL03=19, NM101=87, and NM102=2</i>  <i>Contains Injured Worker Last Name when: HL03=22, NM101=IL, and NM102=1</i>	<b>O AN 1/35</b>
	NM104	1036	<b>Name First</b> Individual first name <i>Contains Injured Worker First Name when: HL03=22, NM101=IL, and NM102=1</i>	<b>O AN 1/25</b>
	NM105	1037	<b>Name Middle</b> Individual middle name or initial <i>Contains Injured Worker Middle Name when: HL03=22, NM101=IL, and NM102=1</i>	<b>O AN 1/25</b>
X	NM106	1038	<b>Name Prefix</b> Prefix to individual name	<b>O AN 1/10</b>

	<b>NM107</b>	<b>1039</b>	<b>Name Suffix</b> Suffix to individual name <i>Contains Injured Worker Suffix when: HL03=22, NM101=IL, and NM102=1</i>	<b>O AN 1/10</b>
>>	<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) 34 Social Security Number <i>Indicates Injured Worker Social Security Number</i> 75 State or Province Assigned Number <i>Indicates MCO Number</i> FI Federal Taxpayer's Identification Number <i>Indicates Billing Provider ID</i> SV Service Provider Number <i>Indicates Pay-To Provider ID</i>	<b>X ID 1/2</b>
>>	<b>NM109</b>	<b>67</b>	<b>Identification Code</b> Code identifying a party or other code <i>Contains MCO Number when: HL03=20, NM101=PR, and NM108=75</i>  <i>Contains Billing Provider ID when: HL03=21, NM101=85, and NM108=FI</i>  <i>Contains Pay-To Provider ID when: HL03=19, NM101=87, and NM108=SV</i>  <i>Contains Injured Worker SSN when: HL03=22, NM101=IL, and NM108=34</i>	<b>X AN 2/80</b>
<b>X</b>	<b>NM110</b>	<b>706</b>	<b>Entity Relationship Code</b> Code describing entity relationship	<b>X ID 2/2</b>
<b>X</b>	<b>NM111</b>	<b>98</b>	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual	<b>O ID 2/3</b>

**Segment:** **PER Administrative Communications Contact**  
**Position:** 080  
**Loop:** 2100 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To identify a person or office to whom administrative communications should be directed  
**Syntax Notes:**

- 1 If either PER03 or PER04 is present, then the other is required.
- 2 If either PER05 or PER06 is present, then the other is required.
- 3 If either PER07 or PER08 is present, then the other is required.

**Semantic Notes:****Comments:**

**Notes:** *This PER segment is only used at the MCO Level to communicate contact information.*

**Data Element Summary**

<b>Ref.</b>	<b>Data</b>	<b>Attributes</b>
<b>Des.</b>	<b>Element Name</b>	
>> PER01	<b>366 Contact Function Code</b> Code identifying the major duty or responsibility of the person or group named IC Information Contact	<b>M ID 2/2</b>
>> PER02	<b>93 Name</b> Free-form name <i>MCO Contact Name</i>	<b>O AN 1/60</b>
>> PER03	<b>365 Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	<b>X ID 2/2</b>
>> PER04	<b>364 Communication Number</b> Complete communications number including country or area code when applicable <i>10 digit communications number including area code or e-mail address</i>	<b>X AN 1/80</b>
PER05	<b>365 Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	<b>X ID 2/2</b>
PER06	<b>364 Communication Number</b> Complete communications number including country or area code when applicable <i>10 digit communications number including area code or e-mail address</i>	<b>X AN 1/80</b>
PER07	<b>365 Communication Number Qualifier</b> Code identifying the type of communication number EM Electronic Mail FX Facsimile TE Telephone	<b>X ID 2/2</b>
PER08	<b>364 Communication Number</b> Complete communications number including country or area code when applicable <i>10 digit communications number including area code or e-mail address</i>	<b>X AN 1/80</b>
X PER09	<b>443 Contact Inquiry Reference</b> Additional reference number or description to clarify a contact number	<b>O AN 1/20</b>

**Segment:** **TRN** Trace  
**Position:** 090  
**Loop:** 2200 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To uniquely identify a transaction to an application  
**Syntax Notes:**  
**Semantic Notes:** 1 TRN02 provides unique identification for the transaction.  
 2 TRN03 identifies an organization.  
 3 TRN04 identifies a further subdivision within the organization.  
**Comments:**  
**Notes:** *Claim Submitter's Identification (from 837)*

