

DRAFT

HIPAA

**Master Data Set for Health Care Claim: Professional (837)
Transaction**

Decision Support 2000+

May 13, 2002

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

Table of Contents

I. Introduction	3
II. Overview of this Transaction	5
III. Data Element Tables.....	14
IV. Key Terms and Important Issues.....	172
V. List of External Code Sources Needed for this Transaction	176

HIPAA
Master Data Set for Health Care Claim:
Professional (837) Transaction
Decision Support 2000+

I. Introduction

The HIPAA Health Care Claim: Professional Transaction (837) is used for submitting professional claims and/or encounters to payers for payment. The transaction originates with the health care provider or the health care provider's designated agent or with payers in an encounter reporting situation. Information is sent to permit the destination payer to begin to adjudicate the claim. The Health Care Claim: Professional Transaction (837) coordinates with a variety of other transactions including, but not limited to, Unsolicited Claim Status (277), Remittance Advice (835), and Functional Acknowledgment (997). It was designed specifically to address issues concerning the handling of coordination of benefits (COB) in a totally EDI environment, particularly COB transactions involving Medicare and Medicaid.

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: Professional Transaction (837). 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 Master Data Set has been taken directly from the Health Care Claim: Professional Transaction (837) Implementation Guide.¹

¹ Health Care Claim: Professional Transaction (837) Implementation Guide, ASCX12N 837 (004010X098), Washington Publishing Company, May 2000.

I. Overview

Uses of the Health Care Claim: Professional Transaction (837)

The Health Care Claim: Professional transaction may be used by providers to submit claims for payment and capitated encounters within a pre-paid managed care context that do not result in a payment. It may also be used by payers to share data with plan sponsors, employers, and regulatory entities who monitor the rendering, billing, and/or payment of health care services and to support the coordination of benefits by transferring each payer's adjudication information to subsequent payers. Providers may transmit claims themselves or use intermediary billers and claims clearinghouses.

Structure of the Transaction Sets

Under HIPAA, business transactions (such as a health care claim submitted by a provider to a payer or a group of benefit enrollments sent from a sponsor 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).

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 requirement designator in the X12 standard (i.e., mandatory [M], optional [O], relational [X]); 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

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. When claims are sorted according to the hierarchy, the information that applies to lower levels does not have to be repeated.

Figure 2 shows the loop hierarchical organization of the data in the transaction. First, the data are divided into two major groupings: Header and Detail. The Header begins with three segments that are followed by two loops and their segments. The Detail has three hierarchical levels—billing/pay-to provider, subscriber, and patient—and, within the patient hierarchical level, two other hierarchical levels, claim and claim service line. The Data Check List shows the hierarchical levels, the loops within the levels, the segments within the loops, and the data elements within the segments.

Figure 2. Loop Hierarchy

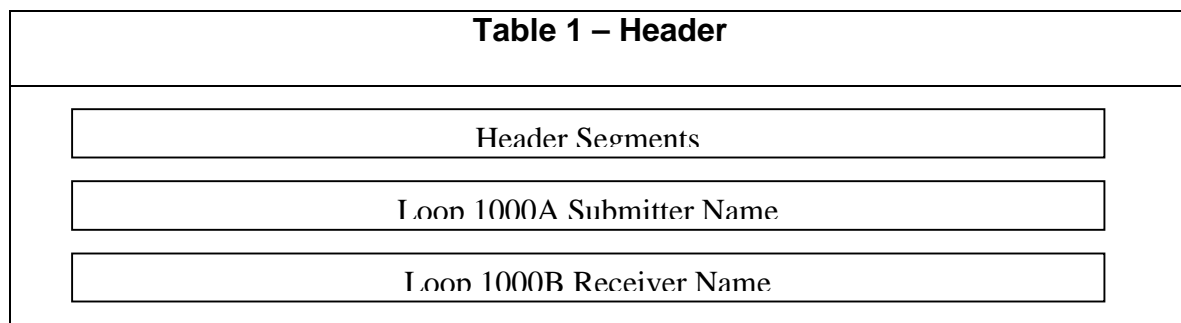


Table 2 – Detail, Billing/Pay-to Provider Hierarchical Level

Loop 2000A Billing/Pay-to Provider Hierarchical Level

Loop 2010AA Billing Provider Name

Loop 2010AB Pay-to Provider Name

**Table 2 – Detail
Subscriber Hierarchical Level**

Loop 2000B Subscriber Hierarchical Level

Loop 2010BA Subscriber Name

Loop 2010BB Payer Name

Loop 2010BC Responsible Party Name

Loop 2010BD Credit/Debit Card Holder



Table 2 – Detail, Patient Hierarchical Level

Loop 2330A Other Subscriber Name
Loop 2330B Other Payer Name
Loop 2330C Other Payer Patient Information
Loop 2330D Other Payer Referring Provider
Loop 2330E Other Payer Rendering Provider
Loop 2330F Other Payer Purchased Service Provider
Loop 2330G Other Payer Service Facility Location
Loop 2330H Other Payer Supervising Provider

Transaction Set Trailer

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
----	TRANSACTION SET HEADER			REQUIRED
		Transaction Set Identifier Code 837 Health Care Claim	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).	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 set. The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.	REQUIRED ST02 329 M AN 4/9
----	BEGINNING OF HIERARCHICAL TRANSACTION (BHT)		To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time. The second example denotes the case where the entire transaction set contains encounters.	REQUIRED
		Hierarchical Structure Code 0019 Information Source, Subscriber,	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set.	REQUIRED BHT01 1005 M ID 4/4
		Transaction Set Purpose Code 00 Original 18 Reissue	Code identifying purpose of transaction set. BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. NSF Reference: AA0-23.0 Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.	REQUIRED BHT02 353

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. BHT03 is the number assigned by the originator to identify the transaction within the originator's business application system. The inventory file number of the tape or transmission assigned by the submitter's system. This number operates as a batch control number. It may or may not be identical to the number carried in ST02. NSF Reference: AA0-05.0	REQUIRED BHT03 127 O AN 1/30
		Date	Date expressed as CCYYMMDD. BHT04 is the date the transaction was created within the business application system. Identifies the date that the submitter created the file. NSF Reference: AA0-15.0	REQUIRED BHT04 373 O DT 8/8
		Time	Time expressed in 24-hour clock time as follows HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows D = tenths (0-9) and DD = hundredths (00-99). BHT05 is the time the transaction was created within the business application system. Use this time to identify the time of day that the submitter created the file. NSF Reference: AA0-16.0	REQUIRED BHT05 337 O TM 4/8
		Transaction Type Code	Code specifying the type of transaction. Although this element is required, submitters are not necessarily required to accurately batch claims and encounters at this level. Generally CH is used for claims and RP is used for encounters. However, if an ST-SE envelope contains both claims and encounters use CH. Some trading partner agreements may specify using only one code.	REQUIRED BHT06 640 O ID 2/2
		CH Chargeable	Use this code when the transaction contains only fee-for-service claims or claims with at least one chargeable line item. If it is not clear whether a transaction contains claims or encounters, or if the transaction contains a mix of claims and encounters, the developers of this implementation guide recommend using code CH.	
		RP Reporting	Use RP when the entire ST-SE envelope contains encounters. Use RP when the transaction is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.	
----	TRANSMISSION TYPE IDENTIFICATION (REF)		To specify identifying information.	REQUIRED
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		87 Functional Category		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. When piloting the transaction set, this value is 004010X098D. When sending the transaction set in a production mode, this value is 004010X098.	REQUIRED REF02 127 X AN 1/30
1000A SUBMITTER NAME	SUBMITTER NAME (NM1)		To supply the full name of an individual or organizational entity. The example in this NM1 and the subsequent N2 demonstrate how a name that is more than 35 characters long could be handled between the NM1 and N2 segments. Because this is a required segment, this is a required loop.	REQUIRED
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		41 Submitter		
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		1 Person 2 Non-Person Entity		
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: AA0-06.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. Required if NM102=1 (person).	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67).	REQUIRED NM108 66 X ID 1/2
		46 Electronic Transmitter Identification Number (ETIN)	Established by trading partner agreement.	
		Identification Code	Code identifying a party or other code. NSF Reference: AA0-02.0, ZAO-02.0	REQUIRED NM109 67 X AN 2/80

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	ADDITIONAL SUBMITTER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	SUBMITTER EDI CONTACT INFORMATION (PER)		To identify a person or office to whom administrative communications should be directed. 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 AAABBCCCC 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. The contact information in this segment should point to the person in the submitter organization who deals with data transmission issues. If data transmission problems arise, this is the person to contact in the submitter organization. There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.	REQUIRED
		Contact Function Code IC Information Contact	Code identifying the major duty or responsibility of the person or group named.	REQUIRED PER01 366 M ID 2/2
		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). NSF Reference: AA0-13.0	REQUIRED PER02 93 O AN 1/60
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail FX Facsimile TE Telephone	Code identifying the type of communication number.	REQUIRED PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. NSF Reference: AA0-14.0	REQUIRED PER04 364 X AN 1/80
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail EX Telephone Extension	Code identifying the type of communication number. Used at the discretion of the submitter.	SITUATIONAL PER05 365 X ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		FX Facsimile TE Telephone		
		Communication Number	Complete communications number including country or area code when applicable. Used at the discretion of the submitter.	SITUATIONAL PER06 364 X AN 1/80
		Communication Number Qualifier	Code identifying the type of communication number. Used at the discretion of the submitter.	SITUATIONAL PER07 365 X ID 2/2
		ED Electronic Data Interchange Access EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone		
		Communication Number	Complete communications number including country or area code when applicable. Used at the discretion of the submitter.	SITUATIONAL PER08 364 X AN 1/80
1000B RECEIVER NAME	RECEIVER NAME (NM1)		To supply the full name of an individual or organizational entity. Because this is a required segment, this is a required loop.	REQUIRED
		Entity Identifier Code 40 Receiver	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 46 Electronic Transmitter Identification Number (ETIN)	Code designating the system/method of code structure used for Identification Code (67).	REQUIRED NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Identification Code	Code identifying a party or other code. NSF Reference: AA0-17.0, ZA9-04.0	REQUIRED NM109 67 X AN 2/80
	RECEIVER ADDITIONAL NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL	BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider. The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims. The Billing/Pay-to Provider HL may contain information about the Pay to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops, there is an implied maximum of 5000. If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.	REQUIRED
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction. HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Level Code	Code defining the characteristic of a level in a hierarchical structure. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item level information.	REQUIRED HL03 735 M ID 1/2

20 Information Source

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Hierarchical Child Code</p> <p>1 Additional Subordinate HL Data Segment in This Hierarchical Structure</p>	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1
	BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION (PRV)		To specify the identifying characteristics of a provider. Required if the Rendering Provider is the same entity as the Billing Provider and/or the Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B. PRV02 qualifies PRV03.	SITUATIONAL
		<p>Provider Code</p> <p>BI Billing PT Pay-To</p>	Code identifying the type of provider.	REQUIRED PRV01 1221 M ID 1/3
		<p>Reference Identification Qualifier</p> <p>ZZ Mutually Defined</p>	Code qualifying the Reference Identification. ZZ is used to indicate the "Health Care Provider Taxonomy" code list (Provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.	REQUIRED PRV02 128 M ID 2/3
		<p>Reference Identification</p>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: BA0-22.0	REQUIRED PRV03 127 M AN 1/30
	FOREIGN CURRENCY INFORMATION (CUR)		To specify the currency (dollars, pounds, francs, etc.) used in a transaction. The CUR segment is required if financial amounts submitted in this ST-SE envelop are for services provided in a currency that is NOT normally used by the receiver for processing claims. For example, claims submitted by United States (U.S.) providers to U.S. receivers are assumed to be in U.S. dollars. Claims submitted by Canadian providers to Canadian receivers are assumed to be in Canadian dollars. Claims submitted by Canadian providers to U.S. receivers are assumed to be in Canadian dollars. In that case the CUR would be used to indicate that the billed amounts are in Canadian dollars. In cases where COB is involved, adjudicated adjustments and amounts must also be in the currency indicated here.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code 85 Billing Provider	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
2010AA BILLING PROVIDER NAME	BILLING PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities. Because this is a required segment, this is a required loop.	REQUIRED
		Entity Identifier Code 85 Billing Provider	Code identifying an organizational entity, a physical location, property or an individual. Use this code to indicate billing provider, billing submitter, and encounter reporting entity.	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. NSF Reference: BA0-18.0 or BA0-19.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: BA0-20.0 Required if NM102=1 (person).	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. NSF Reference: BA0-21.0 Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). If "XX-NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.	REQUIRED NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. NSF Reference: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA-16.0, BA0-17.0, BA0-24.0, YA0-06.0	REQUIRED NM109 67 X AN 2/80
	ADDITIONAL BILLING PROVIDER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	BILLING PROVIDER ADDRESS (N3)		To specify the location of the named party.	REQUIRED
		Address Information	Address information. NSF Reference: BA1-07.0, BA1-13.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. NSF Reference: BA1-08.0, BA1-14.0 Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
	BILLING PROVIDER 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. NSF Reference: BA109.0, BA1-15.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: BA1-1.0, BA1-16.0	REQUIRED N402 156 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	CREDIT/DEBIT CARD BILLING INFORMATION (REF)		To specify identifying information. The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.	SITUATIONAL
		Reference Identification Qualifier 06 System Number 8U Bank Assigned Security Identifier EM Electronic Payment Reference Number IJ Standard Industry Classification (SIC) Code LU Location Number RB Rate code number ST Store Number TT Terminal Code	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
	BILLING PROVIDER CONTACT INFORMATION (PER)		To identify a person or office to whom administrative communications should be directed. Required if this information is different than that contained in the Loop 1000A - Submitter PER segment. 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. There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.	SITUATIONAL
		Contact Function Code IC Information Contact	Code identifying the major duty or responsibility of the person or group named.	REQUIRED PER01 366 M ID 2/2
		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).	REQUIRED PER02 93 O AN 1/60
		Communication Number Qualifier EM Electronic Mail	Code identifying the type of communication number.	REQUIRED PER03 365 X ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		FX Facsimile TE Telephone		
		Communication Number	Complete communications number including country or area code when applicable. NSF Reference: BA1-12.0, BA1-18.0	REQUIRED 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. Used at the discretion of the billing provider.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Used at the discretion of the billing provider.	SITUATIONAL PER06 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. Used at the discretion of the billing provider.	SITUATIONAL PER07 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Used at the discretion of the billing provider.	SITUATIONAL PER08 364 X AN 1/80
2010AB PAY-TO PROVIDER NAME	PAY-TO PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Required if the Pay-to Provider is a different entity than the Billing Provider. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.	SITUATIONAL
		Entity Identifier Code 87 Pay-to Provider	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		1 Person	If Person is used and if the pay-to provider is the same person as the rendering provider, it is not necessary to use the Rendering Provider NM1 loop at the claim loop (Loop ID-2300).	
		2 Non-Person Entity	If Non-Person Entity is used then the rendering provider NM1 loop (Loop ID-2310B) must be used when appropriate to identify the person who rendered the services.	
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: BA-18.0 or BA0-19.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: BA0-20.0 Required if NM102-1 (person).	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. NSF Reference: BA0-21.0 Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). If "XX-NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.	REQUIRED NM108 66 X ID 1/2
		24 Employer's Identification Number		
		34 Social Security Number	The social security number may not be used for Medicare.	
		XX Health Care Financing Administration National Provider Identifier	Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. NSF Reference: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	REQUIRED NM109 67 X AN 2/80
	ADDITIONAL PAY-TO PROVIDER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	PAY-TO PROVIDER ADDRESS		To specify the location of the named party.	REQUIRED
		Address Information	Address information. NSF Reference: BA1-13.0, BA1-07.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. NSF Reference: BA1-14.0, BA1-08.0 Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
	PAY-TO PROVIDER 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. NSF Reference: BA1-15.0, BA1-09.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: BA1-16.0, BA1-10.0	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. NSF Reference: BA1-17.0, BA1-11.0	REQUIRED N403 116 O ID 3/15
		Country Code	Code identifying the country. CODE SOURCE 5: Countries, Currencies and Funds - Required if the address is out of the U.S.	SITUATIONAL N404 26 O ID 2/3
	PAY-TO-PROVIDER SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop. If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 5 times.	SITUATIONAL
		Reference Identification Qualifier 0B State License Number	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Hierarchical ID Number 	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number 	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code 22 Subscriber	Code defining the characteristic of a level in a hierarchical structure. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item level information.	REQUIRED HL03 735 M ID 1/2
		Hierarchical Child Code 0 No Subordinate HL Segment in This Hierarchical Structure. 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment. The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04=0) or when HL04 has subordinate levels indicated (HL04=1). In the first case (HL04=0), the subscriber is the patient and there are no dependent claims. The second case (HL04=1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04=1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) should then be run and the 2300 loop for the dependent/patient would be run after that HL. HL04=1 would also be used when a claim/encounter for a only a dependent is being sent.	REQUIRED HL04 736 O ID 1/1
	SUBSCRIBER INFORMATION (SBR)		To record information specific to the primary insured and the insurance carrier for that insured.	REQUIRED
		Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim. NSF Reference: DA1-02.0, DA0-02.0, DA2-02.0	REQUIRED SBR01 1138 M ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		P Primary S Secondary T Tertiary	Use to indicate 'payer of last resort'.	
		Individual Relationship Code 18 Self	Code indicating the relationship between two individuals or entities. SBR02 specifies the relationship to the person insured. NSF Reference: DA0-17.0 Required when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element.	SITUATIONAL SBR02 1069 O ID 2/2
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SBR03 is policy or group number. NSF Reference: DA0-10.0 Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).	SITUATIONAL SBR03 127 O AN 1/30
		Name	Free-form name. SBR04 is plan name. NSF Reference: DA0-11.0 Required if the subscriber's payer identification includes a Group or Plan Name.	SITUATIONAL SBR04 93 O AN 1/60
		Insurance Type Code 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group 14 Medicare Secondary, No-fault Insurance including Auto is Primary 15 Medicare Secondary Worker's 16 Medicare Secondary Public Health Service (PHS) or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's	Code identifying the type of insurance policy within a specific insurance program. NSF Reference: DA0-06.0 Required when the destination payer (Loop 2010BB) is Medicare and Medicare is not the primary payer (SBR01 equals "S" or "T").	SITUATIONAL SBR05 1336 O ID 1/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary		
		Claim Filing Indicator Code	Code identifying type of claim. Required prior to mandated used of PlanID. Not used after PlanID is	SITUATIONAL SBR09 1032 O ID 1/2
		09 Self-pay		
		10 Central Certification	NSF Reference: CA0-23.0 (K), DA0-05.0 (K)	
		11 Other Non-Federal Programs		
		12 Preferred Provider Organization (PPO)		
		13 Point of Service (POS)		
		14 Exclusive Provider Organization (EPO)		
		15 Indemnity Insurance		
		16 Health Maintenance Organization (HMO)		
		Medicare Risk		
		AM Automobile Medical		
		BL Blue Cross/Blue Shield	NSF Reference: CA0-23.0 (G), DA0-05.0 (G), CA0-23.0 (P), DA0-05.0 (P)	
		CH Champus	NSF Reference: CA0-23.0 (H), DA0-05.0 (H)	
		CI Commercial Insurance Co.	NSF Reference: CA0-23.0 (F), DA0-05.0 (F)	
		DS Disability		
		HM Health Maintenance Organization	NSF Reference: CA0-23.0 (I), DA0-05.0 (I)	
		Liability		
		LM Liability Medical		
		MB Medicare Part B	NSF Reference: CA0-23.0 (C), DA0-05.0 (C)	
		MC Medicaid	NSF Reference: CA0-23.0 (D), DA0-05.0 (D)	
		OF Other Federal Program	NSF Reference: CA0-23.0 (E), DA0-05.0 (E)	
		TV Title V	NSF Reference: DA0-05.0 (T)	
		VA Veteran Administration Plan	Refers to Veteran's Affairs Plan. NSF Reference: DA0-05.0 (V)	
		WC Workers' Compensation Health Claim	NSF Reference: CA0-23.0 (B), DA0-05.0 (B)	
		ZZ Mutually Defined	Unknown. NSF Reference: CA0-23.0 (Z), DA0-05.0 (Z)	

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	PATIENT INFORMATION (PAT)		To supply patient information. Required if the subscriber is the same person as the patient (Loop ID-2000B SBR02=18), and information in this PAT segment (date of death, and/or patient weight) is necessary to file the claim/encounter (see PAT05, 06, 07, and 08).	SITUATIONAL
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. Required if patient is known to be deceased.	SITUATIONAL PAT05 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. PAT06 is the date of death. NSF Reference: CA0-21.0 Required if patient is known to be deceased.	SITUATIONAL PAT06 1251 X AN 1/35
		Unit or Basis for Measurement Code Gram	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Required on claims/encounters for delivery services (newborn's birthweight). This data element is used when the patient's age is less than 29 days old.	SITUATIONAL PAT07 355 X ID 2/2
		Weight	Numeric value of weight. PAT08 is the patient's weight. NSF Reference: FA0-44.0, GU0-17.0 This data element is used when the patient's age is less than 29 days. Required on (1) claims/encounters for delivery services (newborn's birthweight) and (2) claims/encounters involving EPO (epoetin) for patients on dialysis and Medicare Durable Medical Equipment Regional Carriers certificate of medical necessity (DMERC CMN) 02.03 and 10.02.	SITUATIONAL PAT08 81 X R 1/10
		Yes/No Condition or Response Code Y Yes	Code indicating a Yes or No condition or response. PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant; code "N" indicates the patient is not pregnant. Required when required by state law (e.g., Indiana Medicaid). The "Y" code indicates the patient/subscriber is pregnant. If PAT09 is not used it indicates that the patient/subscriber is not pregnant.	SITUATIONAL PAT09 1073 O ID 1/1
2010BA SUBSCRIBER NAME	SUBSCRIBER NAME (NM1)		To supply the full name of an individual or organizational entity. In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state. Because this is a required segment, this is a required loop.	REQUIRED

