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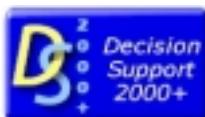
**HIPAA**

**Handbook for Health Care Claim  
Payment/Advice Transaction (835)**

**Decision Support 2000+**

**May 20, 2002**

**Survey and Analysis Branch  
Division of State and Community Systems Development  
Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration**



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**HIPAA  
Handbook for Health Care Claim  
Payment/Advice Transaction (835)  
Decision Support 2000+**

**I. Introduction**

The Health Care Claim Payment/Advice (835) transaction set is used to pay claims and transfer remittance information from a health care payer to a health care provider, either directly or through a Depository Financial Institutions (DFI).. It can be used to make the payment, send an Explanation of Benefits (EOB) remittance advice, or both.

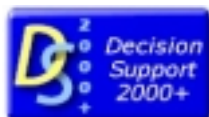
Health care providers receiving the Health Care Claim Payment/Advice (835) transaction include hospitals, nursing homes, laboratories, physicians, dentists, and allied professional groups. Organizations sending the Health Care Claim Payment/Advice (835) transaction include insurance companies, Third Party Administrators (TPAs), service corporations, state and federal agencies and their contractors, plan purchasers, and any other entities that process health care reimbursements. Other business partners affiliated with the 835 include Depository Financial Institutions (DFIs), billing services, consulting services, vendors of systems, software and EDI translators, EDI network intermediaries such as Automated Clearing Houses (ACH), value-added networks (VAN), and telecommunication services.

This Handbook consists of

- an overview of the structure of the transaction;
- tables of the data elements (including definitions, codes, and attributes) that constitute the transaction;
- definitions of key terms and explanations of issues for understanding the information contained in the master data set; and
- a list of external code sources need for the transaction.

The Data Tables define terms, explain usage, and provide technical specifications for the data. Section IV defines key terms and elaborates on important issues for this transaction.

Information in this Handbook is intended to provide a user-friendly summary of the data contained in the Health Care Claim Payment/Advice (835) transaction. When referenced in conjunction with the DS2000+ Master Data Set, this Handbook will help users construct a transaction. For additional technical information not provided in these documents, users should refer to the full Implementation Guide. All information in this



Handbook has been taken directly from the Health Care Claim Payment/Advice (835) transaction.<sup>1</sup>

## II. Overview of this Transaction

### Uses of the Health Care Claim Payment/Advice (835) Transaction

The Health Care Claim Payment/Advice (835) transaction is used to pay a health care claim (i.e., to institute an Electronic Funds Transfer [EFT]), send an electronic Explanation of Benefits (EOB) remittance advice, or both pay the claim and send the remittance advice.

The 835 is also used to provide financial notification of capitation payments from a Managed Care Organization (MCO) to a capitated care provider. (Note that the 835 does not contain the capitation details or membership roster; an associated Eligibility and Benefits Notification Transaction Set (271) is used to communicate these details.)

The 835 contains information about the payee (i.e., providers and/or their agents), the payer (or any third party agent), the amount, and any identifying information regarding the payment. As a remittance advice, the 835 provides detailed payment information including, if applicable, the reasons why the total original charges were not paid in full.

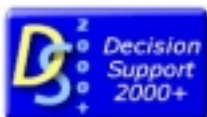
### Flow of Information and Money

Payers can pay claims and send remittance advice in different ways (i.e., together or separately) and through different channels (i.e., directly to the provider or through financial institutions).

- Payment is made by check (sent through the mail) and the payer sends the remittance advice electronically (as a Health Care Claim Payment/Advice (835) transaction) to the payee (Electronic Remittance Advice [ERA]). The payee deposits the check and reconciles the payment and the ERA.
- Payment is made by electronically transferring funds directly from the payer's to the payee's account (i.e., *via* an Electronic Funds Transfer [EFT] in which the Health Care Claim Payment/Advice (835) transaction is used to authorize the payee's Depository Financial Institution (DFI) take funds from the payer's account and transfer those funds to the payee's account). The ERA is sent along with the EFT and the payee's DFI notifies the payee of the receipt of funds via

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<sup>1</sup> Health Care Claim Payment/Advice (835) transaction, ASCX12N 835 (004010X091), Washington Publishing Company, May 2000.



Funds Deposit Notification (FDN) and sends the ERA. The payee does not need to reconcile the payment and the ERA.

- Payment is made by EFT but the ERA is sent to the payee rather than the DFI. The payee's DFI notifies the payee of the receipt of funds via FDN and the payee reconciles the payment and the ERA.
- Payment is made by EFT or check. The payer sends the ERA to the payee's DFI which reconciles the ERA and the payment and notifies the payee.

When payment and remittance advice are sent separately, the provider needs a method to ensure that payment and remittance advice are reconciled in the patient accounting/accounts receivable system. The 835 provides two key pieces of information to facilitate reconciliation, the trace number (TRN02) and the Company ID Number (TRN03).

### **Relationship with Other Transactions (837, 277, NCPDP 3.2)**

A one-for-one relationship does not exist among the Health Care Claim Transaction Set (837), the Health Care Claim Status Notification Transaction Set (277), the Prescription Drug Claim Transaction (NCPDP 3.2), and the 835. One 835 transaction can account for claims submitted using multiple 835 or multiple NCPDP 3.2 transactions. The Claim Submitter's Identifier reported in the 837 and the NCPDP 3.2 claims are returned in the 835 transaction for tracking purposes.

Similarly, a one-for-one relationship does not exist between the 277 and the 835 transactions. The 277's primary use is to convey status information on non-adjudicated claims; the 835 is used to transmit data needed for posting subsequent to the adjudication of a claim. The 277 also can account for claims already paid by an 835. The Claim Submitter's Identifier, reported in the claim within the 837 always is returned in the 835 and frequently is returned in the 277 transaction for tracking purposes.

### **Structure of the Transaction Sets**

Under HIPAA, business transactions (such as a group of benefit enrollments sent from a sponsor to a payer or a health care claim submitted by a provider to a payer) are conducted through formal structures called "transaction sets". Information is transmitted as discrete data elements grouped together into segments; segments are grouped into loops (see Figure 1, below).



**Figure 1. Loops, Segments, and Data Elements**



Transaction sets all adhere to the same format: a control segment called the header segment; loops of data segments, both in specified order; and a control segment called the trailer segment. Within each data segment, the data elements also follow a specified order. Similar transaction sets, called “functional groups,” can be sent together within a transmission; in this case, each transaction set has its own unique identifier that is transmitted as the first data element of the header segment.

The discussion below on data elements, segments, and loops is intended to help readers understand the structure of the transaction and the information presented in the Data Tables.

### **Data Elements**

A data element corresponds to a data field in data processing terminology. Data elements are characterized by:

- name (e.g., “Identification Code”)
- usage (e.g., required or situational [which means that the element is required only under certain circumstances]);
- reference designator (e.g., NM109, which indicates that the element is in the NM1 segment and is the ninth data element in the segment);
- number (e.g., 67); and
- attributes.

The attributes are the condition designator in the X12 standard (i.e., mandatory [M], optional [O], relational [X])<sup>2</sup>; the type of data element (e.g., Numeric [Nn], Decimal [R],

<sup>2</sup> The X12 condition designator defines the circumstances under which a data element may be required to be present or not present in a particular segment. The designation of mandatory (M) is absolute in the sense that there is no dependency on other data elements. The designation of optional (O) means that there is no requirement for a data element to be in the segment and that its presence is at the option of the sender. Relational conditions (X) may exist among two or more simple data elements within the same data segment (e.g., they may be paired or multiple so that if any element specified in the relational condition is present, then all the elements specified must be present).

Identifier [ID], String [AN], Date [DT], Time [TM], Binary [B]); and the minimum and maximum length of the data (i.e., the number of character positions used for numeric, decimal, and binary elements).

For simplicity of presentation, we use the single term “attributes” in the data tables to refer to *all* the characteristics of a data element, i.e., usage, reference designator, number, X12 requirement designator, type, and length. For the data element “subscriber identification code” these “attributes” are listed sequentially as SITUATIONAL NM109 67 X AN 2/80. In this example, the meaning of the terms is as follows:

SITUATIONAL	required only under certain circumstances
NM109	the ninth element in the NM1 segment
X	a relational element in the X12 standard
AN	a string type of element
2/80	a minimum of 2 and a maximum of 80 characters are allowed

### Segments

Logically related data elements are grouped together in units called segments. There are two types of segments—control segments and data segments. These segments have the same structure, but different uses. The control segments are used to convey information about the transaction and the data segments are used to convey the information that necessitated the transaction. Transaction sets always begin and end with a control segment between which are the data segments. The control segment that begins a transaction is called the header (ST) segment and is used to identify the sender and receiver; the control segment that ends a transaction is called the trailer (SE) segment and is used for verification and security purposes. (For more information on control segments, see Section IV. Key Terms)

Each transaction set contains many segments, analogous to a freight train: the segments are like the train’s cars and each one has several data elements just as a train car might have many crates. The sequence of the data elements within one segment and the sequence of segments in the transaction set are both specified by the ASC X12 standard. In a more conventional computing environment, the segments would be equivalent to records, and the data elements equivalent to fields.

Each segment, whether a control or data segment, has its own name and its own purpose. A segment always has the same structure: it begins with a unique identifier, then has one or more logically related data elements, and ends with a segment terminator.

The Data Check List shows all the data elements within each data segment; the data segments within the transaction by segment ID, name, and usage (required or situational); and how the segments are grouped into loops.



## Loops

Loops are groups of logically related data segments. The segments within a loop occur in a specified order; the first (“beginning”) segment in the loop gives the loop its name and establishes whether the loop is required or situational. If the beginning segment in a loop is required, then the loop is required; if the beginning segment is situational, the loop is situational. Loops themselves are not actually sent in a transaction—only the data segments within the loop are sent. A loop (actually, the data segments that comprise the loop) may occur once, repeat an unlimited number of times, or repeat only a specified number of times.

## Loop Hierarchy

The looping structure is hierarchical—i.e., certain loops are subordinated to others. Once the hierarchy is understood, the logic of the data in the transaction becomes apparent.

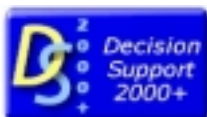
The 835 is divided into three levels, or tables:

- The Header Level, Table 1, contains general payment information, such as amount, payee, payer, trace number, and payment method.
- The Detail level, Table 2, contains the Explanation of Benefits (EOB) information related to adjudicated claims and services.