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	TRN01	481	<b>Trace Type Code</b> M ID 1/2 Code identifying which transaction is being referenced
		2	Referenced Transaction Trace Numbers
>>	TRN02	127	<b>Reference Identification</b> M AN 1/30 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Provider's Patient Control Number.</i> <i>From X12 837 CLM segment, value in element CLM01 (UB92 Form Location 3 or HCFA 1500 Form Location 26)</i>
X	TRN03	509	<b>Originating Company Identifier</b> O AN 10/10 A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9
	TRN04	127	<b>Reference Identification</b> O AN 1/30 Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Billing Account Number</i>

**Segment:** **STC** **Status Information**  
**Position:** 100  
**Loop:** 2200 Optional (Must Use)  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** >1  
**Purpose:** To report the status, required action, and paid information of a claim or service line  
**Syntax Notes:**  
**Semantic Notes:**

- 1 STC02 is the effective date of the status information.
- 2 STC04 is the amount of original submitted charges.
- 3 STC05 is the amount paid.
- 4 STC06 is the paid date.
- 5 STC08 is the check issue date.
- 6 STC12 allows additional free-form status information.

**Comments:**  
**Notes:** *Claim Level Status Information*

**Data Element Summary**

Ref.	Data			
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	
>>	STC01	C043	<b>Health Care Claim Status</b>	M
			Used to convey status of the entire claim or a specific service line <i>Explanation of Benefit (EOB) codes pertinent to the Claim Level</i>	
>>	C04301	1271	<b>Industry Code</b>	M AN 1/30
			Code indicating a code from a specific industry code list <i>Contains value: "R" indicating "Reject"</i>	
>>	C04302	1271	<b>Industry Code</b>	M AN 1/30
			Code indicating a code from a specific industry code list <i>Applicable EOB Code</i>	
X	C04303	98	<b>Entity Identifier Code</b>	O ID 2/3
			Code identifying an organizational entity, a physical location, property or an individual	
X	STC02	373	<b>Date</b>	O DT 8/8
			Date expressed as CCYYMMDD	
>>	STC03	306	<b>Action Code</b>	O ID 1/2
			Code indicating type of action 15 Correct and Resubmit Claim	
X	STC04	782	<b>Monetary Amount</b>	O R 1/18
			Monetary amount	
X	STC05	782	<b>Monetary Amount</b>	O R 1/18
			Monetary amount	
X	STC06	373	<b>Date</b>	O DT 8/8
			Date expressed as CCYYMMDD	
X	STC07	591	<b>Payment Method Code</b>	O ID 3/3
			Code identifying the method for the movement of payment instructions	
X	STC08	373	<b>Date</b>	O DT 8/8
			Date expressed as CCYYMMDD	
X	STC09	429	<b>Check Number</b>	O AN 1/16
			Check identification number	

	<b>STC10</b>	<b>C043</b>	<b>Health Care Claim Status</b>	<b>O</b>	
			Used to convey status of the entire claim or a specific service line		
>>	<b>C04301</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Contains value: "R" indicating "Reject"</i>		
>>	<b>C04302</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Applicable EOB Code</i>		
X	<b>C04303</b>	<b>98</b>	<b>Entity Identifier Code</b>	<b>O</b>	<b>ID 2/3</b>
			Code identifying an organizational entity, a physical location, property or an individual		
	<b>STC11</b>	<b>C043</b>	<b>Health Care Claim Status</b>	<b>O</b>	
			Used to convey status of the entire claim or a specific service line		
>>	<b>C04301</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Contains value: "R" indicating "Reject"</i>		
>>	<b>C04302</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Applicable EOB Code</i>		
X	<b>C04303</b>	<b>98</b>	<b>Entity Identifier Code</b>	<b>O</b>	<b>ID 2/3</b>
			Code identifying an organizational entity, a physical location, property or an individual		
	<b>STC12</b>	<b>933</b>	<b>Free-Form Message Text</b>	<b>O</b>	<b>AN 1/264</b>
			Free-form message text		
			<i>Contains a copy of data in error</i>		

**Segment:** **REF** Reference Identification  
**Position:** 110  
**Loop:** 2200 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 3  
**Purpose:** To specify identifying information  
**Syntax Notes:** 1 At least one of REF02 or REF03 is required.  
 2 If either C04003 or C04004 is present, then the other is required.  
 3 If either C04005 or C04006 is present, then the other is required.  
**Semantic Notes:** 1 REF04 contains data relating to the value cited in REF02.  
**Comments:**