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. NSF Reference: CA0-04.0, DA0-19.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: CA0-05.0, DA0-20.0 Required if NM102=1 (person).	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. NSF Reference: CA0-06.0, DA0-21.0 Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. NSF Reference: CA0-07.0, DA0-22.0 Required if known. Examples: I, II, III, IV, Jr, Sr.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier MI Member Identification Number	Code designating the system/method of code structure used for Identification Code (67). Required if NM102=1 (person). The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc. MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State). In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in REF02.	SITUATIONAL NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		ZZ Mutually Defined	The value "ZZ", when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.	
		Identification Code	Code identifying a party or other code. NSF Reference: DA0-18.0, CA1-05.0, CA1-06.0 Required if NM102=1 (person).	SITUATIONAL NM109 67 X AN 2/80
	ADDITIONAL SUBSCRIBER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	SUBSCRIBER ADDRESS (N3)		To specify the location of the named party. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).	SITUATIONAL
		Address Information	Address information. NSF Reference: CA0-11.0, DA2-04.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. NSF Reference: CA0-2.0, DA2-05.0 Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
	SUBSCRIBER CITY/STATE/ZIP CODE (N4)		To specify the geographic place of the named party. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).	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. NSF Reference: DA2-06.0, CA0-13.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: CA0-14.0, DA2-07.0	REQUIRED N402 156 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Postal Code 	Code defining international postal zone code excluding punctuation and blanks (zip code for United States). CODE SOURCE 51: ZIP Code. NSF Reference: CA0-15.0, DA2-08.0	REQUIRED N403 116 O ID 3/15
		Country Code 	Code identifying the country. Required if the address is out of the U.S. CODE SOURCE 5: Countries, Currencies and Funds.	SITUATIONAL N404 26 O ID 2/3
	SUBSCRIBER DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information. Required if the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02=18 (self)).	SITUATIONAL
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format.	REQUIRED DMG01 1250 X ID 2/3
		Date Time Period 	Expression of a date, a time, or range of dates, times or dates and times. DMG02 is the date of birth. NSF Reference: CA0-08.0, DA0-24.0	REQUIRED DMG02 1251 X AN 1/35
		Gender Code F Female M Male U Unknown	Code indicating the sex of the individual. NSF Reference: CA0-09.0, DA0-23.0	REQUIRED DMG03 1068 O ID 1/1
	SUBSCRIBER SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.	SITUATIONAL
		Reference Identification Qualifier 1W Member Identification Number 23 Client Number IG Insurance Policy Number	Code qualifying the Reference Identification. If NM108 = M1 do not use this code. This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES	
		SY Social Security Number	The social security number may not be used for Medicare.		
		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	
	PROPERTY AND CASUALTY CLAIM NUMBER (REF)		To specify identifying information. In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place. This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer.	SITUATIONAL	
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3	
		Y4 Agency Claim 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	
2010BB PAYER NAME	PAYER NAME (NM1)		To supply the full name of an individual or organizational entity. This is the destination payer. Because this is a required segment, this is a required loop.	REQUIRED	
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3	
		PR Payer			
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1	
		2 Non-Person Entity			
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: DA0-09.0	REQUIRED NM103 1035 O AN 1/35	
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). CODE SOURCE 540: Health Care Financing Administration National PlanID.	REQUIRED NM108 66 X ID 1/2	

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		PI Payor Identification XV Health Care Financing Administration National PlanID	Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. NSF Reference: DA0-07.0	REQUIRED NM109 67 X AN 2/80
	ADDITIONAL PAYER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	PAYER ADDRESS (N3)		To specify the location of the named party. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).	SITUATIONAL
		Address Information	Address information. NSF Reference: DA1-04.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. Required if a second address line exists. NSF Reference: DA1-05.0	SITUATIONAL N302 166 O AN 1/55
	PAYER CITY/STATE/ZIP CODE(N4)		To specify the geographic place of the named party. Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).	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. NSF Reference: DA1-06.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: DA1-07.0	REQUIRED N402 156 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Postal Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States). CODE SOURCE 51: ZIP Code. NSF Reference: DA1-08.0	REQUIRED N403 116 O ID 3/15
		Country Code	Code identifying the country. CODE SOURCE 5: Countries, Currencies and Funds - Required if the address is out of the U.S.	SITUATIONAL N404 26 O ID 2/3
	PAYER SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required if additional identification numbers other than the primary identification number in NM108/09 in this loop are necessary to adjudicate the claim/encounter.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		2U Payer Identification Number FY Claim Office Number NF National Association of Insurance Commissioners (NAIC) Code TJ Federal Taxpayer's Identification Number	Used to identify any payer. 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
2010BC RESPONSIBLE PARTY NAME	RESPONSIBLE PARTY NAME (NM1)		To supply the full name of an individual or organizational entity. In general terms, the responsible party is someone who is not the subscriber/patient but who has financial responsibility for the bill. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required for Medicare claims where there is a representative but the provider of medical services has neither the responsible party's signature nor the patient's signature on file. When a Medicare beneficiary is unable to execute a request for payment because of a mental or physical condition, the request may be executed on the beneficiary's behalf by a legal guardian, representative payee, relative, friend, an employee of the institution providing care, or an employee of a governmental agency providing assistance. In this circumstance, unless the requester is a representative payee for the beneficiary, the claim must show the signature and address of the requester with an attached statement explaining the relationship between the requester and the beneficiary, and why the beneficiary can't sign. This information must be on the claim unless it is on file with the provider.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. NSF Reference: CA0-25.0	REQUIRED NM101 98 M ID 2/3
		QD Responsible Party		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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. NSF Reference: CB0-04.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: CB0-05.0 Required if NM102=1 (person).	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: CB0-06.0	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
	ADDITIONAL RESPONSIBLE PARTY NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	RESPONSIBLE PARTY ADDRESS (N3)		To specify the location of the named party.	REQUIRED
		Address Information	Address information. NSF Reference: CB0-07.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. NSF Reference: CB0-08.0 Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
	RESPONSIBLE PARTY CITY/STATE/ZIP CODE (N4)		To specify the geographic place of the named party.	Optional

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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. NSF Reference: CB0-09.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: CB0-10.0	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. NSF Reference: CB0-11.0	REQUIRED N403 116 O ID 3/15
		Country Code	Code identifying the country. Required if the address is out of the U.S. CODE SOURCE 5: Countries, Currencies and Funds.	SITUATIONAL N404 26 O ID 2/3
2010BD CREDIT/DEBIT CARD HOLDER NAME	CREDIT/DEBIT CARD HOLDER NAME (NM1)		To supply the full name of an individual or organizational entity. It is not intended that credit/debit card information be conveyed to a health care payer. Trading partners are responsible for ensuring that no federal or state privacy regulations are violated if credit/debit card information is carried in the transmission. The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		AO Account Of		
		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 NM103 1035 O AN 1/35
		Name First	Individual first name. Required if NM102=1 (person).	SITUATIONAL NM104 1036 O AN 1/25

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67).	REQUIRED NM108 66 X ID 1/2
		MI Member Identification Number		
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80
	ADDITIONAL CREDIT/DEBIT CARD HOLDER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters. The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	CREDIT/DEBIT CARD INFORMATION (REF)		To specify identifying information. The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		AB Acceptable Source Purchaser ID BB Authorization 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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
2000C PATIENT HIERARCHICAL LEVEL	PATIENT HIERARCHICAL LEVEL (HL)		To identify dependencies among and the content of hierarchically related groups of data segments. This HL is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Patient Hierarchical Level loops, there is an implied maximum of 5000.	SITUATIONAL
		Hierarchical ID Number	A unique number assigned by the sender to identify a particular data segment in a hierarchical structure. HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.	REQUIRED HL01 628 M AN 1/12
		Hierarchical Parent ID Number	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.	REQUIRED HL02 734 O AN 1/12
		Hierarchical Level Code 23 Dependent	Code defining the characteristic of a level in a hierarchical structure HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item level information. The code dependent is meant to convey that the information in this HL applies to the patient when the subscriber and the patient are not the same person.	REQUIRED HL03 735 M ID 1/2
		Hierarchical Child Code 0 No Subordinate HL Segment in This Hierarchical Structure.	Code indicating if there are hierarchical child data segments subordinate to the level being described. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.	REQUIRED HL04 736 O ID 1/1
	PATIENT INFORMATION (PAT)		To supply patient information.	REQUIRED
		Individual Relationship Code 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 09 Adopted Child 10 Foster Child 15 Ward 17 Stepson or Stepdaughter	Code indicating the relationship between two individuals or entities.	REQUIRED PAT01 1069 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner G8 Other Relationship		
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. Required if patient is known to be deceased.	SITUATIONAL PAT05 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. PAT06 is the date of death. Required if patient is known to be deceased. NSF Reference: CA0-21.0	SITUATIONAL PAT06 1251 X AN 1/35
		Unit or Basis for Measurement Code GR Gram	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Required on claims/encounters for delivery services (newborn's birthweight). This data element is used when the patient's age is less than 29 days old.	SITUATIONAL PAT07 355 X ID 2/2
		Weight	Numeric value of weight PAT08 is the patient's weight. Required on claims/encounters where the patient's age is less than 29 days. NSF Reference: FA0-44.0, GU0-17.0	SITUATIONAL PAT08 81 X R 1/10
		Yes/No Condition or Response Code Y Yes	Code indicating a Yes or No condition or response. PAT09 indicates whether the patient is pregnant or not pregnant. Code "Y" indicates the patient is pregnant; code "N" indicates the patient is not pregnant. Required when required by state law (e.g., Indiana Medicaid). The "Y" code indicates that the patient is pregnant. If PAT09 is not used it means the patient is not pregnant.	SITUATIONAL PAT09 1073 O ID 1/1
2010CA PATIENT NAME	PATIENT NAME (NM1)		To supply the full name of an individual or organizational entity.	REQUIRED

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code QC Patient	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		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. NSF Reference: CA0-04.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: CA0-05.0	REQUIRED NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier MI Member Identification Number ZZ Mutually Defined	Code designating the system/method of code structure used for Identification Code (67). Required if the patient identifier is different than the subscriber identifier. The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI – Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc. The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.	SITUATIONAL NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code. Required if the patient identifier is different than the subscriber identifier. NSF Reference: DA0-18.0	SITUATIONAL NM109 67 X AN 2/80
	ADDITIONAL PATIENT NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	PATIENT ADDRESS (N3)		To specify the location of the named party.	REQUIRED
		Address Information	Address information. NSF Reference: CA0-11.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. NSF Reference: CA0-12.0 Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
	PATIENT CITY/STATE/ZIP CODE		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. NSF Reference: CA0-13.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: CA0-14.0	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. NSF Reference: CA0-15.0	REQUIRED N403 116 O ID 3/15
		Country Code	Code identifying the country. Required if the address is out of the U.S. CODE SOURCE 5: Countries, Currencies and Funds.	SITUATIONAL N404 26 O ID 2/3
	PATIENT DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information.	REQUIRED
		Date Time Period Format Qualifier Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format.	REQUIRED DMG01 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. DMG02 is the date of birth. NSF Reference: CA0-08.0	REQUIRED DMG02 1251 X AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Gender Code F Female M Male U Unknown	Code indicating the sex of the individual. NSF Reference: CA0-09.0	REQUIRED DMG03 1068 O ID 1/1
	PATIENT SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required if additional identification numbers are necessary to adjudicate the claim/encounter.	SITUATIONAL
		Reference Identification Qualifier 1W Member Identification Number 23 Client Number IG Insurance Policy Number SY Social Security Number	Code qualifying the Reference Identification. If NM108 = M1 do not use this code. This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHC/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number. The social security number may not be used for Medicare.	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
	PROPERTY AND CASUALTY CLAIM NUMBER (REF)		To specify identifying information. In the case where the patient is the same person as the subscriber, the property and casualty claim number is placed in Loop ID-2010BA. In the case where the patient is a different person than the subscriber, this number is placed in Loop ID-2010CA. This number should be transmitted in only one place. This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer.	SITUATIONAL
		Reference Identification Qualifier Y4 Agency Claim 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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
2300 CLAIM INFORMATION	CLAIM INFORMATION (CLM)		To specify basic data about the claim. Because this is a required segment, this is a required loop. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the	REQUIRED
		Claim Submitter's Identifier	Identifier used to track a claim from creation by the health care provider through payment. The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim. The maximum number of characters to be supported for this field is "20". A provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is "20". Characters beyond 20 are not required to be stored nor returned by an 837-receiving system. NSF Reference: CA0-03.0, CB0-03.0, DA0-03.0, DA1-03.0, DA2-03.0, EQ0-03.0, EA1-03.0, EA2-03.0, FA0-03.0, FB0-03.0, FB1-03.0, FB2-03.0, FD0-03.0, FE0-03.0, GA0-03.0, GC0-03.0, GX0-03.0, GX2-03.0., XA0-03.0, CA1-03.0-GU0-03.0, HA0-03.0	REQUIRED CLM01 1028 M AN 1/38
		Monetary Amount	Monetary amount CLM02 is the total amount of all submitted charges of service segments for this claim. For encounter transmissions, zero (0) may be a valid amount. NSF Reference: XA0-12.0	REQUIRED CLM02 782 O R 1/18
		Health Care Service Location Information	To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered. CLM05 applies to all service lines unless it is overwritten at the line level. NSF Reference: FA0-07.0	REQUIRED CLM05 C023 0
		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. Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below; however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility	REQUIRED CLM05 - 1 1331 M AN 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 50 Federally Qualified Health Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility		
		Claim Frequency Type Code Permissible code values for this sub element: 1 - ORIGINAL (Admit thru Discharge Claim) 6 - CORRECTED (Adjustment of Prior Claim) 7 - REPLACEMENT (Replacement of Prior 8 - VOID (Void/Cancel of Prior Claim)	Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type. Code 8 may only be used where permitted by state law (e.g. New York Medicaid). See the NUBC UB92 manual for definitions of these codes. With the exception of #1 (Original) use 6, 7, and 8 for claims that have already been finalized in the payer's system. CODE SOURCE 235: Claim Frequency Type Code.	REQUIRED CLM05 - 3 1325 O ID 1/1
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file. NSF Reference: EA0-37.0\	REQUIRED CLM06 1073 O ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Provider Accept Assignment Code</p> <p>A Assigned B Assignment Accepted on Clinical Lab C Not Assigned P Patient Refuses to Assign Benefits</p>	<p>Code indicating whether the provider accepts assignment. DLM07 indicates whether the provider accepts Medicare assignment. NSF Reference: EA0-36.0, FA0-59.0 The NSF mapping of FA0-59.0 occurs only in payer-to-payer COB situations.</p>	<p>REQUIRED CLM07 1359 O ID 1/1</p>
		<p>Yes/No Condition or Response Code</p> <p>N No Y Yes</p>	<p>Code indicating a Yes or No condition or response. CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. NSF Reference: DA0-15.0</p>	<p>REQUIRED CLM08 1073 O ID 1/1</p>
		<p>Release of Information Code</p> <p>A Appropriate Release of Information on File at Care Service Provider or at Utilization Review I Informed Consent to Release Medical M The Provider has Limited or Restricted Ability to Release Data Related to a Claim N No, Provider is Not Allowed to Release Data O On file at Payor or at Plan Sponsor Y Yes, Provider has a Signed Statement</p>	<p>Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. NSF Reference: EA0-13.0</p>	<p>REQUIRED CLM09 1363 O ID 1/1</p>
		<p>Patient Signature Source Code</p> <p>B Signed signature authorization form or forms C Signed HCFA-1500 Claim Form on file M Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P Signature generated by provider because the patient was not physically present for services S Signed signature authorization form for HCFA-1500 Claim Form block 12 on file</p>	<p>Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider. CLM10 is required except in cases where code "N" is used in CLM09. NSF Reference: DA0-16.0</p>	<p>SITUATIONAL CLM10 1351 O ID 1/1</p>

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		RELATED CAUSES INFORMATION	To identify one or more related causes and associated state or country information. CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0. If Date of Accident (DTP01-439) is used, then CLM11 is required.	SITUATIONAL CLM11 C024 O
		Related-Causes Code AA Auto Accident AB Abuse AP Another Party Responsible EM Employment OA Other Accident	Code identifying an accompanying cause of an illness, injury or an accident. NSF Reference: EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator	REQUIRED CLM11 - 1 1362 M ID 2/3
		Related-Causes Code AA Auto Accident AB Abuse AP Another Party Responsible EM Employment OA Other Accident	Code identifying an accompanying cause of an illness, injury or an accident. NSF Reference: EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator	SITUATIONAL CLM11 - 2 1362 O ID 2/3
		Related-Causes Code AA Auto Accident AB Abuse AP Another Party Responsible EM Employment OA Other Accident	Code identifying an accompanying cause of an illness, injury or an accident. NSF Reference: EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 - Employment, EA0-09.0 - Responsibility Indicator Used if more than one code applies.	SITUATIONAL CLM11 - 3 1362 O ID 2/3
		State or Province Code	Code (Standard State/Province) as defined by appropriate government agency. Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc). NSF Reference: EA0-10.0	SITUATIONAL CLM11 - 4 156 O ID 2/2
		Country Code	Code identifying the country. Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred. CODE SOURCE 5: Countries, Currencies and Funds.	SITUATIONAL CLM11 - 5 26 O ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Special Program Code</p> <p>Code indicating the Special Program under which the services rendered to the patient were performed. Required if the services were rendered under one of the following circumstances/programs/projects. NSF Reference: EA0-43.0</p> <p>01 Early & Periodic Screening, Diagnosis, and 02 Physically Handicapped Children's Program 03 Special Federal Funding 05 Disability 07 Induced Abortion - Danger to Life 08 Induced Abortion - Rape or Incest 09 Second Opinion or Surgery</p>		SITUATIONAL CLM12 1366 O ID 2/3
		<p>Provider Agreement Code</p> <p>Code indicating the type of agreement under which the provider is submitting this claim. Required if a non-participating (non0par) provider is submitting a participating (par) claim/encounter. Sending the "P" code indicates that a non-par provider is sending a part claim as allowed under certain plans.</p> <p>P Participation Agreement</p>		SITUATIONAL CLM16 1360 O ID 1/1
		<p>Delay Reason Code</p> <p>Code indicating the reason why a request was delayed. This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed. Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.</p> <p>1 Proof of Eligibility Unknown or Unavailable 2 Litigation 3 Authorization Delays 4 Delay in Certifying Provider 5 Delay in Supplying Billing Forms 6 Delay in Delivery of Custom-made 7 Third Party Processing Delay 8 Delay in Eligibility Determination 9 Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules 10 Administration Delay in the Prior Approval 11 Other</p>		SITUATIONAL CLM20 1514 O ID 1/2
	DATE - ORDER DATE (DTP)		To specify any or all of a date, a time, or a time period. Required when claim includes an order (i.e., an order for services or supplies is being billed/reported). Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.	SITUATIONAL
		<p>Date/Time Qualifier</p> <p>Code specifying type of date or time, or both date and time</p> <p>938 Order</p>		REQUIRED DTP01 374 M ID 3/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.	REQUIRED DTP03 1251 M AN 1/35
	DATE - INITIAL TREATMENT (DTP)		To specify any or all of a date, a time, or a time period. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only. Required on all claims involving spinal manipulation.	SITUATIONAL
		Date/Time Qualifier 454 Initial Treatment	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GC0-05.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - REFERRAL DATE (DTP)		To specify any or all of a date, a time, or a time period. Required when claim includes a referral. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.	SITUATIONAL
		Date/Time Qualifier 330 Referral Date	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.	REQUIRED DTP03 1251 M AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - DATE LAST SEEN (DTP)		To specify any or all of a date, a time, or a time period. Required when claims involve services from an independent physical therapist, occupational therapist, or physician services involving routine foot care. This is the date that the patient was seen by the attending/supervising physician for the qualifying medical condition related to the services performed.	SITUATIONAL
		Date/Time Qualifier 304 Latest Visit or Consultation	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.	REQUIRED DTP03 1251 M AN 1/35
	DATE - ONSET OF CURRENT ILLNESS/SYMPTOM (DTP)		To specify any or all of a date, a time, or a time period. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only. Required when information is available and if different than the date of service. If not used, claim/service date is assumed to be the date of onset of illness/ symptoms.	SITUATIONAL
		Date/Time Qualifier 431 Onset of Current Symptoms or Illness	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-07.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - ACUTE MANIFESTATION (DTP)		To specify any or all of a date, a time, or a time period. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only. Required when Loop 2300 CR208 = "A" or "M", the claim involves spinal manipulation, and the payer is Medicare.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date/Time Qualifier 453 Acute Manifestation of a Chronic	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GC0-12.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - SIMILAR ILLNESS/SYMPTOM ONSET (DTP)		To specify any or all of a date, a time, or a time period. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only. Required when claim involves services to a patient experiencing symptoms similar or identical to previously reported	SITUATIONAL
		Date/Time Qualifier 438 Onset of Similar Symptoms or Illness	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-16.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - ACCIDENT (DTP)		To specify any or all of a date, a time, or a time period.	
		Date/Time Qualifier 439 Accident	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		DT Date and Time Expressed in Format CCYYMMDDHHMM	Required if accident hour is known.	
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-07.0 - Accident Date, EA0-11.0 Accident Hour (no minutes)	REQUIRED DTP03 1251 M AN 1/35
	DATE - LAST MENSTRUAL PERIOD (DTP)		To specify any or all of a date, a time, or a time period. Required when claim involves pregnancy.	SITUATIONAL
		Date/Time Qualifier 484 Last Menstrual Period	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-07.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - LAST X-RAY (DTP)		To specify any or all of a date, a time, or a time period. Dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only. Required when claim involves spinal manipulation if an x-ray was taken.	SITUATIONAL
		Date/Time Qualifier 455 Last X-Ray	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GC0-06.0	

