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HIPAA

**Master Data Set for Health Care Claim
Payment/Advice Transaction (835)**

Decision Support 2000+

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**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

Health Care Claim Payment/Advice (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 Master Data Set 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 Master Data Set is intended to provide a user-friendly summary of the data contained in the Health Care Claim Payment/Advice Transaction (835). When referenced in conjunction with the DS2000+ Handbook, the Master Data Set 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.¹

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).

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

- 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 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.

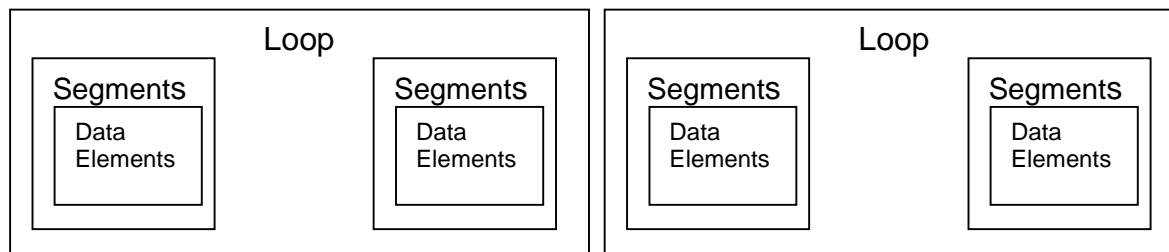
Similarly, a one-for-one relationship does not exist between the 277 and the 835 transactions. The 277's primary use is to convey status information on non-adjudicated claims; the 835 is used to transmit data needed for posting subsequent to the adjudication of a claim. The 277 also can account for claims 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])²; the type of data element (e.g., Numeric [Nn], Decimal [R], 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

² 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).

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:

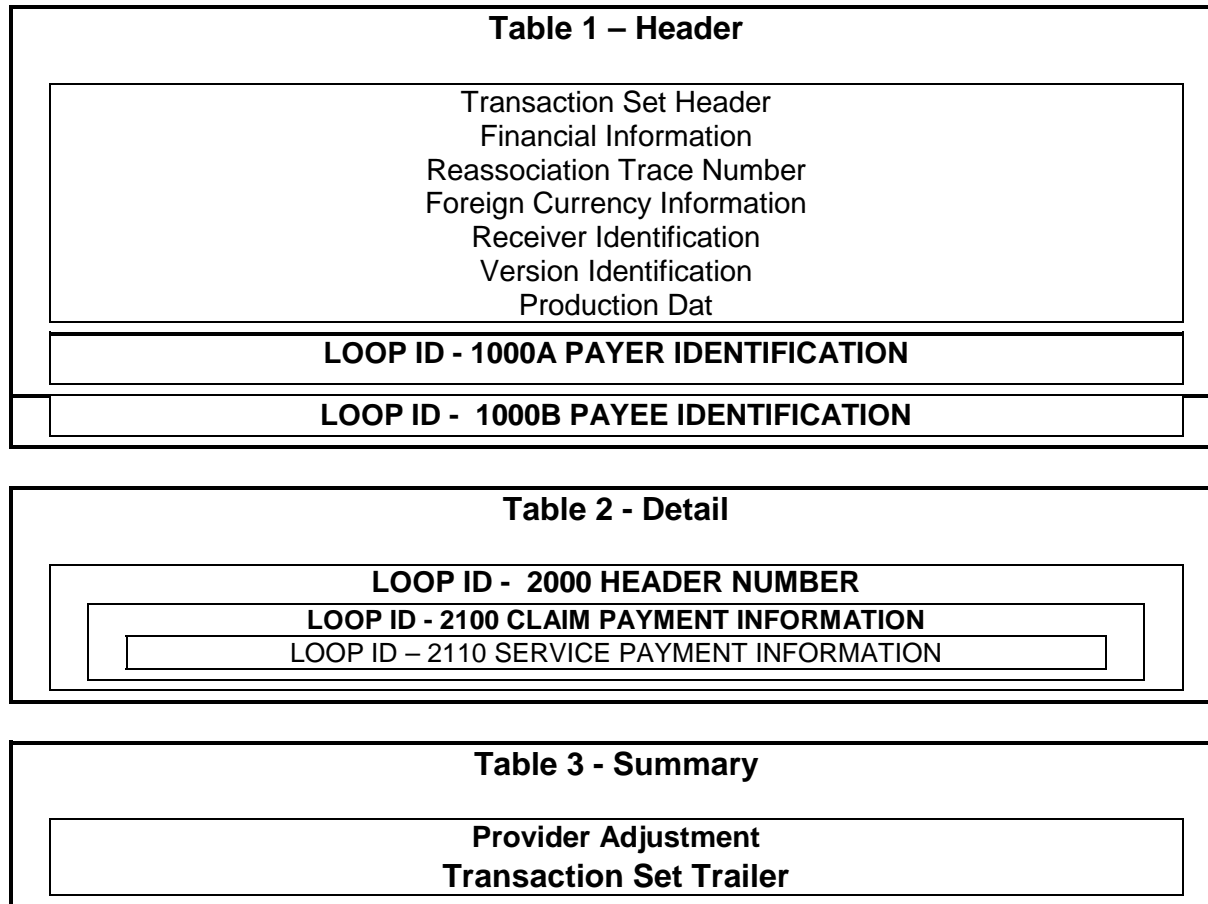
- The Header Level, Table 1, contains general payment information, such as amount, payee, payer, trace number, and payment method.
- The Detail level, Table 2, contains the Explanation of Benefits (EOB) information related to adjudicated claims and services.

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



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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
-----	TRANSACTION SET HEADER		To indicate the start of a transaction set and to assign a control number	REQUIRED
		Transaction Set Identifier Code 835 Health Care Claim Payment/Advice	Code uniquely identifying a Transaction Set. The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set). The only valid value within this transaction set for ST01 is	REQUIRED ST01 143 M ID 3/3
		Transaction Set Control Number	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set03. The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example 0001, and increment from there. This number must be unique within a specific group and interchange, but it can be repeated in other	REQUIRED ST02 329 M AN 4/9
-----	FINANCIAL INFORMATION (BPR)		To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur. Use the BPR to address a single payment to a single payee. A payee may represent a single provider, a provider group, or multiple providers in a chain. The BPR contains mandatory information even when it is not being used to move	REQUIRED
		Transaction Handling Code 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	Code designating the action to be taken by all parties. Use this code to instruct your third party processor to move both funds and remittance detail together through the banking system. Use this code to instruct your third party processor to move only funds through the banking system and to ignore any remittance information. Use this code to pass information only without any reference to payment. Usually this code is used to pass predetermination of benefits information from a payer to a provider. Use this code to indicate to the payee that the remittance detail is moving separately from the payment. This code is used only by the payer and the banking system to initially validate account numbers before beginning an EFT relationship. Contact your VAB for additional information. Use this code to instruct the third party processor to split the payment and remittance detail, and send each on a separate path.	REQUIRED BPR01 305 M ID 1/2

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		X Handling Party's Option to Split Payment and Remittance	Use this code to instruct the third party processor to move the payment and remittance detail, either together or separately, based upon end point requests or capabilities.	
		Monetary Amount	Monetary amount. Total Actual Provider Payment Amount. BPR02 specifies the payment amount. Use BPR02 for the total payment amount for this 835. The total payment amount for this 835 cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the 835 cannot be issued for less than zero dollars.	REQUIRED BPR02 782 M R 1/18
		Credit/Debit Flag Code C Credit D Debit	Code indicating whether amount is a credit or debit. Use this code to indicate a credit to the provider's account and a debit to the payer's account, initiated by the payer. In the case of an EFT, no additional action is required of the provider. Also use this code when a check is issued for the payment. NOT ADVISED Use this code to indicate a debit to the payer's account and a credit to the provider's account, initiated by the provider at the instruction of the payer. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.	REQUIRED BPR03 478 M ID 1/1
		Payment Method Code ACH Automated Clearing House (ACH) BOP Financial Institution Option CHK Check FWT Federal Reserve Funds/Wire Transfer - Nonrepetitive NON Non-Payment Data	Code identifying the method for the movement of payment instructions. Use this code to move money electronically through the ACH, or to notify the provider that an ACH transfer was requested. When this code is used, information in BPR05 through BPR15 must also be included. Use this code to indicate that the third party processor will choose the method of payment based upon end point requests or capabilities. Use this code to indicate that a check has been issued for payment. Use this code to indicate that the funds were sent through the wire system	REQUIRED BPR04 591 M ID 3/3
		Payment Format Code CCP Cash Concentration/Disbursement plus Addenda (CCD+) (ACH)	Code identifying the payment format to be used. When BPR04 is ACH, the recommended code values for BPR05 are CCP and CTX. When BPR04 is any other code, this data element should not be used. Use the CCD+ format to move money and up to 80 characters of data, enough to reassociate dollars and data when the dollars are sent through the ACH and the data is sent on a separate path. The addenda should contain a copy of the TRN segment.	SITUATIONAL BPR05 812 O ID 1/10