## Data Element Summary

	<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification EA Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records Y1 Claim Administrator Claim Number <i>BWC Claim Number</i>	M ID 2/3
	REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <i>Contains Medical Record Id Number when REF01=EA</i> <i>Contains BWC Claim Number when REF01=Y1</i>	X AN 1/30
X	REF03	352	<b>Description</b> A free-form description to clarify the related data elements and their content	X AN 1/80
X	REF04	C040	<b>Reference Identifier</b> To identify one or more reference numbers or identification numbers as specified by the Reference Qualifier	O
X	C04001	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3
X	C04002	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30
X	C04003	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04004	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30
X	C04005	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	X ID 2/3
X	C04006	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30

**Segment:** **DTP** **Date or Time or Period**  
**Position:** 120  
**Loop:** 2200 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**

**Data Element Summary**

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	DTP01	374 <b>Date/Time Qualifier</b>	M ID 3/3
		Code specifying type of date or time, or both date and time	
		472 Service	
		Begin and end dates of the service being rendered	
>>	DTP02	1250 <b>Date Time Period Format Qualifier</b>	M ID 2/3
		Code indicating the date format, time format, or date and time format	
		D8 Date Expressed in Format CCYYMMDD	
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	
		A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date	
>>	DTP03	1251 <b>Date Time Period</b>	M AN 1/35
		Expression of a date, a time, or range of dates, times or dates and times	
		<i>Service Date or Range of Dates</i>	

<b>Segment:</b>	<b>SVC</b> Service Information
<b>Position:</b>	180
<b>Loop:</b>	2220 Optional
<b>Level:</b>	Detail
<b>Usage:</b>	Optional
<b>Max Use:</b>	1
<b>Purpose:</b>	To supply payment and control information to a provider for a particular service
<b>Syntax Notes:</b>	
<b>Semantic Notes:</b>	<ol style="list-style-type: none"> <li>1 SVC01 is the medical procedure upon which adjudication is based.</li> <li>2 SVC02 is the submitted service charge.</li> <li>3 SVC03 is the amount paid this service.</li> <li>4 SVC04 is the National Uniform Billing Committee Revenue Code.</li> <li>5 SVC05 is the paid units of service.</li> <li>6 SVC06 is the original submitted medical procedure.</li> <li>7 SVC07 is the original submitted units of service.</li> </ol>
<b>Comments:</b>	1 For Medicare Part A claims, SVC01 would be the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Code (see code source 130) and SVC04 would be the Revenue Code (see code source 132).
<b>Notes:</b>	<i>Service Line Information.</i> <i>This SVC loop can repeat multiple times to report numerous EOB's.</i>

## Data Element Summary

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
>>	SVC01	<b>C003 Composite Medical Procedure Identifier</b>	<b>M</b>
		To identify a medical procedure by its standardized codes and applicable modifiers	
>>	C00301	<b>235 Product/Service ID Qualifier</b>	<b>M ID 2/2</b>
		Code identifying the type/source of the descriptive number used in Product/Service ID (234)	
		SV Service Rendered	
		<i>Indicates the Service Line Item Number of which the EOB pertains.</i>	
>>	C00302	<b>234 Product/Service ID</b>	<b>M AN 1/48</b>
		Identifying number for a product or service	
		<i>Contains the Service Line Item Number of which the EOB pertains.</i>	
X	C00303	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00304	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00305	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00306	<b>1339 Procedure Modifier</b>	<b>O AN 2/2</b>
		This identifies special circumstances related to the performance of the service, as defined by trading partners	
X	C00307	<b>352 Description</b>	<b>O AN 1/80</b>
		A free-form description to clarify the related data elements and their content	
>>	SVC02	<b>782 Monetary Amount</b>	<b>M R 1/18</b>
		Monetary amount	
		<i>Submitted Charge</i>	
X	SVC03	<b>782 Monetary Amount</b>	<b>O R 1/18</b>
		Monetary amount	

X	SVC04	234	<b>Product/Service ID</b> Identifying number for a product or service	O AN 1/48
X	SVC05	380	<b>Quantity</b> Numeric value of quantity	O R 1/15
X	SVC06	C003	<b>Composite Medical Procedure Identifier</b> To identify a medical procedure by its standardized codes and applicable modifiers	O
X	C00301	235	<b>Product/Service ID Qualifier</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234)	M ID 2/2
X	C00302	234	<b>Product/Service ID</b> Identifying number for a product or service	M AN 1/48
X	C00303	1339	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	O AN 2/2
X	C00304	1339	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	O AN 2/2
X	C00305	1339	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	O AN 2/2
X	C00306	1339	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners	O AN 2/2
X	C00307	352	<b>Description</b> A free-form description to clarify the related data elements and their content	O AN 1/80
X	SVC07	380	<b>Quantity</b> Numeric value of quantity	O R 1/15