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - ESTIMATED DATE OF BIRTH (DTP)		To specify any or all of a date, a time, or a time period. Required when PAT09 is used.	SITUATIONAL
		Date/Time Qualifier ABC Estimated Date of Birth	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.	REQUIRED DTP03 1251 M AN 1/35
	DATE - HEARING AND VISION PRESCRIPTION DATE (DTP)		To specify any or all of a date, a time, or a time period. Required on claims where a prescription has been written for hearing devices or vision frames and lenses and it is being billed on this claim.	SITUATIONAL
		Date/Time Qualifier 471 Prescription	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.	REQUIRED DTP03 1251 M AN 1/35
	DATE - DISABILITY BEGIN (DTP)		To specify any or all of a date, a time, or a time period. Required on claims involving disability where, in the opinion of the provider, the patient was or will be unable to perform the duties normally associated with his/her work.	SITUATIONAL
		Date/Time Qualifier 360 Disability Begin	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-18.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - DISABILITY END (DTP)		To specify any or all of a date, a time, or a time period. Required on claims/encounters involving disability where, in the opinion of the provider, the patient, after having been absent from work for reasons related to the disability, was or will be able to perform the duties normally associated with his/her work.	SITUATIONAL
		Date/Time Qualifier 361 Disability End	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-19.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - LAST WORKED (DTP)		To specify any or all of a date, a time, or a time period. Required on claims where this information is necessary for adjudication of the claim (e.g., workers compensation claims involving absence from work).	SITUATIONAL
		Date/Time Qualifier 297 Date Last Worked	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times.	REQUIRED DTP03 1251 M AN 1/35
	DATE - AUTHORIZED RETURN TO WORK (DTP)		To specify any or all of a date, a time, or a time period. Required on claims where this information is necessary for adjudication of the claim (e.g., workers compensation claims involving absence from work).	SITUATIONAL
		Date/Time Qualifier 296 Return to Work	Code specifying type of date or time, or both date and time. This is the date the provider has authorized the patient to return to work.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA1-12.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - ADMISSION (DTP)		To specify any or all of a date, a time, or a time period. Required on all ambulance claims/encounters when the patient was known to be admitted to the hospital. Also required on inpatient medical visits claims/encounters.	SITUATIONAL
		Date/Time Qualifier 435 Admission	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GA0-23.0 (for ambulance claims only), EA0-28.0	REQUIRED DTP03 1251 M AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - DISCHARGE (DTP)		To specify any or all of a date, a time, or a time period. Required for inpatient claims when the patient was discharged from the facility and the discharge date is known.	SITUATIONAL
		Date/Time Qualifier 096 Discharge	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GA0-22.0 (for Ambulance Claims only), EA0-29.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - ASSUMED AND RELINQUISHED CARE DATES (DTP)		To specify any or all of a date, a time, or a time period. Required on Medicare claims to indicate "assumed care date" and "relinquished care date" for situations where providers share postoperative care (global surgery claims). Assumed Care Date is the date care was assumed by another provider during post-operative care. Relinquished Care Date is the date the provider filing this claim ceased post-operative care. See Medicare guidelines for further explanation of these dates. Example: Surgeon "A" relinquished post-operative care to Physician "B" five days after surgery. When Surgeon "A" submits a claim/encounter "A" will use code "091 - Report End" to indicate the day the surgeon relinquished care of this patient to Physician "B". When Physician "B" submits a claim/encounter "B" will use code "090 - Report Start" to indicate the date they assumed care of this patient from Surgeon "A".	SITUATIONAL
		Date/Time Qualifier 090 Report Start 091 Report End	Code specifying type of date or time, or both date and time. Assumed Care Date. Use code 090 to indicate the date the provider filing this claim assumed care from another provider during post-operative care. Relinquished Care Date. Use code 091 to indicate the date the provider filing this claim relinquished post-operative care to another provider.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA1-25.0 - Provider Assumed Care Date, HA0-05.0 - Provider Relinquished Care Date	REQUIRED DTP03 1251 M AN 1/35
	CLAIM SUPPLEMENTAL INFORMATION (PWK)		To identify the type or transmission or both of paperwork or supporting information. The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope. The PWK segment is required to identify attachments that are sent electronically (PWK02 = EL) but are transmitted in another functional group (e.g., 275) rather than by paper. PWK06 is used to identify the attached electronic documentation. The number in PWK06 would be carried in the TRN of the electronic attachment. The PWK segment can be used to identify paperwork that is being held at the provider's office and is available upon request by the payer (or appropriate entity), but that is not being sent with the claim. Use code AA in PWK02 to convey this specific use of the PWK segment. See code note under PWK02, code AA.	SITUATIONAL
		Report Type Code	Code indicating the title or contents of a document, report or supporting item. NSF Reference: EA0-41.0	REQUIRED PWK01 755 M ID 2/2
		77 Support Data for Verification AS Admission B2 Prescription B3 Physician Order B4 Referral Form CT Certification DA Dental Models DG Diagnostic Report DS Discharge EB Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payor) MT Models NN Nursing Notes OB Operative Note OZ Support Data for Claim PN Physical Therapy Notes PO Prosthetics or Orthotic Certification PZ Physical Therapy Certification RB Radiology Films RR Radiology Reports RT Report of Tests and Analysis Report	REFERRAL. Use this code to indicate a completed referral form.	
		Report Transmission Code	Code defining timing, transmission method or format by which reports are to be sent. NSF Reference: EA0-40.0	REQUIRED PWK02 756 O ID 1/2
		AA Available on Request at Provider Site BM By Mail	This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.	

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		EL Electronically Only EM E-Mail FX By Fax	Use to indicate that attachment is being transmitted in a separate X12 functional group.	
		Identification Code Qualifier AC Attachment Control Number	Code designating the system/method of code structure used for Identification Code (67) PWK05 and PWK06 may be used to identify the addressee by a code number. Required if PWK02 = "BM", "EL", "EM" or "FX".	SITUATIONAL PWK05 66 X ID 1/2
		Identification Code	Code identifying a party or other code. Required if PWK02 = "BM", "EL", "EM" or "FX".	SITUATIONAL PWK06 67 X AN 2/80
	CONTRACT INFORMATION (CN1)		To specify basic data about the contract or contract line item. The developers of this implementation guide recommend that for noncapitated situations, contract information be maintained in the receiver's files and not be transmitted with each claim whenever possible. It is recommended that submitters always include CN1 for encounters that include only capitated services. Required if the provider is contractually obligated to provide contract information on this claim.	SITUATIONAL
		Contract Type Code 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other	Code identifying a contract type.	REQUIRED CN101 1166 M ID 2/2
		Monetary Amount	Monetary amount CN102 is the contract amount. Required if the provider is required by contract to supply this information on the claim.	SITUATIONAL CN102 782 O R 1/18
		Percent	Percent expressed as a percent CN103 is the allowance or charge percent. Allowance or charge percent. Required if the provider is required by contract to supply this information on the claim.	SITUATIONAL CN103 332 O R 1/6
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. CN104 is the contract code. Required if the provider is required by contract to supply this information on the claim.	SITUATIONAL CN104 127 O AN 1/30

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Terms Discount Percent	Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or	SITUATIONAL CN105 338 O R 1/6
		Version Identifier	Revision level of a particular format, program, technique or algorithm CN106 is an additional identifying number for the contract. Required if the provider is required by contract to supply this information on the claim.	SITUATIONAL CN106 799 O AN 1/30
	CREDIT/DEBIT CARD MAXIMUM AMOUNT (AMT)		To indicate the total monetary amount. Use this segment only for claims that contain credit/debit card information. This segment indicates the maximum amount that can be credited to the account indicated in 2010BD - CREDIT/DEBIT CARD HOLDER NAME. The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services. In this case, it is the responsibility of the collection service organization to remove this segment before forwarding the claim to the payer.	SITUATIONAL
		Amount Qualifier Code	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount.	REQUIRED AMT02 782 M R 1/18
	PATIENT AMOUNT PAID (AMT)		To indicate the total monetary amount. Required if the patient has paid any amount towards the claim. Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s). Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative(s). The Patient Amount Paid indicated in this segment applies to the entire claim. It is recommended that the Patient Amount Paid AMT segment be used at either the line(s) or claim level but not at both.	SITUATIONAL
		Amount Qualifier Code F5 Patient Amount Paid	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. NSF Reference: XA0-19.0	REQUIRED AMT02 782 M R 1/18
	TOTAL PURCHASED SERVICE AMOUNT (AMT)		To indicate the total monetary amount. Required if there are purchased service components to this claim.	SITUATIONAL
		Amount Qualifier Code NE Net Billed	Code to qualify amount. Use this code to indicate Total Purchased Service Charges.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. NSF Reference: EAP-31.0	REQUIRED AMT02 782 M R 1/18

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	SERVICE AUTHORIZATION EXCEPTION CODE (REF)		To specify identifying information. Required when providers are required by state law (e.g., New York State Medicaid) to obtain authorization for specific services but, for the reasons listed in REF02, performed the service without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.	SITUATIONAL
		Reference Identification Qualifier 4N Special Payment Reference Number	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		Reference Identification 1 Immediate/Urgent Care 2 Services Rendered in a Retroactive Period 3 Emergency Care 4 Client as Temporary Medicaid 5 Request from County for Second Opinion to Recipient can Work 6 Request for Override Pending 7 Special Handling	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
	MANDATORY MEDICARE (SECTION 4081) CROSSOVER INDICATOR (REF)		To specify identifying information. Required for Medicare COB crossover claims when Beneficiary Assignment for mandatory Medicare (Section 4081) claim applies. This segment is only completed by Medicare; providers do not use this segment. If this segment is not used that means this situation does not apply.	SITUATIONAL
		Reference Identification Qualifier F5 Medicare Version Code	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		Reference Identification The allowed values for this element are: Y 4081 N Regular crossover	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: DA0-30.0 NSF Value 1 NSF Value 2	REQUIRED REF02 127 X AN 1/30
	MAMMOGRAPHY CERTIFICATION NUMBER (REF)		To specify identifying information. Required on Medicare claims for all mammography services.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		EW Mammography Certification Number		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: FA0-31.0	REQUIRED REF02 127 X AN 1/30
	PRIOR AUTHORIZATION OR REFERRAL NUMBER (REF)		To specify identifying information. Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line. Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		9F Referral Number G1 Prior Authorization Number		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: DA0-14.0	REQUIRED REF02 127 X AN 1/30
	ORIGINAL REFERENCE NUMBER (ICN/DCN) (REF)		To specify identifying information. Required when CLM05-3 (Claim Submission Reason Code) = "6", "7", or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver. This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and, for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number. In this case the payer is expecting the provider to give them back their (the payer's) claim number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows this is not a duplicate claim. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		F8 Original Reference Number		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. NSF Reference: EA0-47.0	REQUIRED REF02 127 X AN 1/30
	CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER (REF)		To specify identifying information. Required on Medicare and Medicaid claims for any laboratory performing tests covered by the CLIA Act. If a CLIA number is indicated at the line level (Loop ID-2400) in addition to the claim level (Loop ID-2300), that would indicate an exception to the CLIA number at the claim level for that individual line. In cases where this claim contains both in-house and outsourced laboratory services: For laboratory services performed by the billing or rendering provider the CLIA number is reported here; for laboratory services which were outsourced, report that CLIA number at the 2400 loop.	SITUATIONAL
		Reference Identification Qualifier X4 Clinical Laboratory Improvement Amendment 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. NSF Reference: FA0-34.0	REQUIRED REF02 127 X AN 1/30
	REPRICED CLAIM NUMBER (REF)		To specify identifying information. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL
		Reference Identification Qualifier 9A Repriced Claim Reference 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. NSF Reference: FE0-06.0 (TPO Reference Number)	REQUIRED REF02 127 X AN 1/30
	ADJUSTED REPRICED CLAIM NUMBER (REF)		To specify identifying information. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL
		Reference Identification Qualifier 9C Adjusted Repriced Claim Reference	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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 REF02 127 X AN 1/30
	INVESTIGATIONAL DEVICE EXEMPTION NUMBER (REF)		To specify identifying information. Required when claim involves an FDA assigned investigational device exemption (IDE) number. Only one IDE per claim is to be reported.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		LX Qualified Products List		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: EA0-54.0	REQUIRED REF02 127 X AN 1/30
	CLAIM IDENTIFICATION NUMBER FOR CLEARING HOUSES AND OTHER TRANSMISSION INTERMEDIARIES (REF)		To specify identifying information. Used only by transmission intermediaries (Automated Clearing Houses, and others) who need to attach their own unique claim number. Although this REF is supplied for transmission intermediaries to attach their own unique claim number to a claim/encounter, 837- recipients are not required under HIPAA to return this number in any HIPAA transaction. Trading partners may voluntarily agree to this interaction if they wish.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification. Number assigned by clearinghouse/van/etc.	REQUIRED REF01 128 M ID 2/3
		D9 Claim Number		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. The value carried in this element is limited to a maximum of 20 positions.	REQUIRED REF02 127 X AN 1/30
	AMBULATORY PATIENT GROUP (APG) (REF)		To specify identifying information. Required if the contractual reimbursement arrangement between provider and payer is based on APG and their contractual arrangement requires that the provider send APG information to the payer on each claim.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification.	REQUIRED REF01 128 M ID 2/3
		1S Ambulatory Patient Group (APG) 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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	MEDICAL RECORD NUMBER (REF)		To specify identifying information. Used at discretion of submitter.	SITUATIONAL
		Reference Identification Qualifier EA Medical Record 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
	DEMONSTRATION PROJECT IDENTIFIER (REF)		To specify identifying information. Required on claims/encounters where a demonstration project is being billed/reported. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.	SITUATIONAL
		Reference Identification Qualifier P4 Project Code	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. NSF Reference: EA0-43.0	REQUIRED REF02 127 X AN 1/30
	FILE INFORMATION (K3)		To transmit a fixed-format record or matrix contents. At the time of publication K3 segments have no specific use. However, they have been included in this implementation guide to be used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority. This data element can only be required if the specific use is a result of a state law or a regulation issued by a state agency after the publication of this implementation guide, and only if the appropriate national body (X12N, HCPCS, NUBC, NUCC, etc) cannot offer an alternative solution within the current structure of the implementation guide. This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement, and X12N determines that there is no method to meet the requirement. Only then may the state require the temporary use of the K3 to meet the requirement. X12N will submit the necessary data maintenance and refer the request to the appropriate data content committee.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Fixed Format Information	Data in fixed format agreed upon by sender and receiver. NSF Reference: HA0-05.0	REQUIRED K301 449 M AN 1/80
	CLAIM NOTE (NTE)		To transmit information in a free-form format, if necessary, for or special instruction. Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID- 2400. Information is considered to be overridden when the value in NTE01 in Loop ID-2400 is the same as the value in NTE01 in Loop ID- 2300. The developers of this implementation guide discourage using narrative information within the 837. Trading partners who require narrative information with claims are encouraged to codify that information within the ASC X12 environment. Required when: (1) State regulations mandate information not identified elsewhere within the claim set; or (2) in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.	SITUATIONAL
		Note Reference Code ADD Additional Information CER Certification Narrative DCP Goals, Rehabilitation Potential, or DGN Diagnosis Description PMT Payment TPO Third Party Organization Notes	Code identifying the functional area or purpose for which the note applies.	REQUIRED NTE01 363 O ID 3/3
		Description	A free-form description to clarify the related data elements and their content. NSF Reference: HA0-05.0	REQUIRED NTE02 352 M AN 1/80
	AMBULANCE TRANSPORT INFORMATION (CR1)		To supply information related to the ambulance service rendered to a patient. The CR1 segment in Loop ID-2300 applies to the entire claim unless an exception is reported in the CR1 segment in Loop ID-2400. Required on all claims involving ambulance services.	SITUATIONAL
		Unit or Basis for Measurement Code LB Pound	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Required if needed to justify extra ambulance services.	SITUATIONAL CR101 355 X ID 2/2
		Weight	Numeric value of weight CR102 is the weight of the patient at time of transport. Required if needed to justify extra ambulance services. NSF Reference: GA0-05.0	SITUATIONAL CR102 81 X R 1/10
		Ambulance Transport Code I Initial Trip	Code indicating the type of ambulance transport. NSF Reference: GA0-07.0	REQUIRED CR103 1316 O ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		R Return Trip T Transfer Trip X Round Trip		
		Ambulance Transport Reason Code A Patient was transported to nearest facility for care of symptoms, complaints, or both B Patient was transported for the benefit of a preferred physician C Patient was transported for the nearness of family members D Patient was transported for the care of a specialist or for availability of specialized E Patient Transferred to Rehabilitation Facility	Code indicating the reason for ambulance transport. NSF Reference: GA0-15.0 Can be used to indicate that the patient was transferred to a residential facility.	REQUIRED CR104 1317 O ID 1/1
		Unit or Basis for Measurement Code DH Miles	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	REQUIRED CR105 355 X ID 2/2
		Quantity	Numeric value of quantity CR106 is the distance traveled during transport. NSF Reference: GA0-17.0, FA0-50.0 NSF crosswalk to FA0-50.0 is used only in Medicare payer-to-payer COB situations.	REQUIRED CR106 380 X R 1/15
		Description	A free-form description to clarify the related data elements and their content CR109 is the purpose for the round trip ambulance service. Required if CR103 (Ambulance Transport Code) = "X - Round Trip"; otherwise not used. NSF Reference: GA0-20.0	SITUATIONAL CR109 352 O AN 1/80
		Description	A free-form description to clarify the related data elements and their content. CR110 is the purpose for the usage of a stretcher during ambulance service. Required if needed to justify usage of stretcher. NSF Reference: GA0-21.0	SITUATIONAL CR110 352 O AN 1/80
	SPINAL MANIPULATION SERVICE INFORMATION (CR2)		To supply information related to the chiropractic service rendered to a patient. The CR2 segment in Loop ID-2300 applies to the entire claim unless overridden by the presence of a CR2 segment in Loop ID-2400. Required on all claims involving spinal manipulation. Such claims could originate with chiropractors, physical therapists, DOs, and many other types of health care providers.	SITUATIONAL
		Count	Occurrence counter. CR201 is the number this treatment is in the series. NSF Reference: GC0-07.0	REQUIRED CR201 609 X N0 1/9

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity	Numeric value of quantity. CR202 is the total number of treatments in the series. NSF Reference: GC0-07.0	REQUIRED CR202 380 X R 1/15
		Subluxation Level Code C1 Cervical 1 C2 Cervical 2 C3 Cervical 3 C4 Cervical 4 C5 Cervical 5 C6 Cervical 6 C7 Cervical 7 CO Coccyx IL Ileum L1 Lumbar 1 L2 Lumbar 2 L3 Lumbar 3 L4 Lumbar 4 L5 Lumbar 5 OC Occiput SA Sacrum T1 Thoracic 1 T10 Thoracic 10 T11 Thoracic 11 T12 Thoracic 12 T2 Thoracic 2 T3 Thoracic 3 T4 Thoracic 4 T5 Thoracic 5 T6 Thoracic 6 T7 Thoracic 7 T8 Thoracic 8 T9 Thoracic 9	Code identifying the specific level of subluxation. When both CR203 and CR204 are present, CR203 is the beginning level of subluxation and CR204 is the ending level of subluxation. Required if subluxation is involved in the claim. NSF Reference: GC0-08.0	SITUATIONAL CR203 1367 X ID 2/3
		Subluxation Level Code C1 Cervical 1 C2 Cervical 2 C3 Cervical 3 C4 Cervical 4 C5 Cervical 5 C6 Cervical 6	Code identifying the specific level of subluxation. Required if additional subluxation is involved in claim to indicate a range (i.e., subluxation from CR203 to CR204). NSF Reference: GC0-08.0	SITUATIONAL CR204 1367 O ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		C7 Cervical 7 CO Coccyx IL Ileum L1 Lumbar 1 L2 Lumbar 2 L3 Lumbar 3 L4 Lumbar 4 L5 Lumbar 5 OC Occiput SA Sacrum T1 Thoracic 1 T10 Thoracic 10 T11 Thoracic 11 T12 Thoracic 12 T2 Thoracic 2 T3 Thoracic 3 T4 Thoracic 4 T5 Thoracic 5 T6 Thoracic 6 T7 Thoracic 7 T8 Thoracic 8 T9 Thoracic 9		
		Unit or Basis for Measurement Code DA Days MO Months WK Week YR Years	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	REQUIRED CR205 355 X ID 2/2
		Quantity	Numeric value of quantity. CR206 is the time period involved in the treatment series. NSF Reference: GC0-09.0	REQUIRED CR206 380 X R 1/15
		Quantity	Numeric value of quantity. CR207 is the number of treatments rendered in the month of service. NSF Reference: GC0-10.0	REQUIRED CR207 380 O R 1/15
		Nature of Condition Code A Acute Condition C Chronic Condition D Non-acute E Non-Life Threatening F Routine G Symptomatic	Code indicating the nature of a patient's condition. NSF Reference: GC0-11.0	REQUIRED CR208 1342 O ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		M Acute Manifestation of a Chronic Condition		
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CR209 is complication indicator. A "Y" value indicates a complicated condition; an "N" value indicates an uncomplicated condition. NSF Reference: GC0-13.0	REQUIRED CR209 1073 O ID 1/1
		Description	A free-form description to clarify the related data elements and their content. CR210 is a description of the patient's condition. Used at discretion of submitter. NSF Reference: GC0-14.0	SITUATIONAL CR210 352 O AN 1/80
		Description	A free-form description to clarify the related data elements and their content. CR211 is an additional description of the patient's condition. Used at discretion of submitter. NSF Reference: GC0-14.0	SITUATIONAL CR211 352 O AN 1/80
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CR212 is X-rays availability indicator. A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are not maintained and available for carrier review. NSF Reference: GC0-15.0	REQUIRED CR212 1073 O ID 1/1
	AMBULANCE CERTIFICATION (CRC)		To supply information on conditions. The CRC segment in Loop ID-2300 applies to the entire claim unless overridden by a CRC segment at the service line level in Loop ID-2400 with the same value in CRC01. Required on ambulance claims/encounters, i.e. when CR1 segment is used.	SITUATIONAL
		Code Category 07 Ambulance Certification	Specifies the situation or category to which the code applies. CRC01 qualifies CRC03 through CRC07.	REQUIRED CRC01 1136 M ID 2/2
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.	REQUIRED CRC02 1073 M ID 1/1
		Condition Indicator	Code indicating a condition.	REQUIRED CRC03 1321 M ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		01 Patient was admitted to a hospital	NSF Reference: GA0-06.0	
		02 Patient was bed confined before the ambulance service	NSF Reference: GA0-08.0	
		03 Patient was bed confined after the ambulance service	NSF Reference: GA0-09.0	
		04 Patient was moved by stretcher	NSF Reference: GA0-10.0	
		05 Patient was unconscious or in shock	NSF Reference: GA0-11.0	
		06 Patient was transported in an emergency situation	NSF Reference: GA0-12.0	
		07 Patient had to be physically restrained	NSF Reference: GA0-13.0	
		08 Patient had visible hemorrhaging	NSF Reference: GA0-14.0	
		09 Ambulance service was medically necessary	NSF Reference: GA0-16.0	
		60 Transportation Was To the Nearest Facility	NSF Reference: GA0-24.0	
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC04 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC05 1321 O ID 2/2
		Condition Indicator	Code indicating a condition Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC06 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC07 1321 O ID 2/2
	PATIENT CONDITION INFORMATION VISION (CRC)		To supply information on conditions. Required on vision claims/encounters involving replacement lenses or frames.	SITUATIONAL
		Code Category	Specifies the situation or category to which the code applies. CRC01 qualifies CRC03 through CRC07.	REQUIRED CRC01 1136 M ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		E1 Spectacle Lenses E2 Contact Lenses E3 Spectacle Frames		
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.	REQUIRED CRC02 1073 M ID 1/1
		Condition Indicator L1 General Standard of 20 Degree or .5 Diopter Sphere or Cylinder Change Met L2 Replacement Due to Loss or Theft L3 Replacement Due to Breakage or Damage L4 Replacement Due to Patient Preference L5 Replacement Due to Medical Reason	Code indicating a condition.	REQUIRED CRC03 1321 M ID 2/2
		Condition Indicator	Code indicating a condition. Use codes listed in CRC03. Required if additional condition codes are needed.	SITUATIONAL CRC04 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Use codes listed in CRC03. Required if additional condition codes are needed.	SITUATIONAL CRC05 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Use codes listed in CRC03. Required if additional condition codes are	SITUATIONAL CRC06 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Use codes listed in CRC03. Required if additional condition codes are	SITUATIONAL CRC07 1321 O ID 2/2
	HOMEBOUND INDICATOR (CRC)		To supply information on conditions. Required for Medicare claims/encounters when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient.	SITUATIONAL
		Code Category 75 Functional Limitations	Specifies the situation or category to which the code applies. CRC01 qualifies CRC03 through CRC07.	REQUIRED CRC01 1136 M ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Yes/No Condition or Response Code</p> <p>Y Yes</p>	Code indicating a Yes or No condition or response. CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.	REQUIRED CRC02 1073 M ID 1/1
		<p>Condition Indicator</p> <p>IH Independent at Home</p>	Code indicating a condition. NSF Reference: EA0-50.0	REQUIRED CRC03 1321 M ID 2/2
	HEALTH CARE DIAGNOSIS CODE (HI)		To supply information related to the delivery of health care. Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims). Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.	SITUATIONAL
		<p>Health Care Code Information</p>	To send health care codes and their associated dates, amounts and quantities. With a few exceptions, it is not recommended to put E codes in HI01. E codes may be put in any other HI element using BF as the qualifier. The diagnosis listed in this element is assumed to be the principal diagnosis.	REQUIRED HI01 C022 M
		<p>Code List Qualifier Code</p> <p>BK Principal Diagnosis</p>	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure ICD-9 Codes	REQUIRED HI01 - 1 1270 M ID 1/3
		<p>Industry Code</p>	Code indicating a code from a specific industry code list. NSF Reference: EA0-32.0, GX0-31.0, GU0-12.0	REQUIRED HI01 - 2 1271 M AN 1/30
		<p>Health Care Code Information</p>	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses. Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.	SITUATIONAL HI02 C022 O
		<p>Code List Qualifier Code</p> <p>BF Diagnosis</p>	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure. ICD-9 Codes	REQUIRED HI02 - 1 1270 M ID 1/3
		<p>Industry Code</p>	Code indicating a code from a specific industry code list. NSF Reference: EA0-33.0, GX0-32.0, GU0-13.0	REQUIRED HI02 - 2 1271 M AN 1/30