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		CTX Corporate Trade Exchange (CTX) (ACH)	Use the CTX format to move dollars and data through the ACH. The CTX format can contain up to 9,999 addenda records of 80 characters each. The CTX encapsulates the complete 835 and all envelope segments.	
		(DFI) ID Number Qualifier	Code identifying the type of identification number of Depository Financial Institution (DFI). When using this transaction set to initiate a payment, all or some of BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used. BPR06 through BPR09 relate to the originating financial institution and the originator's account (never). This element is required when BPR04 is ACH, BOP or	SITUATIONAL BPR06 506 X ID 2/2
		01 ABA Transit Routing Number Including Check Digits (9 digits)	ABA is a unique number identifying every bank in the United States. CODE SOURCE 4: ABA Routing Number.	
		04 Canadian Bank Branch and Institution Number	CODE SOURCE 91: Canadian Financial Institution Branch and Institution Number.	
		(DFI) Identification Number	Depository Financial Institution (DFI) identification number. CODE SOURCE 60: (DFI) Identification Number. Use this number for the identifying number of the financial institution sending the transaction into the ACH network. This element is required when BPR04 is ACH, BOP or FWT.	SITUATIONAL BPR07 507 X AN 3/12
		Account Number Qualifier	Code indicating the type of account. BPR08 is a code identifying the type of bank account or other financial asset. Use this code to identify the type of account in BPR09. This element is required when BPR04 is ACH, BOP	SITUATIONAL BPR08 569 O ID 1/3
		DA Demand Deposit		
		Account Number	Account number assigned. BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order. Use this number for the originator's account number at his or her financial institution. This element is	SITUATIONAL BPR09 508 X AN 1/35
		Originating Company Identifier	A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9. BPR10 must be the Federal Tax ID Number, preceded by a "1." When BPR10 is used, it must be identical to	SITUATIONAL BPR10 509 O AN 10/10

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Originating Company Supplemental Code	A code defined between the originating company and the originating depository financial institution (ODFI) that uniquely identifies the company initiating the transfer instructions. Use this code to further identify the payer by division or region. If used, this code must be identical to TRN04. This element is required when BPR10 is used and additional information is necessary for the payee to identify the source of the payment	SITUATIONAL BPR11 510 O AN 9/9
		ID Number Qualifier (DFI)	Code identifying the type of identification number of Depository Financial Institution (DFI). BPR12 and BPR13 relate to the receiving depository financial institution (RDFI). BPR12 through BPR15 relate to the receiving financial institution and the receiver's account. This element is required	SITUATIONAL BPR12 506 X ID 2/2
		01 ABA Transit Routing Number Including Check Digits (9 digits)	ABA is a unique number identifying every bank in the United States. CODE SOURCE 4: ABA Routing Number.	
		04 Canadian Bank Branch and Institution	CODE SOURCE 91: Canadian Financial Institution Branch and Institution	
		(DFI) Identification Number	Depository Financial Institution (DFI) identification number. CODE SOURCE 60: (DFI) Identification Number. Use this number for the identifying number of the financial institution receiving the transaction from the ACH network. This element is required when BPR04 is ACH, BOP or	SITUATIONAL BPR13 507 X AN 3/12
		Account Number Qualifier	Code indicating the type of account. BPR14 is a code identifying the type of bank account or other financial asset. Use this code to identify the type of account in BPR15. This element is required when BPR04 is ACH, BOP	SITUATIONAL BPR14 569 O ID 1/3
		DA Demand Deposit		
		SG Savings		
		Account Number	Account number assigned. BPR15 is the account number of the receiving company to be debited or credited with the payment order. Use this number for the receiver's account number at the financial institution. This element is required when BPR04 is ACH, BOP or FWT.	SITUATIONAL BPR15 508 X AN 1/35
		Date	Date expressed as CCYYMMDD. BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date). Use this code for the effective entry date. If BPR04 is ACH, this code is the date that the money moves from the payer and is available to the payee. If BPR04 is CHK, this code is the check issuance date. If BPR04 is FWT, this code is the date that the payer anticipates the money to move. As long as the effective date is a business day, this is the settlement date.	REQUIRED BPR16 373 O DT 8/8

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
-----	REASSOCIATION TRACE NUMBER (TRN)		This segment's purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated. To uniquely identify a transaction to an application.	REQUIRED
		Trace Type Code 1 Current Transaction Trace Numbers	Code identifying which transaction is being referenced.	REQUIRED TRN01 481 M ID 1/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. TRN02 provides unique identification for the transaction. This number must be unique within the sender/receiver relationship. The number is assigned by the sender. For example, if a payment is made by check, this number should be the check number. There may be a number of uses for the trace number. If payment and remittance detail are separated, this number is used to reassociate data	REQUIRED TRN02 127 M AN 1/30
		Originating Company Identifier	A unique identifier designating the company initiating the funds transfer instructions. The first character is one-digit ANSI identification code designation (ICD) followed by the nine-digit identification number which may be an IRS employer identification number (EIN), data universal numbering system (DUNS), or a user assigned number; the ICD for an EIN is 1, DUNS is 3, user assigned number is 9. TRN02 identifies an organization. TRN03 must contain the Federal Tax ID Number, preceded by a "1". When BPR10	REQUIRED TRN03 509 O AN 10/10
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. TRN04 identifies a further subdivision within the organization. If both TRN04 and BPR11 are used, they must be identical. This element is required when information beyond the Originating Company Identifier in TRN03 is necessary for the payer to identify the source of the payment	SITUATIONAL TRN04 127 O AN 1/30
-----	FOREIGN CURRENCY INFORMATION (CUR)		To specify the currency (dollars, pounds, francs, etc.) used in a transaction. Use the CUR segment in the 835 to specify the currency and exchange rate, if applicable, when the payment is not being made in United States	SITUATIONAL
		Entity Identifier Code PR Payer	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED CUR01 98 M ID 2/3
		Currency Code	Code (Standard ISO) for country in whose currency the charges are specified. CODE SOURCE 5: Countries, Currencies and Funds.	REQUIRED CUR02 100 M ID 3/3

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Exchange Rate	Value to be used as a multiplier conversion factor to convert monetary value from one currency to another. Use this element when the currency for payment is not the same as the currency specified in the original claims submitted for payment. For instance, when the claims were submitted in United States (US) dollars and paid in Canadian dollars, present the exchange rate from US dollars to Canadian dollars here.	SITUATIONAL CUR03 280 O R 4/10
-----	RECEIVER IDENTIFICATION (REF)		To specify identifying information. Use this segment only when the receiver of the transaction is other than the payee (e.g., Clearing House or billing)	SITUATIONAL
		Reference Identification Qualifier EV Receiver Identification Number	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
-----	VERSION IDENTIFICATION (REF)		To specify identifying information. Use this Reference Number Segment to report the version number of the adjudication system that generated the claim payments in this transaction. Update this reference number whenever a change in the version or release number affects the 835. (This is not the ANSI ASCX12 version number as reported in the GS segment.) Provide the version number when this information is required by the PAYER in order to resolve customer service questions from the PAYEE	SITUATIONAL
		Reference Identification Qualifier F2 Version Code – Local	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
-----	PRODUCTION DATE (DTM)		To specify pertinent dates and times. The production date must be supplied when the cutoff date of the adjudication system is different from the date of the 835. Under most circumstances, this segment is expected to be sent.	SITUATIONAL
		Date/Time Qualifier 405 Production	Code specifying type of date or time, or both date and time. Use this code for the end date for the adjudication production cycle for claims included in this 835.	REQUIRED DTM01 374 M ID 3/3

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date	Date expressed as CCYYMMDD	REQUIRED DTM02 373 X DT 8/8
1000A PAYER IDENTIFICATION	PAYER IDENTIFICATION (N1)		To identify a party by type of organization, name, and code. Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if	REQUIRED
		Entity Identifier Code PR Payer	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED N101 98 M ID 2/3
		Name	Free-form name. Required if the National PlanID is not transmitted in N104.	SITUATIONAL N102 93 X AN 1/60
		Identification Code Qualifier XV Health Care Financing Administration National PlanID	Code designating the system/method of code structure used for identification. Required if the National PlanID is not transmitted in N104. Under most circumstances, this element is expected to be sent. Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. CODE SOURCE 540: Health Care Financing Administration National PlanID.	SITUATIONAL N103 66 X ID 1/2
		Identification Code	Code identifying a party or other code. ADVISORY: Under most circumstances, this element is expected to be sent. This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party. Required if	SITUATIONAL N104 67 X AN 2/80
-----	PAYER ADDRESS (N3)		To specify the location of the named party.	REQUIRED
		Address Information	Address information.	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
-----	PAYER CITY, STATE, ZIP CODE (N4)		To specify the geographic place of the named party	REQUIRED
		City Name	Free-form text for city name. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	REQUIRED N401 19 O AN 2/30

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		State or Province Code	Code (Standard State/Province) as defined by appropriate government agency. N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	REQUIRED N402 156 O ID 2/2
		Postal Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States). CODE SOURCE 51: ZIP Code.	REQUIRED N403 116 O ID 3/15
	ADDITIONAL PAYER IDENTIFICATION (REF)		To specify identifying information. Use this REF segment whenever additional payer identification numbers are required. The ID numbers available in the TRN and N1 segments should be used before using the REF segment. Under most circumstances, this segment is not sent.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		2U Payer Identification Number	For Medicare carriers or intermediaries, use this number for the Medicare carrier or intermediary ID number. For Blue Cross and Blue Shield Plans, use this number for the Blue Cross Blue Shield association plan code.	
		EO Submitter Identification Number	This should be considered required when the transaction sender is not the payer or is identified by an identifier other than those already provided.	
		HI Health Industry Number (HIN)	CODE SOURCE 121: Health Industry Identification Number	
		NF National Association of Insurance Commissioners (NAIC) Code	Advised. CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code.	
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
	PAYER CONTACT INFORMATION (PER)		To identify a person or office to whom administrative communications should be directed. This should be used anytime the PAYEE can not be reasonably expected to know how to contact the Payer about this remittance advice. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the	SITUATIONAL
		Contact Function Code	Code identifying the major duty or responsibility of the person or group	REQUIRED PER01 366 M ID 2/2
		CX Payers Claim Office		