<b>Segment:</b>	<b>STC</b> Status Information
<b>Position:</b>	190
<b>Loop:</b>	2220 Optional
<b>Level:</b>	Detail
<b>Usage:</b>	Mandatory
<b>Max Use:</b>	>1
<b>Purpose:</b>	To report the status, required action, and paid information of a claim or service line
<b>Syntax Notes:</b>	
<b>Semantic Notes:</b>	<ol style="list-style-type: none"> <li>1 STC02 is the effective date of the status information.</li> <li>2 STC04 is the amount of original submitted charges.</li> <li>3 STC05 is the amount paid.</li> <li>4 STC06 is the paid date.</li> <li>5 STC08 is the check issue date.</li> <li>6 STC12 allows additional free-form status information.</li> </ol>
<b>Comments:</b>	
<b>Notes:</b>	<i>Service Line Status Information</i>

## Data Element Summary

Ref.	Data		Attributes
<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	STC01	C043	<b>Health Care Claim Status</b> Used to convey status of the entire claim or a specific service line <i>Explanation of Benefit (EOB) codes pertinent to the Service Line Level</i> M
>>	C04301	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list <i>Contains value: "R" indicating "Reject"</i> M AN 1/30
>>	C04302	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list <i>Applicable EOB Code</i> M AN 1/30
X	C04303	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual O ID 2/3
X	STC02	373	<b>Date</b> Date expressed as CCYYMMDD O DT 8/8
>>	STC03	306	<b>Action Code</b> Code indicating type of action 15 Correct and Resubmit Claim O ID 1/2
X	STC04	782	<b>Monetary Amount</b> Monetary amount <i>Amount of original submitted charges</i> O R 1/18
X	STC05	782	<b>Monetary Amount</b> Monetary amount O R 1/18
X	STC06	373	<b>Date</b> Date expressed as CCYYMMDD O DT 8/8
X	STC07	591	<b>Payment Method Code</b> Code identifying the method for the movement of payment instructions O ID 3/3
X	STC08	373	<b>Date</b> Date expressed as CCYYMMDD O DT 8/8
X	STC09	429	<b>Check Number</b> Check identification number O AN 1/16

	<b>STC10</b>	<b>C043</b>	<b>Health Care Claim Status</b>	<b>O</b>	
			Used to convey status of the entire claim or a specific service line		
>>	<b>C04301</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Contains value: "R" indicating "Reject"</i>		
>>	<b>C04302</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Applicable EOB Code</i>		
X	<b>C04303</b>	<b>98</b>	<b>Entity Identifier Code</b>	<b>O</b>	<b>ID 2/3</b>
			Code identifying an organizational entity, a physical location, property or an individual		
	<b>STC11</b>	<b>C043</b>	<b>Health Care Claim Status</b>	<b>O</b>	
			Used to convey status of the entire claim or a specific service line		
>>	<b>C04301</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Contains value: "R" indicating "Reject"</i>		
>>	<b>C04302</b>	<b>1271</b>	<b>Industry Code</b>	<b>M</b>	<b>AN 1/30</b>
			Code indicating a code from a specific industry code list		
			<i>Applicable EOB Code</i>		
X	<b>C04303</b>	<b>98</b>	<b>Entity Identifier Code</b>	<b>O</b>	<b>ID 2/3</b>
			Code identifying an organizational entity, a physical location, property or an individual		
	<b>STC12</b>	<b>933</b>	<b>Free-Form Message Text</b>	<b>O</b>	<b>AN 1/264</b>
			Free-form message text		
			<i>Contains a copy of data in error</i>		

**Segment:** **DTP** **Date or Time or Period**  
**Position:** 210  
**Loop:** 2220 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time 472 Service Begin and end dates of the service being rendered	<b>M ID 3/3</b>
>>	DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date	<b>M ID 2/3</b>
>>	DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <i>Service Date or Range of Dates</i>	<b>M AN 1/35</b>

**Segment:** **SE** Transaction Set Trailer  
**Position:** 270  
**Loop:**  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