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Health Care Code Information	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses. Refer to HI01-1(C22-01) and HI01-3(C022-03) for C022-01 and C022-03.	SITUATIONAL HI03 C022 O
		Code List Qualifier Code	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure.	REQUIRED HI03 - 1 1270 M ID 1/3
		BF Diagnosis	ICD-9 Codes	
		Industry Code	Code indicating a code from a specific industry code list. NSF Reference: EA0-34.0, GX0-33.0, GU0-14.0	REQUIRED HI03 - 2 1271 M AN 1/30
		Health Care Code Information	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses. Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.	SITUATIONAL HI04 C022 O
		Code List Qualifier Code	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure.	REQUIRED HI04 - 1 1270 M ID 1/3
		BF Diagnosis	ICD-9 Codes	
		Industry Code	Code indicating a code from a specific industry code list. NSF Reference: EA0-35.0, GX0-34.0, GU0-15.0	REQUIRED HI04 - 2 1271 M AN 1/30
		Health Care Code Information	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses. Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.	SITUATIONAL HI05 C022 O
		Code List Qualifier Code	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure.	REQUIRED HI05 - 1 1270 M ID 1/3
		BF Diagnosis	ICD-9 Codes	
		Industry Code	Code indicating a code from a specific industry code list.	REQUIRED HI05 - 2 1271 M AN 1/30
		Health Care Code Information	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses. Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.	SITUATIONAL HI06 C022 O

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Code List Qualifier Code BF Diagnosis	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure. ICD-9 Codes	REQUIRED HI06 - 1 1270 M ID 1/3
		Industry Code	Code indicating a code from a specific industry code list.	REQUIRED HI06 - 2 1271 M AN 1/30
		Health Care Code Information	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.	SITUATIONAL HI07 C022 O
		Code List Qualifier Code BF Diagnosis	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure. ICD-9 Codes	REQUIRED HI07 - 1 1270 M ID 1/3
		Industry Code	Code indicating a code from a specific industry code list.	REQUIRED HI07 - 2 1271 M AN 1/30
		Health Care Code Information	To send health care codes and their associated dates, amounts and quantities. Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other	SITUATIONAL HI08 C022 O
		Code List Qualifier Code BF Diagnosis	Code identifying a specific industry code list. CODE SOURCE 131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure. ICD-9 Codes	REQUIRED HI08 - 1 1270 M ID 1/3
		Industry Code	Code indicating a code from a specific industry code list.	REQUIRED HI08 - 2 1271 M AN 1/30
	CLAIM PRICING/REPRICING INFORMATION (HCP)		To specify pricing or repricing information about a health care claim or line item. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop. For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim.	SITUATIONAL
		Pricing Methodology 00 Zero Pricing	Code specifying pricing methodology at which the claim or line item has been priced or repriced. Trading partners need to agree on the codes to use in this element. There do not appear to be standard definitions for the code elements. Not Covered Under Contract	REQUIRED HCP01 1473 X ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		01 Priced as Billed at 100% 02 Priced at the Standard Fee Schedule 03 Priced at a Contractual Percentage 04 Bundled Pricing 05 Peer Review Pricing 07 Flat Rate Pricing 08 Combination Pricing 09 Maternity Pricing 10 Other Pricing 11 Lower of Cost 12 Ratio of Cost 13 Cost Reimbursed 14 Adjustment Pricing		
		Monetary Amount	Monetary amount. HCP02 is the allowed amount. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	REQUIRED HCP02 782 O R 1/18
		Monetary Amount	Monetary amount. HCP03 is the savings amount. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP03 782 O R 1/18
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. HCP04 is the repricing organization identification number. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP04 127 O AN 1/30
		Rate	Rate expressed in the standard monetary denomination for the currency specified. HCP05 is the pricing rate associated with per diem or flat rate repricing. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP05 118 O R 1/9
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. HCP06 is the approved DRG code. HCP06, HCP07, HCP08, HCP10, and HCP12 are fields that will contain different values from the original submitted values. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP06 127 O AN 1/30
		Monetary Amount	Monetary amount. HCP07 is the approved DRG amount. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP07 782 O R 1/18
		Reject Reason Code	Code assigned by issuer to identify reason for rejection. HCP13 is the rejection message returned from the third party organization. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP13 901 X ID 2/2
		T1 Cannot Identify Provider as TPO (Third Party Organization) Participant		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		T2 Cannot Identify Payer as TPO (Third Party Organization) Participant T3 Cannot Identify Insured as TPO (Third Party Organization) Participant T4 Payer Name or Identifier Missing T5 Certification Information Missing T6 Claim does not contain enough information		
		Policy Compliance Code 1 Procedure Followed (Compliance) 2 Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 Not Medically Necessary (Non-Compliance) 4 Not Followed Other (Non-Compliance Other) 5 Emergency Admit to Non-Network Hospital	Code specifying policy compliance. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP14 1526 O ID 1/2
		Exception Code 1 Non-Network Professional Provider in Network Hospital 2 Emergency Care 3 Services or Specialist not in Network 4 Out-of-Service Area 5 State Mandates 6 Other	Code specifying the exception reason for consideration of out-of-network health care services. HCP15 is the exception reason generated by a third party organization. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP15 1527 O ID 1/2
2305 HOME HEALTH CARE PLAN INFORMATION	HOME HEALTH CARE PLAN INFORMATION (CR7)		To supply information related to the home health care plan of treatment and services. Required on home health claims/encounters that involve billing/reporting home health visits.	SITUATIONAL
		Discipline Type Code AI Home Health Aide MS Medical Social Worker OT Occupational Therapy PT Physical Therapy SN Skilled Nursing ST Speech Therapy	Code indicating disciplines ordered by a physician.	REQUIRED CR701 921 M ID 2/2
		Number	A generic number. CR702 is the total visits on this bill rendered prior to the recertification "to" date.	REQUIRED CR702 1470 M NO 1/9
		Number	A generic number. CR703 is the total visits projected during this certification period.	REQUIRED CR703 1470 M NO 1/9

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	HEALTH CARE SERVICES DELIVERY (HSD)		To specify the delivery pattern of health care services. Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment. The HSD segment is used to specify the delivery pattern of the health care services. This is how it is used: HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit". Between HSD02 and HSD03 verbally insert a "per every." HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days." Between HSD04 and HSD05 verbally insert a "for." HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days." The total message reads: HSD*VS*1*DA*3*7*21- = "One visit per every three days for 21 days." Another similar data string of HSD*VS*2*DA*4*7*20- = Two visits per every four days for 20 days. An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1*****SX'D- means "1 visit on Wednesday and	SITUATIONAL
		Quantity Qualifier VS Visits	Code specifying the type of quantity. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD01 673 X ID 2/2
		Quantity	Numeric value of quantity. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD02 380 X R 1/15
		Unit or Basis for Measurement Code MO Months DA Days Q1 Quarter (Time) WK Week	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Required if the order/prescription for the service contains the data. Month	SITUATIONAL HSD03 355 O ID 2/2
		Sample Selection Modulus	To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD04 1167 O R 1/6
		Time Period Qualifier 7 Day 35 Week	Code defining periods. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD05 615 X ID 1/2
		Number of Periods	Total number of periods. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD06 616 O N0 1/3
		Ship/Delivery or Calendar Pattern Code 1 1st Week of the Month 2 2nd Week of the Month 3 3rd Week of the Month	Code which specifies the routine shipments, deliveries, or calendar pattern. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD07 678 O ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		4 4th Week of the Month 5 5th Week of the Month 6 1st & 3rd Weeks of the Month 7 2nd & 4th Weeks of the Month A Monday through Friday B Monday through Saturday C Monday through Sunday D Monday E Tuesday F Wednesday G Thursday H Friday J Saturday K Sunday L Monday through Thursday N As Directed O Daily Mon. through Fri. S Once Anytime Mon. through Fri. SA Sunday, Monday, Thursday, Friday, SB Tuesday through Saturday SC Sunday, Wednesday, Thursday, Friday, SD Monday, Wednesday, Thursday, Friday, SG Tuesday through Friday SL Monday, Tuesday and Thursday SP Monday, Tuesday and Friday SX Wednesday and Thursday SY Monday, Wednesday and Thursday SZ Tuesday, Thursday and Friday W Whenever Necessary		
		Ship/Delivery Pattern Time Code D A.M. E P.M. F As Directed	Code which specifies the time for routine shipments or deliveries. Required if the order/prescription for the service contains the data.	SITUATIONAL HSD08 679 O ID 1/1
2310A REFERRING PROVIDER NAME	REFERRING PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101. When there is only one referral on the claim, use code "DN – Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required if claim involved a referral. When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Entity Identifier Code DN Referring Provider P3 Primary Care Provider	Code identifying an organizational entity, a physical location, property or an individual. The entity identifier in NM101 applies to all segments in this Loop ID-2310. Use on first iteration of this loop. Use if loop is used only once. Use only if loop is used twice. Use only on second iteration of this loop.	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. NSF Reference: EA0-24.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. Required if NM102=1 (person). NSF Reference: EA0-25.0	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: EA0-26.0	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration Provider Identifier	Code designating the system/method of code structure used for Identification Code (67). Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	SITUATIONAL NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code. Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known. NSF Reference: EA0-20.0	SITUATIONAL NM109 67 X AN 2/80
	REFERRING PROVIDER SPECIALTY INFORMATION (PRV)		To specify the identifying characteristics of a provider. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01. Required if required under provider-payer contract. PRV02 qualifies PRV03.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. NSF Reference: EA0-20.0	REQUIRED REF02 127 X AN 1/30
2310B RENDERING PROVIDER NAME	RENDERING PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenans) was used, that person should be entered here.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. The entity identifier in NM101 applies to all segments in this Loop ID-2310. 82 Rendering Provider	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103. 1 Person 2 Non-Person Entity	REQUIRED NM102 1065 M ID 1/1
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: FB1-140.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. Required if NM102=1 (person). NSF Reference: FB1-15.0	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: FB1-16.0	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims. NSF Reference: FA0-57.0	REQUIRED NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. FA0-58.0 crosswalk is only used in Medicare COB payer-to-payer claims. NSF Reference: FA0-23.0, FA0-58.0	REQUIRED NM109 67 X AN 2/80
	RENDERING PROVIDER SPECIALTY INFORMATION (PRV)		To specify the identifying characteristics of a provider. The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01. PRV02 qualifies PRV03.	SITUATIONAL
		Provider Code	Code identifying the type of provider.	REQUIRED PRV01 1221 M ID 1/3
		Reference Identification Qualifier	Code qualifying the Reference Identification. ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site: http://www.wpc-edi.com . This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.	REQUIRED PRV02 128 M ID 2/3
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: FA0-37.0	REQUIRED PRV03 127 M AN 1/30
	ADDITIONAL RENDERING PROVIDER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	RENDERING PROVIDER SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Reference Identification Qualifier</p> <p>0B State License Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number 1G Provider UPIN Number 1H CHAMPUS Identification Number EI Employer's Identification Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification</p> <p>SY Social Security Number</p> <p>X5 State Industrial Accident Provider Number</p>	<p>Code qualifying the Reference Identification. NSF Reference: FA0-57.0</p> <p>The social security number may not be used for Medicare.</p>	REQUIRED REF01 128 M ID 2/3
		<p>Reference Identification</p>	<p>Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: FA0-58.0</p>	REQUIRED REF02 127 X AN 1/30
2310C PURCHASED SERVICE PROVIDER NAME	PURCHASED SERVICE PROVIDER NAME (NM1)		<p>To supply the full name of an individual or organizational entity. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules. Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.</p>	SITUATIONAL
		<p>Entity Identifier Code</p> <p>QB Purchase Service Provider</p>	<p>Code identifying an organizational entity, a physical location, property or an individual.</p>	REQUIRED NM101 98 M ID 2/3
		<p>Entity Type Qualifier</p> <p>1 Person 2 Non-Person Entity</p>	<p>Code qualifying the type of entity. NM102 qualifies NM103.</p>	REQUIRED NM102 1065 M ID 1/1
		<p>Identification Code Qualifier</p> <p>24 Employer's Identification Number 34 Social Security Number</p>	<p>Code designating the system/method of code structure used for Identification Code (67). Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.</p>	SITUATIONAL NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	SERVICE FACILITY LOCATION (NM1)		To supply the full name of an individual or organizational entity. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops. Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05-1 should indicate that the service occurred in the patient's home. NSF Reference: FBO-11.0	SITUATIONAL
		Entity Identifier Code 77 Service Location FA Facility LI Independent Lab TL Testing Laboratory	Code identifying an organizational entity, a physical location, property or an individual. Use when other codes in this element do not apply.	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 except when service was rendered in the patient's home. NSF Reference: EAO-39.0	SITUATIONAL NM103 1035 O AN 1/35
		Identification Code Qualifier 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67). Required if either Employer's Identification/Social Security Number or National Provider Identifier is known. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	SITUATIONAL NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Identification Code	Code identifying a party or other code. Required if either Employer's Identification/Social Security Number or National Provider Identifier is known. NSF Reference: EA1-04.0, EAP-53.0	SITUATIONAL NM109 67 X AN 2/80
2310D SERVICE FACILITY LOCATION	ADDITIONAL SERVICE FACILITY LOCATION NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	SERVICE FACILITY LOCATION ADDRESS (N3)		To specify the location of the named party. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80").	SITUATIONAL
		Address Information	Address information. NSF Reference: EA1-06.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. Required if a second address line exists. NSF Reference: EA1-07.0	SITUATIONAL N302 166 O AN 1/55
	SERVICE FACILITY LOCATION CITY/STATE/ZIP (N4)		To specify the geographic place of the named party. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.	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. NSF Reference: EA1-08.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: EA1-09.0	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. NSF Reference: EA1-10.0	REQUIRED N403 116 O ID 3/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Country Code	Code identifying the country. Required if the address is out of the U.S. CODE SOURCE 5: Countries, Currencies and Funds.	SITUATIONAL N404 26 O ID 2/3
	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.	SITUATIONAL
		Reference Identification Qualifier 0B State License Number 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 G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification TJ Federal Taxpayer's Identification Number X4 Clinical Laboratory Improvement Amendment Number X5 State Industrial Accident Provider 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. NSF Reference: EA1-04.0, EA0-53.0	REQUIRED REF02 127 X AN 1/30
2310E SUPERVISING PROVIDER NAME	SUPERVISING PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101. Required when the rendering provider is supervised by a physician. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.	SITUATIONAL
		Entity Identifier Code DQ Supervising Physician	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		1 Person		
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: EA1-18.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: EA1-19.0	REQUIRED NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: EA1-20.0	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). Required if either Employer's Identification/Social Security Number or National provider Identifier is known.	SITUATIONAL NM108 66 X ID 1/2
		24 Employer's Identification Number		
		34 Social Security Number	The social security number may not be used for Medicare.	
		XX Health Care Financing Administration National Provider Identifier	Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. Required if either Employer's Identification/Social Security Number or National Provider Identifier is known. NSF Reference: EA1-16.0	SITUATIONAL NM109 67 X AN 2/80
	ADDITIONAL SUPERVISING PROVIDER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name.	REQUIRED N201 93 M AN 1/60
	SUPERVISING PROVIDER SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/9 in this loop.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Reference Identification Qualifier</p> <p>0B State License Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number 1G Provider UPIN Number 1H CHAMPUS Identification Number EI Employer's Identification Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification ..</p> <p>SY Social Security Number</p> <p>X5 State Industrial Accident Provider Number</p>	<p>Code qualifying the Reference Identification.</p> <p>The social security number may not be used for Medicare.</p>	<p>REQUIRED REF01 128 M ID 2/3</p>
		<p>Reference Identification</p>	<p>Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: EA1-16.0</p>	<p>REQUIRED REF02 127 X AN 1/30</p>
2320 OTHER SUBSCRIBER INFORMATION	OTHER SUBSCRIBER INFORMATION (SBR)		<p>To record information specific to the primary insured and the insurance carrier for that insured. Required if other payers are known to potentially be involved in paying on this claim. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 Loop again with it's respective 2330 Loops.</p>	<p>SITUATIONAL</p>
		<p>Payer Responsibility Sequence Number Code</p> <p>P Primary S Secondary T Tertiary</p>	<p>Code identifying the insurance carrier's level of responsibility for a payment of a claim. NSF Reference: DA0-02.0, DA1-02.0, DA2-02.0</p>	<p>REQUIRED SBR01 1138 M ID 1/1</p>
		<p>Individual Relationship Code</p> <p>01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece</p>	<p>Code indicating the relationship between two individuals or entities. SBR02 specifies the relationship to the person insured. NSF Reference: DA0-17.0</p>	<p>REQUIRED SBR02 1069 O ID 2/2</p>