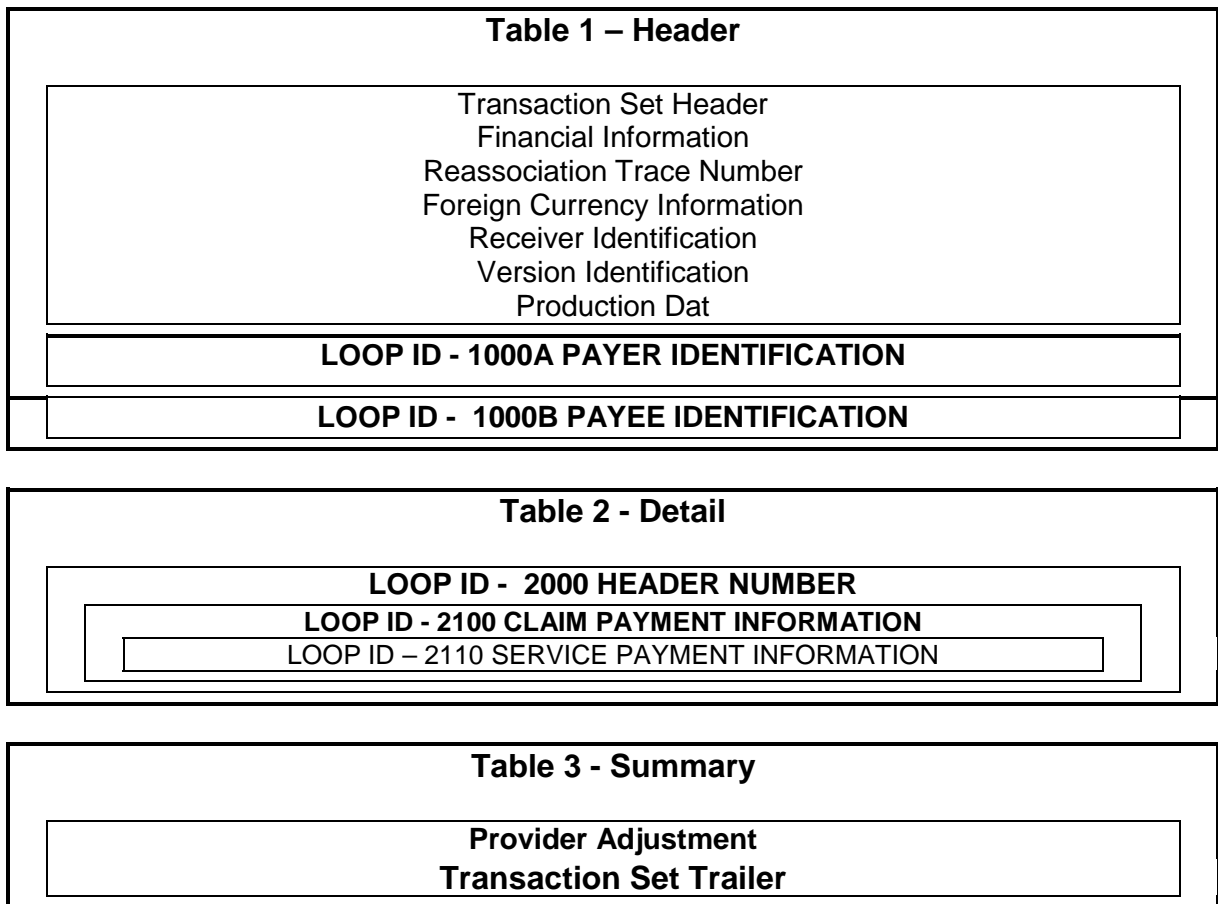
The Summary level, Table 3, contains the Provider Level Adjustment Segment, PLB, which provides information related to adjustments to the payment amount not specific to Table 2 claims. These adjustments can either increase or decrease the actual payment with respect to the Table 2 claim charges. The 835 uses a standardized list of codes that provide the reason for the adjustment.

Although the remittance information in Tables 2 and 3 are not always provided, the intention of this business use of the 835 is for payers to provide some claim or provider-specific information along with the payment information. When dollars and data are delivered separately, an 835 with no Table 2 or PLB information can initiate a financial transaction.

Figure 3 on the next page shows the hierarchical organization of the data in this transaction.



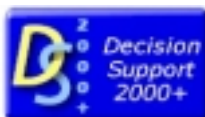
**Figure 3. Loop Hierarchy for the Health Care Claim Payment/Advice (835) Transaction**



### III. Data Check List

The Data Check List for each transaction shows the hierarchical levels, the loops within the levels, the segments within the loops, and the data elements within the segments. It helps ensure that users have or collect all the information they need to process the transaction.

<b>Table 1 — Header</b>		
<b>SEG. ID</b>	<b>NAME</b>	<b>USAGE</b>
<b>ST</b>	<b>Transaction Set Header</b>	<b>R</b>
	Transaction Set Identifier Code	<b>R</b>
	Transaction Set Control Number	<b>R</b>
<b>BPR</b>	<b>Financial Information</b>	<b>R</b>
	Transaction Handling Code	<b>R</b>
	Monetary Amount	<b>R</b>
	Credit/Debit Flag Code	<b>R</b>
	Payment Method Code	<b>R</b>
	Payment Format Code	<b>S</b>
	(DFI) ID Number Qualifier	<b>S</b>
	(DFI) ID Identification Number	<b>S</b>
	Account Number Qualifier	<b>S</b>
	Account Number	<b>S</b>
	Originating Company Identifier	<b>S</b>
	Originating Company Supplemental Code	<b>S</b>
	ID Number Qualifier (DFI)	<b>S</b>
	(DFI) Identification Number	<b>S</b>
	Account Number Qualifier	<b>S</b>
	Account Number	<b>S</b>
	Date	<b>R</b>
<b>TRN</b>	<b>Reassociation Trace Number</b>	<b>R</b>
	Trace Type Code	<b>R</b>
	Reference Identification	<b>R</b>
	Originating Company Identifier	<b>R</b>
	Reference Identification	<b>S</b>
<b>CUR</b>	<b>Foreign Currency Information</b>	<b>S</b>
	Entity Identifier Code	<b>R</b>
	Currency Code	<b>R</b>
	Exchange Rate	<b>S</b>
<b>REF</b>	<b>Receiver Identification</b>	<b>S</b>
	Reference Identification Qualifier	<b>R</b>
	Reference Identification	<b>R</b>
<b>REF</b>	<b>Version Identification</b>	<b>S</b>
	Reference Identification Qualifier	<b>R</b>
	Reference Identification	<b>R</b>

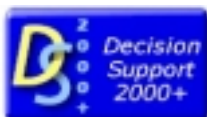


<b>DTM</b>	<b>Production Date</b>	<b>S</b>
	Date/Time Qualifier	<b>R</b>
	Date	<b>R</b>
<b>LOOP 1000A PAYER IDENTIFICATION</b>		
<b>N1</b>	<b>Payer Identification</b>	<b>R</b>
	Entity Identifier Code	<b>R</b>
	Name	<b>S</b>
	Identification Code Qualifier	<b>S</b>
	Identification Code	<b>S</b>
<b>N3</b>	<b>Payer Address</b>	<b>R</b>
	Address Information	<b>R</b>
	Address Information	<b>S</b>
<b>N4</b>	<b>PAYER CITY, STATE, ZIP CODE</b>	<b>R</b>
	City Name	<b>R</b>
	State or Province Code	<b>R</b>
	Postal Code	<b>R</b>

Table 2 — Detail		
SEG. ID	NAME	USAGE
<b>REF</b>	<b>Additional Payer Identification</b>	<b>S</b>
	Reference Identification Qualifier	<b>R</b>
	Reference Identification	<b>R</b>
<b>PER</b>	<b>Payer Contact Information</b>	<b>S</b>
	Contact Function Code	<b>R</b>
	Name	<b>S</b>
	Communication Number Qualifier	<b>S</b>
	Communication Number	<b>S</b>
	Communication Number Qualifier	<b>S</b>
	Communication Number	<b>S</b>
	Communication Number Qualifier	<b>S</b>
	Communication Number	<b>S</b>
<b>LOOP 1000B PAYEE IDENTIFICATION</b>		
<b>NI</b>	<b>Payer Identification</b>	<b>R</b>
	Entity Identifier Code	<b>R</b>
	Name	<b>S</b>
	Identification Code Qualifier	<b>R</b>
	Identification Code	<b>R</b>
<b>N3</b>	<b>Payee Address</b>	<b>S</b>
	Address Information	<b>R</b>
	Address Information	<b>S</b>
<b>N4</b>	<b>Payee City, State, Zip Code</b>	<b>S</b>



	City Name	R
	State or Province Code	R
	Postal Code	R
	Country Code	S
<b>REF</b>	<b>Payee Additional Identification</b>	<b>S</b>
	Reference Identification Qualifier	R
	Reference Identification	R
<b>LOOP 2000 HEADER NUMBER</b>		
<b>LX</b>	<b>Header Number</b>	<b>S</b>
	Assigned Number	S
<b>TS3</b>	<b>Provider Summary Information</b>	<b>S</b>
	Reference Identification	R
	Facility Code Value	R
	Date	R
	Quantity	R
	Monetary Amount	R
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Quantity	S
	Monetary Amount	S
<b>TS2</b>	<b>Provider Supplemental Summary Information</b>	<b>S</b>
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Quantity	S
	Monetary Amount	S
	Monetary Amount	S



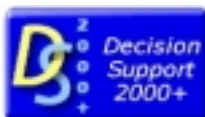
	Quantity	S
	Quantity	S
	Quantity	S
	Quantity	S
	Quantity	S
	Monetary Amount	S
	Quantity	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S

**LOOP 2100 CLAIM PAYMENT INFORMATION**

<b>CLP</b>	<b>Claim Payment Information</b>	<b>R</b>
	Claim Submitter's Identifier	R
	Claim Status Code	R
	Monetary Amount	R
	Monetary Amount	R
	Monetary Amount	S
	Claim Filing Indicator Code	R
	Reference Identification	S
	Facility Code Value	S
	Claim Frequency Type Code	S
	Diagnosis Related Group (DRG) Code	S
	Quantity	S
	Percent	S
<b>CAS</b>	<b>Claim Adjustment</b>	<b>S</b>
	Claim Adjustment Group Code	R
	Claim Adjustment Reason Code	R
	Monetary Amount	R
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S