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name	Free-form name. Required if identifying an individual or other contact point to discuss information related to this transaction. Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	SITUATIONAL PER02 93 O AN 1/60
		Communication Number Qualifier EM Electronic Mail FX Facsimile TE Telephone	Code identifying the type of communication number. Required if a contact communications number is to be transmitted.	SITUATIONAL PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Required if a contact communications number is to be	SITUATIONAL PER04 364 X AN 1/80
		Communication Number Qualifier EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone	Code identifying the type of communication number. Required if a contact communications number is to be transmitted. When used, the value following this code is the extension for the preceding communications contact number.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Required if a contact communications number is to be	SITUATIONAL PER06 364 X AN 1/80
		Communication Number Qualifier EX Telephone Extension	Code identifying the type of communication number. Use this code only to provide the extension for the previous communications contact number. Required to convey a second communications contact number.	SITUATIONAL PER07 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Use this code only to provide the extension for the previous communications contact number. Required to convey a second	SITUATIONAL PER08 364 X AN 1/80

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
1000B PAYEE IDENTIFICATION	PAYEE IDENTIFICATION (N1)		To identify a party by type of organization, name, and code. Use this N1 loop to provide the name/address information of the payee. The identifying reference number should be provided in N104.	REQUIRED
		Entity IdentifierCode PE Payee	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED N101 98 M ID 2/3
		Name	Free-form name. Required when N104 does not contain the National Provider Identifier.	SITUATIONAL N102 93 X AN 1/60
		Identification Code Qualifier FI Federal Taxpayer's Identification Number XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67). Required when N104 does not contain the For individual providers as payees, use this number to represent the Social Security Number. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	REQUIRED N103 66 X ID 1/2
		Identification Code	Code identifying a party or other code. This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.	REQUIRED N104 67 X AN 2/80
-----	PAYEE ADDRESS (N3)		To specify the location of the named party. Use of this segment is at the discretion of the payer for situations where the sender needs to communicate the payee address to a transaction receiver (for example, a	SITUATIONAL
		Address Information	Address information.	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
-----	PAYEE CITY, STATE, ZIP CODE (N4)		To specify the geographic place of the named party. Using this segment is at the discretion of the payer contingent on the business needs of the payee	SITUATIONAL
		City Name	Free-form text for city name. A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.	REQUIRED N401 19 O AN 2/30

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		State or Province Code	Code (Standard State/Province) as defined by appropriate government agency. N402 is required only if city name (N401) is in the U.S. or Canada. CODE SOURCE 22: States and Outlying Areas of the U.S.	REQUIRED N402 156 O ID 2/2
		Postal Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States). CODE SOURCE 51: ZIP Code.	REQUIRED N403 116 O ID 3/15
		Country Code	Code identifying the country. Required if country is other than USA. CODE SOURCE 5: Countries, Currencies and Funds.	SITUATIONAL N404 26 O ID 2/3
-----	PAYEE ADDITIONAL IDENTIFICATION (REF)		To specify identifying information. Use this REF segment only when more than one identification number is required to identify the payee. Always use the ID number available in the N1 segment before using the REF segment.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		0B State License Number		
		1A Blue Cross Provider Number	NOT ADVISED	
		1B Blue Shield Provider Number	NOT ADVISED	
		1C Medicare Provider Number	NOT ADVISED	
		1D Medicaid Provider Number	NOT ADVISED	
		1E Dentist License Number	NOT ADVISED	
		1F Anesthesia License Number	NOT ADVISED	
		1G Provider UPIN Number		
		1H CHAMPUS Identification Number	NOT ADVISED	
		D3 National Association of Boards of Pharmacy Number	CODE SOURCE 307: National Association of Boards of Pharmacy Number.	
		G2 Provider Commercial Number	NOT ADVISED	
		N5 Provider Plan Network Identification	NOT ADVISED	
		PQ Payee Identification		
		TJ Federal Taxpayer's Identification Number	This information should be in the N1 segment unless the National Provider ID was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number.	

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED 127 X AN 1/30
2000 HEADER NUMBER	HEADER NUMBER (LX)		To reference a line number in a transaction set. The LX segment is required whenever any information in the LX loop is included in the transaction. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments. Any Table 2 data must commence with an LX segment. Multiple sorts are accomplished through multiple LX loops. For Medicare Part A, write/read the LX segment once for each provider's fiscal period end year and month/type of bill summary break in the file (TTYMM in LX01). For Medicare Part B, write/read the LX segment once for unassigned claims.	SITUATIONAL
		Assigned Number	Number assigned for differentiation within a transaction set.	REQUIRED LX01 554 M N0 1/6
-----	PROVIDER SUMMARY INFORMATION (TS3)		To supply provider-level control information. Payers and payees outside the Medicare Part A community may need to use this segment to identify 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). For this purpose, TS301 identifies the subsidiary provider. The remaining mandatory elements (TS302 through 05) must be valid with appropriate data, as defined by the TS3 segment. Only Medicare Part A should use the data elements in TS306-24. Each total is for that provider for this type of bill for this fiscal period. When available, use the National Provider ID in TS301. All situational quantities and amounts in this segment are required unless the nature of the data is different than -----	SITUATIONAL
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. TS301 is the provider number. Use this number for the provider number.	REQUIRED TS301 127 M AN 1/30
		Facility Code Value	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format	REQUIRED TS302 1331 M AN 1/2
		Date	Date expressed as CCYYMMDD. TS303 is the last day of the provider's fiscal year. Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, use December 31st of the	REQUIRED TS303 373 M DT 8/8
		Quantity	Numeric value of quantity. TS304 is the total number of claims. Use this number for the total number of claims.	REQUIRED TS304 380 M R 1/15

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. TS305 is the total of reported charges. Use this monetary amount for the total reported charges for all claims.	REQUIRED TS305 782 M R 1/18
		Monetary Amount	Monetary amount. TS306 is the total of covered charges. Use this monetary amount for the total covered charges. This is submitted charges less the non-covered charges.	SITUATIONAL TS306 782 O R 1/18
		Monetary Amount	Monetary amount. TS307 is the total of non-covered charges. Use this monetary amount for the total of non-covered charges.	SITUATIONAL TS307 782 O R 1/18
		Monetary Amount	Monetary amount. TS308 is the total of denied charges. Use this monetary amount for the total of denied charges.	SITUATIONAL TS308 782 O R 1/18
		Monetary Amount	Monetary amount. TS309 is the total provider payment. Use this monetary amount for the total provider payment. The total provider payment amount includes the total of all interest paid. The amount can be less than zero.	SITUATIONAL TS309 782 O R 1/18
		Monetary Amount	Monetary amount. TS310 is the total amount of interest paid. Use this monetary amount for the total amount of interest paid.	SITUATIONAL TS310 782 O R 1/18
		Monetary Amount	Monetary amount. TS311 is the total contractual adjustment. Use this monetary amount for the total contractual adjustment.	SITUATIONAL TS311 782 O R 1/18
		Monetary Amount	Monetary amount. TS312 is the total Gramm-Rudman Reduction.	SITUATIONAL TS312 782 O R 1/18
		Monetary Amount	Monetary amount. TS313 is the total Medicare Secondary Payer (MSP) primary payer amount. Use this monetary amount for the total MSP primary	SITUATIONAL TS313 782 O R 1/18
		Monetary Amount	Monetary amount. TS314 is the total blood deductible amount in dollars. Use this monetary amount for the total blood deductible amount in dollars.	SITUATIONAL TS314 782 O R 1/18
		Monetary Amount	Monetary amount. TS315 is the summary of non-lab charges. Use this monetary amount for the sum of non-lab charges.	SITUATIONAL TS315 782 O R 1/18
		Monetary Amount	Monetary amount. TS316 is the total coinsurance amount. Use this monetary amount for the total co-insurance amount.	SITUATIONAL TS316 782 O R 1/18

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges. Use this monetary amount for the total of HCPCS reported charges.	SITUATIONAL TS317 782 O R 1/18
		Monetary Amount	Monetary amount. TS318 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount. Use this monetary amount for the total of HCPCS payable amount.	SITUATIONAL TS318 782 O R 1/18
		Monetary Amount	Monetary amount. TS319 is the total deductible amount. Use this monetary amount for the total cash deductible.	SITUATIONAL TS319 782 O R 1/18
		Monetary Amount	Monetary amount. TS320 is the total professional component amount. Use this monetary amount for the total professional component amount. The professional component amount must also be reported in the CAS segment with a Claim Adjustment Reason Code value of 89.	SITUATIONAL TS320 782 O R 1/18
		Monetary Amount	Monetary amount. TS321 is the total Medicare Secondary Payer (MSP) patient liability met. Use this monetary amount for the total MSP patient	SITUATIONAL TS321 782 O R 1/18
		Monetary Amount	Monetary amount. TS322 is the total patient reimbursement. Use this monetary amount for the total patient reimbursement.	SITUATIONAL TS322 782 O R 1/18
		Quantity	Numeric value of quantity. TS323 is the total periodic interim payment (PIP) number of claims. Use this number for the total PIP number of claims.	SITUATIONAL TS323 380 O R 1/15
		Monetary Amount	Monetary amount. Use the monetary amount for the payment amount for PIP claims. TS324 is total periodic interim payment (PIP) adjustment.	SITUATIONAL TS324 782 O R 1/18
-----	PROVIDER SUPPLEMENTAL SUMMARY INFORMATION (TS2)		To provide supplemental summary control information by provider fiscal year and bill Type. Use the TS2 segment only after a TS3 segment. This segment provides summary information specific to an iteration of the LX loop. This segment is expected to be used only for Medicare Part A claims. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Each total is for that provider for this	SITUATIONAL
		Monetary Amount	Monetary amount. TS201 is the total diagnosis related group (DRG) amount. Use this monetary amount for the total DRG amount. For Medicare, this includes: operating federal-specific amount, operating hospital-specific amount, operating Indirect Medical Education amount, and operating Disproportionate Share Hospital amount. It does not include any	SITUATIONAL TS201 782 O R 1/18.