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner G8 Other Relationship		
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SBR03 is policy or group number. Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109). NSF Reference: DA0-10.0	SITUATIONAL SBR03 127 O AN 1/30
		Name	Free-form name. SBR04 is plan name. Required if the subscriber's payer identification includes a Group or Plan Name. NSF Reference: DA0-11.0	SITUATIONAL SBR04 93 O AN 1/60
		Insurance Type Code AP Auto Insurance Policy C1 Commercial CP Medicare Conditionally Primary GP Group Policy HM Health Maintenance Organization (HMO) IP Individual Policy LD Long Term Policy LT Litigation MB Medicare Part B MC Medicaid MI Medigap Part B MP Medicare Primary OT Other	Code identifying the type of insurance policy within a specific insurance program. NSF Reference: DA0-06.0	REQUIRED SBR05 1336 O ID 1/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		PP Personal Payment (Cash - No Insurance) SP Supplemental Policy		
		Claim Filing Indicator Code 09 Self-pay 10 Central Certification 11 Other Non-Federal Programs 12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Risk AM Automobile Medical BL Blue Cross/Blue Shield CH Champus CI Commercial Insurance Co. DS Disability HM Health Maintenance Organization LI Liability LM Liability Medical MB Medicare Part B MC Medicaid OF Other Federal Program TV Title V VA Veteran Administration Plan WC Workers' Compensation Health Claim ZZ Mutually Defined	Code identifying type of claim. Required prior to mandated used of PlanID. Not used after PlanID is mandated. NSF Reference: DA0-05.0 NSF Reference: CA0-23.0 (K), DA0-05.0 (K) Refers to Veterans Affairs Plan. Unknown.	SITUATIONAL SBR09 1032 O ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	CLAIM LEVEL ADJUSTMENTS (CAS)		To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid. Submitters should use this CAS segment to report prior payers' claim level adjustments that cause the amount paid to differ from the amount originally charged. Only one Group Code is allowed per CAS. If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment again. Codes and associated amounts should come from 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information. To locate the claim adjustment group codes (CAS01) and claim adjustment reason codes (CAS02, 05, 08, 11, 14, and 17) see the Washington Publishing Company web site. Follow the buttons to Code Lists - Claim Adjustment Reason Codes. There several NSF fields which are not directly crosswalked from the 837 to NSF, particularly with respect to payer-to-payer COB situations. Below is a list of some of these NSF fields and some suggestions regarding how to handle them in the 837. Provider Adjustment Amt (DA3-25.0). This would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level. Beneficiary liability amount (FA0-53.0). This amount would equal the sum of all the adjustment amounts in CAS03, 06, 09, 12, 15, and 18 at both the claim and the line level when CAS01 = PR (patient responsibility). Amount paid to Provider (DA1-33.0). This would be calculated through the use of the CAS codes. Balance bill limit charge (FA0-54.0). This would equal any CAS adjustment where CAS01=CO and one of the adjustment reason code elements equaled "45". Beneficiary Adjustment Amt (DA3-26.0). Amount paid to beneficiary (DA1-30.0). The amount paid to the beneficiary is indicated by the use of CAS code "100 - Payment made to patient/insured/responsible party". Original Paid Amount (DA3-28.0): The original paid amount can be calculated from the original COB claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.	SITUATIONAL
		Claim Adjustment Group Code CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	Code identifying the general category of payment adjustment.	REQUIRED CAS01 1033 M ID 1/2
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code. NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-16.0, DA1-30.0	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. NSF Reference: D1-09.0, DA1-10.0, DA1-11.0, DA1-12.0, DA1-13.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0	REQUIRED CAS03 782 M R 1/18
		Quantity	Numeric value of quantity. CAS04 is the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS04 380 O R 1/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Use as needed to show payer adjustment. CODE SOURCE 139: Claim Adjustment Reason Code. NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-17.0, DA1-30.0	SITUATIONAL CAS05 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS06 is the amount of the adjustment. Use as needed to show payer adjustment. NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0	SITUATIONAL CAS06 782 X R 1/18
		Quantity	Numeric value of quantity. CAS07 is the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS07 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Use as needed to show payer adjustment. CODE SOURCE 139: Claim Adjustment Reason Code. NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0, DA1-18.0	SITUATIONAL CAS08 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS09 is the amount of the adjustment. Use as needed to show payer adjustment. NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA133.0, DA3-25.0, DA3-26.0	SITUATIONAL CAS09 782 X R 1/18
		Quantity	Numeric value of quantity. CAS10 is the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS10 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Use as needed to show payer adjustment. CODE SOURCE 139: Claim Adjustment Reason Code. NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0	SITUATIONAL CAS11 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS12 is the amount of the adjustment. Use as needed to show payer adjustment. NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0	SITUATIONAL CAS12 782 X R 1/18
		Quantity	Numeric value of quantity. CAS13 is the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS13 380 X R 1/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Use as needed to show payer adjustment. CODE SOURCE 139: Claim Adjustment Reason Code. NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0	SITUATIONAL CAS14 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS15 is the amount of the adjustment. Use as needed to show payer adjustment. NSF Reference: DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0	SITUATIONAL CAS15 782 X R 1/18
		Quantity	Numeric value of quantity. CAS16 is the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS16 380 X R 1/15
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. Use as needed to show payer adjustment. CODE SOURCE 139: Claim Adjustment Reason Code. NSF Reference: DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0, DA1-30.0	SITUATIONAL CAS17 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS18 is the amount of the adjustment. Use as needed to show payer adjustment. NSF Reference: DA3-05.0, DA3-07.0, D3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA1-30.0, DA1-33.0, DA3-25.0, DA3-26.0	SITUATIONAL CAS18 782 X R 1/18
		Quantity	Numeric value of quantity. CAS19 is the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS19 380 X R 1/15
	COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT		To indicate the total monetary amount. Required if claim has been adjudicated by payer identified in this loop. It is acceptable to show "0" amount paid.	SITUATIONAL
		Amount Qualifier Code D Payor Amount Paid	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from CLP04 in 835 when doing COB.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) APPROVED AMOUNT (AMT)		To indicate the total monetary amount. Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available. The approved amount equals the amount for the total claim that was approved by the payer sending this 837 to another payer.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Amount Qualifier Code</p> <p>AAE Approved Amount</p>	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. NSF Reference: DA1-37.0	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) ALLOWED AMOUNT (AMT)		To indicate the total monetary amount. Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available. The allowed amount equals the amount for the total claim that was allowed by the payer sending this 837 to another payer.	SITUATIONAL
		<p>Amount Qualifier Code</p> <p>B6 Allowed – Actual</p>	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) PATIENT RESPONSIBILITY AMOUNT (AMT)		To indicate the total monetary amount. Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1).	SITUATIONAL
		<p>Amount Qualifier Code</p> <p>F2 Patient Responsibility – Actual</p>	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from CLP05 in 835 when doing COB.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) COVERED AMOUNT (AMT)		To indicate the total monetary amount. Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available. The covered amount equals the amount for the total claim that was covered by the payer sending this 837 to another payer.	SITUATIONAL
		Amount Qualifier Code	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		AU Coverage Amount		
		Monetary Amount	Monetary amount. This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = AU.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) DISCOUNT AMOUNT (AMT)		To indicate the total monetary amount. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.	SITUATIONAL
		Amount Qualifier Code D8 Discount Amount	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = D8.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) PER DAY LIMIT AMOUNT (AMT)		To indicate the total monetary amount. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.	SITUATIONAL
		Amount Qualifier Code DY Per Day Limit	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = DY.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) PATIENT PAID AMOUNT (AMT)		To indicate the total monetary amount. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results. The amount carried in this segment is the total amount of money paid by the payer to the patient (rather than to the provider) on this claim.	SITUATIONAL
		Amount Qualifier Code F5 Patient Amount Paid	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = F5.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) TAX AMOUNT (AMT)		To indicate the total monetary amount. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Amount Qualifier Code</p> <p>T Tax</p>	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from AMT in 835 (Loop CLP, position 062) when AMT01 = T.	REQUIRED AMT02 782 M R 1/18
	COORDINATION OF BENEFITS (COB) TOTAL CLAIM BEFORE TAXES AMOUNT (AMT)		To indicate the total monetary amount. Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.	SITUATIONAL
		<p>Amount Qualifier Code</p> <p>T2 Total Claim Before Taxes</p>	Code to qualify amount.	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. This is a crosswalk from MT in 835 (Loop CLP, position 062) when AMT01 = T2.	REQUIRED AMT02 782 M R 1/18
	SUBSCRIBER DEMOGRAPHIC INFORMATION (DMG)		To supply demographic information. Required when 2330A NM102 = 1 (person).	SITUATIONAL
		<p>Date Time Period Format Qualifier</p> <p>D8 Date Expressed in Format CCYYMMDD</p>	Code indicating the date format, time format, or date and time format.	REQUIRED DMG01 1250 X ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. DMG02 is the date of birth. NSF Reference: DA0-24.0	REQUIRED DMG02 1251 X AN 1/35
		<p>Gender Code</p> <p>F Female M Male U Unknown</p>	Code indicating the sex of the individual. NSF Reference: DA0-23.0	REQUIRED DMG03 1068 O ID 1/1
	OTHER INSURANCE COVERAGE INFORMATION - (OI)		To specify information associated with other health insurance coverage. All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Yes/No Condition or Response Code</p> <p>N No Y Yes</p>	Code indicating a Yes or No condition or response. OI03 is the assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. This is a crosswalk from CLM08 when doing COB. NSF Reference: DA0-15.0	REQUIRED OI03 1073 O ID 1/1
		<p>Patient Signature Source Code</p> <p>B Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file C Signed HCFA-1500 Claim Form on file M Signed signature authorization form for HCFA-1500 Claim Form block 13 on file P Signature generated by provider because the patient was not physically present for services S Signed signature authorization form for HCFA-1500 Claim Form block 12 on file</p>	Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider. Required except in cases where "N" is used in OI06. This is a crosswalk from CLM10 when doing COB. NSF Reference: DA0-16.0	SITUATIONAL OI04 1351 O ID 1/1
		<p>Release of Information Code</p> <p>A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes M The Provider has Limited or Restricted Ability to Release Data Related to a Claim N No, Provider is Not Allowed to Release Data O On file at Payor or at Plan Sponsor Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim</p>	Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations. This is a crosswalk from CLM09 when doing COB.	REQUIRED OI06 1363 O ID 1/1
	MEDICARE OUTPATIENT ADJUDICATION INFORMATION (MOA)		To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting. Required if returned in the electronic remittance advice (835).	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Percent	Percentage expressed as a decimal. MOA01 is the reimbursement rate. Required if returned in the electronic remittance advice (835).	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. Required if returned in the electronic remittance advice (835).	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. See Code Source 411. Required if returned in the electronic remittance advice (835). NSF Reference: 2554 DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0	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. See Code Source 411. Required if returned in the electronic remittance advice (835). NSF Reference: 2554 DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0	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. MOA04 is the Remittance Remark Code. See Code Source 411. Required if returned in the electronic remittance advice (835). NSF Reference: 2554 DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0	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. MOA04 is the Remittance Remark Code. See Code Source 411. Required if returned in the electronic remittance advice (835). NSF Reference: 2554 DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0	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. MOA04 is the Remittance Remark Code. See Code Source 411. Required if returned in the electronic remittance advice (835). NSF Reference: 2554 DA3-18.0, DA3-19.0, DA3-20.0, DA3-21.0, DA3-22.0	SITUATIONAL MOA07 127 O AN 1/30
		Monetary Amount	Monetary amount. MOA08 is the End Stage Renal Disease (ESRD) payment amount. Required if returned in the electronic remittance advice (835).	SITUATIONAL MOA08 782 O R 1/18

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Monetary Amount	Monetary amount. MOA09 is the professional component amount billed but not payable. Required if returned in the electronic remittance advice (835).	SITUATIONAL MOA09 782 O R 1/18
2330A OTHER SUBSCRIBER NAME	OTHER SUBSCRIBER NAME (NM1)		To supply the full name of an individual or organizational entity. Submitters are required to send information on all known other subscribers in Loop ID-2330. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		IL Insured or Subscriber		
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		1 Person 2 Non-Person Entity		
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: DA0-19.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. Required if NM102=1 (person). NSF Reference: DA0-20.0	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: DA0-21.0	SITUATIONAL NM105 1037 O AN 1/25
Name Suffix	Suffix to individual name. Required if known. DA0-22.0 Required if known. Examples: I, II, III, IV, Jr, Sr	SITUATIONAL NM107 1039 O AN 1/10		
Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67)	REQUIRED NM108 66 X ID 1/2		
MI Member Identification Number	The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI - Member Identification Number to convey the following terms Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.			

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		ZZ Mutually Defined	The value 'ZZ', when used in this data element shall be defined as "HIPAA Individual Identifier" once this identifier has been adopted. Under the Health Insurance Portability and Accountability Act of 1996, the Secretary of the Department of Health and Human Services must adopt a standard individual identifier for use in this transaction.	
		Identification Code	Code identifying a party or other code. NSF Reference: DA0-18.0	REQUIRED NM109 67 X AN 2/80
	ADDITIONAL OTHER SUBSCRIBER NAME INFORMATION - (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name	REQUIRED N201 93 M AN 1/60
	OTHER SUBSCRIBER ADDRESS - (N3)		To specify the location of the named party. Required when information is available.	SITUATIONAL
		Address Information	Address information. NSF Reference: DA2-04.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. NSF Reference: DA2-05.0 Required if a second address line exists.	SITUATIONAL N302 166 O AN 1/55
	OTHER SUBSCRIBER CITY/STATE/ZIP CODE - (N4)		To specify the geographic place of the named party. Required when information is available.	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. NSF Reference: DA2-06.0	SITUATIONAL N401 19 O AN 2/30
		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. Required when information is available. CODE SOURCE 22: States and Outlying Areas of the U.S. NSF Reference: DA2-07.0	SITUATIONAL N402 156 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Postal Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Required when information is available. CODE SOURCE: 51 ZIP Code NSF Reference: DA2-08.0	SITUATIONAL N403 116 O ID 3/15
		Country Code	Code identifying the country. Required if the address is out of the U.S. CODE SOURCE 5: Countries, Currencies and Funds	SITUATIONAL N404 26 O ID 2/3
	OTHER SUBSCRIBER SECONDARY IDENTIFICATION - (REF)		To specify identifying information. Required if additional identification numbers are necessary to adjudicate the claim/encounter.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		1W Member Identification Number 23 Client Number	This code is intended to be used only in claims submitted to the Indian Health Service/Contract Health Services (IHC/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.	
		IG Insurance Policy Number SY Social Security Number	The social security number may not be used for Medicare.	
		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
2330B OTHER PAYER NAME	OTHER PAYER NAME (NM1)		To supply the full name of an individual or organizational entity. Submitters are required to send all known information on other payers in this Loop ID-2330. This 2330 loop is required when Loop ID-2320 - Other Subscriber Information is used. Otherwise, this loop is not used.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		PR Payer		
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		2 Non-Person Entity		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: DA0-09.0	REQUIRED NM103 1035 O AN 1/35
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). CODE SOURCE 540: Health Care Financing Administration National PlanID	REQUIRED NM108 66 X ID 1/2
		PI Payor Identification XV Health Care Financing Administration National PlanID	Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. This number must be identical to SVD01 (Loop ID-2430) for COB. NSF Reference: DA0-07.0	REQUIRED NM109 67 X AN 2/80
	ADDITIONAL OTHER PAYER NAME INFORMATION - (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name	REQUIRED N201 93 M AN 1/60
	OTHER PAYER CONTACT INFORMATION - (PER)		To identify a person or office to whom administrative communications should be directed. This segment is used only in payer-to-payer COB situations. This segment may be completed by a payer who has adjudicated the claim and is passing it on to a secondary payer. It is not completed by submitting providers. 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. There are 2 repetitions of the PER segment to allow for six possible combination of communication numbers including extensions.	SITUATIONAL
		Contact Function Code	Code identifying the major duty or responsibility of the person or group named	REQUIRED PER01 366 M ID 2/2
		IC Information Contact		
		Name	Free-form name.	REQUIRED PER02 93 O AN 1/60

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail FX Facsimile TE Telephone	Code identifying the type of communication number.	REQUIRED PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable.	REQUIRED PER04 364 X AN 1/80
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone	Code identifying the type of communication number. Used at the discretion of the submitter.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Used at the discretion of the submitter.	SITUATIONAL PER06 364 X AN 1/80
		Communication Number Qualifier ED Electronic Data Interchange Access EM Electronic Mail EX Telephone Extension FX Facsimile TE Telephone	Code identifying the type of communication number. Used at the discretion of the submitter.	SITUATIONAL PER07 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Used at the discretion of the submitter.	SITUATIONAL PER08 364 X AN 1/80
	CLAIM ADJUDICATION DATE - (DTP)		To specify any or all of a date, a time, or a time period. This segment is required when the payer identified in this iteration of the 2330 loop has previously adjudicated the claim and Loop-ID 2430 (Line Adjudication Information) is not used.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Date/Time Qualifier</p> <p>573 Date Claim Paid</p>	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		<p>Date Time Period Format Qualifier</p> <p>D8 Date Expressed in Format CCYYMMDD</p>	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		<p>Date Time Period</p>	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: DA1-27.0	REQUIRED DTP03 1251 M AN 1/35
	OTHER PAYER SECONDARY IDENTIFIER (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop. Used when it is necessary to identify the 'other' payer's claim number in a payer-to-payer COB situation (use code F8). Code F8 is not used by providers. There can only be a maximum of three REF segments in any one iteration of the 2330 loop.	SITUATIONAL
		<p>Reference Identification Qualifier</p> <p>2U Payer Identification Number</p> <p>F8 Original Reference Number</p> <p>FY Claim Office Number</p> <p>NF National Association of Insurance Commissioners (NAIC) Code</p> <p>Federal Taxpayer's Identification Number</p>	<p>Code qualifying the Reference Identification</p> <p>Use to indicate the payer's claim number for this claim for the payer identified in this iteration of the 2330B loop.</p> <p>CODE SOURCE 245: National Association of Insurance</p>	REQUIRED REF01 128 M ID 2/3
		<p>Reference Identification</p>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. The DA3-29.0 crosswalk is only used in payer-to-payer COB situations. NSF Reference: DA3-29.0	REQUIRED REF02 127 X AN 1/30
	OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER (REF)		To specify identifying information. Used when the payer identified in this loop has given a prior authorization or referral number to this claim. This element is primarily used in payer-to-payer COB situations. There can only be a maximum of three REF segments in any one iteration of the 2330 loop.	Optional

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Reference Identification Qualifier</p> <p>9F Referral Number G1 Prior Authorization Number</p>	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		<p>Reference Identification</p>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	REQUIRED REF02 127 X AN 1/30
	OTHER PAYER CLAIM ADJUSTMENT INDICATOR - (REF)		To specify identifying information. Used only in payer-to-payer COB. In that situation, the destination payer is secondary to the payer identified in this loop. Providers/other submitters do not use this segment. Required when the payer identified in this loop has previously paid this claim and has indicated so to the destination payer. In this case the payer identified in this loop has readjudicated the claim and is sending the adjusted payment information to the destination payer. This REF segment is used to indicate that this claim is an adjustment of a previously adjudicated claim. If the claim has not been previously adjudicated this REF is not used. There can only be a maximum of three REF segments in any one iteration of the 2330 loop.	SITUATIONAL
		<p>Reference Identification Qualifier</p> <p>T4 Signal Code</p>	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		<p>Reference Identification</p>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. Allowable values are "Y" indicating that the payer in this loop has previously adjudicated this claim and sent a record of that adjudication to the destination payer identified in the 2010BB loop. The claim being transmitted in this iteration of the 2300 loop is a readjudicated version of that claim. NSF Reference: DA3-24.0	REQUIRED REF02 127 X AN 1/30
2330C OTHER PAYER PATIENT INFORMATION	OTHER PAYER PATIENT INFORMATION - (REF)		To supply the full name of an individual or organizational entity. Required when it is necessary, in COB situations, to send one or more payer-specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330 loop are those patient ID's which belong to non-destination (COB) payers. The patient ID(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling non-destination payer patient identifiers and other COB elements. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required"	SITUATIONAL
		<p>Entity Identifier Code</p> <p>QC Patient</p>	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		<p>Entity Type Qualifier</p> <p>1 Person</p>	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
		Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67).	REQUIRED NM108 66 X ID 1/2
		MI Member Identification Number	The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology to convey the same number. Therefore the 837 Professional Workgroup recommends using MI – Member Identification Number to convey the following terms Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.	
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80
	OTHER PAYER PATIENT IDENTIFICATION - (NM1)		To specify identifying information. Used when a COB payer (listed in 2330B loop) has one or more proprietary patient identification numbers for this claim. The patient (name, DOB, etc) is identified in the 2010BA or 2010CA loop.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		1W Member Identification Number	If NM108 = M1 do not use this code.	
		23 Client Number	This code is intended to be used only in claims submitted to the Indian Health Service/Contract. Health Services (IHC/CHS) Fiscal Intermediary for the purpose of reporting the Health Record Number.	
		IG Insurance Policy Number		
		SY Social Security Number	Do not use for Medicare.	
		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
2330D OTHER PAYER REFERRING PROVIDER	OTHER PAYER REFERRING PROVIDER - (REF)		To supply the full name of an individual or organizational entity. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		DN Referring Provider	Use on first iteration of this loop. Use if loop is used only once.	
		P3 Primary Care Provider	Use only if loop is used twice. Use only on second iteration of this loop.	
		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 NM103 1035 O AN 1/35
	OTHER PAYER REFERRING PROVIDER IDENTIFICATION - (NM1)		To specify identifying information. Non-destination (COB) payers' provider identification number(s).	SITUATIONAL
		Reference Identification Qualifier 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number E1 Employer's Identification Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification ..	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
2330E OTHER PAYER RENDERING PROVIDER	OTHER PAYER RENDERING PROVIDER - (NM1)		To supply the full name of an individual or organizational entity. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.	SITUATIONAL
		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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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 NM103 1035 O AN 1/35
	OTHER PAYER RENDERING PROVIDER SECONDARY IDENTIFICATION - (REF)		To specify identifying information. Non-destination (COB) payers' provider identification number(s).	SITUATIONAL
		Reference Identification Qualifier 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number E1 Employer's Identification Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification	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. Other Payer Rendering Provider Secondary Identification.	REQUIRED REF02 127 X AN 1/30
2330F OTHER PAYER PURCHASED SERVICE PROVIDER	OTHER PAYER PURCHASED SERVICE PROVIDER (NM1)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.	SITUATIONAL
		Entity Identifier Code QB Purchase Service 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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Last or Organization Name	Individual last name or organizational name.	REQUIRED NM103 1035 O AN 1/35
	OTHER PAYER PURCHASED SERVICE PROVIDER IDENTIFICATION - (REF)		To specify identifying information Non-destination (COB) payers' provider identification number(s).	REQUIRED
		Reference Identification Qualifier 1A Blue Cross Provider Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number EI Employer's Identification Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification	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. Other Payer Purchased Service Provider Identification.	REQUIRED REF02 127 X AN 1/30
2330G OTHER PAYER SERVICE FACILITY LOCATION	OTHER PAYER SERVICE FACILITY LOCATION (NM1)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.	SITUATIONAL
		Entity Identifier Code 77 Service Location FA Facility LI Independent Lab TL Testing Laboratory	Code identifying an organizational entity, a physical location, property or an individual. Use when other codes in this element do not apply.	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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Last or Organization Name	Individual last name or organizational name	REQUIRED NM103 1035 O AN 1/35
	OTHER PAYER SERVICE FACILITY LOCATION IDENTIFICATION (REF)		To specify identifying information. Non-destination (COB) payers' provider identification number(s).	REQUIRED
		Reference Identification Qualifier 1A Blue Cross Provider Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification	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
2330H OTHER PAYER SUPERVISING PROVIDER	OTHER PAYER SUPERVISING PROVIDER - (NM1)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.	SITUATIONAL
		Entity Identifier Code DQ Supervising Physician	Code identifying an organizational entity, a physical location, property or an individual.	REQUIRED NM101 98 M ID 2/3
		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 Name Last or Organization Name O AN 1/35
	OTHER PAYER SUPERVISING PROVIDER IDENTIFICATION - (REF)		To specify identifying information. Non-destination (COB) payers' provider identification number(s).	REQUIRED