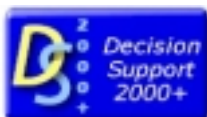
<b>NM1</b>	<b>Patient Name</b>	<b>R</b>
	Entity Identifier Code	<b>R</b>
	Entity Type Qualifier	<b>R</b>
	Name Last or Organization Name	<b>R</b>
	Name First	<b>R</b>
	Name Middle	<b>S</b>
	Name Suffix	<b>S</b>
	Identification Code Qualifier	<b>S</b>
	Identification Code	<b>S</b>
<b>NM1</b>	<b>Insured Name</b>	<b>S</b>
	Entity Identifier Code	<b>R</b>
	Entity Type Qualifier	<b>R</b>
	Name Last or Organization Name	<b>S</b>
	Name First	<b>S</b>
	Name Middle	<b>S</b>
	Name Suffix	<b>S</b>
	Identification Code Qualifier	<b>R</b>
	Identification Code	<b>R</b>
<b>NM1</b>	<b>Corrected Patient/Insured Name</b>	<b>S</b>
	Entity Identifier Code	<b>R</b>
	Entity Type Qualifier	<b>R</b>
	Name Last or Organization Name	<b>S</b>
	Name First	<b>S</b>
	Name Middle	<b>S</b>
	Name Suffix	<b>S</b>
	Identification Code Qualifier	<b>S</b>
	Identification Code	<b>S</b>
<b>NM1</b>	<b>Service Provider Name</b>	<b>S</b>
	Entity Identifier Code	<b>R</b>
	Entity Type Qualifier	<b>R</b>
	Name Last or Organization Name	<b>S</b>
	Name First	<b>S</b>
	Name Middle	<b>S</b>
	Name Suffix	<b>S</b>
	Identification Code Qualifier	<b>R</b>
	Identification Code	<b>R</b>
<b>NM1</b>	<b>Crossover Carrier Name</b>	<b>S</b>
	Entity Identifier Code	<b>R</b>
	Entity Type Qualifier	<b>R</b>
	Name Last or Organization Name	<b>R</b>
	Identification Code Qualifier	<b>R</b>
	Identification Code	<b>R</b>
<b>NM1</b>	<b>Corrected Priority Payer Name</b>	<b>S</b>
	Entity Identifier Code	<b>R</b>
	Entity Type Qualifier	<b>R</b>
	Name Last or Organization Name	<b>R</b>



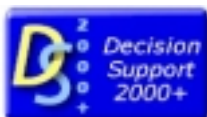
	Identification Code Qualifier	R
	Identification Code	R
<b>MIA</b>	<b>Inpatient Adjudication Information</b>	<b>S</b>
	Quantity	R
	Quantity	S
	Quantity	S
	Monetary Amount	S
	Reference identification	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Quantity	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Monetary Amount	S
	Reference Identification	S
	Reference Identification	S
	Reference Identification	S
	Reference Identification	S
	Monetary Amount	S
<b>MOA</b>	<b>Outpatient Adjudication Information</b>	<b>S</b>
	Percent	S
	Monetary Amount	S
	Reference Identification	S
	Reference Identification	S
	Reference Identification	S
	Reference Identification	S
	Reference Identification	S
	Monetary Amount	S
	Monetary Amount	S
<b>REF</b>	<b>Other Claim Related Identification</b>	<b>S</b>
	Reference Identification Qualifier	R
	Reference Identification	R
<b>REF</b>	<b>Rendering Provider Identification</b>	<b>S</b>
	Reference Identification Qualifier	R
	Reference Identification	R
<b>DTM</b>	<b>Claim Date</b>	<b>S</b>
	Date/Time Qualifier	R
	Date	R



<b>PER</b>	<b>Claim Contact Information</b>	<b>S</b>
	Contact Function Code	R
	Name	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
	Communication Number Qualifier	S
	Communication Number	S
<b>AMT</b>	<b>Claim Supplemental Information</b>	<b>S</b>
	Amount Qualifier Code	R
	Monetary Amount	R
<b>QTY</b>	<b>Claim Supplemental Information Quantity</b>	<b>S</b>
	Quantity Qualifier	R
	Quantity	R
<b>LOOP 2110 SERVICE PAYMENT INFORMATION</b>		
<b>SVC</b>	<b>Service Payment Information</b>	<b>S</b>
	Composite Medical Procedure Identifier	R
	Product/Service ID Qualifier	R
	Product/Service ID	R
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Description	S
	Monetary Amount	R
	Monetary Amount	R
	Product/Service ID	S
	Quantity	S
	Composite Medical Procedure Identifier	S
	Product/Service ID Qualifier	R
	Product/Service ID	R
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Procedure Modifier	S
	Description	S
	Quantity	S
<b>DTM</b>	<b>Service Date</b>	<b>S</b>
	Date/Time Qualifier	R
	Date	R
<b>CAS</b>	<b>Service Adjustment</b>	<b>S</b>
	Claim Adjustment Group Code	R



	Claim Adjustment Reason Code	R
	Monetary Amount	R
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
	Claim Adjustment Reason Code	S
	Monetary Amount	S
	Quantity	S
<b>REF</b>	<b>Service Identification</b>	<b>S</b>
	Reference Identification Qualifier	R
	Reference Identification	R
<b>REF</b>	<b>Rendering Provider Information</b>	<b>S</b>
	Reference Identification Qualifier	R
	Reference Identification	R
<b>AMT</b>	<b>Service Supplemental Amount</b>	<b>S</b>
	Amount Qualifier Code	R
	Monetary Amount	R
<b>QTY</b>	<b>Service Supplemental Quantity</b>	<b>S</b>
	Quantity Qualifier	R
	Quantity	R
<b>LQ</b>	<b>Health Care Remark Codes</b>	<b>S</b>
	Code List Qualifier Code	R
	Industry Code	R
<b>PLB</b>	<b>Provider Adjustment</b>	<b>S</b>
	Reference Identification	R
	Date	R
	Adjustment Identifier	R
	Adjustment Reason Code	R
	Reference Identification	S
	Monetary Amount	R
	Adjustment Identifier	S
	Adjustment Reason Code	R
	Reference Identification	S
	Monetary Amount	S
	Adjustment Identifier	S
	Adjustment Reason Code	R



	Reference Identification	<b>S</b>
	Monetary Amount	<b>S</b>
	Adjustment Identifier	<b>S</b>
	Adjustment Reason Code	<b>R</b>
	Reference Identification	<b>S</b>
	Monetary Amount	<b>S</b>
	Adjustment Identifier	<b>S</b>
	Adjustment Reason Code	<b>R</b>
	Reference Identification	<b>S</b>
	Monetary Amount	<b>S</b>
	Adjustment Identifier	<b>S</b>
	Adjustment Reason Code	<b>R</b>
	Reference Identification	<b>S</b>
	Monetary Amount	<b>S</b>
<b>SE</b>	<b>Transaction Set Trailer</b>	<b>S</b>
	Number of Included Segments	<b>R</b>
	Transaction Set Control	<b>R</b>



## IV. Data Element Tables

The Data Element Tables give the purpose and definition, codes, and technical specifications for all the data elements in the Benefit Enrollment and Maintenance Transaction. Section V below explains and defines key terms. Readers should refer to the Implementation Guide for additional technical information.

### TRANSACTION SET HEADER (ST)

**REQUIRED**

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

<b>Name</b>	<b>Transaction Set Identifier Code</b>
<b>Purpose/Definition</b>	Uniquely identifies the transaction set as the health care claim payment/advice transaction.
<b>Codes</b>	835 Health Care Claim Payment/Advice
<b>Attributes</b>	REQUIRED ST01 143 M ID 3/3

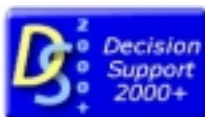
<b>Name</b>	<b>Transaction Set Control Number</b>
<b>Purpose/Definition</b>	A control number that uniquely identifies the transaction set assigned by the originator.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED ST02 329 M AN 4/9

### FINANCIAL INFORMATION (BPR)

**REQUIRED**

Indicates the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount and enables related transfer of funds and/or information from payer to payee to occur.

<b>Name</b>	<b>Transaction Handling Code</b>
<b>Purpose/Definition</b>	Designates the action to be taken by all parties.
<b>Codes</b>	C Payment Accompanies Remittance Advice D Make Payment Only H Notification Only I Remittance Information Only P Prenotification of Future Transfers U Split Payment and Remittance X Handling Party's Option to Split Payment and Remittance
<b>Attributes</b>	REQUIRED BPR01 305 M ID 1/2



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Specifies the payment amount.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED BPR02 782 M R 1/18

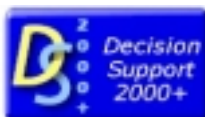
<b>Name</b>	<b>Credit/Debit Flag Code</b>
<b>Purpose/Definition</b>	Indicates whether amount is a credit or debit.
<b>Codes</b>	C Credit D Debit
<b>Attributes</b>	REQUIRED BPR03 478 M ID 1/1

<b>Name</b>	<b>Payment Method Code</b>
<b>Purpose/Definition</b>	Identifies the method for the movement of payment instructions.
<b>Codes</b>	ACH Automated Clearing House (ACH) BOP Financial Institution Option CHK Check FWT Federal Reserve Funds/Wire Transfer - Nonrepetitive NON Non-Payment Data
<b>Attributes</b>	REQUIRED BPR04 591 M ID 3/3

<b>Name</b>	<b>Payment Format Code</b>
<b>Purpose/Definition</b>	Identifies the payment format to be used.
<b>Codes</b>	CCP Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) CTX Corporate Trade Exchange (CTX) (ACH)
<b>Attributes</b>	SITUATIONAL BPR05 812 O ID 1/10

<b>Name</b>	<b>(DFI) ID Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of identification number of the originating financial institution in BPR07.
<b>Codes</b>	01 ABA Transit Routing Number Including Check Digits (9 digits) 04 Canadian Bank Branch and Institution Number
<b>Attributes</b>	SITUATIONAL BPR06 506 X ID 2/2

<b>Name</b>	<b>(DFI) Identification Number</b>
-------------	------------------------------------



<b>Purpose/Definition</b>	Identifies the originating financial institution sending the transaction into the ACH network.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL BPR07 507 X AN 3/12

<b>Name</b>	<b>Account Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of bank account or other financial asset in BPR09.
<b>Codes</b>	DA Demand Deposit
<b>Attributes</b>	SITUATIONAL BPR08 569 O ID 1/3

<b>Name</b>	<b>Account Number</b>
<b>Purpose/Definition</b>	Account number of the company originating the payment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL BPR09 508 X AN 1/35

<b>Name</b>	<b>Originating Company Identifier</b>
<b>Purpose/Definition</b>	Designates the company initiating the funds transfer instructions.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL BPR10 509 O AN 10/10

<b>Name</b>	<b>Originating Company Supplemental Code</b>
<b>Purpose/Definition</b>	Identifies the company initiating the transfer instructions and further identifies the payer by division or region.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL BPR11 510 O AN 9/9

<b>Name</b>	<b>ID Number Qualifier (DFI)</b>
<b>Purpose/Definition</b>	Identifies the type of receiving financial institution (RDFI) in BPR13.