**Syntax Notes:**

**Semantic Notes:**

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

**Data Element Summary**

	<u>Ref.</u>	<u>Data</u>		<u>Attributes</u>
	<u>Des.</u>	<u>Element</u>	<u>Name</u>	
>>	SE01	96	<b>Number of Included Segments</b> Total number of segments included in a transaction set including ST and SE segments	M N0 1/10
>>	SE02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	M AN 4/9

**X12 997 – version 004010**  
**Functional Acknowledgment**

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## **A. 997 OVERVIEW**

The X12 997 standard contains a special transaction set called the X12 997 Functional Acknowledgment. It is used to acknowledge the receipt of transactions and is generated by the receiving trading partner and transmitted back to the originating trading partner or their representative. The X12 997 must be set up to acknowledge at the transaction set (ST loop) level.

The X12 997 will report back to the sender that a transaction set (ST loop) was received, whether it was accepted or not, and identify any X12 syntax errors found in each transaction set (ST loop). For ISA and GS envelopes containing more than one ST loop, an X12 997 AK5 segment is sent back for each ST loop. So, it is possible that some ST transaction sets could be rejected and other ST transaction sets could be accepted from one ISA/GS envelope. For example, one ISA/GS envelope with 4 ST transaction set loops, could have ST loops 1 & 3 accepted, and ST loops 2 & 4 rejected.

When a provider or their representative receives a 997 response to an 837 Health Care Claim transaction set (ST loop) with a status of accepted or accepted with errors (AK501=A or E), the MCO is responsible for processing the bill data contained in the transaction set (ST loop). In the above example, the MCO is responsible for processing ST transaction sets 1 and 3.

When the provider or their representative receives a 997 response to an 837 Health Care Claim transaction set (ST loop) with any rejected status (AK501= M, R, W or X), the provider or their representative is responsible for re-submitting the corrected transaction set (ST loop) to the MCO. In the above example, the provider is responsible for re-submitting the corrected ST transaction sets 2 and 4.

The X12 997 is expected for all transaction sets transmitted as a part of the billing process. In other words,

- The Provider submits an 837 then the MCO responds with a 997.
- The MCO sends a 277 to the Provider and the Provider responds with a 997.
- The MCO sends an 835 and the Provider responds with a 997.

## **B. 997 IMPLEMENTATION GUIDE**

The 997 Implementation Guide contains the detailed structure of the X12 997 document. It includes:

- a graphical depiction of the X12 997 looping structure
- all ASC X12 semantic and syntax notes
- indicators identifying mandatory and optional segments according to X12 rules
- indicators identifying which segments are used by BWC
- indicators identifying mandatory, optional, and conditional data elements according to X12 rules
- indicators identifying which data elements of the used segments are used by BWC
- subsets of valid code values used by BWC for ID type data elements

# 997 Functional Acknowledgment

Functional Group ID=**FA**

## Introduction:

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
>> 010	ST	Transaction Set Header	M	1		n1
>> 020	AK1	Functional Group Response Header	M	1		n2
		LOOP ID - AK2			999999	
030	AK2	Transaction Set Response Header	O	1		n3
		LOOP ID - AK3			999999	
040	AK3	Data Segment Note	O	1		c1
050	AK4	Data Element Note	O	99		
>> 060	AK5	Transaction Set Response Trailer	M	1		
>> 070	AK9	Functional Group Response Trailer	M	1		
>> 080	SE	Transaction Set Trailer	M	1		

## Transaction Set Notes

- These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments. Nor shall a Functional Acknowledgment be sent to report errors in a previous Functional Acknowledgment.  
The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.  
There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.
- AK1 is used to respond to the functional group header and to start the acknowledgement for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.
- AK2 is used to start the acknowledgement of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

## Transaction Set Comments

- The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

**Segment:** **ST** Transaction Set Header  
**Position:** 010  
**Loop:**  
**Level:**  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the start of a transaction set and to assign a control number  
**Syntax Notes:**  
**Semantic Notes:** 1 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).  
**Comments:**

**Data Element Summary**

Ref.	Data		
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	ST01	143	<b>Transaction Set Identifier Code</b> Code uniquely identifying a Transaction Set Refer to 004010 Data Element Dictionary for acceptable code values.
>>	ST02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

**Segment:** **AK1** Functional Group Response Header  
**Position:** 020  
**Loop:**  
**Level:**  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To start acknowledgment of a functional group  
**Syntax Notes:**  
**Semantic Notes:**

- 1 AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.
- 2 AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.