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Reference Identification Qualifier</p> <p>1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number E1 Employer's Identification Number G2 Provider Commercial Number N5 Provider Plan Network Identification</p>	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		<p>Reference Identification</p>	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF02 127 X AN 1/30
2400 SERVICE LINE	SERVICE LINE - (LX)		To reference a line number in a transaction set. The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter. The datum in the LX is not usually returned in the 835 (Remittance Advice) transaction. LX01 may be used as a line item control number by the payer in the 835 if a line item control number has not been submitted on the service line. LX01 is used to indicate bundling/unbundling in SVC06. Because this is a required segment, this is a required loop.	REQUIRED
		<p>Assigned Number</p>	Number assigned for differentiation within a transaction set. The service line number incremented by 1 for each service line. NSF Reference: FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0	REQUIRED LX01 554 M NO 1/6
	PROFESSIONAL SERVICE - (SV1)		To specify the claim service detail for a Health Care professional.	REQUIRED
		<p>COMPOSITE MEDICAL PROCEDURE IDENTIFIER</p>	To identify a medical procedure by its standardized codes and applicable modifiers.	REQUIRED SV101 C003 M
		<p>Product/Service ID Qualifier</p> <p>HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.</p> <p>IV Home Infusion EDI Coalition (HIEC) Product/Service Code</p> <p>N1 National Drug Code in 4-4-2 Format</p>	Code identifying the type/source of the descriptive number used in Product/Service ID (234). CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System. CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List CODE SOURCE 240: National Drug Code by Format	REQUIRED SV101 - 1 235 M ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		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	
		ZZ Mutually Defined	Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.	
		Product/Service	Identifying number for a product or service. NSF Reference: FA0-09.0, FB0-15.0, GU0-07.0	REQUIRED SV101 - 2 234 ID M AN 1/48
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Use this modifier for the first procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. NSF Reference: FA0-10.0, GU0-08.0	SITUATIONAL SV101 - 3 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Use this modifier for the second procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. NSF Reference: FA0-11.0	SITUATIONAL SV101 - 4 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Use this modifier for the third procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. NSF Reference: FA0-12.0	SITUATIONAL SV101 - 5 1339 O AN 2/2
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Use this modifier for the fourth procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. NSF Reference: FA0-36.0	SITUATIONAL SV101 - 6 1339 O AN 2/2
		Monetary Amount	Monetary amount. SV102 is the submitted charge amount. For encounter transmissions, zero (0) may be a valid amount. NSF Reference: FA0-13.0	REQUIRED SV102 782 O R 1/18
		Unit or Basis for Measurement Code	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. FA0-50.0 is only used in Medicare COB payer-to-payer situations. NSF Reference: FA0-50.0	REQUIRED SV103 355 X ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		F2 International Unit MJ Minutes UN Unit	International Unit is used to indicate dosage amount. Dosage amount is only used for drug claims when the dosage of the drug is variable within a single NDC number (e.g., blood factors).	
		Quantity	Numeric value of quantity. Note: If a decimal is needed to report units, include it in this element, e.g., "15.6". NSF Reference: FA0-18.0, FA0-19.0, FB0-16.0	REQUIRED SV104 380 X R 1/15
		Facility Code Value 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room - Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance - Land 42 Ambulance - Air or Water 50 Federally Qualified Health Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory	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. SV105 is the place of service. Required if value is different than value carried in CLM05-1 in Loop ID-2300. Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here. NSF Reference: FA0-07.0, GU0-05.0	SITUATIONAL SV105 1331 O AN 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		99 Other Unlisted Facility		
		COMPOSITE DIAGNOSIS CODE POINTER	To identify one or more diagnosis code pointers. Required if HI segment in Loop ID-2300 is used.	SITUATIONAL SV107 C004 O
		Diagnosis Code Pointer	A pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line). Use remaining diagnosis pointers in declining level of importance to service line. Acceptable values are 1 through 8, inclusive. NSF Reference: FA0-14.0	REQUIRED SV107 - 1 1328 M N0 1/2
		Diagnosis Code Pointer	A pointer to the claim diagnosis code in the order of importance to this service. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive. Use this pointer for the second diagnosis code pointer. NSF Reference: FA0-15.0	SITUATIONAL SV107 - 2 1328 O N0 1/2
		Diagnosis Code Pointer	A pointer to the claim diagnosis code in the order of importance to this service. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive. Use this pointer for the third diagnosis code pointer. NSF Reference: FA0-16.0	SITUATIONAL SV107 - 3 1328 O N0 1/2
		Diagnosis Code Pointer	A pointer to the claim diagnosis code in the order of importance to this service. Required if the service relates to that specific diagnosis and is needed to substantiate the medical treatment. Acceptable values are 1 through 8, inclusive. Use this pointer for the fourth diagnosis code pointer. NSF Reference: FA0-17.0	SITUATIONAL SV107 - 4 1328 O N0 1/2
		Yes/No Condition or Response Code	Code indicating a Yes or No condition or response. SV109 is the emergency-related indicator; a "Y" value indicates service provided was emergency related; an "N" value indicates service provided was not emergency related. NSF Reference: FA0-20.0	REQUIRED SV109 1073 O ID 1/1
		N No Y Yes		
		Yes/No Condition or Response Code	Code indicating a Yes or No condition or response. SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement. Required if Medicaid services are the result of a screening referral. NSF Reference: FB0-22.0	SITUATIONAL SV111 1073 O ID 1/1
		Y Yes		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Yes/No Condition or Response Code</p> <p>Y Yes</p>	<p>Code indicating a Yes or No condition or response. SV112 is the family planning involvement indicator. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement. Required if applicable for Medicaid claims. NSF Reference: FB0-23.0</p>	SITUATIONAL SV112 1073 O ID 1/1
		<p>Copay Status Code</p> <p>0 Copay exempt</p>	<p>Code indicating whether or not co-payment requirements were met on a line by line basis. Required if patient was exempt from co-pay. NSF Reference: FB0-21.0</p>	SITUATIONAL SV115 1327 O ID 1/1
	PRESCRIPTION NUMBER - (SV4)		<p>To specify the claim service detail for prescription drugs. Required if dispense of the drug has been done with an assigned Rx number. In cases where a compound drug is being billed, the components of the compound will all have the same prescription number. Payers receiving the claim can relate all the components by matching the prescription number.</p>	SITUATIONAL
		<p>Reference Identification</p>	<p>Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. SV401 is a prescription number. 004010X098 - 837 - 2400</p>	REQUIRED SV401 127 M AN 1/30
	DMERC CMN INDICATOR (PWK)		<p>To identify the type or transmission or both of paperwork or supporting information. Required on Medicare claims when DMERC CMN is included in this claim.</p>	SITUATIONAL
		<p>Report Type Code</p> <p>CT Certification</p>	<p>Code indicating the title or contents of a document, report or supporting item</p>	REQUIRED PWK01 755 M ID 2/2
		<p>Report Transmission Code</p> <p>AB Previously Submitted to Payer AD Certification Included in this Claim AF Narrative Segment Included in this Claim AG No Documentation is Required</p>	<p>Code defining timing, transmission method or format by which reports are to be sent. NSF Reference: EA0-40.0</p>	REQUIRED PWK02 756 O ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		NS Not Specified	NS = Paperwork is available on request at the provider's site. This means that the paperwork is not being sent with the claim at this time. Instead, it is available to the payer (or appropriate entity) at their request.	
	AMBULANCE TRANSPORT INFORMATION (CR1)		To supply information related to the ambulance service rendered to a patient. Required on all ambulance claims if the information is different than in the CR1 at the claim level (Loop ID-2300).	SITUATIONAL
		Unit or Basis for Measurement Code LB Pound	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Required if CR102 is present.	SITUATIONAL CR101 355 X ID 2/2
		Weight	Numeric value of weight. CR102 is the weight of the patient at time of transport. Required if it is necessary to justify the medical necessity of the level of ambulance services. NSF Reference: GA0-05.0	SITUATIONAL CR102 81 X R 1/10
		Ambulance Transport Code I Initial Trip R Return Trip T Transfer Trip X Round Trip	Code indicating the type of ambulance transport. NSF Reference: GA0-07.0	REQUIRED CR103 1316 O ID 1/1
		Ambulance Transport Reason Code A Patient was transported to nearest facility for care of symptoms, complaints, or both B Patient was transported for the benefit of a preferred physician C Patient was transported for the nearness of family members D Patient was transported for the care of a specialist or for availability of specialized equipment E Patient Transferred to Rehabilitation Facility	Code indicating the reason for ambulance transport. NSF Reference: GA0-15.0	REQUIRED CR104 1317 O ID 1/1
		Unit or Basis for Measurement Code DH Miles	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken.	REQUIRED CR105 355 X ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity	Numeric value of quantity. CR106 is the distance traveled during transport. NSF crosswalk to FA0-50.0 is used only in Medicare payer-to-payer COB situations. NSF Reference: GA0-17.0, FA0-50.0	REQUIRED CR106 380 X R 1/15
		Description	A free-form description to clarify the related data elements and their content. CR109 is the purpose for the round trip ambulance service. Required if CR103 (Ambulance Transport Code) = "X - Round Trip"; otherwise not used. NSF Reference: GA0-20.0	SITUATIONAL CR109 352 O AN 1/80
		Description	A free-form description to clarify the related data elements and their content. CR110 is the purpose for the usage of a stretcher during ambulance service. Required if needed to justify usage of stretcher. NSF Reference: GA0-21.0	SITUATIONAL CR110 352 O AN 1/80
	SPINAL MANIPULATION SERVICE INFORMATION - (CR2)		To supply information related to the chiropractic service rendered to a patient. Required on all claims involving spinal manipulation if information is different from Loop-ID 2300 CR2 information. Such claims could originate with chiropractors, physical therapists, DOs, and many other types of health care providers.	SITUATIONAL
		Count	Occurrence counter. CR201 is the number this treatment is in the series. NSF Reference: GC0-07.0	REQUIRED CR201 609 X N0 1/9
		Quantity	Numeric value of quantity. CR202 is the total number of treatments in the series.	REQUIRED CR202 380 X R 1/15
		Subluxation Level Code	Code identifying the specific level of subluxation. When both CR203 and CR204 are present, CR203 is the beginning level of subluxation and CR204 is the ending level of subluxation. Required if subluxation is involved in claim. NSF Reference: GC0-08.0	SITUATIONAL CR203 1367 X ID 2/3
		C1 Cervical 1 C2 Cervical 2 C3 Cervical 3 C4 Cervical 4 C5 Cervical 5 C6 Cervical 6 C7 Cervical 7 CO Coccyx IL Ileum L1 Lumbar 1 L2 Lumbar 2 L3 Lumbar 3 L4 Lumbar 4		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		L5 Lumbar 5 OC Occiput SA Sacrum T1 Thoracic 1 T10 Thoracic 10 T11 Thoracic 11 T12 Thoracic 12 T2 Thoracic 2 T3 Thoracic 3 T4 Thoracic 4 T5 Thoracic 5 T6 Thoracic 6 T7 Thoracic 7 T8 Thoracic 8 T9 Thoracic 9		
		<p>Subluxation Level Code</p> C1 Cervical 1 C2 Cervical 2 C3 Cervical 3 C4 Cervical 4 C5 Cervical 5 C6 Cervical 6 C7 Cervical 7 CO Coccyx IL Ileum L1 Lumbar 1 L2 Lumbar 2 L3 Lumbar 3 L4 Lumbar 4 L5 Lumbar 5 OC Occiput SA Sacrum T1 Thoracic 1 T10 Thoracic 10 T11 Thoracic 11 T12 Thoracic 12 T2 Thoracic 2 T3 Thoracic 3 T4 Thoracic 4 T5 Thoracic 5 T6 Thoracic 6 T7 Thoracic 7 T8 Thoracic 8 T9 Thoracic 9	Code identifying the specific level of subluxation. Required if additional subluxation is involved in claim to indicate a range (i.e., subluxation from CR203 to CR204). NSF Reference: GC0-07.0	SITUATIONAL CR204 1367 O ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Unit or Basis for Measurement Code DA Days MO Months WK Week YR Years	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken	REQUIRED CR205 355 X ID 2/2
		Quantity	Numeric value of quantity./ CR206 is the time period involved in the treatment series. NSF Reference: GC0-08.0 NSF Reference: GC0-09.0	REQUIRED CR206 380 X R 1/15
		Quantity	Numeric value of quantity. CR207 is the number of treatments rendered in the month of service. NSF Reference: GC0-10.0	REQUIRED CR207 380 O R 1/15
		Nature of Condition Code A Acute Condition C Chronic Condition D Non-acute E Non-Life Threatening F Routine G Symptomatic M Acute Manifestation of a Chronic Condition	Code indicating the nature of a patient's condition. NSF Reference: GC0-11.0	REQUIRED CR208 1342 O ID 1/1
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CR209 is complication indicator. A "Y" value indicates a complicated condition; an "N" value indicates an uncomplicated condition. NSF Reference: GC0-13.0	REQUIRED CR209 1073 O ID 1/1
		Description	A free-form description to clarify the related data elements and their content	SITUATIONAL CR210 352 O AN 1/80
		Description	A free-form description to clarify the related data elements and their content CR210 is a description of the patient's condition.	SITUATIONAL CR211 352 O AN 1/80

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Yes/No Condition or Response Code</p> <p>N No Y Yes</p>	Code indicating a Yes or No condition or response. CR212 is X-rays availability indicator. A "Y" value indicates X-rays are maintained and available for carrier review; an "N" value indicates X-rays are not maintained and available for carrier review.	REQUIRED CR212 1073 O ID 1/1
	DURABLE MEDICAL EQUIPMENT CERTIFICATION (CR3)		To supply information regarding a physician's certification for durable medical equipment. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician.	Optional
		<p>Certification Type Code</p> <p>I Initial R Renewal S Revised</p>	Code indicating the type of certification	REQUIRED CR301 1322 O ID 1/1
		<p>Unit or Basis for Measurement Code</p> <p>MO Months</p>	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. CR302 and CR303 specify the time period covered by this certification.	REQUIRED CR302 355 X ID 2/2
		Quantity	Numeric value of quantity	REQUIRED CR303 380 X R 1/15
	HOME OXYGEN THERAPY INFORMATION (CR5)		To supply information regarding certification of medical necessity for home oxygen therapy. Required on all initial, renewal, and revision home oxygen therapy claims.	
		<p>Certification Type Code</p> <p>I Initial R Renewal S Revised</p>	Code indicating the type of certification	REQUIRED CR501 1322 O ID 1/1
		Quantity	Numeric value of quantity. CR502 is the number of months covered by this certification.	REQUIRED CR502 380 O R 1/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity	Numeric value of quantity. CR510 is the arterial blood gas. Either CR510 or CR511 is required. Required on claims which report arterial blood gas. NSF Reference: GX0-22.0	SITUATIONAL CR510 380 O R 1/15
		Quantity	Numeric value of quantity. CR511 is the oxygen saturation. Either CR510 or CR511 is required. Required on claims which report oxygen saturation quantity. NSF Reference: GX0-23.0	SITUATIONAL CR511 380 O R 1/15
		Oxygen Test Condition Code E Exercising R At rest on room air S Sleeping	Code indicating the conditions under which a patient was tested.	REQUIRED CR512 1349 O ID 1/1
		Oxygen Test Findings Code 1 Dependent edema suggesting congestive heart failure	Code indicating the findings of oxygen tests performed on a patient. Required if patient's arterial PO2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.	SITUATIONAL CR513 1350 O ID 1/1
		Oxygen Test Findings Code 2 "P" Pulmonale on Electrocardiogram (EKG)	Code indicating the findings of oxygen tests performed on a patient. Required if patient's arterial PO2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate.	SITUATIONAL CR514 1350 O ID 1/1
		Oxygen Test Findings Code 3 Erythrocythemia with a hematocrit greater than 56 percent	Code indicating the findings of oxygen tests performed on a patient. Required if patient's arterial PO2 is greater than 55 mmHg and less than 60 mmHg, or oxygen saturation is greater than 88%. Use CR513, CR514, or CR515 as appropriate. NSF Reference: GXO-27.0	SITUATIONAL CR515 1350 O ID 1/1
	AMBULANCE CERTIFICATION (CRC)		To supply information on conditions. The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed. Required on all service lines which bill/report ambulance services if the information is different when CRC01=07 in Loop ID-2300.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Code Category 07 Ambulance Certification	Specifies the situation or category to which the code applies. CRC01 qualifies CRC03 through CRC07.	REQUIRED CRC01 1136 M ID 2/2
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.	REQUIRED CRC02 1073 M ID 1/1
		Condition Indicator 01 Patient was admitted to a hospital 02 Patient was bed confined before the ambulance service 03 Patient was bed confined after the ambulance service 04 Patient was moved by stretcher 05 Patient was unconscious or in shock 06 Patient was transported in an emergency situation 07 Patient had to be physically restrained 08 Patient had visible hemorrhaging 09 Ambulance service was medically necessary 60 Transportation Was To the Nearest Facility	Code indicating a condition NSF Reference: GAO-06.0 NSF Reference: GAO-08.0 NSF Reference: GAO-09.0 NSF Reference: GAO-10.0 NSF Reference: GAO-11.0 NSF Reference: GAO-12.0 NSF Reference: GAO-13.0 NSF Reference: GAO-14.0 NSF Reference: GAO-15.0 NSF Reference: GAO-16.0	REQUIRED CRC03 1321 M ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC04 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC05 1321 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC06 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC07 1321 O ID 2/2
	HOSPICE EMPLOYEE INDICATOR (CRC)		To supply information on conditions. Can be used to indicate whether the rendering provider is an employee of the hospice. The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed. Required on all Medicare claims involving physician services to hospice patients.	SITUATIONAL
		Code Category 70 Hospice	Specifies the situation or category to which the code applies. CRC01 qualifies CRC03 through CRC07.	REQUIRED CRC01 1136 M ID 2/2
		Yes/No Condition or Response Code N No Y Yes	Code indicating a Yes or No condition or response. CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply. NSF Reference: FA0-40.0 A "Y" value indicates the provider is employed by the hospice. A "N" value indicates the provider is not employed by the hospice.	REQUIRED CRC02 1073 M ID 1/1
		Condition Indicator 65 Open	Code indicating a condition Use this code as a place holder (element is mandatory) when reporting whether the provider is a hospice employee.	REQUIRED CRC03 1321 M ID 2/2
		DMERC CONDITION INDICATOR (CRC)		To supply information on conditions. Required on all oxygen therapy and DME claims that require a certificate of medical necessity (CMN). The maximum number of CRC segments which can occur per 2400 loop is 3. Submitters are free to mix and match the three types of service line level CRC segments shown in this implementation guide to meet their billing/reporting needs but no more than a total of 3 CRC segments per 2400 loop are allowed. The first example shows a case where an item billed was not a replacement
	Code Category 09 Durable Medical Equipment Certification 11 Oxygen Therapy Certification		Specifies the situation or category to which the code applies. CRC01 qualifies CRC03 through CRC07.	REQUIRED CRC01 1136 M ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Yes/No Condition or Response Code</p> <p>N No Y Yes</p>	Code indicating a Yes or No condition or response. CRC02 is a Certification Condition Code applies indicator. A "Y" value indicates the condition codes in CRC03 through CRC07 apply; an "N" value indicates the condition codes in CRC03 through CRC07 do not apply.	REQUIRED CRC02 1073 M ID 1/1
		<p>Condition Indicator</p> <p>37 Oxygen delivery equipment is stationary</p> <p>38 Certification signed by the physician is on file at the supplier's office GU0-24.0</p> <p>AL Ambulation Limitations</p> <p>P1 Patient was Discharged from the First</p> <p>ZV Replacement Item</p>	<p>Code indicating a condition.</p> <p>Use "P1" (GX0-20.0) to answer the Medicare Oxygen CMN question: "The test was performed either with the patient in a chronic stable state as an outpatient or within two days prior to discharge from an inpatient facility to home." Code ZV was approved by ASC X12 in the version 004011 Data Dictionary but is included in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entities who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this exception code.</p> <p>NSF Reference: GX0-05.0</p> <p>NSF Reference: GX0-35.0, GU0-24.0</p> <p>NSF Reference: GX0-05.0</p> <p>NSF Reference: GX0-20.0</p> <p>NSF Reference: GU0-06.0</p>	REQUIRED CRC03 1321 M ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC04 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC05 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC06 1321 O ID 2/2
		Condition Indicator	Code indicating a condition. Required if additional condition codes are needed. Use the codes listed in CRC03.	SITUATIONAL CRC07 1321 O ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - SERVICE DATE (DTP)		The total number of DTP segments in the 2400 loop cannot exceed 15. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).	REQUIRED
		Date/Time Qualifier 472 Service	Code specifying type of date or time, or both date and time. Use RD8 in DTP02 to indicate begin/end or from/to dates.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	Code indicating the date format, time format, or date and time format Use RD8 if it is necessary to indicate begin/end dates. Date range indicates drug duration for which the supply of drug be will used by the patient. The difference in dates, including both the begin and end dates, are the days supply of the drug.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: FAO-05.0, FAO-06.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - CERTIFICATION REVISION DATE (DTP)		To specify any or all of a date, a time, or a time period. Required if CR301 (DMERC Certification) = "R" or "S". The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 607 Certification Revision	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GU0-20.0, GX0-11.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - REFERRAL DATE (DTP)		To specify any or all of a date, a time, or a time period. Required when service line includes a referral. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		330 Referral Date		
		Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		D8 Date Expressed in Format CCYYMMDD		
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
	DATE - BEGIN THERAPY DATE (DTP)		To specify any or all of a date, a time, or a time period. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		463 Begin Therapy		
		Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		D8 Date Expressed in Format CCYYMMDD		
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GU0-19.0, GX0-10.0	REQUIRED DTP03 1251 M AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - LAST CERTIFICATION DATE (DTP)		To specify any or all of a date, a time, or a time period. Required if it is necessary to include supporting documentation in an electronic form for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician. Required on oxygen therapy certificates of medical necessity (CMN). This is the date the ordering physician signed the CMN. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 461 Last Certification	Code specifying type of date or time, or both date and time.	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GX0-11.0, GU0-22.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - ORDER DATE (DTP)		To specify any or all of a date, a time, or a time period. Required when service line includes an order for services or supplies. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 938 Order	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - DATE LAST SEEN (DTP)		Required when claim is from an independent physical therapist, occupational therapist, or physician providing routine footcare if the date last seen by an attending or supervising physician is different from that listed at the claim level (Loop ID-2300). The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 304 Latest Visit or Consultation	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times NSF Reference: EA0-48.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - TEST (DTP)		To specify any or all of a date, a time, or a time period. Required on initial EPO claims service lines where test results are being billed/reported. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 738 Most Recent Hemoglobin or Hematocrit or Both 739 Most Recent Serum Creatine	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times NSF Reference: FA0-41.0, FA0-46.0	REQUIRED DTP03 1251 M AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - OXYGEN SATURATION/ARTERIAL BLOOD GAS TEST (DTP)		To specify any or all of a date, a time, or a time period. Required on initial oxygen therapy service line(s) involving certificate of medical necessity (CMN). The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		119 Test Performed	Use for any 4 liter/minute test date. Results for this test date are reported in MEA03 using either the GRA or ZO qualifiers in MEA02 480 Arterial Blood Gas Test. Do not use to report any 4 liter/minute test date. Results for the arterial blood gas test are reported in CR510.	
		481 Oxygen Saturation Test	Do not use to report any 4 liter/minute test date. Results for the oxygen saturation test are reported in CR511.	
		Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
	D8 Date Expressed in Format CCYYMMDD			
	Date Time Period	Expression of a date, a time, or range of dates, times or dates and times NSF Reference: GX0-19.0, GX0-24.0	REQUIRED DTP03 1251 M AN 1/35	
	DATE - SHIPPED (DTP)		To specify any or all of a date, a time, or a time period. Required when billing/reporting shipped products. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		011 Shipped		
Date Time Period Format Qualifier		Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3	
D8 Date Expressed in Format CCYYMMDD				
Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	DATE - ONSET OF CURRENT SYMPTOM/ILLNESS (DTP)		To specify any or all of a date, a time, or a time period. Required if different from that entered at claim level (Loop ID-2300). Required on claims involving services to a patient experiencing symptoms similar or identical to previously reported symptoms. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 431 Onset of Current Symptoms or Illness	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: EA0-07.0, EA0-16.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - LAST X-RAY (DTP)		To specify any or all of a date, a time, or a time period. Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300). The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 455 Last X-Ray	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GC0-06.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - ACUTE MANIFESTATION (DTP)		To specify any or all of a date, a time, or a time period. Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300). The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date/Time Qualifier 453 Acute Manifestation of a Chronic	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GC0-12.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - INITIAL TREATMENT (DTP)		To specify any or all of a date, a time, or a time period. Required for spinal manipulation certifications if different than information at claim level (Loop ID-2300). The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 454 Initial Treatment	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times. NSF Reference: GC0-05.0	REQUIRED DTP03 1251 M AN 1/35
	DATE - SIMILAR ILLNESS/SYMPTOM ONSET (DTP)		To specify any or all of a date, a time, or a time period. Required if line value is different than value given at claim level (Loop ID-2300) and claim involves services to a patient experiencing symptoms similar or identical to previously reported symptoms. The total number of DTP segments in the 2400 loop cannot exceed 15.	SITUATIONAL
		Date/Time Qualifier 438 Onset of Similar Symptoms or Illness	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
	ANESTHESIA MODIFYING UNITS (QTY)		To specify quantity information. Required on anesthesia service lines if one or more of the extenuating circumstances coded in QTY01 was present at the time of service.	SITUATIONAL
		Quantity Qualifier BF Age Modifying Units EC Use of Extracorporeal Circulation EM Emergency Modifying Units HM Use of Hypothermia HO Use of Hypotension HP Use of Hyperbaric Pressurization P3 Physical Status III P4 Physical Status IV P5 Physical Status V SG Swan-Ganz	Code specifying the type of quantity	REQUIRED QTY01 673 M ID 2/2
		Quantity	Numeric value of quantity	REQUIRED QTY02 380 X R 1/15
	TEST RESULT (MEA)		To specify physical measurements or counts, including dimensions, tolerances, variances, and weights. Required on service lines which bill/report the following Concentration, Hemoglobin, Hematocrit, Epoetin Starting Dosage, Creatin, and Oxygen.	SITUATIONAL
		Measurement Reference ID Code OG Original Starting dosage TR Test Results	Code identifying the broad category to which a measurement applies	REQUIRED MEA01 737 O ID 2/2
		Measurement Qualifier CON Concentration GRA Gas Test Rate HT Height R1 Hemoglobin R2 Hematocrit R3 Epoetin Starting Dosage	Code identifying a specific product or process characteristic to which a measurement applies	REQUIRED MEA02 738 O ID 1/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		R4 Creatin ZO Oxygen		
		Measurement Value	The value of the measurement. FA0-42.0 - Hemoglobin, FA0-43.0 - Hematocrit, FA0-45.0 - Epoetin Starting Dosage, FA0-47.0 - Creatin, GX0-17.0 - Arterial Blood Gas on 4 liters/minute, GX0-18.0 - Oxygen Saturation on 4 liters/minute, GU0-16.0 - Patient Height	REQUIRED MEA03 739 X R 1/20
	CONTRACT INFORMATION (CN1)		To specify basic data about the contract or contract line item. Information contained at this level overwrites CN1 information at the claim level for this specific service line.	SITUATIONAL
		Contract Type Code 01 Diagnosis Related Group (DRG) 02 Per Diem 03 Variable Per Diem 04 Flat 05 Capitated 06 Percent 09 Other	Code identifying a contract type	REQUIRED CN101 1166 M ID 2/2
		Monetary Amount	Monetary amount. CN102 is the contract amount. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL CN102 782 O R 1/18
		Percent	Percent expressed as a percent. CN103 is the allowance or charge percent. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL CN103 332 O R 1/6
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. CN104 is the contract code. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL CN104 127 O AN 1/30
		Terms Discount Percent	Terms discount percentage, expressed as a percent, available to the purchaser if an invoice is paid on or before the Terms Discount Due Date. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL CN105 338 O R 1/6
		Version Identifier	Revision level of a particular format, program, technique or algorithm. CN106 is an additional identifying number for the contract. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL CN106 799 O AN 1/30