<b>Codes</b>	01 ABA Transit Routing Number Including Check Digits (9 digits) 04 Canadian Bank Branch and Institution Number
<b>Attributes</b>	<b>SITUATIONAL BPR12 506 X ID 2/2</b>

<b>Name</b>	<b>(DFI) Identification Number</b>
<b>Purpose/Definition</b>	Identifies the financial institution receiving the transaction from the ACH network.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL BPR13 507 X AN 3/12

<b>Name</b>	<b>Account Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of bank account or other financial asset in BPR15. Use this code to identify the type of account in BPR15. This element is required when BPR04 is ACH, BOP or FWT.
<b>Codes</b>	DA Demand Deposit SG Savings
<b>Attributes</b>	SITUATIONAL BPR14 569 O ID 1/3

<b>Name</b>	<b>Account Number</b>
<b>Purpose/Definition</b>	Receiver's account number at the financial institution.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL BPR15 508 X AN 1/35

<b>Name</b>	<b>Date</b>
<b>Purpose/Definition</b>	The date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).
<b>Codes</b>	
<b>Attributes</b>	REQUIRED BPR16 373 O DT 8/8

**REASSOCIATION TRACE NUMBER (TRN) REQUIRED**  
 Uniquely identifies this transaction set and aids in reassociating payments and remittances that have been separated.

<b>Name</b>	<b>Trace Type Code</b>
-------------	------------------------



<b>Purpose/Definition</b>	Identifies which transaction is being referenced.
<b>Codes</b>	1 Current Transaction Trace Numbers
<b>Attributes</b>	REQUIRED TRN01 481 M ID 1/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	A number assigned by the sender that uniquely identifies the transaction. For example, if a payment is made by check, this number should be the check number.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED TRN02 127 M AN 1/30

<b>Name</b>	<b>Originating Company Identifier</b>
<b>Purpose/Definition</b>	Designates the originating company initiating the funds transfer instructions.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED TRN03 509 O AN 10/10

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Identifies a further subdivision within the organization in TRN03.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TRN04 127 O AN 1/30



**FOREIGN CURRENCY INFORMATION (CUR)****SITUATIONAL**

To specify the currency (dollars, pounds, francs, etc.) used in a transaction when the payment is not being made in United States dollars or when the payment is made in a currency different from that in the original claim.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Identifies that the information in this segment refers to the payer.
<b>Codes</b>	PR Payer
<b>Attributes</b>	REQUIRED CUR01 98 M ID 2/3

<b>Name</b>	<b>Currency Code</b>
<b>Purpose/Definition</b>	Identifies the country in whose currency the charges are specified.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CUR02 100 M ID 3/3

<b>Name</b>	<b>Exchange Rate</b>
<b>Purpose/Definition</b>	Value to be used as a multiplier conversion factor to convert monetary value from one currency to another.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CUR03 280 O R 4/10

**RECEIVER IDENTIFICATION (REF)****SITUATIONAL**

Specifies identifying information when the receiver of the transaction is other than the payee (e.g., Clearing House or billing service ID).

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates that REF02 is the Receiver Identification Number.
<b>Codes</b>	EV Receiver Identification Number
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Receiver Identification Number
<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30



**VERSION IDENTIFICATION (REF)****SITUATIONAL**

Specifies the version number of the adjudication system that generated the claim payments in this transaction.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates that REF02 is the version code.
<b>Codes</b>	F2 Version Code – Local
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Version Identification Number
<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

**PRODUCTION DATE (DTM)****SITUATIONAL**

Specifies the production date.

<b>Name</b>	<b>Date/Time Qualifier</b>
<b>Purpose/Definition</b>	Indicates that DTM02 is the production date.
<b>Codes</b>	405 Production
<b>Attributes</b>	REQUIRED DTM01 374 M ID 3/3

<b>Name</b>	<b>Date</b>
<b>Purpose/Definition</b>	Production Date.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED DTM02 373 X DT 8/8

**LOOP 1000A PAYER IDENTIFICATION****PAYER IDENTIFICATION (N1)****REQUIRED**

Identifies the type of payer and provides the name/address information.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Indicates that N102 is the payer.
<b>Codes</b>	PR Payer
<b>Attributes</b>	REQUIRED N101 98 M ID 2/3

<b>Name</b>	<b>Name</b>
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<b>Purpose/Definition</b>	Payer Name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL N102 93 X AN 1/60

<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates N104 is the Health Care Financing Administration National PlanID.
<b>Codes</b>	XV Health Care Financing Administration National PlanID
<b>Attributes</b>	SITUATIONAL N103 66 X ID 1/2

<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Payer Identifier.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL N104 67 X AN 2/80

**PAYER ADDRESS (N3)**

**REQUIRED**

Specifies the location of the payer.

<b>Name</b>	<b>Address Information</b>
<b>Purpose/Definition</b>	Payer Address.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N301 166 M AN 1/55

<b>Name</b>	<b>Address Information</b>
<b>Purpose/Definition</b>	Payer Address line 2.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL N302 166 O AN 1/55

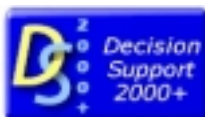
**PAYER CITY, STATE, ZIP CODE (N4)**

**REQUIRED**

Specifies the geographic location of the payer.

<b>Name</b>	<b>City Name</b>
<b>Purpose/Definition</b>	Payer City Name.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N401 19 O AN 2/30

<b>Name</b>	<b>State or Province Code</b>
<b>Purpose/Definition</b>	Payer State Code.



<b>Codes</b>	
<b>Attributes</b>	REQUIRED N402 156 O ID 2/2

<b>Name</b>	<b>Postal Code</b>
<b>Purpose/Definition</b>	Payer Postal Cone or Zip Code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N403 116 O ID 3/15

**ADDITIONAL PAYER IDENTIFICATION (REF)**

**SITUATIONAL**

Specifies identifying information whenever additional payer identification numbers are required.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of identification in REF02.
<b>Codes</b>	2U Payer Identification Number EO Submitter Identification Number HI Health Industry Number (HIN) NF National Association of Insurance Commissioners (NAIC) Code
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Additional Payer Identifier.
<i>Codes</i>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

**PAYER CONTACT INFORMATION (PER)**

**SITUATIONAL**

Identifies the person or office to whom administrative communications should be directed.

<b>Name</b>	<b>Contact Function Code</b>
<b>Purpose/Definition</b>	Identifies the contact in PER02 is for the Payers Claim Office.
<b>Codes</b>	CX Payers Claim Office
<b>Attributes</b>	REQUIRED PER01 366 M ID 2/2

<b>Name</b>	<b>Name</b>
<b>Purpose/Definition</b>	Payer's Contact Name.
<b>Codes</b>	



<b>Attributes</b>	SITUATIONAL PER02 93 O AN 1/60
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<b>Name</b>	<b>Communication Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of communication number in PER04.
<b>Codes</b>	EM Electronic Mail FX Facsimile TE Telephone
<b>Attributes</b>	SITUATIONAL PER03 365 X ID 2/2

<b>Name</b>	<b>Communication Number</b>
<b>Purpose/Definition</b>	Payer Contact Communications Number.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PER04 364 X AN 1/80

<b>Name</b>	<b>Communication Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of communication number in PER06.
<b>Codes</b>	EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone
<b>Attributes</b>	SITUATIONAL PER05 365 X ID 2/2

<b>Name</b>	<b>Communication Number</b>
<b>Purpose/Definition</b>	Payer Contact Communications Number.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PER06 364 X AN 1/80

<b>Name</b>	<b>Communication Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies PER08 as a telephone extension.
<b>Codes</b>	EX Telephone Extension
<b>Attributes</b>	SITUATIONAL PER07 365 X ID 2/2

<b>Name</b>	<b>Communication Number</b>
<b>Purpose/Definition</b>	Payer Contact Telephone Extension.
<b>Codes</b>	



<b>Attributes</b>	SITUATIONAL PER08 364 X AN 1/80
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## LOOP 1000B PAYEE IDENTIFICATION

### PAYEE IDENTIFICATION (N1)

**REQUIRED**

Identifies the type of payee code and provides the name/address information.

<b>Name</b>	<b>Entity IdentifierCode</b>
<b>Purpose/Definition</b>	Indicates that N102 is the Payee.
<b>Codes</b>	PE Payee
<b>Attributes</b>	REQUIRED N101 98 M ID 2/3

<b>Name</b>	<b>Name</b>
<b>Purpose/Definition</b>	Payee Name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL N102 93 X AN 1/60

<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of payer identification code in N014.
<b>Codes</b>	FI Federal Taxpayer's Identification Number XX Health Care Financing Administration National Provider Identifier
<b>Attributes</b>	REQUIRED N103 66 X ID 1/2

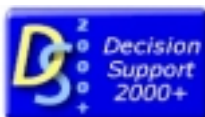
<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Payee Identification Code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N104 67 X AN 2/80

### PAYEE ADDRESS (N3)

**SITUATIONAL**

Specifies the location of the payee.

<b>Name</b>	<b>Address Information</b>
<b>Purpose/Definition</b>	Payee Address.
<b>Codes</b>	



<b>Attributes</b>	REQUIRED N301 166 M AN 1/55
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<b>Name</b>	<b>Address Information</b>
<b>Purpose/Definition</b>	Payee Address.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL N302 166 O AN 1/55

**PAYEE CITY, STATE, ZIP CODE (N4)**

**SITUATIONAL**

Specifies the geographic location of the payee.

<b>Name</b>	<b>City Name</b>
<b>Purpose/Definition</b>	Payee City Name.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N401 19 O AN 2/30

<b>Name</b>	<b>State or Province Code</b>
<b>Purpose/Definition</b>	Payee State Code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N402 156 O ID 2/2

<b>Name</b>	<b>Postal Code</b>
<b>Purpose/Definition</b>	Payee Post Zone or Zip Code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED N403 116 O ID 3/15

<b>Name</b>	<b>Country Code</b>
<b>Purpose/Definition</b>	Payee Country Code.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL N404 26 O ID 2/3

**PAYEE ADDITIONAL IDENTIFICATION (REF)**

**SITUATIONAL**

Specifies additional identifying information when more than one identification number is required to identify the payee.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of additional payee identifier in REF02.



<b>Codes</b>	0B State License Number 1A Blue Cross Provider Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number 1E Dentist License Number 1F Anesthesia License Number 1G Provider UPIN Number 1H CHAMPUS Identification Number D3 National Association of Boards of Pharmacy Number G2 Provider Commercial Number N5 Provider Plan Network Identification Number PQ Payee Identification TJ Federal Taxpayer's Identification Number
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Additional Payee Identifier.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

## LOOP 2000 HEADER NUMBER

### HEADER NUMBER (LX)

**SITUATIONAL**

References a line number in a transaction set.

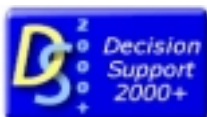
<b>Name</b>	<b>Assigned Number</b>
<b>Purpose/Definition</b>	Number assigned for differentiation within a transaction set.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED LX01 554 M N0 1/6

### PROVIDER SUMMARY INFORMATION (TS3)

**SITUATIONAL**

Identifies provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity (i.e., the corporate office of a hospital chain).

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Identifier.