**Comments:**

**Data Element Summary**

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>		
>>	AK101	479 <b>Functional Identifier Code</b>	M ID 2/2
		Code identifying a group of application related transaction sets	
		HC Health Care Claim (837)	
		HN Health Care Claim Status Notification (277)	
		HP Health Care Claim Payment/Advice (835)	
>>	AK102	28 <b>Group Control Number</b>	M N0 1/9
		Assigned number originated and maintained by the sender	

**Segment:** **AK2** Transaction Set Response Header  
**Position:** 030  
**Loop:** AK2 Optional  
**Level:**  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To start acknowledgment of a single transaction set  
**Syntax Notes:**  
**Semantic Notes:**

- 1 AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.
- 2 AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.

**Comments:**

**Data Element Summary**

Ref.	Data	Name	Attributes
<u>Des.</u>	<u>Element</u>		
>>	AK201	143 <b>Transaction Set Identifier Code</b>	M ID 3/3
		Code uniquely identifying a Transaction Set	
		277 Health Care Claim Status Notification	
		835 Health Care Claim Payment/Advice	
		837 Health Care Claim	
>>	AK202	329 <b>Transaction Set Control Number</b>	M AN 4/9
		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	

**Segment:** **AK3** Data Segment Note  
**Position:** 040  
**Loop:** AK3 Optional  
**Level:**  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To report errors in a data segment and identify the location of the data segment  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>
>>	AK301	721	<b>Segment ID Code</b> Code defining the segment ID of the data segment in error (See Appendix A - Number 77)	<b>M ID 2/3</b>
>>	AK302	719	<b>Segment Position in Transaction Set</b> The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1	<b>M N0 1/6</b>
	AK303	447	<b>Loop Identifier Code</b> The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE	<b>O AN 1/6</b>
	AK304	720	<b>Segment Syntax Error Code</b> Code indicating error found based on the syntax editing of a segment	<b>O ID 1/3</b>
		1	Unrecognized segment ID	
		2	Unexpected segment	
		3	Mandatory segment missing	
		4	Loop Occurs Over Maximum Times	
		5	Segment Exceeds Maximum Use	
		6	Segment Not in Defined Transaction Set	
		7	Segment Not in Proper Sequence	
		8	Segment Has Data Element Errors	

**Segment:** **AK4** Data Element Note

**Position:** 050

**Loop:** AK3 Optional

**Level:**

**Usage:** Optional

**Max Use:** 99

**Purpose:** To report errors in a data element or composite data structure and identify the location of the data element

**Syntax Notes:**

**Semantic Notes:** 1 In no case shall a value be used for AK404 that would generate a syntax error, e.g., an invalid character.

**Comments:**

**Data Element Summary**

Ref.	Data Element	Name	Attributes
>> AK401	C030	<b>Position in Segment</b>	<b>M</b>
		Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	
>> C03001	722	<b>Element Position in Segment</b>	<b>M N0 1/2</b>
		This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID	
C03002	1528	<b>Component Data Element Position in Composite</b>	<b>O N0 1/2</b>
		To identify the component data element position within the composite that is in error	
AK402	725	<b>Data Element Reference Number</b>	<b>O N0 1/4</b>
		Reference number used to locate the data element in the Data Element Dictionary	
>> AK403	723	<b>Data Element Syntax Error Code</b>	<b>M ID 1/3</b>
		Code indicating the error found after syntax edits of a data element	
		1 Mandatory data element missing	
		2 Conditional required data element missing.	
		3 Too many data elements.	
		4 Data element too short.	
		5 Data element too long.	
		6 Invalid character in data element.	
		7 Invalid code value.	
		8 Invalid Date	
		9 Invalid Time	
		10 Exclusion Condition Violated	
AK404	724	<b>Copy of Bad Data Element</b>	<b>O AN 1/99</b>
		This is a copy of the data element in error	