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. TS202 is the total federal specific amount. Use this monetary amount for the total federal-specific amount.	SITUATIONAL TS202 782 O R 1/18
		Monetary Amount	Monetary amount. TS203 is the total hospital specific amount. Use this monetary amount for the total hospital-specific amount.	SITUATIONAL TS203 782 O R 1/18
		Monetary Amount	Monetary amount. TS204 is the total disproportionate share amount. Use this monetary amount for the total disproportionate share amount.	SITUATIONAL TS204 782 O R 1/18
		Monetary Amount	Monetary amount. TS205 is the total capital amount. Use this monetary amount for the total capital amount. For Medicare, this includes: capital federal-specific amount, hospital federal-specific amount, hold harmless amount, Indirect Medical Education amount, Disproportionate Share Hospital amount. and the exception amount. It does not include any capital	SITUATIONAL TS205 782 O R 1/18
		Monetary Amount	Monetary amount. TS206 is the total indirect medical education amount. Use this monetary amount for the total indirect medical education amount.	SITUATIONAL TS206 782 O R 1/18.
		Quantity	Numeric value of quantity. TS207 is the total number of outlier days. Use this number for the total number of outlier days.	SITUATIONAL TS207 380 O R 1/15
		Monetary Amount	Monetary amount. TS208 is the total day outlier amount. Use this monetary amount for the total day outlier amount.	SITUATIONAL TS208 782 O R 1/18
		Monetary Amount	Monetary amount. TS209 is the total cost outlier amount. Use this monetary amount for the total cost outlier amount.	SITUATIONAL TS209 782 O R 1/18
		Quantity	Numeric value of quantity. TS210 is the diagnosis related group (DRG) average length of stay. Use this number for the DRG average length of	SITUATIONAL TS210 380 O R 1/15
		Quantity	Numeric value of quantity. TS211 is the total number of discharges. Use this number for the total number of discharges. For Medicare, this is the discharge count produced by PPS PRICER SOFTWARE.	SITUATIONAL TS211 380 O R 1/15
		Quantity	Numeric value of quantity. TS212 is the total number of cost report days. Use this number for the total number of cost report days.	SITUATIONAL TS212 380 O R 1/15
		Quantity	Numeric value of quantity. TS213 is the total number of covered days. Use this number for the total number of covered days.	SITUATIONAL TS213 380 O R 1/15

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity	Numeric value of quantity. TS214 is the total number of non-covered days. Use this number for the total number of non-covered days.	SITUATIONAL TS214 380 O R 1/15
		Monetary Amount	Monetary amount. TS215 is the total Medicare Secondary Payer (MSP) pass-through amount calculated for a non-Medicare payer. Use this amount for is the total MSP pass through amount calculated for a non-	SITUATIONAL TS215 782 O R 1/18
		Quantity	Numeric value of quantity. TS216 is the average diagnosis-related group (DRG) weight. Use this number for the average DRG weight.	SITUATIONAL TS216 380 O R 1/15
		Monetary Amount	Monetary amount. TS217 is the total prospective payment system (PPS) capital, dfederal-specific portion, diagnosis-related group (DRG) amount. Use this monetary amount for the total PPS capital. federal-specific portion	SITUATIONAL TS217 782 O R 1/18
		Monetary Amount	Monetary amount. TS218 is the total prospective payment system (PPS0) capital, hospital-specific portion, diagnosis-related group (DRG) amount. Use this monetary amount for the total PPS capital. hospital-specific portion	SITUATIONAL TS218 782 O R 1/18
		Monetary Amount	Monetary amount. TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount. Use this monetary amount for the total PPS disproportionate share, hospital	SITUATIONAL TS219 782 O R 1/18
2100 CLAIM PAYMENT	CLAIM PAYMENT INFORMATION (CLP)		To supply information common to all services of a claim.	REQUIRED
		Claim Submitter's Identifier	Identifier used to track a claim from creation by the health care provider through payment. Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database	REQUIRED CLP01 1028 M AN 1/38
		Claim Status Code 1 Processed as Primary 2 Processed as Secondary 3 Processed as Tertiary 4 Denied 5 Pended	Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization. NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	REQUIRED CL02 1029 M ID 1/2

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		10 Received, but not in process	NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	
		13 Suspended	NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	
		15 Suspended - investigation with field	NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	
		16 Suspended - return with material	NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	
		17 Suspended - review pending	NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	
		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		
		27 Reviewed	NOT ADVISED. Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.	
		Monetary Amount	Monetary amount. CLP03 is the amount of submitted charges this claim. This amount does not include interest. Use this monetary amount for the submitted charges for this claim. The amount can be zero or less, but the value in BPR02 may not be negative.	REQUIRED CLP03 782 M R 1/18
		Monetary Amount	Monetary amount. CLP04 is the amount paid this claim. This amount does not include interest. Use this monetary amount for the amount paid for this claim. It can be zero or less, but the value in BPR02 may not be negative.	REQUIRED CLP04 782 M R 1/18
		Monetary Amount	Monetary amount. Under most circumstances, this element is expected to be sent. CLP05 is the patient responsibility amount. Amounts in CLP05 should have supporting adjustments reflected in CAS segments at the CLP or SVC loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility). Use this monetary amount for the payer's statement of the patient responsibility amount for this claim, which can include such items as deductible, non-covered services, co-pay, and co-insurance. This amount must be entered if it is greater than zero. For	SITUATIONAL CLP05 782 O R 1/18

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Claim Filing Indicator Code</p> <p>Code identifying type of claim. For many providers to electronically post the 835 remittance data to their patient accounting systems without human intervention, a unique, provider-specific insurance plan code is needed. This code allows the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider. Because most payers maintain the same Originating Company Identifier in the TRN03/BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03/BPR10 to identify the unique, provider-specific insurance plan code needed to post the payment without human intervention. The nature should mirror the nature received in the original claim transmission.</p> <p>12 Preferred Provider Organization (PPO)</p> <p>13 Point of Service (POS)</p> <p>14 Exclusive Provider Organization (EPO)</p> <p>15 Indemnity Insurance</p> <p>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</p> <p>OF Other Federal Program</p> <p>TV Title V VA Veteran Administration Plan WC Workers' Compensation Health Claim</p>	<p>Use this code for Blue Cross/Blue Shield pararrangements.</p> <p>Use this code for Blue Cross/Blue Shield non-pararrangements.</p> <p>Use this code for the Black Lung Program.</p>	<p>REQUIRED CLP06 1032 O ID 1/2</p>
		<p>Reference Identification</p>	<p>Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. CLP07 is the payer's internal control number. Use this number for the payer's internal control number. This number must apply to the entire claim. Report service variations at the SVC loop. This must be provided whenever the PAYER assigns an internal claim number and desires this reference from the provider as a part of any customer service contact or appeal process.</p>	<p>SITUATIONAL CLP07 127 O AN 1/30</p>

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Facility Code Value	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format. State the facility code here when the submitted code has been modified through adjudication. This code is expected to be from the same code list as that identified in the original claim. This number was received in CI M05-1 of the	SITUATIONAL CLP08 1331 O AN 1/2
		Claim Frequency Type Code	Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type. This data element is specific to institutional claims and is required when it was received on the original claim. This does not apply to other types of claims. This number was received in CLM05-2 of the 837 claim. CODE SOURCE 235: Claim	SITUATIONAL CLP09 1325 O ID 1/1
		Diagnosis Related Group (DRG) Code	Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems. This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims. CODE SOURCE 229:	SITUATIONAL CLP11 1354 Code O ID 1/4
		Quantity	Numeric value of quantity. CL12 is the diagnosis-related group (DRG) weight. This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims. Use this number for the DRG Weight.	SITUATIONAL CLP12 380 O R 1/15
		Percent	Percentage expressed as a decimal. CLP13 is the discharge fraction. This data element is specific to institutional claims and is required when considered in the adjudication process. This does not apply to other types of claims. Use this number for the discharge fraction.	SITUATIONAL CLP13 954 O R 1/10
-----	CLAIM ADJUSTMENT (CAS)		To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid. The CAS segment is used to reflect changes to amounts. Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth.	SITUATIONAL
		Claim Adjustment Group Code	Code identifying the general category of payment adjustment. Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. (Note: This does not mean that the adjustments must be reported in this order.)	REQUIRED CAS01 1033 Code M ID 1/2

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		CO Contractual Obligations	Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.	
		CR Correction and Reversals	Use this code for corrections and reversals to PRIOR claims. Use when CLP02=22, Reversal of previous payment.	
		OA Other adjustments		
		PI Payor Initiated Reductions	Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).	
		PR Patient Responsibility		
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code.	REQUIRED CAS02 1034 M ID 1/5
		Monetary Amount	Monetary amount. CAS03 is the amount of adjustment. When the submitted charges are paid in full, the value for CAS03 should be zero. Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment.	REQUIRED CAS03 782 M R 1/18
		Quantity	Numeric value of quantity. CAS04 is the units of service being adjusted. A positive value decreases the paid units of service, and a negative number increases the paid units. This element may be used only when the units of service are being adjusted.	SITUATIONAL CAS04 380 O R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Used when additional adjustments apply within the group identified in CAS01. CODE SOURCE 139: Claim Adjustment Reason Code.	SITUATIONAL CAS05 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS06 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS06 782 X R 1/18
		Quantity	Numeric value of quantity. CAS07 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS07 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Used when additional adjustments apply within the group identified in CAS01. CODE SOURCE 139: Claim Adjustment Reason Code.	SITUATIONAL CAS08 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS09 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS09 782 X R 1/18