<b>Codes</b>	
<b>Attributes</b>	REQUIRED TS301 127 M AN 1/30

<b>Name</b>	<b>Facility Code Value</b>
<b>Purpose/Definition</b>	Identifies the type of facility where services were performed.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED TS302 1331 M AN 1/2

<b>Name</b>	<b>Date</b>
<b>Purpose/Definition</b>	Last day of provider's fiscal year.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED TS303 373 M DT 8/8

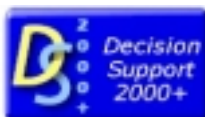
<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	The total number of claims.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED TS304 380 M R 1/15

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total reported charges for all claims.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED TS305 782 M R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total of covered charges.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS306 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total of non-covered charges.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS307 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
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<b>Purpose/Definition</b>	The total of denied charges.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS308 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total provider payment amount including the total of all interest paid.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS309 782 O R 1/18

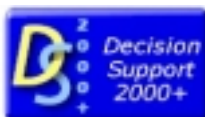
<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total amount of interest paid.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS310 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total contractual adjustment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS311 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total Gramm-Rudman Reduction.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS312 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total Medicare Secondary Payer (MSP) primary payer amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS313 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total blood deductible amount in dollars. amount in dollars.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS314 782 O R 1/18



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The sum of non-lab charges.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS315 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total co-insurance amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS316 782 O R 1/18

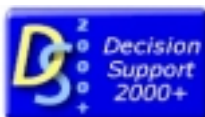
<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS317 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS318 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The total cash deductible.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS319 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total professional component amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS320 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the total Medicare Secondary Payer (MSP) patient liability met amount.



<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS321 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total patient reimbursement.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS322 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total periodic interim payment (PIP) adjustment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS324 782 O R 1/18

**PROVIDER SUPPLEMENTAL SUMMARY INFORMATION (TS2) SITUATIONAL**  
 To provide supplemental summary control information by provider fiscal year and bill Type.

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total diagnosis related group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS201 782 O R 1/18.

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total federal specific amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS202 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total hospital specific amount. Use this monetary amount for the total hospital-specific amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS203 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total disproportionate share amount.
<b>Codes</b>	



<b>Attributes</b>	SITUATIONAL TS204 782 O R 1/18
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<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total capital amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS205 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total indirect medical education amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS206 782 O R 1/18.

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Total number of outlier days
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS207 380 O R 1/15

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total day outlier amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS208 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total cost outlier amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS209 782 O R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	The diagnosis related group (DRG) average length of stay.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS210 380 O R 1/15

<b>Name</b>	<b>Quantity</b>
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<b>Purpose/Definition</b>	The total number of discharges.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS211 380 O R 1/15

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Total number of cost report days.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS212 380 O R 1/15

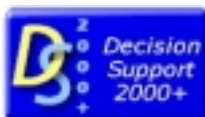
<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Total number of covered days.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS213 380 O R 1/15

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Total number of non-covered days.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS214 380 O R 1/15

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS215 782 O R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Average diagnosis-related group (DRG) weight.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS216 380 O R 1/15

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS217 782 O R 1/18



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total prospective payment system (PPS0 capital, hospital-specific portion, diagnosis-related group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS218 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL TS219 782 O R 1/18

## LOOP 2100 CLAIM PAYMENT INFORMATION

### CLAIM PAYMENT INFORMATION (CLP)

**REQUIRED**

Supplies information common to all services of a claim.

<b>Name</b>	<b>Claim Submitter's Identifier</b>
<b>Purpose/Definition</b>	Identifier used to track a claim from creation by the health care provider through payment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CLP01 1028 M AN 1/38

<b>Name</b>	<b>Claim Status Code</b>
<b>Purpose/Definition</b>	Identifies the status of an entire claim as assigned by the payor, claim review organization or repricing organization.



<b>Codes</b>	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
<b>Attributes</b>	REQUIRED CLP02 1029 M ID 1/2

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	CLP03 is the amount of submitted charges this claim.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CLP03 782 M R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	CLP04 is the amount paid this claim.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CLP04 782 M R 1/18



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Under most circumstances, this element is expected to be sent. CLP05 is the patient responsibility amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP05 782 O R 1/18

<b>Name</b>	<b>Claim Filing Indicator Code</b>
<b>Purpose/Definition</b>	Identifies the type of claim to allow the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider.
<b>Codes</b>	12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Risk AM Automobile Medical CH Champus DS Disability HM Health Maintenance Organization LM Liability Medical MA Medicare Part A MB Medicare Part B MC Medicaid OF Other Federal Program TV Title V VA Veteran Administration Plan WC Workers' Compensation Health Claim
<b>Attributes</b>	REQUIRED CLP06 1032 O ID 1/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Payer's internal control number.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP07 127 O AN 1/30

<b>Name</b>	<b>Facility Code Value</b>
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<b>Purpose/Definition</b>	Identifies 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.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP08 1331 O AN 1/2

<b>Name</b>	<b>Claim Frequency Type Code</b>
<b>Purpose/Definition</b>	Specifies the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP09 1325 O ID 1/1

<b>Name</b>	<b>Diagnosis Related Group (DRG) Code</b>
<b>Purpose/Definition</b>	Indicates a patient's diagnosis group based on a patient's illness, diseases, and medical problems.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP11 1354 Code O ID 1/4

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the diagnosis-related group (DRG) weight.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP12 380 O R 1/15

<b>Name</b>	<b>Percent</b>
<b>Purpose/Definition</b>	Percentage representing the discharge fraction.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CLP13 954 O R 1/10



**CLAIM ADJUSTMENT (CAS)****SITUATIONAL**

Supplies adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid.

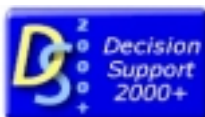
<b>Name</b>	<b>Claim Adjustment Group Code</b>
<b>Purpose/Definition</b>	Identifies the general category of payment adjustment.
<b>Codes</b>	CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility
<b>Attributes</b>	REQUIRED CAS01 1033 Code M ID 1/2

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CAS02 1034 M ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of adjustment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CAS03 782 M R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS04 380 O R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS05 1034 X ID 1/5



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS06 782 X R 1/18

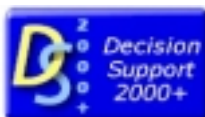
<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value of units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS07 380 X R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS08 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS09 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value of quantity for the units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS10 380 X R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
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<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS11 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS12 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS13 380 X R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS14 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS15 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
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<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS16 380 X R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS17 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS18 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS19 380 X R 1/15

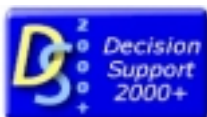
**PATIENT NAME (NM1)**

**REQUIRED**

Supplies the full name of an individual or organizational entity and the patient's identification number in NM109.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Indicates NM103 is the patient.
<b>Codes</b>	QC Patient
<b>Attributes</b>	REQUIRED NM101 98 M ID 2/3

<b>Name</b>	<b>Entity Type Qualifier</b>
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<b>Purpose/Definition</b>	Indicates that NM103 is a person.
<b>Codes</b>	1 Person
<b>Attributes</b>	REQUIRED NM102 1065 M ID 1/1

<b>Name</b>	<b>Name Last or Organization Name</b>
<b>Purpose/Definition</b>	Patient Last Name.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM103 1035 O AN 1/35

<b>Name</b>	<b>Name First</b>
<b>Purpose/Definition</b>	Patient First Name.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM104 1036 O AN 1/25

<b>Name</b>	<b>Name Middle</b>
<b>Purpose/Definition</b>	Patient Middle Name or Initial.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM105 1037 O AN 1/25

<b>Name</b>	<b>Name Suffix</b>
<b>Purpose/Definition</b>	Patient Name Suffix.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM107 1039 O AN 1/10

<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of code in NM109.
<b>Codes</b>	34 Social Security Number HN Health Insurance Claim (HIC) Number II United States National Individual Identifier MI Member Identification Number MR Medicaid Recipient Identification Number
<b>Attributes</b>	SITUATIONAL NM108 66 X ID 1/2

<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Patient Identifier.
<b>Codes</b>	



<b>Attributes</b>	SITUATIONAL NM109 67 X AN 2/80
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**INSURED NAME (NM1)**

**SITUATIONAL**

Supplies the full name of and may be used to identify the insured or subscriber whenever the insured or subscriber is different from the patient.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Indicates that NM103 is the insured or subscriber.
<b>Codes</b>	IL Insured or Subscriber
<b>Attributes</b>	REQUIRED NM101 98 M ID 2/3

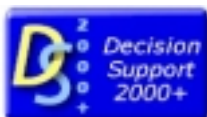
<b>Name</b>	<b>Entity Type Qualifier</b>
<b>Purpose/Definition</b>	Identifies NM103 as a person or organization.
<b>Codes</b>	1 Person 2 Non-Person Entity
<b>Attributes</b>	REQUIRED NM102 1065 M ID 1/1

<b>Name</b>	<b>Name Last or Organization Name</b>
<b>Purpose/Definition</b>	Insured or Subscriber's Last Name or Organizational Name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM103 1035 O AN 1/35

<b>Name</b>	<b>Name First</b>
<b>Purpose/Definition</b>	Insured or Subscriber First Name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM104 1036 O AN 1/25

<b>Name</b>	<b>Name Middle</b>
<b>Purpose/Definition</b>	Insured or Subscriber Middle Name or Initial.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM105 1037 O AN 1/25

<b>Name</b>	<b>Name Suffix</b>
<b>Purpose/Definition</b>	Insured or Subscriber Name Suffix.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM107 1039 O AN 1/10



<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of number in NM109.
<b>Codes</b>	34 Social Security Number HN Health Insurance Claim (HIC) Number MI Member Identification Number
<b>Attributes</b>	REQUIRED NM108 66 X ID 1/2

<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Insured or Subscriber Identifier.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM109 67 X AN 2/80

**CORRECTED PATIENT/INSURED NAME (NM1)**

**SITUATIONAL**

Supplies corrected information about the patient or insured.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Indicates that NM103 is the corrected insured.
<b>Codes</b>	74 Corrected Insured
<b>Attributes</b>	REQUIRED NM101 98 M ID 2/3

<b>Name</b>	<b>Entity Type Qualifier</b>
<b>Purpose/Definition</b>	Indicates NM103 is a person organization.
<b>Codes</b>	1 Person 2 Non-Person Entity
<b>Attributes</b>	REQUIRED NM102 1065 M ID 1/1

<b>Name</b>	<b>Name Last or Organization Name</b>
<b>Purpose/Definition</b>	Corrected patient or insured last name or organizational name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM103 1035 O AN 1/35

<b>Name</b>	<b>Name First</b>
<b>Purpose/Definition</b>	Corrected patient or insured first name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM104 1036 O AN 1/25

<b>Name</b>	<b>Name Middle</b>
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<b>Purpose/Definition</b>	Corrected patient or insured middle name or initial
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM105 1037 O AN 1/25