**Segment:** **AK5** Transaction Set Response Trailer  
**Position:** 060  
**Loop:** AK2 Optional  
**Level:**  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To acknowledge acceptance or rejection and report errors in a transaction set  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
>> AK501	717	<b>Transaction Set Acknowledgment Code</b>	<b>M ID 1/1</b>
		Code indicating accept or reject condition based on the syntax editing of the transaction set	
		A Accepted	
		E Accepted But Errors Were Noted	
		M Rejected, Message Authentication Code (MAC) Failed	
		R Rejected	
		W Rejected, Assurance Failed Validity Tests	
		X Rejected, Content After Decryption Could Not Be Analyzed	
AK502	718	<b>Transaction Set Syntax Error Code</b>	<b>O ID 1/3</b>
		Code indicating error found based on the syntax editing of a transaction set	
		1 Transaction Set Not Supported	
		2 Transaction Set Trailer Missing	
		3 Transaction Set Control Number in Header and Trailer Do Not Match	
		4 Number of Included Segments Does Not Match Actual Count	
		5 One or More Segments in Error	
		6 Missing or Invalid Transaction Set Identifier	
		7 Missing or Invalid Transaction Set Control Number	
		8 Authentication Key Name Unknown	
		9 Encryption Key Name Unknown	
		10 Requested Service (Authentication or Encrypted) Not Available	
		11 Unknown Security Recipient	
		12 Incorrect Message Length (Encryption Only)	
		13 Message Authentication Code Failed	
		15 Unknown Security Originator	
		16 Syntax Error in Decrypted Text	
		17 Security Not Supported	
		19 S1E Security End Segment Missing for S1S Security Start Segment	
		20 S1S Security Start Segment Missing for S1E Security End Segment	
		21 S2E Security End Segment Missing for S2S Security Start Segment	
		22 S2S Security Start Segment Missing for S2E Security End Segment	

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Transaction Set Control Number Not Unique within the  
Functional Group

<b>AK503</b>	<b>718</b>	<b>Transaction Set Syntax Error Code</b>	<b>O ID 1/3</b>
		Code indicating error found based on the syntax editing of a transaction set Refer to 004010 Data Element Dictionary for acceptable code values.	
<b>AK504</b>	<b>718</b>	<b>Transaction Set Syntax Error Code</b>	<b>O ID 1/3</b>
		Code indicating error found based on the syntax editing of a transaction set Refer to 004010 Data Element Dictionary for acceptable code values.	
<b>AK505</b>	<b>718</b>	<b>Transaction Set Syntax Error Code</b>	<b>O ID 1/3</b>
		Code indicating error found based on the syntax editing of a transaction set Refer to 004010 Data Element Dictionary for acceptable code values.	
<b>AK506</b>	<b>718</b>	<b>Transaction Set Syntax Error Code</b>	<b>O ID 1/3</b>
		Code indicating error found based on the syntax editing of a transaction set Refer to 004010 Data Element Dictionary for acceptable code values.	

**Segment:** **AK9** **Functional Group Response Trailer**  
**Position:** 070  
**Loop:**  
**Level:**  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group

**Syntax Notes:**

**Semantic Notes:**

**Comments:** 1 If AK901 contains the value "A" or "E", then the transmitted functional group is accepted.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Attributes</u>
<u>Des.</u>	<u>Element</u>		
>> <b>AK901</b>	<b>715</b>	<b>Functional Group Acknowledge Code</b> Code indicating accept or reject condition based on the syntax editing of the functional group A Accepted E Accepted, But Errors Were Noted. M Rejected, Message Authentication Code (MAC) Failed P Partially Accepted, At Least One Transaction Set Was Rejected R Rejected W Rejected, Assurance Failed Validity Tests X Rejected, Content After Decryption Could Not Be Analyzed	<b>M ID 1/1</b>
>> <b>AK902</b>	<b>97</b>	<b>Number of Transaction Sets Included</b> Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	<b>M N0 1/6</b>
>> <b>AK903</b>	<b>123</b>	<b>Number of Received Transaction Sets</b> Number of Transaction Sets received	<b>M N0 1/6</b>
>> <b>AK904</b>	<b>2</b>	<b>Number of Accepted Transaction Sets</b> Number of accepted Transaction Sets in a Functional Group	<b>M N0 1/6</b>
<b>AK905</b>	<b>716</b>	<b>Functional Group Syntax Error Code</b> Code indicating error found based on the syntax editing of the functional group header and/or trailer 1 Functional Group Not Supported 2 Functional Group Version Not Supported 3 Functional Group Trailer Missing 4 Group Control Number in the Functional Group Header and Trailer Do Not Agree 5 Number of Included Transaction Sets Does Not Match Actual Count 6 Group Control Number Violates Syntax 10 Authentication Key Name Unknown 11 Encryption Key Name Unknown 12 Requested Service (Authentication or Encryption) Not Available 13 Unknown Security Recipient 14 Unknown Security Originator	<b>O ID 1/3</b>