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	REPRICED LINE ITEM REFERENCE NUMBER (REF)		To specify identifying information. This segment is intended to be used exclusively by repricing (pricing) organizations who have a need to identify a certain line in their claim submission transmission to their payer organization.	SITUATIONAL
		Reference Identification Qualifier 9B Repriced Line Item Reference 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
	ADJUSTED REPRICED LINE ITEM REFERENCE NUMBER (REF)		To specify identifying information. This segment is intended to be used exclusively by repricing (pricing) organizations who have a need to identify a certain line in their claim submission transmission to their payer organization.	SITUATIONAL
		Reference Identification Qualifier 9D Adjusted Repriced Line Item Reference 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
	PRIOR AUTHORIZATION OR REFERRAL NUMBER (REF)		To specify identifying information. Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim level (Loop-ID 2300).	SITUATIONAL
		Reference Identification Qualifier 9F Referral Number G1 Prior Authorization 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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	LINE ITEM CONTROL NUMBER (REF)		To specify identifying information. Required if it is necessary to send a line control or inventory number. Providers are strongly encouraged to routinely send a unique line item control number on all service lines, particularly if the provider automatically posts their remittance advice. Submitting a unique line item control number gives providers the capability to automatically post by service line. The line item control number should be unique within a patient control number (CLM01). Payers are required to return this number in the remittance advice transaction (835) if the providers sends it to them in the 837.	SITUATIONAL
		Reference Identification Qualifier 6R Provider Control 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. NSF Reference: FA0-04.0, FB0-04.0, FB1-04.0, FB2-04.0, FD0-04.0, FE0-04.0, HA0-04.0	REQUIRED REF02 127 X AN 1/30
	MAMMOGRAPHY CERTIFICATION NUMBER (REF)		To specify identifying information. Required for Medicare claims for all mammography services.	SITUATIONAL
		Reference Identification Qualifier EW Mammography Certification 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. NSF Reference: FA0-31.0	REQUIRED REF02 127 X AN 1/30
	CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) IDENTIFICATION (REF)		To specify identifying information. Required for all CLIA certified facilities performing CLIA covered laboratory services and if number is different than CLIA number reported at claim level (Loop ID-2300).	
		Reference Identification Qualifier X4 Clinical Laboratory Improvement Amendment Number	Code qualifying the Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier.	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. NSF Reference: FAO-34.0.	REQUIRED REF02 127 X AN 1/30
	REFERRING CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) FACILITY IDENTIFICATION (REF)		To specify identifying information. Required for Medicare claims for any laboratory that referred tests to another laboratory covered by the CLIA Act that is billed on this line.	SITUATIONAL
		Reference Identification Qualifier F4 Facility Certification 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
	IMMUNIZATION BATCH NUMBER (REF)		To specify identifying information. Use when required by state law for health data reporting.	SITUATIONAL
		Reference Identification Qualifier BT Batch 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
	AMBULATORY PATIENT GROUP		To specify identifying information. Used at discretion of submitter.	SITUATIONAL
		Reference Identification Qualifier 1S Ambulatory Patient Group (APG) 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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	OXYGEN FLOW RATE (REF)		To specify identifying information. Required on oxygen therapy certificate of medical necessity (CMN) claim where service line reports oxygen flow rate.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
		TP Test Specification Number Oxygen Flow Rate		
	UNIVERSAL PRODUCT NUMBER (UPN) (REF)	Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: GXO-14.0 Valid values are 1-999 liters per minute and X for less than 1 liter per minute.	REQUIRED REF02 127 X AN 1/30
			To specify identifying information. This information may be required on Medicare and some state Medicaid claims in the future. This segment has been added to the 4010 implementation guide to allow providers to meet the Medicare/Medicaid requirements when they are implemented. When implemented by Medicare/Medicaid, the UPN is required on claim/encounters when an item/supply is being billed/reported that has an associated UPN included in the Health Care Uniform Code Council system or the Health Industry Business Communications Council system.	SITUATIONAL
		Reference Identification Qualifier	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3
	UNIVERSAL PRODUCT NUMBER (UPN) (REF)	OZ Product Number	Use to indicate Health Care Uniform Code Council System.	
		Code Source 41 VP Vendor Product Number	Use to indicate Health Industry Business Communications Council system.	
	UNIVERSAL PRODUCT NUMBER (UPN) (REF)	Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: FAO-62.0	REQUIRED REF02 127 X AN 1/30
	SALES TAX AMOUNT (AMT)		Required if sales tax applies to service line and submitter is required to report that information to the receiver. To indicate the total monetary amount.	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		<p>Amount Qualifier Code</p> <p>T Tax</p>	Code to qualify amount	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount	REQUIRED AMT02 782 M R 1/18
	APPROVED AMOUNT (AMT)		To indicate the total monetary amount. Used primarily in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers (in a provider-to-payer COB situation) do not usually complete this information but may do so if the information is available. The allowed amount equals the amount for the service line that was approved by the payer sending this 837 to another payer.	SITUATIONAL
		<p>Amount Qualifier Code</p> <p>AAE Approved Amount</p>	Code to qualify amount	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount. NSF Reference: FAO-51.0	REQUIRED AMT02 782 M R 1/18
	POSTAGE CLAIMED AMOUNT (AMT)		To indicate the total monetary amount. Required if service line charge (SV102) includes postage amount claimed in this service line.	SITUATIONAL
		<p>Amount Qualifier Code</p> <p>F4 Postage Claimed</p>	Code to qualify amount	REQUIRED AMT01 522 M ID 1/3
		Monetary Amount	Monetary amount	REQUIRED AMT02 782 M R 1/18
	FILE INFORMATION (K3)		To transmit a fixed-format record or matrix contents. This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup, requested a review of the K3 data requirement to ensure there is not an existing method within the implementation guide to meet this requirement, and X12N determines that there is no method to meet the requirement. Only then may the state require the temporary use of the K3 to meet the requirement.	SITUATIONAL
		Fixed Format Information	Data in fixed format agreed upon by sender and receiver. NSF Reference: HAO-05.0	REQUIRED K301 449 M AN 1/80

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	LINE NOTE (NTE)		To transmit information in a free-form format, if necessary, for or special instruction. Required if submitter used a "not otherwise classified" (NOC) procedure code on this service line (use ADD in NTE01). Otherwise, use at providers discretion.	SITUATIONAL
		Note Reference Code ADD Additional Information DCP Goals, Rehabilitation Potential, or Discharge Plans PMT Payment TPO Third Party Organization Notes	Code identifying the functional area or purpose for which the note applies	REQUIRED NTE01 363 O ID 3/3
		Description	A free-form description to clarify the related data elements and their content. NSF Reference: HAO-050.	REQUIRED NTE02 352 M AN 1/80
	PURCHASED SERVICE INFORMATION (PS1)		To specify the information about services that are purchased. Using the PS1 segment indicates that services were purchased from another source. Required on service lines involving purchased services/tests if different than the information given at the claim level (Loop ID = 2310C).	SITUATIONAL
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. PS101 is provider identification number. NSF Reference: FBO-11.0	REQUIRED PS101 127 M AN 1/30
		Monetary Amount	Monetary amount. NSF Reference: FBO-05.0.	REQUIRED PS102 782 M R 1/18
	HEALTH CARE SERVICES DELIVERY (HSD)		To specify the delivery pattern of health care services. The HSD segment is used to specify the delivery pattern of the health care services. This is how it is used: HSD01 qualifies HSD02: If the value in HSD02=1 and the value in HSD01=VS (Visits), this means "one visit". Between HSD02 and HSD03 verbally insert a "per every." HSD03 qualifies HSD04: If the value in HSD04=3 and the value in HSD03=DA (Day), this means "three days." Between HSD04 and HSD05 verbally insert a "for." HSD05 qualifies HSD06: If the value in HSD06=21 and the value in HSD05=7 (Days), this means "21 days." The total message reads: HSD*VS*1*DA*3*7*21- = "One visit per every three days for 21 days." Another similar data string of HSD*VS*2*DA*4*7*20- = Two visits per every four days for 20 days. An alternate way to use HSD is to employ HSD07 and/or HSD08. A data string of HSD*VS*1*****SX*D- means "1 visit on Wednesday and Thursday morning." Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment and if information is different than that given at claim level	SITUATIONAL

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Quantity Qualifier VS Visits	Code specifying the type of quantity. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD01 673 X ID 2/2
		Quantity	Numeric value of quantity. HD502 qualifies HD501 Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD02 380 X R 1/15
		Unit or Basis for Measurement Code DA Days MO Months Month Q1 Quarter (Time) WK Week	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD03 355 O ID 2/2
		Sample Selection Modulus	To specify the sampling frequency in terms of a modulus of the Unit of Measure, e.g., every fifth bag, every 1.5 minutes. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD04 1167 O R 1/6
		Time Period Qualifier 7 Day 34 Month 35 Week	Code defining periods. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD05 615 X ID 1/2
		Number of Periods	Total number of periods. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD06 616 O N0 1/3
		Ship/Delivery or Calendar Pattern Code 1 1st Week of the Month 2 2nd Week of the Month 3 3rd Week of the Month 4 4th Week of the Month 5 5th Week of the Month 6 1st & 3rd Weeks of the Month 7 2nd & 4th Weeks of the Month A Monday through Friday B Monday through Saturday C Monday through Sunday	Code which specifies the routine shipments, deliveries, or calendar pattern. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD07 678 O ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		D Monday E Tuesday F Wednesday G Thursday H Friday J Saturday K Sunday L Monday through Thursday N As Directed O Daily Mon. through Fri. SA Sunday, Monday, Thursday, Friday, SB Tuesday through Saturday SC Sunday, Wednesday, Thursday, Friday, Saturday SD Monday, Wednesday, Thursday, Friday, Saturday SG Tuesday through Friday SL Monday, Tuesday and Thursday SP Monday, Tuesday and Friday SX Wednesday and Thursday SY Monday, Wednesday and Thursday SZ Tuesday, Thursday and Friday W Whenever Necessary		
		Ship/Delivery Pattern Time Code D A.M. E P.M. F As Directed	Code which specifies the time for routine shipments or deliveries. Required if information is different than that given at claim level (Loop ID-2300).	SITUATIONAL HSD08 679 O ID 1/1
	LINE PRICING/REPRICING INFORMATION (HCP)		To specify pricing or repricing information about a health care claim or line item. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL
		Pricing Methodology 00 Zero Pricing (Not Covered Under Contract) 01 Priced as Billed at 100% 02 Priced at the Standard Fee Schedule 03 Priced at a Contractual Percentage 04 Bundled Pricing 05 Peer Review Pricing 06 Per Diem Pricing 07 Flat Rate Pricing	Code specifying pricing methodology at which the claim or line item has been priced or repriced. Trading partners need to agree on the codes to use in this element. There do not appear to be standard definitions for the code elements.	REQUIRED HCP01 1473 X ID 2/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		08 Combination Pricing 09 Maternity Pricing 10 Other Pricing 11 Lower of Cost 12 Ratio of Cost 13 Cost Reimbursed 14 Adjustment Pricing		
		Monetary Amount	Monetary amount. HCP02 is the allowed amount.	REQUIRED HCP02 782 O R 1/18
		Monetary Amount	Monetary amount. HCP03 is the savings amount. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP03 782 O R 1/18
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. HCP04 is the repricing organization identification number. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP04 127 O AN 1/30
		Rate	Rate expressed in the standard monetary denomination for the currency specified. HCP05 is the pricing rate associated with per diem or flat rate repricing. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP05 118 O R 1/9
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. HCP06 is the approved DRG code. HCP06, HCP07, HCP08, HCP10, and HCP12 are fields that will contain different values from the original submitted values. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP06 127 O AN 1/30
		Monetary Amount	Monetary amount. HCP07 is the approved DRG amount. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP07 782 O R 1/18
		Product/Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234). Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP09 235 X ID 2/2
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS)	Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.	

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		IV Home Infusion EDI Coalition (HIEC) Product/Service Code Jurisdictionally Defined Procedure and Supply Codes	CODE SOURCE 513: Home Infusion EDI Coalition (HEIC) Product/Service Code List (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.	
		Product/Service ID	Identifying number for a product or service. HCP10 is the approved procedure code. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP10 234 ID X AN 1/48
		Unit or Basis for Measurement Code DA Days UN Unit	Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP11 355 X ID 2/2
		Quantity	Numeric value of quantity. HCP12 is the approved service units or inpatient days. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP12 380 X R 1/15
		Reject Reason Code T1 Cannot Identify Provider as TPO (Third Party Organization) Participant T2 Cannot Identify Payer as TPO (Third Party Organization) Participant T3 Cannot Identify Insured as TPO (Third Party Organization) Participant T4 Payer Name or Identifier Missing T5 Certification Information Missing T6 Claim does not contain enough information for repricing	Code assigned by issuer to identify reason for rejection. HCP13 is the rejection message returned from the third party organization. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP13 901 X ID 2/2
		Policy Compliance Code	Code specifying policy compliance. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP14 1526 O ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		1 Procedure Followed (Compliance) 2 Not Followed - Call Not Made (Non-Compliance Call Not Made) 3 Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 Not Followed Other (Non-Compliance Other) 5 Emergency Admit to Non-Network Hospital		
		Exception Code 1 Non-Network Professional Provider in Network Hospital 2 Emergency Care 3 Services or Specialist not in Network 4 Out-of-Service Area 5 State Mandates 6 Other	Code specifying the exception reason for consideration of out-of-network health care services. HCP15 is the exception reason generated by a third party organization. Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.	SITUATIONAL HCP15 1527 O ID 1/2
LOOP 2420A RENDERING PROVIDER NAME	RENDERING PROVIDER NAME - (NM1)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider than what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.	SITUATIONAL
		Entity Identifier Code 82 Rendering Provider	Code identifying an organizational entity, a physical location, property or an individual. The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.	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

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name Last or Organization Name	Individual last name or organizational name. NSF Reference: FB1: 14.0.	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. Required if NM102=1 (person). NSF Reference: FB1:15.0	SITUATIONAL NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. NSF Reference: FB1:16.0 Required if NM102=1 and the middle name/initial of the person is known.	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67). NSF Reference: FAO-57.0 Social Security Number cannot be used for Medicare claims. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	REQUIRED NM108 66 X ID 1/2
		Identification Code	Code identifying a party or other code	REQUIRED NM109 67 X AN 2/80
	RENDERING PROVIDER SPECIALTY INFORMATION - (PRV)		To specify the identifying characteristics of a provider. PRV02 qualifies PRV03.	
		Provider Code PE Performing	Code identifying the type of provider	REQUIRED PRV01 1221 M ID 1/3
		Reference Identification Qualifier ZZ Mutually Defined	Code qualifying the Reference Identification Health Care Provider Taxonomy Code list	REQUIRED PRV02 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
2420C SERVICE FACILITY LOCATION		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. NSF Reference: FB0-11.0	REQUIRED REF02 127 X AN 1/30
	SERVICE FACILITY LOCATION - (NM1)		Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider), 2010AB (Pay-to Provider), or 2310D Service Facility Location loops. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.	SITUATIONAL
		Entity Identifier Code	Code identifying an organizational entity, a physical location, property or an individual. Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.	REQUIRED NM101 98 Entity M ID 2/3
		77 Service Location FA Facility LI Independent Lab TL Testing Laboratory	Use when other codes in this element do not apply.	
		Entity Type Qualifier	Code qualifying the type of entity. NM102 qualifies NM103.	REQUIRED NM102 1065 M ID 1/1
		2 Non-Person Entity		
		Name Last or Organization Name	Individual last name or organizational name. Required except when service was rendered in the patient's home. NSF Reference: GXO-25.0.	SITUATIONAL NM103 1035 O AN 1/35
	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code (67). Required if either Employer's Identification/Social Security Number (tax ID of service location) or National Provider Identifier is known.	SITUATIONAL NM108 66 X ID 1/2	
	24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	Do not use for Medicare claims. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.		