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity	Numeric value of quantity. CAS10 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS10 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Used when additional adjustments apply within the group identified in CAS01. CODE SOURCE 139: Claim Adjustment Reason Code.	SITUATIONAL CAS11 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS12 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS12 782 X R 1/18
		Quantity	Numeric value of quantity. CAS13 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS13 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Used when additional adjustments apply within the group identified in CAS01. CODE SOURCE 139: Claim Adjustment Reason Code.	SITUATIONAL CAS14 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS15 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS15 782 X R 1/18
		Quantity	Numeric value of quantity. CAS16 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS16 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Used when additional adjustments apply within the group identified in CAS01. CODE SOURCE 139: Claim Adjustment Reason Code.	SITUATIONAL CAS17 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS18 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS18 782 X R 1/18
		Quantity	Numeric value of quantity. CAS19 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS19 380 X R 1/15
----	PATIENT NAME (NM1)		To supply the full name of an individual or organizational entity. Provide the patient's identification number in NM109.	REQUIRED
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		QC Patient		
		Entity Type Qualifier 1 Person	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name.	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name.	REQUIRED NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. If this data element is used and contains only one character, it is assumed to represent the middle initial. The middle name or initial is required when the individual has a middle name or initial	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber. Under most circumstances, this element is not sent.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 34 Social Security Number HN Health Insurance Claim (HIC) Number II United States National Individual Identifier MI Member Identification Number MR Medicaid Recipient Identification	Code designating the system/method of code structure used for Identification Code (67). Under most circumstances, this element is expected to be sent. Required if the patient identifier is known or was ADVISED This code is not part of the ASC X12 004010 release. Use this code if mandated in a final Federal Rule.	SITUATIONAL NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code. Required if the patient identifier is known or was reported on the health care claim. Under most circumstances, this element is expected to be sent.	SITUATIONAL NM109 67 X AN 2/80
-----	INSURED NAME (NM1)		To supply the full name of an individual or organizational entity. Use this NM1 segment to identify the insured or subscriber whenever the insured or subscriber is different from the patient. Any necessary identification number should be provided in NM109. In the case of Medicare and Medicaid, the insured patient is always the subscriber and this segment should not be	SITUATIONAL

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code IL Insured or Subscriber	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 1 Person 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name.	SITUATIONAL NM103 1035 O AN 1/35
		Name First	Individual first name. Required when the subscriber is a person	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. If this data element is used and contains only one character, it is assumed to represent the middle initial. The Middle name or initial is required when the individual has a middle name or initial. Required if the subscriber is a person (NM102=1) and the information is	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber. Required if the subscriber is a person (NM102=1) and the information is known. Under most circumstances, this element is not sent.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 34 Social Security Number HN Health Insurance Claim (HIC) Number MI Member Identification Number	Code designating the system/method of code structure used for Identification Code 67). Use this number for the payer's ID number for the insured.	REQUIRED NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code.	REQUIRED NM109 67 X AN 2/80
-----	CORRECTED PATIENT/INSURED NAME (NM1)		To supply the full name of an individual or organizational entity. Use this NM1 segment to provide corrected information about the patient or insured. Because the patient is always the insured for Medicare and Medicaid, this segment always provides corrected patient information for Medicare and Medicaid. For other carriers, this will always be the corrected insured	SITUATIONAL

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code 74 Corrected Insured	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 1 Person 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name. Required when corrected information for the Insured is available.	SITUATIONAL NM103 1035 O AN 1/35
		Name First	Individual first name. Required when corrected information for the Insured is available. This element may only be used when NM102 is 1 (person).	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. If this data element is used and contains only one character, it is assumed to represent the middle initial. Required when corrected information for the Insured is available. This element may only be used when NM102 is 1 (person).	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required when corrected information for the Insured is available. This element may only be used when NM102 is 1 (person). Under most circumstances, this element is not sent.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier C Insured's Changed Unique Identification Number	Code designating the system/method of code structure used for Identification Code (67). Required when a value is reported in NM109.	SITUATIONAL NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code. Required when corrected information for the Insured is available.	SITUATIONAL NM109 67 X AN 2/80
-----	SERVICE PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Use this NM1 segment to provide information about the rendering provider. Any reference number should be provided in NM109. This segment is required when the rendering provider is different from the Payee. This information is provided to facilitate identification of the claim within a payee's system. Other providers related to the claim but not directly related to the payment are not supported and are not necessary for claim identification.	SITUATIONAL

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code 82 Rendering Provider	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 1 Person 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name. Required when needed to confirm the identifier in NM109.	SITUATIONAL NM103 1035 O AN 1/35
		Name First	Individual first name. If NM102 is a "2" this element is not used. Used when NM102=1 and the information is known.	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. If NM102 is a "2" this element is not used. If this data element is used and contains only one character, it is assumed to represent the middle initial. The Middle name or initial is required when the individual has a middle name or initial. Used when NM102=1 and the	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber. Under most circumstances, this element is not sent.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 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 XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67). For individual providers as payees, use this number to represent the Social Security Number. ADVISED.	REQUIRED NM108 66 X ID 1/2
			Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used. ADVISED.	

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Identification Code	Code identifying a party or other code.	REQUIRED NM109 67 X AN 2/80
-----	CROSSOVER CARRIER NAME (NM1)		To supply the full name of an individual or organizational entity. Use this NM1 segment to provide information about the crossover carrier. Provide any reference numbers in NM109. The crossover carrier is defined as any payer to which the claim is transferred for further payment after being	SITUATIONAL
		Entity Identifier Code TT Transfer To	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name. Name of the crossover carrier associated with this claim.	REQUIRED NM103 1035 O AN 1/35
		Identification Code Qualifier 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	Code designating the system/method of code structure used for Identification Code (67). ADVISED. Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. ADVISED. CODE SOURCE 540: Health Care Financing Administration National PlanID.	REQUIRED NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code.	REQUIRED NM109 67 X AN 2/80
-----		CORRECTED PRIORITY PAYER NAME (NM1)		To supply the full name of an individual or organizational entity. This segment is required when the current payer believes that another payer has priority for making a payment. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. It is not necessary to use the Crossover Carrier NM1 segment in addition to this segment.

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code PR Payer	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier 2 Non-Person Entity	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name.	REQUIRED NM103 1035 O AN 1/35
		Identification Code Qualifier 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	Code designating the system/method of code structure used for Identification Code (67). ADVISED. Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. ADVISED. CODE SOURCE 540: Health Care Financing Administration National PlanID.	REQUIRED NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code.	REQUIRED NM109 67 X AN 2/80
-----	INPATIENT ADJUDICATION INFORMATION (MIA)		To provide claim-level data related to the adjudication of Medicare inpatient claims. This segment should be generated by Medicare intermediaries. Either MIA or MOA will appear, but not both. This segment should not be used for covered days or lifetime reserve days. Use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Payers and Payees outside of Medicare.	SITUATIONAL
		Quantity	Numeric value of quantity. MIA01 is the covered days. Implementers of this guideline always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.	REQUIRED MIA01 380 M R 1/15

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III. Data Elements Table

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity	Numeric value of quantity. MIA02 is the lifetime reserve days. Use this to report PPS Operating Outlier. Additional payment for excessive cost	SITUATIONAL MIA02 380 O R 1/15
		Quantity	Numeric value of quantity. MIA03 is the lifetime psychiatric days. Use this number for the lifetime psychiatric days.	SITUATIONAL MIA03 380 O R 1/15.
		Monetary Amount	Monetary amount. MIA04 is the Diagnosis Related Group (DRG) amount. Use this monetary amount for the DRG amount.	SITUATIONAL MIA04 782 O R 1/18.
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MIA05 is the Remittance Remark Code. See Code Source 411. Used when a Remittance Remark	SITUATIONAL MIA05 127 O AN 1/30
		Monetary Amount	Monetary amount. MIA06 is the disproportionate share amount. Use this monetary amount for the disproportionate share amount.	SITUATIONAL MIA06 782 O R 1/18
		Monetary Amount	Monetary amount. MIA07 is the Medicare Secondary Payer (MSP) pass-through amount. Use this monetary amount for the MSP pass through	SITUATIONAL MIA07 782 O R 1/18
		Monetary Amount	Monetary amount. MIA08 is the total Prospective Payment System (PPS) capital amount. Use this monetary amount for the total PPS capital amount.	SITUATIONAL MIA08 782 O R 1/18
		Monetary Amount	Monetary amount. MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount. Use this monetary amount for the PPS capital, federal-specific portion DRG	SITUATIONAL MIA09 782 O R 1/18
		Monetary Amount	Monetary amount. MIA10 is the Prospective Payment System (PPS) capital. Hospital specific portion, Diagnosis Related Group (DRG) amount. Use this monetary amount for the PPS capital, hospital-specific portion DRG	SITUATIONAL MIA10 782 O R 1/18
		Monetary Amount	Monetary amount. MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount. Use this monetary amount for the PPS capital, disproportionate	SITUATIONAL MIA11 782 O R 1/18
		Monetary Amount	Monetary amount. MIA12 is the old capital amount. Use this monetary amount for the old capital amount.	SITUATIONAL MIA12 782 O R 1/18
		Monetary Amount	Monetary amount. MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount. Use this monetary amount for the PPS capital indirect medical education claim amount.	SITUATIONAL MIA13 782 O R 1/18