		15	Syntax Error in Decrypted Text	
		16	Security Not Supported	
		17	Incorrect Message Length (Encryption Only)	
		18	Message Authentication Code Failed	
		19	S1E Security End Segment Missing for S1S Security Start Segment	
		20	S1S Security Start Segment Missing for S1E End Segment	
		21	S2E Security End Segment Missing for S2S Security Start Segment	
		22	S2S Security Start Segment Missing for S2E Security End Segment	
<b>AK906</b>	<b>716</b>		<b>Functional Group Syntax Error Code</b>	<b>O ID 1/3</b>
			Code indicating error found based on the syntax editing of the functional group header and/or trailer	
			Refer to 004010 Data Element Dictionary for acceptable code values.	
<b>AK907</b>	<b>716</b>		<b>Functional Group Syntax Error Code</b>	<b>O ID 1/3</b>
			Code indicating error found based on the syntax editing of the functional group header and/or trailer	
			Refer to 004010 Data Element Dictionary for acceptable code values.	
<b>AK908</b>	<b>716</b>		<b>Functional Group Syntax Error Code</b>	<b>O ID 1/3</b>
			Code indicating error found based on the syntax editing of the functional group header and/or trailer	
			Refer to 004010 Data Element Dictionary for acceptable code values.	
<b>AK909</b>	<b>716</b>		<b>Functional Group Syntax Error Code</b>	<b>O ID 1/3</b>
			Code indicating error found based on the syntax editing of the functional group header and/or trailer	
			Refer to 004010 Data Element Dictionary for acceptable code values.	

**Segment:** **SE** Transaction Set Trailer  
**Position:** 080  
**Loop:**  
**Level:**  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

**Syntax Notes:**  
**Semantic Notes:**  
**Comments:** 1 SE is the last segment of each transaction set.

**Data Element Summary**

	<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Attributes</u>
>>	SE01	96	<b>Number of Included Segments</b> Total number of segments included in a transaction set including ST and SE segments	M N0 1/10
>>	SE02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set	M AN 4/9

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# **APPENDIX A**

## **Partner Profile**

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## **TRADING PARTNER PROFILE OVERVIEW**

There are two Trading Partner Profile sheets included in this section. The first profile is for the MCOs partner information. This should be used by the MCOs for their trading partners' setup. The second profile needs to be completed by each provider and returned to each MCO before testing can begin.

Control numbers at each of the envelope levels should be sequentially incremented so they uniquely identify the interchange, group, and transaction set by trading partner.

## MCO TRADING PARTNER PROFILE

### Transaction

Set: \_\_\_\_\_

### General Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Value Added Network (VAN) Information

VAN Name: \_\_\_\_\_

### Interchange Information

Interchange Envelope: ISA Version: \_\_\_\_\_

TP's Test Sender/Receiver ID's: \_\_\_\_\_ Qualifier: \_\_\_\_\_

TP's Prod Sender/Receiver ID's: \_\_\_\_\_ Qualifier: \_\_\_\_\_

Subelement Separator: \_\_\_\_\_

Element Separator: \_\_\_\_\_

Segment Terminator: \_\_\_\_\_

### Group Information

Group Envelope: GS Version: 004010

TP's Sender/Receiver ID: \_\_\_\_\_

### Acknowledgment Information

Acknowledgment Transaction Generated Outbound: 997

Acknowledgment Transaction Expected Inbound: 997

Level of Acknowledgments Expected Inbound: Transaction  
(Interchange, Group, Transaction, or None)

## PROVIDER TRADING PARTNER PROFILE

### Transaction

Set: \_\_\_\_\_

### General Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Value Added Network (VAN) Information

VAN Name: \_\_\_\_\_

### Interchange Information

Interchange Envelope: ISA Version: \_\_\_\_\_

TP's Test Sender/Receiver ID's: \_\_\_\_\_ Qualifier: \_\_\_\_\_

TP's Prod Sender/Receiver ID's: \_\_\_\_\_ Qualifier: \_\_\_\_\_

Subelement Separator: \_\_\_\_\_

Element Separator: \_\_\_\_\_

Segment Terminator: \_\_\_\_\_

### Group Information

Group Envelope: GS Version: 004010

TP's Sender/Receiver ID: \_\_\_\_\_

### Acknowledgment Information

Acknowledgment Transaction Generated Outbound: 997

Acknowledgment Transaction Expected Inbound: 997

Level of Acknowledgments Expected Inbound: Transaction

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