<b>Name</b>	<b>Name Suffix</b>
<b>Purpose/Definition</b>	Corrected patient or insured suffix.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM107 1039 O AN 1/10

<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates NM109 is the insured's changed unique identification number.
<b>Codes</b>	C Insured's Changed Unique Identification Number
<b>Attributes</b>	SITUATIONAL NM108 66 X ID 1/2

<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Corrected Insured Identification Code.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM109 67 X AN 2/80

### SERVICE PROVIDER NAME (NM1)

**SITUATIONAL**

Supplies information about the rendering provider.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Indicates that NM103 is the Rendering Provider.
<b>Codes</b>	82 Rendering Provider
<b>Attributes</b>	REQUIRED NM101 98 M ID 2/3

<b>Name</b>	<b>Entity Type Qualifier</b>
<b>Purpose/Definition</b>	Indicates that NM103 is a person or organization.
<b>Codes</b>	1 Person 2 Non-Person Entity
<b>Attributes</b>	REQUIRED NM102 1065 M ID 1/1

<b>Name</b>	<b>Name Last or Organization Name</b>
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<b>Purpose/Definition</b>	Rendering Provider's last name or organizational name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM103 1035 O AN 1/35

<b>Name</b>	<b>Name First</b>
<b>Purpose/Definition</b>	Rendering Provider's First Name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM104 1036 O AN 1/25

<b>Name</b>	<b>Name Middle</b>
<b>Purpose/Definition</b>	Rendering Provider's middle name or initial.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM105 1037 O AN 1/25

<b>Name</b>	<b>Name Suffix</b>
<b>Purpose/Definition</b>	Rendering Provider's Suffix.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL NM107 1039 O AN 1/10



<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of code in NM109.
<b>Codes</b>	BD Blue Cross Provider Number BS Blue Shield Provider Number FI Federal Taxpayer's Identification Number MC Medicaid Provider Number PC Provider Commercial Number SL State License Number UP Unique Physician Identification Number (UPIN) XX Health Care Financing Administration National Provider Identifier
<b>Attributes</b>	REQUIRED NM108 66 X ID 1/2

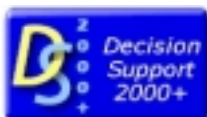
<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Rendering Provider Identifier.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM109 67 X AN 2/80

**CROSSOVER CARRIER NAME (NM1) SITUATIONAL**

Supplies information about the crossover carrier. Any payer to which the claim is transferred for further payment after being finalized by the current payer.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Identifies that the organization in NM103 is the "transfer to" payer.
<b>Codes</b>	TT Transfer To
<b>Attributes</b>	REQUIRED NM101 98 M ID 2/3

<b>Name</b>	<b>Entity Type Qualifier</b>
<b>Purpose/Definition</b>	Indicates NM103 is an organization.
<b>Codes</b>	2 Non-Person Entity
<b>Attributes</b>	REQUIRED NM102 1065 M ID 1/1



<b>Name</b>	<b>Name Last or Organization Name</b>
<b>Purpose/Definition</b>	Name of the crossover carrier associated with this claim.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM103 1035 O AN 1/35

<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of code used in NM109.
<b>Codes</b>	AD Blue Cross Blue Shield Association Plan Code FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification PI Payor Identification PP Pharmacy Processor Number XV Health Care Financing Administration National PlanID
<b>Attributes</b>	REQUIRED NM108 66 X ID 1/2

<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Coordination of Benefits Carrier Identifier.
<i>Codes</i>	
<b>Attributes</b>	REQUIRED NM109 67 X AN 2/80

**CORRECTED PRIORITY PAYER NAME (NM1)**

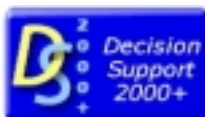
**SITUATIONAL**

Supplies the full name of the priority payer when the current payer believes that another payer has priority for making a payment.

<b>Name</b>	<b>Entity Identifier Code</b>
<b>Purpose/Definition</b>	Indicates NM103 is the payer.
<b>Codes</b>	PR Payer
<b>Attributes</b>	REQUIRED NM101 98 M ID 2/3

<b>Name</b>	<b>Entity Type Qualifier</b>
<b>Purpose/Definition</b>	Indicates NM103 is an organization.
<b>Codes</b>	2 Non-Person Entity
<b>Attributes</b>	REQUIRED NM102 1065 M ID 1/1

<b>Name</b>	<b>Name Last or Organization Name</b>
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<b>Purpose/Definition</b>	Organizational name of the priority payer.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM103 1035 O AN 1/35

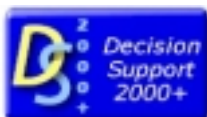
<b>Name</b>	<b>Identification Code Qualifier</b>
<b>Purpose/Definition</b>	Indicates type of code in NM109.
<b>Codes</b>	AD Blue Cross Blue Shield Association Plan Code FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification PI Payor Identification PP Pharmacy Processor Number XV Health Care Financing Administration National PlanID
<b>Attributes</b>	REQUIRED NM108 66 X ID 1/2

<b>Name</b>	<b>Identification Code</b>
<b>Purpose/Definition</b>	Code identifying a party or other code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED NM109 67 X AN 2/80

**INPATIENT ADJUDICATION INFORMATION (MIA) SITUATIONAL**  
Provides claim-level data related to the adjudication of Medicare inpatient claims.

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the covered days.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED MIA01 380 M R 1/15

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the lifetime reserve days.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA02 380 O R 1/15



<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the lifetime psychiatric days.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA03 380 O R 1/15.

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	The Diagnosis Related Group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA04 782 O R 1/18.

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	The Remittance Remark Code.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA05 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Claim disproportionate share amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA06 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Medicare Secondary Payer (MSP) pass-through amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA07 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Total Prospective Payment System (PPS) capital amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA08 782 O R 1/18



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA09 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Prospective Payment System (PPS) capital. Hospital specific portion, Diagnosis Related Group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA10 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA11 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Old capital amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA12 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Prospective Payment System (PPS) capital indirect medical education claim amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA13 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Hospital specific Diagnosis Related Group (DRG) Amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA14 782 O R 1/18



<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value of quantity for the cost report days.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA15 380 O R 1/15

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the PPS (operating)/federal-specific DRG amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA16 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for Prospective Payment System (PPS) Capital Outlier amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA17 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the indirect teaching amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA18 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the professional component amount billed but not payable.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA19 782 O R 1/18

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA20 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
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<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA21 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA22 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA23 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the capital exception amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MIA24 782 O R 1/18

**OUTPATIENT ADJUDICATION INFORMATION (MOA) SITUATIONAL**  
 Conveys claim-level data related to the adjudication of Medicare claims not related to an inpatient setting.

<b>Name</b>	<b>Percent</b>
<b>Purpose/Definition</b>	Percentage for reimbursement rate.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA01 954 O R 1/10

<b>Name</b>	<b>Monetary Amount</b>
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<b>Purpose/Definition</b>	Monetary amount for the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA02 782 O R 1/18

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA03 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA04 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA05 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA06 127 O AN 1/30

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Remittance Remark Code when additional remittance remarks apply to this claim.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA07 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the End Stage Renal Disease (ESRD) payment amount.



<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA08 782 O R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the professional component amount billed but not payable.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL MOA09 782 O R 1/18.

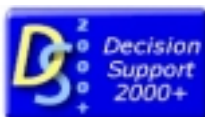
**OTHER CLAIM RELATED IDENTIFICATION (REF)** **SITUATIONAL**  
Specifies reference numbers specific to the claim identified in the CLP segment.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of identifier in REF02.
<b>Codes</b>	1L Group or Policy Number 1W Member Identification Number 9A Repriced Claim Reference Number 9C Adjusted Repriced Claim Reference Number A6 Employee Identification Number BB Authorization Number CE Class of Contract Code EA Medical Record Identification Number F8 Original Reference Number G1 Prior Authorization Number G3 Predetermination of Benefits Identification Number IG Insurance Policy Number SY Social Security Number
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Other Claim Related Identifier.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

**RENDERING PROVIDER IDENTIFICATION (REF)** **SITUATIONAL**  
Specifies reference numbers that are not already identified in NM1 segments within the CLP loop.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of identifier in REF02.



<b>Codes</b>	1A Blue Cross Provider Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number 1G Provider UPIN Number 1H CHAMPUS Identification Number D3 National Association of Boards of Pharmacy Number G2 Provider Commercial Number
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Rendering Provider Secondary Identifier.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

**CLAIM DATE (DTM)**

**SITUATIONAL**

Specifies dates at the claim level (2-050-DTM), the service line level (2-080-DTM), or both.

<b>Name</b>	<b>Date/Time Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of date in DTM02.
<b>Codes</b>	036 Expiration 050 Received 232 Claim Statement Period Start 233 Claim Statement Period End
<b>Attributes</b>	REQUIRED DTM01 374 M ID 3/3

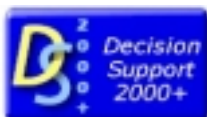
<b>Name</b>	<b>Date</b>
<b>Purpose/Definition</b>	Claim Date
<b>Codes</b>	
<b>Attributes</b>	REQUIRED DTM02 373 X DT 8/8

**CLAIM CONTACT INFORMATION (PER)**

**SITUATIONAL**

Identifies a person or office to whom administrative communications should be directed when there is a claim specific communications contact instruction.

<b>Name</b>	<b>Contact Function Code</b>
<b>Purpose/Definition</b>	Identifies that PER02 is the Payers Claim Office.