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. MIA14 is hospital specific Diagnosis Related Group (DRG) Amount. Use this monetary amount for the PPS (operating)/hospital-specific DRG amount.	SITUATIONAL MIA14 782 O R 1/18
		Quantity	Numeric value of quantity. MIA15 is the cost report days. Use this number for the cost report days.	SITUATIONAL MIA15 380 O R 1/15
		Monetary Amount	Monetary amount. MIA16 is the federal specific Diagnosis Related Group (DRG) amount. Use this monetary amount for the PPS (operating)/federal-specific DRG amount.	SITUATIONAL MIA16 782 O R 1/18
		Monetary Amount	Monetary amount. MIA17 is the Prospective Payment System (PPS) Capital Outlier amount. Use this monetary amount for the PPS capital outlier amount. This amount excludes the operating outlier amount, which is	SITUATIONAL MIA17 782 O R 1/18
		Monetary Amount	Monetary amount. MIA18 is the indirect teaching amount. Use this monetary amount for the indirect teaching amount.	SITUATIONAL MIA18 782 O R 1/18
		Monetary Amount	Monetary amount. MIA19 is the professional component amount billed but not payable. Use this monetary amount for the professional component amount billed but not payable.	SITUATIONAL MIA19 782 O R 1/18
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MIA20 is the Remittance Remark Code. Used when additional remittance remarks apply to this	SITUATIONAL MIA20 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MIA21 is the Remittance Remark Code. Used when additional remittance remarks apply to this	SITUATIONAL MIA21 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MIA22 is the Remittance Remark Code. Used when additional remittance remarks apply to this	SITUATIONAL MIA22 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MIA23 is the Remittance Remark Code. See Code Source 411. Used when additional remittance remarks apply to this claim.	SITUATIONAL MIA23 127 O AN 1/30

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. MIA24 is the capital exception amount. Use this monetary amount for the capital exception amount.	SITUATIONAL MIA24 782 O R 1/18
	OUTPATIENT ADJUDICATION INFORMATION (MOA)		To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting. This segment should be generated by Medicare carriers or Intermediaries. Either MIA or MOA will appear, but not both. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Payers and payees outside of Medicare community may need to use this segment	SITUATIONAL
		Percent	Percentage expressed as a decimal. MOA01 is the reimbursement rate. Use this number for the reimbursement rate. This does not apply to claims processed by Medicare Carriers.	SITUATIONAL MOA01 954 O R 1/10
		Monetary Amount	Monetary amount. MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount. Use this monetary amount for the HCPCS payable amount. This does not apply to claims processed by Medicare Carriers.	SITUATIONAL MOA02 782 O R 1/18
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MOA03 is the Remittance Remark Code. Used when a Remittance Remark Code applies	SITUATIONAL MOA03 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MOA04 is the Remittance Remark Code. Used when additional remittance remarks apply	SITUATIONAL MOA04 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MOA05 is the Remittance Remark Code. Used when additional remittance remarks apply	SITUATIONAL MOA05 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MOA06 is the Remittance Remark Code. Used when additional remittance remarks apply	SITUATIONAL MOA06 127 O AN 1/30
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. MOA07 is the Remittance Remark Code. Used when additional remittance remarks apply	SITUATIONAL MOA07 127 O AN 1/30
		Monetary Amount	Monetary amount. MOA08 is the End Stage Renal Disease (ESRD) payment amount. Use this monetary amount for the ESRD payment amount. This does not apply to claims processed by Medicare Carriers.	SITUATIONAL MOA08 782 O R 1/18

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. MOA09 is the professional component amount billed but not payable. Use this monetary amount for the professional component amount billed but not payable. This does not apply to claims processed by	SITUATIONAL MOA09 782 O R 1/18.
-----	OTHER CLAIM RELATED IDENTIFICATION (REF)		To specify identifying information. Use this REF segment for reference numbers specific to the claim identified in the CLP segment. This is used to provide additional information used in the process of adjudicating this claim.	SITUATIONAL
		Reference Identification Qualifier 1L Group or Policy Number 1W Member Identification Number 9A Repriced Claim Reference Number 9C Adjusted Repriced Claim Reference 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	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
-----	RENDERING PROVIDER IDENTIFICATION (REF)		To specify identifying information. This REF segment should be used to provide reference numbers that are not already identified in NM1 segments within the CLP loop. The NM1 segment should always contain the primary reference number. This segment should only be used when additional reference numbers were submitted on the original claim.	SITUATIONAL
		Reference Identification Qualifier 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	Code qualifying the Reference Identification. CODE SOURCE 307: National Association of Boards of Pharmacy Number	REQUIRED REF01 128 M ID 2/3

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		G2 Provider Commercial Number		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
-----	CLAIM DATE (DTM)		To specify pertinent dates and times. Dates must be provided at the claim level (2-050-DTM), the service line level (2-080-DTM), or both. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear. When claim dates are not provided, service dates are required for every service line. When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time.	REQUIRED DTM01 374 M ID 3/3
		036 Expiration	Use this code to convey the expiration date of coverage.	
		050 Received	Use this code to convey the date that the claim was received by the payer.	
		232 Claim Statement Period Start	If the claim statement period start date is conveyed without a subsequent claim statement period end date, the end date is assumed to be the same as the start date. This date or code 233 should be 233 Claim Statement	
		233 Claim Statement Period End	If a claim statement period end date is conveyed without a claim statement period start date, then the start date is assumed to be different from the end date but not conveyed at the payer's discretion. See the note on code 232.	
		Date	Date expressed as CCYYMMDD	REQUIRED DTM02 373 X DT 8/8
-----	CLAIM CONTACT INFORMATION (PER)		To identify a person or office to whom administrative communications should be directed. This segment should only be used when there is a claim specific communications contact instruction. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number. For definition of the standard, if	SITUATIONAL
		Contact Function Code	Code identifying the major duty or responsibility of the person or group	REQUIRED PER01 366 M ID 2/2
		CX Payers Claim Office		

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name	Free-form name. Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	SITUATIONAL PER02 93 O AN 1/60
		Communication Number Qualifier EM Electronic Mail FX Facsimile TE Telephone	Code identifying the type of communication number. Required if a contact communications number is to be transmitted.	SITUATIONAL PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Required if a contact communications number is to be	SITUATIONAL PER04 364 X AN 1/80
		Communication Number Qualifier EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone	Code identifying the type of communication number. Required if a contact communications number is to be transmitted. When used, the value following this code is the extension for the preceding communication contact number.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Required if a contact communications number is to be	SITUATIONAL PER06 364 X AN 1/80
		Communication Number Qualifier EX Telephone Extension	Code identifying the type of communication number. Use this code only to provide the extension for the previous communications contact number. Required to convey a second communications contact number.	SITUATIONAL PER07 364 X AN 1/80
		Communication Number	Complete communications number including country or area code when applicable. Use this code only to provide the extension for the previous communications contact number. Required to convey a second	SITUATIONAL PER08 364 X AN 1/80
-----	CLAIM SUPPLEMENTAL INFORMATION (AMT)		To indicate the total monetary amount. Use this segment to convey information only. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.	SITUATIONAL

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Amount Qualifier Code 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	Code to qualify amount. Use this monetary amount to report the total covered charges. Prompt Pay Discount Amount. Use this monetary amount for the amount the patient has already paid. Used only by Medicare Part A and Medicare Part B. Use this number for the operational cost or day outlier amount. (Used exclusively by Medicare PartA). NOT ADVISED.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount.	REQUIRED AMT02 782 M R 1/18
-----	CLAIM SUPPLEMENTAL INFORMATION QUANTITY (QTY)		To specify quantity information. Use this segment to convey information only. Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.	SITUATIONAL
		Quantity Qualifier CA Covered - Actual CD Co-insured - Actual LA Life-time Reserve - Actual LE Life-time Reserve - Estimated	Code specifying the type of quantity.	REQUIRED QTY01 673 M ID 2/2

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 -Category4 ZO Federal Medicare or Medicaid Payment Mandate - Category 5		
		Quantity	Numeric value of quantity.	REQUIRED QTY02 380 X R 1/15
2110 SERVICE PAYMENT INFORMATION	SERVICE PAYMENT INFORMATION (SVC)		To supply payment and control information to a provider for a particular service. Although the SVC loop is optional, there are times when it should be considered mandatory. Whenever the actual payment has been reduced due to service line specific adjustments, the SVC loop is necessary in order to understand the remittance information. This situation is particularly applicable to professional and fee-based services. An exception occurs with institutional claims when the room per diem is the only service line adjustment. In this instance, a claim level CAS adjustment to the per diem is appropriate (i.e. CAS*CO*7R*25~). Under most circumstances this	SITUATIONAL
		Composite Medical Procedure Identifier	To identify a medical procedure by its standardized codes and applicable modifiers. Use the adjudicated Medical Procedure Code. This code is a composite data structure.	REQUIRED SVC01 C0003 M
		Product/Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234). The value in SVC01-01 qualifies the values in SVC01-02, SVC01-03, SVC01-04, SVC01-05, and SVC01-06.	REQUIRED SVC01 - 1 235 M ID 2/2
		AD American Dental Association Codes	CODE SOURCE 135: American Dental Association Codes.	
		ER Jurisdiction Specific Procedure and Supply Codes	This is specific to Workman's Compensation Claims.	
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes.	Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding	

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		ID International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure.	
		IV Home Infusion EDI Coalition (HIEC) Product/Service Code	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List.	
		N1 National Drug Code in 4-4-2 Format	CODE SOURCE 240: National Drug Code by Format.	
		N2 National Drug Code in 5-3-2 Format	CODE SOURCE 240: National Drug Code by Format.	
		N3 National Drug Code in 5-4-1 Format	CODE SOURCE 240: National Drug Code by Format.	
		N4 National Drug Code in 5-4-2 Format	CODE SOURCE 240: National Drug Code by Format.	
		ND National Drug Code (NDC)	CODE SOURCE 134: National Drug Code.	
		NU National Uniform Billing Committee (NUBC) UB92 Codes	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes.	
		RB National Uniform Billing Committee (NUBC) UB82 Codes	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes.	
		ZZ Mutually Defined	This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from: Division of Institutional Care Health Care Financing Administration S1-03-06 7500 Security Boulevard Baltimore, MD 21244-1850	
		Product/Service ID	Identifying number for a product or service.	REQUIRED SVC01 - 2 234 M AN 1/48
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC01 - 3 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC01 - 4 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC01 - 5 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC01 - 6 1339 O AN 2/2

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Description	A free-form description to clarify the related data elements and their content. Avoid using the description to make it easier for the computer to process the information provided. Used only when a description was received for the service on the original claim, and the adjudicated code is the submitted code. Under most circumstances, this component is not sent.	SITUATIONAL SVC01 - 7 352 O AN 1/80
		Monetary Amount	Monetary amount. SVC02 is the submitted service charge. Use this monetary amount for the submitted service charge amount.	REQUIRED SVC02 782 M R 1/18
		Monetary Amount	Monetary amount. SVC03 is the amount paid this service. Use this number for the service amount paid. The value in SVC03 should equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of	REQUIRED SVC03 782 O R 1/18
		Product/Service ID	Identifying number for a product or service. SVC04 is the National Uniform Billing Committee Revenue Code. Use the National Uniform Billing Committee Revenue Code. Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If the original claim and adjudication only referenced an NIIRC revenue code that is supplied in SVC01 and this element is not	SITUATIONAL SVC04 234 O AN 1/48
		Quantity	Numeric value of quantity. SVC05 is the paid units of service. Use this number for the paid units of service. If not present, the value is assumed to	SITUATIONAL SVC05 380 O R 1/15
		Composite Medical Procedure Identifier	To identify a medical procedure by its standardized codes and applicable modifiers. This is REQUIRED when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. This is NOT USED when the submitted code is the same as the code on SVC01. This code is a composite data structure.	SITUATIONAL SVC06 C003 O
		Product/Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234). The value in SVC06-01 qualifies the values in SVC06-02, SVC06-03, SVC06-04, SVC06-05, and SVC06-06.	REQUIRED SVC06 - 1 235 M ID 2/2
		AD American Dental Association Codes	CODE SOURCE 135: American Dental Association Codes.	
		ER Jurisdiction Specific Procedure and Supply Codes	This is specific to Workman's Compensation Claims.	
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes	Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. CODE SOURCE 130: Health Care Financing Administration.	
		ID International Classification of Diseases Clinical Modification (ICD-9-CM) - Procedure	CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure.	

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		IV Home Infusion EDI Coalition (HIEC) Product/Service Code	CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List.	
		N1 National Drug Code in 4-4-2 Format	CODE SOURCE 240: National Drug Code by Format.	
		N2 National Drug Code in 5-3-2 Format	CODE SOURCE 240: National Drug Code by Format.	
		N3 National Drug Code in 5-4-1 Format	CODE SOURCE 240: National Drug Code by Format.	
		N4 National Drug Code in 5-4-2 Format	CODE SOURCE 240: National Drug Code by Format.	
		ND National Drug Code (NDC)	CODE SOURCE 134: National Drug Code.	
		NU National Uniform Billing Committee (NUBC) UB92 Codes	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes.	
		RB National Uniform Billing Committee (NUBC) UB82 Codes	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes.	
		ZZ Mutually Defined	This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code. This code list is available from: Division of Institutional Care Health Care Financing Administration S1-03-06 7500 Security Boulevard Baltimore, MD 21244-1850	
		Product/Service ID	Identifying number for a product or service.	REQUIRED SVC06 - 2 234 M AN 1/48
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC06 - 3 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC06 - 4 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC06 - 5 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when procedure code modifiers apply to this service.	SITUATIONAL SVC06 - 6 1339 O AN 2/2

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Description	A free-form description to clarify the related data elements and their content. Avoid using the description to make it easier for the computer to process the information provided. Required when a description was received for the service on the original claim. Under most circumstances, this component is	SITUATIONAL SVC06 - 7 352 O AN 1/80
		Quantity	Numeric value of quantity. SVC07 is the original submitted units of service. This is REQUIRED when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. This is NOT USED when the submitted units is the same as the value in SVC05.	SITUATIONAL SVC07 380 O R 1/15
-----	SERVICE DATE (DTM)		To specify pertinent dates and times. The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment. Dates must be provided at the claim level (2-050-DTM), the service line level (2-080-DTM), or both. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear. When claim dates are not provided, service dates are required for every service line. When claim dates are provided, service dates are not required, but they may be used to "override" the claim dates for individual service lines.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time.	REQUIRED DTM01 374 M ID 3/3
		150 Service Period Start	Use this code only for reporting the beginning of multi-day services.	
		151 Service Period End	Use this code only for reporting the end of multi-day services.	
		472 Service	Use this code to indicate a single day service. ADVISED.	
		Date	Date expressed as CCYYMMDD.	REQUIRED DTM02 373 X DT 8/8
-----	SERVICE ADJUSTMENT (CAS)		To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid. The CAS segment is used to reflect changes to amounts. This CAS segment is optional and is intended to reflect reductions in payment due to adjustments particular to a specific service in the claim. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a particular Claim Adjustment Group Code (CAS01). The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported	SITUATIONAL

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Claim Adjustment Group Code	Code identifying the general category of payment adjustment. Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. (Note: This does not mean that the adjustments must be reported in this order.)	REQUIRED CAS01 1033 M ID 1/2
		CO Contractual Obligations	Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.	
		CR Correction and Reversals	Use this code for corrections and reversals to PRIOR claims. Use when	
		OA Other adjustments		
		PI Payor Initiated Reductions	Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but no supporting contract exists between the provider and the payer.	
		PR Patient Responsibility		
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code.	REQUIRED CAS02 1034 M ID 1/5
		Monetary Amount	Monetary amount. CAS03 is the amount of adjustment. When the submitted charges are paid in full, the value for CAS03 should be zero. Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment	REQUIRED CAS03 782 M R 1/18
		Quantity	Numeric value of quantity. CAS04 is the units of service being adjusted. This element may be used only when the units of service are being adjusted. A positive number decreases paid units, and a negative value	SITUATIONAL CAS04 380 O R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS05 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS06 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS06 782 X R 1/18
		Quantity	Numeric value of quantity. CAS07 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS07 380 X R 1/15

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS08 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS09 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS09 782 X R 1/18
		Quantity	Numeric value of quantity. CAS10 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS10 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS11 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS12 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS12 782 X R 1/18
		Quantity	Numeric value of quantity. CAS13 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS13 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS14 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS15 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS15 782 X R 1/18
		Quantity	Numeric value of quantity. CAS16 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS16 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS17 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS18 is the amount of the adjustment. Used when additional adjustments apply within the group identified in CAS01.	SITUATIONAL CAS18 782 X R 1/18
		Quantity	Numeric value of quantity. CAS19 is the units of service being adjusted. Used when additional adjustments apply within the group identified in	SITUATIONAL CAS19 380 X R 1/15

HIPAA

Master Data Set Health Care Claim
Payment/Advice (835) Transaction
Decision Support 2000+

DRAFT 5/20/02

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
-----	SERVICE IDENTIFICATION (REF)		To specify identifying information. Use this REF segment for reference numbers specific to the service identified by the SVC segment. This is used to provide additional information used in the process of adjudicating this	SITUATIONAL
		Reference Identification Qualifier 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	Code qualifying the Reference Identification. This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
-----	RENDERING PROVIDER INFORMATION (REF)		To specify identifying information. Use this REF segment for 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	SITUATIONAL
		Reference Identification Qualifier 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	Code qualifying the Reference Identification CODE SOURCE 537: Health Care Financing Administration National Provider Identifier.	REQUIRED REF01 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
-----	SERVICE SUPPLEMENTAL AMOUNT (AMT)		To indicate the total monetary amount. This segment is used to convey information only. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are Non-zero.	SITUATIONAL
		Amount Qualifier Code 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	Code to qualify amount. Medicare uses this to report the provider per diem amount, where applicable. NOT ADVISED. Late Filing Reduction. NOT ADVISED. Use this monetary amount for the service charge before taxes.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount.	REQUIRED AMT02 782 M R 1/18
-----	SERVICE SUPPLEMENTAL QUANTITY (QTY)		To specify quantity information. Use this segment to convey information only. Use this segment only when the value of specific quantities identified in the QTY01 qualifier are Non-zero.	SITUATIONAL
		Quantity Qualifier NE Non-Covered - Estimated ZK Federal Medicare or Medicaid Payment Mandate -Category 1	Code specifying the type of quantity. Use this code for actual line item non-covered visits.	REQUIRED QTY01 673 M ID 2/2

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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		
		Quantity	Numeric value of quantity.	REQUIRED QTY02 380 X R 1/15
-----	HEALTH CARE REMARK CODES (LQ)		Code to transmit standard industry codes. Use this segment to provide informational remarks only. This segment has no impact on the actual payment. Changes in claim payment amounts are provided in the CAS	SITUATIONAL
		Code List Qualifier Code	Code identifying a specific industry code list.	REQUIRED LQ01 1270 O ID 1/3
		HE Claim Payment Remark Codes	CODE SOURCE 411: Remittance Remark Codes.	
		RX National Council for Prescription Drug Programs Reject/Payment Codes	CODE SOURCE 530: National Council for Prescription Drug Programs Reject/Payment Codes.	
		Industry Code	Code indicating a code from a specific industry code list.	REQUIRED LQ02 1271 X AN 1/30
-----	PROVIDER ADJUSTMENT (PLB)		To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service. Use the PLB segment to allow adjustments that are NOT specific to a particular claim or service to the amount of the actual payment. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Some examples of PLB adjustments are a loan repayment or a capitation payment. Multiple adjustments can be placed in one PLB segment, grouped by the provider identified in PLB01 and the period identified in PLB02. Although the PLB	SITUATIONAL
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. PLB01 is the provider number assigned by the payer. Use this number for the provider identifier	REQUIRED PLB01 127 M AN 1/30
		Date	Date expressed as CCYYMMDD. PLB02 is the last day of the provider's fiscal year. Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31st of the current year.	REQUIRED PLB02 373 M DT 8/8