<b>Codes</b>	CX Payers Claim Office
<b>Attributes</b>	REQUIRED PER01 366 M ID 2/2

<b>Name</b>	<b>Name</b>
<b>Purpose/Definition</b>	Claim Contact Name.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PER02 93 O AN 1/60

<b>Name</b>	<b>Communication Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type of communication number in PER04.
<b>Codes</b>	EM Electronic Mail FX Facsimile TE Telephone
<b>Attributes</b>	SITUATIONAL PER03 365 X ID 2/2

<b>Name</b>	<b>Communication Number</b>
<b>Purpose/Definition</b>	Claim Contact Communications Number.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PER04 364 X AN 1/80

<b>Name</b>	<b>Communication Number Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of communication number in PER06.
<b>Codes</b>	EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone
<b>Attributes</b>	SITUATIONAL PER05 365 X ID 2/2

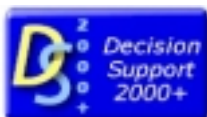
<b>Name</b>	<b>Communication Number</b>
<b>Purpose/Definition</b>	Claim Contact Communications Number.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PER06 364 X AN 1/80

<b>Name</b>	<b>Communication Number Qualifier</b>
<b>Purpose/Definition</b>	Identifies PER08 as a telephone extension.
<b>Codes</b>	EX Telephone Extension



<b>Attributes</b>	SITUATIONAL PER07 364 X AN 1/80
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<b>Name</b>	<b>Communication Number</b>
<b>Purpose/Definition</b>	Claim Contact Communication Number Extension.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PER08 364 X AN 1/80



**CLAIM SUPPLEMENTAL INFORMATION (AMT)****SITUATIONAL**

Indicates the total monetary amount when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

<b>Name</b>	<b>Amount Qualifier Code</b>
<b>Purpose/Definition</b>	Indicates the type of amount in AMT02.
<b>Codes</b>	AU Coverage Amount D8 Discount Amount DY Per Day Limit F5 Patient Amount Paid I Interest NL Negative Ledger Balance T Tax T2 Total Claim Before Taxes ZK Federal Medicare or Medicaid Payment Mandate - Category 1 ZL Federal Medicare or Medicaid Payment Mandate - Category 2 ZM Federal Medicare or Medicaid Payment Mandate - Category 3 ZN Federal Medicare or Medicaid Payment Mandate - Category 4 ZO Federal Medicare or Medicaid Payment Mandate - Category 5 ZZ Mutually Defined
<b>Attributes</b>	REQUIRED AMT01 522 M ID 1/3

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Claim Supplemental Information Amount.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED AMT02 782 M R 1/18



**CLAIM SUPPLEMENTAL INFORMATION QUANTITY (QTY)****SITUATIONAL**

Specifies the value of specific quantities identified in the QTY01 qualifier are Non-zero.

<b>Name</b>	<b>Quantity Qualifier</b>
<b>Purpose/Definition</b>	Specifies type of quantity in QTY02.
<b>Codes</b>	CA Covered - Actual CD Co-insured - Actual LA Life-time Reserve - Actual LE Life-time Reserve - Estimated NA Number of Non-covered Days NE Non-Covered - Estimated NR Not Replaced Blood Units OU Outlier Days PS Prescription VS Visits ZK Federal Medicare or Medicaid Payment Mandate - Category 1 ZL Federal Medicare or Medicaid Payment Mandate - Category 2 ZM Federal Medicare or Medicaid Payment Mandate - Category 3 ZN Federal Medicare or Medicaid Payment Mandate - Category 4 ZO Federal Medicare or Medicaid Payment Mandate - Category 5
<b>Attributes</b>	REQUIRED QTY01 673 M ID 2/2

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Claim Supplemental Information Quantity.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED QTY02 380 X R 1/15



## LOOP 2110 SERVICE PAYMENT INFORMATION

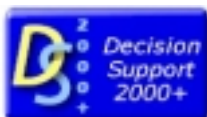
### SERVICE PAYMENT INFORMATION (SVC)

### SITUATIONAL

Supplies payment and control information to a provider for a particular service whenever the actual payment has been reduced due to service line specific adjustments.

<b>Name</b>	<b>Composite Medical Procedure Identifier</b>
<b>Purpose/Definition</b>	Identifies a medical procedure by its standardized codes and applicable modifiers.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED SVC01 C0003 M

<b>Name</b>	<b>Product/Service ID Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type/source of the descriptive number used in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06.
<b>Codes</b>	AD American Dental Association Codes ER Jurisdiction Specific Procedure and Supply Codes HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. ID International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code N1 National Drug Code in 4-4-2 Format N2 National Drug Code in 5-3-2 Format N3 National Drug Code in 5-4-1 Format N4 National Drug Code in 5-4-2 Format ND National Drug Code (NDC) NU National Uniform Billing Committee (NUBC) UB92 Codes RB National Uniform Billing Committee (NUBC) UB82 Codes ZZ Mutually Defined
<b>Attributes</b>	REQUIRED SVC01 - 1 235 M ID 2/2



<b>Name</b>	<b>Product/Service ID</b>
<b>Purpose/Definition</b>	Procedure Code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED SVC01 - 2 234 M AN 1/48

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC01 - 3 1339 O AN 2/2

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC01 - 4 1339 O AN 2/2

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC01 - 5 1339 O AN 2/2

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC01 - 6 1339 O AN 2/2



<b>Name</b>	<b>Description</b>
<b>Purpose/Definition</b>	Procedure Code Description to clarify the related data elements and their content.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC01 - 7 352 O AN 1/80

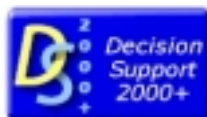
<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Submitted service charge
<b>Codes</b>	
<b>Attributes</b>	REQUIRED SVC02 782 M R 1/18

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount paid this service.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED SVC03 782 O R 1/18

<b>Name</b>	<b>Product/Service ID</b>
<b>Purpose/Definition</b>	National Uniform Billing Committee Revenue Code.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC04 234 O AN 1/48

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the paid units of service.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC05 380 O R 1/15

<b>Name</b>	<b>Composite Medical Procedure Identifier</b>
<b>Purpose/Definition</b>	Identifies a medical procedure by its standardized codes and applicable modifiers.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC06 C003 O



<b>Name</b>	<b>Product/Service ID Qualifier</b>
<b>Purpose/Definition</b>	Identifies the type/source of the descriptive number used in SVC06-02, SVC06-03, SVC06-04, SVC06-05, and SVC06-06.
<b>Codes</b>	AD American Dental Association Codes ER Jurisdiction Specific Procedure and Supply Codes HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure IV Home Infusion EDI Coalition (HIEC) Product/Service Code N1 National Drug Code in 4-4-2 Format N2 National Drug Code in 5-3-2 Format N3 National Drug Code in 5-4-1 Format N4 National Drug Code in 5-4-2 Format ND National Drug Code (NDC) NU National Uniform Billing Committee (NUBC) UB92 Codes RB National Uniform Billing Committee (NUBC) UB82 Codes ZZ Mutually Defined
<b>Attributes</b>	REQUIRED SVC06 - 1 235 M ID 2/2

<b>Name</b>	<b>Product/Service ID</b>
<b>Purpose/Definition</b>	Procedure Code.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED SVC06 - 2 234 M AN 1/48

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC06 - 3 1339 O AN 2/2



<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC06 - 4 1339 O AN 2/2

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC06 - 5 1339 O AN 2/2

<b>Name</b>	<b>Procedure Modifier</b>
<b>Purpose/Definition</b>	Identifies special circumstances related to the performance of the service, as defined by trading partners.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC06 - 6 1339 O AN 2/2

<b>Name</b>	<b>Description</b>
<b>Purpose/Definition</b>	Procedure code description to clarify the related data elements and their content.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC06 - 7 352 O AN 1/80

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the original submitted units of service.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL SVC07 380 O R 1/15



**SERVICE DATE (DTM)****SITUATIONAL**

Specifies dates at the claim level (2-050-DTM), the service line level (2-080-DTM), or both.

<b>Name</b>	<b>Date/Time Qualifier</b>
<b>Purpose/Definition</b>	Specifies the type of date in DTM02.
<b>Codes</b>	150 Service Period Start 151 Service Period End 472 Service
<b>Attributes</b>	REQUIRED DTM01 374 M ID 3/3

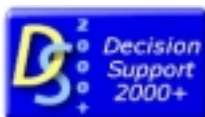
<b>Name</b>	<b>Date</b>
<b>Purpose/Definition</b>	Service Date.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED DTM02 373 X DT 8/8

**SERVICE ADJUSTMENT (CAS)****SITUATIONAL**

Supplies adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid.

<b>Name</b>	<b>Claim Adjustment Group Code</b>
<b>Purpose/Definition</b>	Identifies the general category of payment adjustment.
<b>Codes</b>	CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility
<b>Attributes</b>	REQUIRED CAS01 1033 M ID 1/2

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CAS02 1034 M ID 1/5



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Monetary amount for the amount of adjustment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED CAS03 782 M R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service begin adjusted.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS04 380 O R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS05 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS06 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value of quantity when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS07 380 X R 1/15



<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS08 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS09 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS10 380 X R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS11 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS12 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS13 380 X R 1/15



<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS14 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS15 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS16 380 X R 1/15

<b>Name</b>	<b>Claim Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Identifies the detailed reason the adjustment was made when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS17 1034 X ID 1/5

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Amount of the adjustment when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS18 782 X R 1/18

<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Numeric value for the units of service being adjusted when additional adjustments apply within the group identified in CAS01.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL CAS19 380 X R 1/15

**SERVICE IDENTIFICATION (REF)**

**SITUATIONAL**

HIPAA  
Handbook for Health Care Claim  
Payment/Advice (835) Transaction  
Decision Support 2000+  
DRAFT 5/20/02



Specifies reference numbers specific to the service identified by the SVC segment.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of Provider Identifier in REF02.
<b>Codes</b>	1S Ambulatory Patient Group (APG) Number 6R Provider Control Number BB Authorization Number E9 Attachment Code G1 Prior Authorization Number G3 Predetermination of Benefits Identification Number LU Location Number RB Rate code number
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Identifier.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

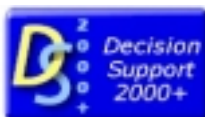
#### RENDERING PROVIDER INFORMATION (REF)

#### SITUATIONAL

Specifies reference numbers specific to the service identified by the SVC segment. The provider-related reference number at this level should be the rendering provider number, but only if the provider number is specific to this particular service line.

<b>Name</b>	<b>Reference Identification Qualifier</b>
<b>Purpose/Definition</b>	Indicates the type of rendering provider identifier in REF02.
<b>Codes</b>	1A Blue Cross Provider Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number 1G Provider UPIN Number 1H CHAMPUS Identification Number 1J Facility ID Number HPI Health Care Financing Administration National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number
<b>Attributes</b>	REQUIRED REF01 128 M ID 2/3

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Rendering Provider Identifier.



<b>Codes</b>	
<b>Attributes</b>	REQUIRED REF02 127 X AN 1/30

**SERVICE SUPPLEMENTAL AMOUNT (AMT)**

**SITUATIONAL**

Indicates the total monetary service supplemental amount when the value of specific amounts identified in the AMT01 qualifier are Non-zero.

<b>Name</b>	<b>Amount Qualifier Code</b>
<b>Purpose/Definition</b>	Indicates the type of service supplemental amount in AMT02.
<b>Codes</b>	B6 Allowed - Actual DY Per Day Limit KH Deduction Amount NE Net Billed T Tax T2 Total Claim Before Taxes ZK Federal Medicare or Medicaid Payment Mandate - Category 1 ZL Federal Medicare or Medicaid Payment Mandate - Category 2 ZM Federal Medicare or Medicaid Payment Mandate - Category 3 ZN Federal Medicare or Medicaid Payment Mandate - Category 4 ZO Federal Medicare or Medicaid Payment Mandate - Category 5
<b>Attributes</b>	REQUIRED AMT01 522 M ID 1/3

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Service Supplemental Amount.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED AMT02 782 M R 1/18



**SERVICE SUPPLEMENTAL QUANTITY (QTY)****SITUATIONAL**

Specifies service supplemental quantity information. Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.

<b>Name</b>	<b>Quantity Qualifier</b>
<b>Purpose/Definition</b>	Specifies the type of quantity in QTY02.
<b>Codes</b>	NE Non-Covered - Estimated ZK Federal Medicare or Medicaid Payment Mandate - Category 1 ZL Federal Medicare or Medicaid Payment Mandate - Category 2 ZM Federal Medicare or Medicaid Payment Mandate - Category 3 ZN Federal Medicare or Medicaid Payment Mandate - Category 4 ZO Federal Medicare or Medicaid Payment Mandate - Category 5
<b>Attributes</b>	REQUIRED QTY01 673 M ID 2/2

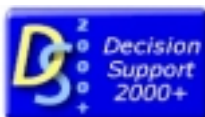
<b>Name</b>	<b>Quantity</b>
<b>Purpose/Definition</b>	Service Supplemental Quantity Count
<b>Codes</b>	
<b>Attributes</b>	REQUIRED QTY02 380 X R 1/15

**HEALTH CARE REMARK CODES (LQ)****SITUATIONAL**

Transmits standard industry codes to provide informational remarks only. This segment has no impact on the actual payment.

<b>Name</b>	<b>Code List Qualifier Code</b>
<b>Purpose/Definition</b>	Identifies the type of industry code in LQ02.
<b>Codes</b>	HE Claim Payment Remark Codes RX National Council for Prescription Drug Programs Reject/Payment Codes
<b>Attributes</b>	REQUIRED LQ01 1270 O ID 1/3

<b>Name</b>	<b>Industry Code</b>
<b>Purpose/Definition</b>	Remark Code
<b>Codes</b>	
<b>Attributes</b>	REQUIRED LQ02 1271 X AN 1/30

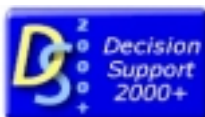
**PROVIDER ADJUSTMENT (PLB)****SITUATIONAL**

Conveys 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.

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider number assigned by the payer.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB01 127 M AN 1/30

<b>Name</b>	<b>Date</b>
<b>Purpose/Definition</b>	Last day of the provider's fiscal year.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB02 373 M DT 8/8

<b>Name</b>	<b>Adjustment Identifier</b>
<b>Purpose/Definition</b>	Identifies the reason and identifying information for the adjustment dollar amount in PLB04.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB03 C042 M



Name	Adjustment Reason Code
<b>Purpose/Definition</b>	Indicates reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
<b>Codes</b>	50 Late Charge 51 Interest Penalty Charge 72 Authorized Return 90 Early Payment Allowance 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 L6 Interest Owed 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 Indicates 22 Mutually Defined
<b>Attributes</b>	REQUIRED PLB03 - 1 426 M ID 2/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Adjustment Identifier
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB03 - 2 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Adjustment amount for the adjustment reason in PLB03-1.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB04 782 M R 1/18

<b>Name</b>	<b>Adjustment Identifier</b>
<b>Purpose/Definition</b>	Provides the category and identifying reference information for an adjustment when additional adjustments apply.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB05 C042 X

<b>Name</b>	<b>Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Indicates the reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB05 - 1 426 M ID 2/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Adjustment Identifier
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB05 - 2 127 O AN 1/30



<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Adjustment amount for PLB05-1.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB06 782 X R 1/18

<b>Name</b>	<b>Adjustment Identifier</b>
<b>Purpose/Definition</b>	Provides the category and identifying reference information for an adjustment when additional adjustments apply.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB07 C042 X

<b>Name</b>	<b>Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Indicates the reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB07 - 1 426 M ID 2/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Adjustment Identifier.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB07 - 2 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Adjustment amount for PLB07-1.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB08 782 X R 1/18

<b>Name</b>	<b>Adjustment Identifier</b>
<b>Purpose/Definition</b>	Provides the category and identifying reference information for an adjustment when additional adjustments apply.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB09 C042 X



<b>Name</b>	<b>Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Indicates the reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB09 - 1 426 M ID 2/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Adjustment Identifier.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB09 - 2 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Adjustment amount for PLB09-1.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB10 782 X R 1/18

<b>Name</b>	<b>Adjustment Identifier</b>
<b>Purpose/Definition</b>	To provide the category and identifying reference information for an adjustment. Used when additional adjustments apply.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB11 C042 X

<b>Name</b>	<b>Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Indicates the reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB11 - 1 426 M ID 2/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Adjustment Identifier.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB11 - 2 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Adjustment amount for PLB11-1.



<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB12 782 X R 1/18

<b>Name</b>	<b>Adjustment Identifier</b>
<b>Purpose/Definition</b>	Provides the category and identifying reference information for an adjustment.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB13 C042 X

<b>Name</b>	<b>Adjustment Reason Code</b>
<b>Purpose/Definition</b>	Indicates the reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED PLB13 - 1 426 M ID 2/2

<b>Name</b>	<b>Reference Identification</b>
<b>Purpose/Definition</b>	Provider Adjustment Identifier.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB13 - 2 127 O AN 1/30

<b>Name</b>	<b>Monetary Amount</b>
<b>Purpose/Definition</b>	Adjustment amount for PLB13-1.
<b>Codes</b>	
<b>Attributes</b>	SITUATIONAL PLB14 782 X R 1/18

**TRANSACTION SET TRAILER (SE)** **REQUIRED**  
Indicates the end of the transaction set and provides the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).

<b>Name</b>	<b>Number of Included Segments</b>
<b>Purpose/Definition</b>	Total number of segments included in a transaction set including ST and SE segments.
<b>Codes</b>	
<b>Attributes</b>	<b>REQUIRED SE01 96 M N0 1/10</b>

<b>Name</b>	<b>Transaction Set Control Number</b>
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<b>Purpose/Definition</b>	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set.
<b>Codes</b>	
<b>Attributes</b>	REQUIRED SE02 329 M AN 4/9



## V. Key Terms and Important Issues

### A. Business Definitions for these Transactions

#### **Premium Receiver**

The premium receiver is the party receiving the payment. It can be either an insurance company, a government agency, or a health care organization.

#### **Premium Payer of Remitter**

The premium payer is the party responsible for paying the premium. It can be an employer-operated internal department or an outside agency which performs payroll processing on behalf of an employer; a government agency paying health care premiums; or an employer paying group premiums.

#### **Subscriber**

The subscriber is a person who can be uniquely identified to an information source, traditionally referred to as a member. The subscriber may or may not be the patient.

#### **Dependent**

The dependent is a person who cannot be uniquely identified to an information source, but can be identified by an information source when associated with a subscriber.

#### **Payer/Insurer**

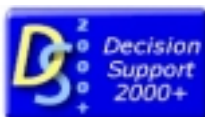
The payer is the party that pays claims and/or administers the insurance coverage, benefit, or product. A payer can be an insurance company; Health Maintenance Organization (HMO); Preferred Provider Organization (PPO); a government agency, such as Medicare or Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or another organization contracted by one of these groups.

### B. Technical Definitions and Issues

#### **Data Standards**

In the HIPAA framework, the transmission of data proceeds according to very strict format rules to ensure the integrity and maintain the efficiency of the interchange. These rules are contained in the ASC X12 standards.

Data standards may not be modified by specific trading partners. However, since the transactions in each trading partner's individual system will vary from site to site (e.g., payer to payer), it is important that trading partners communicate their processing capacity in trading partner agreements.



## **Control Segments**

There are two types of transaction control segments, the header segment (the ST segment) and the trailer segment (the SE segment). Header and trailer segments are used to identify the sender and receiver; allow for authorization and security information; and specify various technical features of the transaction.

The header segment identifies the start of a transaction and the transaction set. The trailer segment identifies the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

If similar transaction sets (i.e., functional groups) are sent together in a transmission, the functional group is delineated by the functional group header (GS) segment and the functional group trailer (GE) segment. The functional group header segment starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

## **Use of Data Segments and Elements Marked “Situational”**

Many data segments and elements are marked “situational”; users should consult the notes in the implementation guide to determine when they should be used.

## **Character Sets and Delimiters**

Transactions use commonly accepted basic characters sets, although encoding schemes other than those specified in the Implementation Guides may be used as long as a common mapping is available and the parties to the transaction agree. Delimiters are characters used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data. They are specified in the interchange header segment and must not be used in a data element value elsewhere in the interchange. Character sets and delimiters are shown in the full Implementation Guide.

## **Batch Transactions**

When transactions are used in batch mode, they are typically grouped together in large quantities and processed en-masse. In a batch mode, the sender sends multiple transactions to the receiver, either directly or through a switch (clearinghouse), and does not remain connected while the receiver processes the transactions. If there is an associated business response transaction (such as a 271 response to a 270 for eligibility), the receiver creates the response transaction for the sender off-line and the original sender reconnects at a later time to pick up the response transaction. Typically, the results of a transaction that is processed in a batch mode would be completed for the next business day. When in batch mode, the 997 Functional Acknowledgment transaction must be returned as quickly as possible to acknowledge that the receiver



has or has not successfully received the batch transaction. In addition, the TA1 segment must be supported for interchange level errors.

### **Real Time Transactions**

Transactions that are used in a real time mode typically are those that require an immediate response. In a real time mode, the sender sends a request transaction to the receiver, either directly or through a switch (clearinghouse), and remains connected while the receiver processes the transaction and returns a response transaction to the original sender. Typically, response times range from a few seconds to around thirty seconds, and should not exceed one minute. The 997 Functional Acknowledgment transaction and the TA1 segment must also be used as in batch mode.

### **Version**

This Handbook is derived from the Implementation Guide based on the ANSI ASC X12 standards, approved for publication in October of 1997, referred to as Version 4, Release 1, Sub-release 0 (004010).

## **VI. List of External Code Sources Needed for this Transaction**

- 4 ABA Routing Number
- 5 Countries, Currencies and Funds
- 22 States and Outlying Areas of the U.S
- 51 ZIP Code
- 60 (DFI) Identification Number
- 77 X12 Directories
- 91 Canadian Financial Institution Branch and Institution Number
- 121 Health Industry Identification Number
- 130 Health Care Financing Administration Common Procedural Coding System
- 131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
- 132 National Uniform Billing Committee (NUBC) Codes
- 134 National Drug Code
- 135 American Dental Association Codes
- 139 Claim Adjustment Reason Code
- 229 Diagnosis Related Group Number (DRG)
- 235 Claim Frequency Type Code
- 240 National Drug Code by Format
- 245 National Association of Insurance Commissioners (NAIC) Code
- 307 National Association of Boards of Pharmacy Number
- 411 Remittance Remark Codes
- 513 Home Infusion EDI Coalition (HIEC) Product/Service Code List
- 530 National Council for Prescription Drug Programs Reject/Payment Codes
- 537 Health Care Financing Administration National Provider Identifier
- 540 Health Care Financing Administration National PlanID