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Adjustment Identifier	To provide the category and identifying reference information for an adjustment. This code is a composite data structure. The composite identifies the reason and identifying information for the adjustment dollar	REQUIRED PLB03 C042 M
		Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.	REQUIRED PLB03 - 1 426 M ID 2/2
		50 Late Charge	Use this code for the Late Claim Filing Penalty or Medicare Late Cost Report Penalty. PLB03-2 identifies the Medicare Late Cost Report Penalty with a code value of LR.	
		51 Interest Penalty Charge	Use this code for the interest assessment for late filing. Medicare Part A provides code "IP" in PLB03-2.	
		72 Authorized Return	This monetary amount is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 should always contain an identifying reference number when the value issued. PLB04 should contain a negative value. This adjustment should always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset. Medicare A	
		90 Early Payment Allowance		
		AM Applied to Borrower's Account	Use this monetary amount for the loan repayment amount.	
		AP Acceleration of Benefits	Use this code to reflect accelerated payment amounts or withholdings. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment. Medicare Part A will provide code "AP" for accelerated payment amounts and code "AW" for accelerated payment	
		B2 Rebate	Use this code for the refund adjustment. Medicare Part A will provide code "RF" in PLB03-2.	
		B3 Recovery Allowance	This code is used by Medicare to represent the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. Part A or Part B trust fund for Medicare use is identified in PLB03-2. "RA" is used for Medicare A. "RB" is used for Medicare Part B. PLB04 should contain a NEGATIVE value. This adjustment should always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code	
		BD Bad Debt Adjustment	Use this code for the bad debt passthrough. Medicare Part A will provide code "BD" in PLB03-2.	
		BN Bonus		

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III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		C5 Temporary Allowance	This is the tentative adjustment. Medicare Part A will provide code "TS" in PLB03-2.	
		CR Capitation Interest		
		CS Adjustment	Provide supporting identification information in PLB03-2. Medicare Part A will provide code "CA" for Manual Claim Adjustment, "AA" for Receivable Today. Medicare Part A and Part B will provide code "RI" for Reissued Check Amount in PLB03-2.	
		CT Capitation Payment		
		CV Capital Passthru	Medicare Part A will provide code "CP" in PLB03-2.	
		CW Certified Registered Nurse Anesthetist Passthru	Medicare Part A will provide code "CR" in PLB03-2.	
		DM Direct Medical Education Passthru	Medicare Part A will provide code "DM" in PLB03-2.	
		E3 Withholding	Medicare Part A will provide code "CW" in PLB03-2.	
		FB Forwarding Balance	Use this monetary amount for the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number should be supplied in PLB03-2 for tracking purposes. Medicare Part A will provide code "RF" for negative values and	
		FC Fund Allocation	The specific fund should be identified in PLB03-2.	
		GO Graduate Medical Education Passthru	Medicare Part A will provide code "GM" in PLB03-2.	
		IP Incentive Premium Payment		
		IR Internal Revenue Service Withholding	Use this number for the interim rate lump sum adjustment. Medicare Part A will provide code "IR" in PLB03-2.	
		IS Interim Settlement		
		J1 Nonreimbursable	Use this to offset claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of	
		L3 Penalty	Use this number for the capitation-related penalty, penalty withholding, or penalty release adjustment. Withholding or release is identified by the sign in PLB04. Medicare Part A will provide code "PW" for Penalty Withhold, "RS" for Penaltv Release. and "SW" for Settlement Withhold Amount in	
		L6 Interest Owed	Use this monetary amount for the interest paid on claims. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I." Medicare Part A will provide code "IN" in PLB03-2.	
		LE Levy	IRS Levy.	

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table

LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		LS Lump Sum	Use this for a disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2. Medicare Part A will provide code "DS" for Disproportionate Share Adjustment, "IM" for Indirect Medical Education Passthrough, "NP" for Non-physician Passthrough, "PS" for Passthrough Lump Sum, and "PO" for Other Passthrough in PLB03-2.	
		OA Organ Acquisition Passthru	Medicare Part A will provide code "KA" in PLB03-2.	
		OB Offset for Affiliated Providers	Part A or Part B trust fund identification for the source of the offset is in PLB03-2. Use "OA" for the Part A trust fund and "OB" for the Part B trust	
		PI Periodic Interim Payment	Use this monetary amount for the PIP lump sum, PIP payment, or adjustment after PIP. The sign of the amount in PLB04 determines whether this is a payment (negative) or adjustment (positive). Medicare Part A will provide code "PL" for PIP Lump Sum, "PP" for PIP Payment, and "PA" for	
		PL Payment Final	Use this number for the final settlement. Medicare Part A will provide code "FS" in PLB03-2.	
		RA Retro-activity Adjustment	Medicare Part A will provide code "TR" in PLB03-2.	
		RE Return on Equity	Medicare Part A will provide code "RE" in PLB03-2.	
		SL Student Loan Repayment		
		TL Third Party Liability		
		WO Overpayment Recovery	Use this for the recovery of previous overpayment. An identifying number should be provided in PLB03-2. Medicare Part A will provide code "OR" in	
		WU Unspecified Recovery	Use this for the outside recovery adjustment. Medicare Part A will provide code "OS" in PLB03-2.	
		ZZ Mutually Defined	Use this to report hemophilia clotting factor supplement amount until data maintenance approved by ASC X12. NOT ADVISED.	
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Medicare intermediaries must enter the applicable Medicare code (see Medicare A notes in PLB03-1) in positions 1-2, the Financial Control Number or other pertinent identifier in positions 3-19, and the patient's Health Insurance Claim Number (HIC) in positions 20-30 when the adjustment is related to a previously processed claim. Non-Medicare payers report any internally assigned reference	SITUATIONAL PLB03 - 2 127 O AN 1/30
		Monetary Amount	Monetary amount. PLB04 is the adjustment amount. Use this monetary amount for the adjustment amount for the preceding adjustment reason.	REQUIRED PLB04 782 M R 1/18

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Adjustment Identifier	To provide the category and identifying reference information for an adjustment. See PLB03 for details. Used when additional adjustments	SITUATIONAL PLB05 C042 X
		Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.	REQUIRED PLB05 - 1 426 M ID 2/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	SITUATIONAL PLB05 - 2 127 O AN 1/30
		Monetary Amount	Monetary amount. PLB06 is the adjustment amount. Use this monetary amount for the adjustment amount for the preceding adjustment reason.	SITUATIONAL PLB06 782 X R 1/18
		Adjustment Identifier	To provide the category and identifying reference information for an adjustment. Used when additional adjustments apply.	SITUATIONAL PLB07 C042 X
		Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.	REQUIRED PLB07 - 1 426 M ID 2/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	SITUATIONAL PLB07 - 2 127 O AN 1/30
		Monetary Amount	Monetary amount. PLB08 is the adjustment amount. Use this monetary amount for the adjustment amount for the preceding adjustment reason.	SITUATIONAL PLB08 782 X R 1/18
		Adjustment Identifier	To provide the category and identifying reference information for an adjustment. Used when additional adjustments apply.	SITUATIONAL PLB09 C042 X
		Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.	REQUIRED PLB09 - 1 426 M ID 2/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	SITUATIONAL PLB09 - 2 127 O AN 1/30
		Monetary Amount	Monetary amount. PLB10 is the adjustment amount. Use this monetary amount for the adjustment amount for the preceding adjustment reason.	SITUATIONAL PLB10 782 X R 1/18

HIPAA HEALTH CARE CLAIM PAYMENT / ADVICE (835) TRANSACTION - MASTER DATA SET FOR DS 2000+

III. Data Elements Table				
LOOPS	SEGMENT NAMES	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Adjustment Identifier	To provide the category and identifying reference information for an adjustment. Used when additional adjustments apply.	SITUATIONAL PLB11 C042 X
		Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.	REQUIRED PLB11 - 1 426 M ID 2/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	SITUATIONAL PLB11 - 2 127 O AN 1/30
		Monetary Amount	Monetary amount. PLB12 is the adjustment amount. Use this monetary amount for the adjustment amount for the preceding adjustment reason.	SITUATIONAL PLB12 782 X R 1/18
		Adjustment Identifier	To provide the category and identifying reference information for an adjustment. See PLB03 for details. Used when additional adjustments	SITUATIONAL PLB13 C042 X
		Adjustment Reason Code	Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment.	REQUIRED PLB13 - 1 426 M ID 2/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	SITUATIONAL PLB13 - 2 127 O AN 1/30
		Monetary Amount	Monetary amount. PLB14 is the adjustment amount. Use this monetary amount for the adjustment amount for the preceding adjustment reason.	SITUATIONAL PLB14 782 X R 1/18
-----	TRANSACTION SET TRAILER (SE)		To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE))	REQUIRED
		Number of Included Segments	Total number of segments included in a transaction set including ST and SE segments.	REQUIRED SE01 96 M N0 1/10
		Transaction Set Control Number	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set. The Transaction Set Control Numbers in ST02 and SE02 must be identical. The originator assigns the Transaction Set Control Number, which must be	REQUIRED SE02 329 M AN 4/9

IV. Key Terms and Issues

A. Business Definitions

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).

V. 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