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Identification Code	Code identifying a party or other code. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	SITUATIONAL NM109 67 X AN 2/80
	ADDITIONAL SERVICE FACILITY LOCATION NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	
		Name	Free-form name	REQUIRED N201 93 M AN 1/60
	SERVICE FACILITY LOCATION ADDRESS (N3)		To specify the location of the named party. If service facility location is in an area where there are no street addresses, enter a description of where the service was rendered (e.g., "crossroad of State Road 34 and 45" or "Exit near Mile marker 265 on Interstate 80".)	REQUIRED
		Address Information	Address information. NSF Reference: GX2-04.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. Required if a second address line exists. NSF Reference: GX2-05.0	SITUATIONAL N302 166 O AN 1/55
	SERVICE FACILITY LOCATION CITY/STATE/ZIP (N4)		To specify the geographic place of the named party. If service facility location is in an area where there are no street addresses, enter the name of the nearest town, state and zip of where the service was rendered.	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. NSF Reference GX2-06.0	REQUIRED N401 19 O AN 2/30
		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. Required if the address is out of the U.S. CODE SOURCE 22: State and Outlying Areas of the U.S. NSF Reference: GX2-07.0.	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 - NSF Reference: GX2-08.0	REQUIRED N403 116 O ID 3/15
		Country Code	Code identifying the country. Required if the address is out of the U.S. CODE SOURCE 5: Countries, Currencies and Funds	SITUATIONAL N404 26 O ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.	SITUATIONAL
		Reference Identification Qualifier 0B State License Number 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 G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification TJ Federal Taxpayer's Identification Number X4 Clinical Laboratory Improvement Amendment Number X5 State Industrial Accident Provider 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
LOOP 2420D SUPERVISING PROVIDER NAME	SUPERVISING PROVIDER NAME (NM)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required when rendering provider is supervised by a physician and the supervising physician is different than that listed at the claim level for this service line. All payer-specific identifying numbers belong to the destination payer identified in loop 2010BB.	SITUATIONAL
		Entity Identifier Code DQ Supervising Physician	Code identifying an organizational entity, a physical location, property or an individual	REQUIRED NM101 98 M ID 2/3
		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. NSF Reference: FB1-18.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: FB1-19.0	REQUIRED NM104 1036 O AN 1/25

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. NSF Reference: FB1-21.0	REQUIRED REF02 127 X AN 1/30
LOOP 2420E ORDERING PROVIDER NAME	ORDERING PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required if a service or supply was ordered by a provider and that provider is a different entity than the rendering provider for this service line. All payer-specific identifiers belong to the destination payer identified in the 2010BB loop.	
		Entity Identifier Code DK Ordering Physician	Code identifying an organizational entity, a physical location, property or an individual. The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.	REQUIRED NM101 98 M ID 2/3
		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. NSF Reference: FB1-06.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: FB1-07.0	REQUIRED NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: FB1-08.0	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 O AN 1/10
		Identification Code Qualifier 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier	Code designating the system/method of code structure used for Identification Code (67). Required if either Employer's Identification/Social Security Number (Ordering provider's tax ID) or National Provider Identifier is known. The social security number may not be used for Medicare. Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	SITUATIONAL NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
	ADDITIONAL ORDERING PROVIDER NAME INFORMATION (N2)	Identification Code	Code identifying a party or other code. NSF Reference: FBO-09.0, GXO-29.0. Required if either Employer's Identification/Social Security Number (Ordering provider's tax ID) or National Provider Identifier is known. To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters. See example in Loop ID-1000A Submitter, NM1 and N2 for how to handle long names.	SITUATIONAL NM109 67 X AN 2/80
		Name	Free-form name	REQUIRED N201 93 M AN 1/60
	ORDERING PROVIDER ADDRESS (N3)		To specify the location of the named party. Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.	SITUATIONAL
		Address Information	Address information. NSF Reference: FB2-06.0	REQUIRED N301 166 M AN 1/55
		Address Information	Address information. Required if a second address line exists. NSF Reference: FB2-07.0	SITUATIONAL N302 166 O AN 1/55
	ORDERING PROVIDER CITY/STATE/ZIP CODE (N4)		To specify the geographic place of the named party. Required when a Durable Medical Equipment Regional Carrier Certificate of Medical Necessity (Medicare DMERC CMN) is used on service line for Medicare claims.	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. NSF Reference: FB2-08.0	REQUIRED N401 19 O AN 2/30
		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. NSF Reference: FB2-0.0, FB2-09.0	REQUIRED N402 156 O ID 2/2
		Postal Code	Code defining international postal zone code excluding punctuation and blanks (zip code for United States). NSF Reference: FB2-10.0 CODE SOURCE 51 ZIP Code	REQUIRED N403 116 O ID 3/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Name	Free-form name	REQUIRED PER02 93 O AN 1/80
		Communication Number Qualifier EM Electronic Mail FX Facsimile TE Telephone	Code identifying the type of communication number	REQUIRED PER03 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. NSF Reference: GXO-30.0, GUO-23.0	REQUIRED 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 . Use at discretion of submitter.	SITUATIONAL PER05 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable. Use at discretion of submitter.	SITUATIONAL PER06 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. Use at discretion of submitter.	SITUATIONAL PER07 365 X ID 2/2
		Communication Number	Complete communications number including country or area code when applicable.	SITUATIONAL PER08 364 X AN 1/80

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
LOOP 2420F REFERRING PROVIDER NAME	REFERRING PROVIDER NAME (NM1)		To supply the full name of an individual or organizational entity. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A). All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop. When there is only one referral on the service line use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this service line. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.	SITUATIONAL
		Entity Identifier Code DN Referring Provider P3 Primary Care Provider	Code identifying an organizational entity, a physical location, property or an individual Use on the first iteration of this loop. Use if loop is used only once. Use only if loop is used twice. Use only on second iteration of this loop.	REQUIRED NM101 98 M ID 2/3
		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. NSF Reference: FB1-10.0	REQUIRED NM103 1035 O AN 1/35
		Name First	Individual first name. NSF Reference: FB1-11.0	REQUIRED NM104 1036 O AN 1/25
		Name Middle	Individual middle name or initial. Required if NM102=1 and the middle name/initial of the person is known. NSF Reference: FB1-12.0	SITUATIONAL NM105 1037 O AN 1/25
		Name Suffix	Suffix to individual name. Required if known.	SITUATIONAL NM107 1039 AN 1/10
		Identification Code Qualifier 24 Employer's Identification Number 34 Social Security Number	Code designating the system/method of code structure used for Identification Code (67). Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known. The social security number may not be used for Medicare.	SITUATIONAL NM108 66 X ID 1/2

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		XX Health Care Financing Administration National Provider Identifier	Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	
		Identification Code	Code identifying a party or other code. Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known. NSF Reference: FB1-13.0, FAO-24.0.	SITUATIONAL NM109 67 X AN 2/80
	REFERRING PROVIDER SPECIALTY INFORMATION (PRV)		To specify the identifying characteristics of a provider. Required if required under provider-payer contract. PRV02 qualifies PRV03.	SITUATIONAL
		Provider Code RF Referring	Code identifying the type of provider	REQUIRED PRV01 1221 M ID 1/3
		Reference Identification Qualifier ZZ Mutually Defined	Code qualifying the Reference Identification Health Care Provider Taxonomy Code list	REQUIRED PRV02 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 PRV03 127 M AN 1/30
	ADDITIONAL REFERRING PROVIDER NAME INFORMATION (N2)		To specify additional names or those longer than 35 characters in length. Required if the name in NM103 is greater than 35 characters.	SITUATIONAL
		Name	Free-form name - additional text	REQUIRED N201 93 M AN 1/60
	REFERRING PROVIDER SECONDARY IDENTIFICATION (REF)		To specify identifying information. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.	
		Reference Identification Qualifier 0B State License Number 1B Blue Shield Provider Number 1C Medicare Provider Number 1D Medicaid Provider Number 1G Provider UPIN Number 1H CHAMPUS Identification Number	Code qualifying the Reference Identification	REQUIRED REF01 128 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
LOOP 2420G OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER	OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER (NM1)	EI Employer's Identification Number G2 Provider Commercial Number LU Location Number N5 Provider Plan Network Identification SY Social Security Number X5 State Industrial Accident Provider Number	The social security number may not be used for Medicare.	
		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
			To supply the full name of an individual or organizational entity. Required when it is necessary, in COB situations, to send a payer-specific line level referral number or prior authorization number. The payer-specific numbers carried in the REF in this loop belong to the non-destination (COB) payers. The strategy in using this loop is to use NM109 to identify which payer the prior authorization/referral number carried in the REF of this loop belongs to. For example, if there are 2 COB payers (non-destination payers) who have additional referral numbers for this service line the data string for the 2420G loop would look like this: NM1*PR*2*****PI*PAYER #1 ID- (This payer ID would be identified in an iteration of loop 2330B in it's own 2320 loop) REF*9F*AAAAAA-NM1*PR*2*****PI*PAYER#2 ID- (This payer ID would also be identified in an iteration of loop 2330B in it's own 2320 loop) REF*9F*2BBBBBB- Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment.	SITUATIONAL
		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 Identification Code Qualifier PI Payor Identification XV Health Care Financing Administration National PlanID	Individual last name or organizational name. 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 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	REQUIRED NM103 1035 O AN 1/35

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
LOOP 2430 LINE ADJUDICATION INFORMATION	LINE ADJUDICATION INFORMATION (SVD)	Identification Code	Code identifying a party or other code. Must match corresponding Other Payer Identifier in NM109 in 2330B loop(s).	REQUIRED NM109 67 X AN 2/80
		OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER (REF)	To specify identifying information. Non-destination (COB) payers' provider identification number(s).	REQUIRED
		Reference Identification Qualifier 9F Referral Number G1 Prior Authorization 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 To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers . To show unbundled lines: If, in the original claim, line 3 is unbundled into (for examples) 2 additional lines, then the SVD for line 3 is used 3 times: once for the original adjustment to line 3 and then two more times for the additional unbundled lines. If a line item control number (REF01 = 6R) exists for the line, that number may be used in SVD06 instead of the LX number when a line is unbundled. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.	REQUIRED REF02 127 X AN 1/30 SITUATIONAL
		Identification Code	Code identifying a party or other code. SVD01 is the payer identification code. This number should match NM109 in Loop ID-2330B identifying Other Payer.	REQUIRED SVD01 67 M AN 2/80
		Monetary Amount	Monetary amount. SVD02 is the amount paid for this service line. Zero "0" is an acceptable value for this element. FAO-52.0. The FAO-52.0 NSF crosswalk is only used in payer-to-payer COB situations.	REQUIRED SVD02 782 M R 1/18
		COMPOSITE MEDICAL PROCEDURE IDENTIFIER	To identify a medical procedure by its standardized codes and applicable modifiers. This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transmission.	REQUIRED SVD03 C003
		Product/Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID (234)	REQUIRED SVD03 - 1 235 M ID 2/2
		HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes	Because the AMA's CPT codes are also level 1. HCPCS codes, they are reported under HC. CODE SOURCE 130: Health Care Financing Administration Common Procedural Coding System.	

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		IV Home Infusion EDI Coalition (HIEC) Product/Service Code	CODE SOURCE 513: Home Infusion EDI Coalition (HEIC) 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	
		ZZ Mutually Defined	Jurisdictionally Defined Procedure and Supply Codes. (Used for Worker's Compensation claims). Contact your local (State) Jurisdiction for a list of these codes.	
		Product/Service ID	Identifying number for a product or service	REQUIRED SVD03 - 2 234 ID M AN
		Procedure Modifier	This identifies special circumstances related to the performance of the service, as defined by trading partners. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Use this modifier for the first procedural code modifier.	SITUATIONAL SVD03 - 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 a modifier clarifies/improves the reporting accuracy of the associated procedure code. Use this modifier for the second procedure code modifier.	SITUATIONAL SVD03 - 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 a modifier clarifies/improves the reporting accuracy of the associated procedure code. Use this modifier for the third procedure code modifier.	SITUATIONAL SVD03 - 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 a modifier clarifies/improves the reporting accuracy of the associated procedure code. Use this modifier for the fourth procedure code modifier.	SITUATIONAL SVD03 - 6 1339 O AN 2/2
		Description	A free-form description to clarify the related data elements and their content. Required if SVC01-7 was returned in the 835 transaction.	SITUATIONAL SVD03 - 7 352 O AN 1/80
		Quantity	Numeric value of quantity. SVD05 is the paid units of service. Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.	REQUIRED SVD05 380 O R 1/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES	
		Assigned Number	Number assigned for differentiation within a transaction set. SVD06 is only used for bundling of service lines. It references the LX. Assigned Number of the service line into which this service line was bundled. Use the LX from this transaction which points to the bundled/unbundled line. Required if payer bundled/unbundled this service line. Assigned Number of the service line into which this service line was bundled. Use the LX from this transaction which points to the bundled/unbundled line.	SITUATIONAL SVD06 554 O N0 1/6	
	LINE 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. Required if the payer identified in Loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged. Mapping CAS information into a flat file format may involve reading specific Claim Adjustment Reason Codes and then mapping the subsequent Monetary Amount and/or Quantity elements to specific fields in the flat file. There are some NSF COB elements which are covered through the use of the CAS segment. Please see the claim level CAS segment for a note on handling those crosswalks at the claim level. Some of that information may apply at the line level. Further information is given below which is more specific to line level issues. Balance bill limiting charge (FA0-54.0). The adjustment for this information would be conveyed in a CAS amount element if the provider billed for more than they were allowed to under contract.		
		Claim Adjustment Group Code CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	Code identifying the general category of payment adjustment	REQUIRED CAS01 1033 M ID 1/2	
		Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made. CODE SOURCE 139: Claim Adjustment Reason Code NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use the Claim Adjustment Reason Code list.	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. NSF Reference: FA0-27.0, FA0-28.0, FA0-35.0, FA0-48.0, FBO-06.0, FBO-07.0, FBO-08.0, FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FA0-53.0, FA0-54.0. Use this amount for the adjustment amount.	REQUIRED CAS03 782 M R 1/18	
		Quantity	Numeric value of quantity. CAS04 is the units of service being adjusted. Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS04 380 O R 1/15	
			Claim Adjustment Reason Code	Code identifying the detailed reason the adjustment was made	SITUATIONAL CAS05 1034 X ID 1/5

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
			CODE SOURCE 139 Claim Adjustment Reason Code. NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list.	
		Monetary Amount	Monetary amount. NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use the Claim Adjustment Reason Code list.	SITUATIONAL CAS06 782 X R 1/18
		Quantity	Numeric value of quantity. CAS07 is the units of service being adjusted. Use this quantity for the units of service being adjusted. Use as needed to who payer adjustment.	SITUATIONAL CAS07 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. NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list.	SITUATIONAL CAS08 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS09 is the amount of the adjustment. FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FAO-53.0, FAO-54.0. Use this amount for the adjustment amount. Use as needed to show payer adjustment.	SITUATIONAL CAS09 782 X R 1/18
		Quantity	Numeric value of quantity. CAS10 is the units of service being adjusted. Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	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. NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list.	SITUATIONAL CAS11 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS12 is the amount of the adjustment. NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FAO-53.0, FAO-54.0. Use this amount for the adjustment amount. Use as needed to show payer adjustment.	SITUATIONAL CAS12 782 X R 1/18
		Quantity	Numeric value of quantity. CAS13 is the units of service being adjusted. Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS13 380 X R 1/15

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	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. NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list.	SITUATIONAL CAS14 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS15 is the amount of the adjustment. NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FAO-53.0, FAO-54.0. Use this amount for the adjustment amount. Use as needed to show payer adjustment.	SITUATIONAL CAS15 782 X R 1/18
		Quantity	Numeric value of quantity. CAS16 is the units of service being adjusted. Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	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. NSF Reference: FB3-050, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0. Use as needed to show payer adjustment. Use the Claim Adjustment Reason Code list.	SITUATIONAL CAS17 1034 X ID 1/5
		Monetary Amount	Monetary amount. CAS18 is the amount of the adjustment. NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0, FAO-53.0, FAO-54.0. Use this amount for the adjustment amount. Use as needed to show payer adjustment.	SITUATIONAL CAS18 782 X R 1/18
		Quantity	Numeric value of quantity. CAS19 is the units of service being adjusted. Use this quantity for the units of service being adjusted. Use as needed to show payer adjustment.	SITUATIONAL CAS19 380 X R 1/15
	LINE ADJUDICATION DATE (DTP)		To specify any or all of a date, a time, or a time period	
		Date/Time Qualifier 573 Date Claim Paid	Code specifying type of date or time, or both date and time	REQUIRED DTP01 374 M ID 3/3
		Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	Code indicating the date format, time format, or date and time format. DTP02 is the date or time or period format that will appear in DTP03.	REQUIRED DTP02 1250 M ID 2/3

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Date Time Period	Expression of a date, a time, or range of dates, times or dates and times	REQUIRED DTP03 1251 M AN 1/35
LOOP 2440 FORM IDENTIFICATION CODE	FORM IDENTIFICATION CODE (LQ)		Required if the provider is required to routinely include supporting documentation (a standardized paper form) in electronic format. An example is for Medicare DMERC claims for which the provider is required to obtain a certificate of medical necessity (CMN) from the physician. Medicare or other payers may require other supporting documentation for other types of claims (e.g., home health). The 2440 loop is designed to allow providers to attach any type of standardized supplemental information to the claim when required to do so by the payer. The LQ segment contains information to identify the form (LQ01) and the specific form number (LQ02). Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then the LQ and FRM segments are "Required". Loop 2440 was approved by ASC X12 in the version 004011 Data Dictionary but is included in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entities who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this loop. Code to	SITUATIONAL
		Code List Qualifier Code	Code identifying a specific industry code list	REQUIRED LQ01 1270 O ID 1/3
		AS Form Type Code	Use code AS to indicate that a Home Health form is being identified.	
		UT Health Care Financing Administration (HCFA) Durable Medical Equipment Regional (DMERC) Certificate of Medical Necessity (CMN) Forms		
		Industry Code	Code indicating a code from a specific industry code list. NSF Reference: GUO-25.0	REQUIRED LQ02 1271 X AN 1/30
	SUPPORTING DOCUMENTATION (FRM)		To specify information in response to a codified questionnaire document. The LQ segment is used to identify the general (LQ01) and specific type (LQ02) for the form being reported in the 2440. The FRM segment is used to answer specific questions on the form identified in the LQ. FRM01 is used to indicate the question being answered. Answers can take one of 4 forms: FRM02 for Yes/No questions, FRM03 for text/uncodified answers, FRM04 for answers which use dates, and FRM05 for answers which are percents. For each FRM01 (question) use a remaining FRM element, choosing the element which has the most appropriate format. One FRM segment is used for each question/answer pair. Loop 2440 was approved by ASC X12 in the version 004011 Data Dictionary but is included in this guide to provide standard way to report DMERC claims within the HIPAA implementation time frame. It is recommended that entities who have a need to submit or receive DMERC claims customize their 004010 translator map to allow this loop.	REQUIRED

HIPAA HEALTH CARE CLAIM: PROFESSIONAL (837) Master Data Set for Decision Support 2000+ (DRAFT)

III. Data Element Tables

LOOPS	SEGMENTS	DATA ELEMENTS and CATEGORIES	PURPOSE AND DEFINITIONS	ATTRIBUTES
		Assigned Identification	Alphanumeric characters assigned for differentiation within a transaction set. FRM01 is the question number on a questionnaire or codified form.	REQUIRED FRM01 350 M AN 1/20
		Yes/No Condition or Response Code N No W Not Applicable Y Yes	Code indicating a Yes or No condition or response FRM02, FRM03, FRM04 and FRM05 are responses which only have meaning in reference to the question identified in FRM01. GUO-26.0, GUO-27.0, GUO-28.0, GUO-29.0, GUO-30.0, GUO-31.0, GUO-32.0, GUO-33.0, GUO-34.0, GUO-35.0, GUO-36.0, GUO-37.0, GUO-38.0, GUO-39.0, GUO-40.0, GUO-43.0, GUO-44.0. FRM02, 03, 04, or 05 is required. Used to answer question identified in FRM01 which utilizes a Yes/No response format.	SITUATIONAL FRM02 1073 X ID 1/1
		Reference Identification	Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier. GUO-28.0, GUO-31.0, GUO-33.0, GUO-45.0, GUO-46.0, GUO-47.0, GUO-48.0, GUO-49.0, GUO-50.0, GUO-51.0, GUO-57.0, GUO-58.0, GUO-59.0, GUO-60.0, GUO-61.0, GUO-62.0, GUO-63.0, GUO-64.0, GUO-65.0, GUO-66.0, GUO-67.0, GUO-68.0. FRM02, 03, 04, or 05 is required. Used to answer question identified in FRM01 which utilizes a text or uncoded response format.	SITUATIONAL FRM03 127 X AN 1/30
		Date	Date expressed as CCYYMMDD. NSF Reference: GUO-53.0, GUO-54.0, GUO-55.0, GUO-56.0. FRM02, 03, 04 or 05 is required. Used to answer question identified in FRM01 which utilizes a date response format.	SITUATIONAL FRM04 373 X DT 8/8
	TRANSACTION SET TRAILER - SE Transaction Set Trailer		To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)	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 Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.	REQUIRED SE02 329 M AN 4/9

IV. Key Terms and Important Issues

A. Business Definitions

Dependent

A dependent is an individual who is eligible for coverage because of his or her association with a subscriber. Typically, a dependent is a member of the subscriber's family.

Insured or Member

An insured individual or member is a subscriber or dependent who has been enrolled for coverage under an insurance plan. Dependents of a Subscriber who have not been individually enrolled for coverage are not included in Insured or Member.

Patient

The patient is a person covered by the subscriber's insurance plan who receives the health care services. The patient may be the subscriber or a dependent.

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 an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups.

Provider

Health care providers are individuals and organizations that provide health care services. Health care providers can include physicians, hospitals, clinics, pharmacies, long-term care facilities, and entities providing medical information to meet regulatory requirements. The legal definition of health care provider is included in section 262, Administrative Simplification, of the Health Insurance Portability and Accountability Act of 1996.



Generically, in this transaction, the provider is the entity that originally submitted the claim/encounter. Specifically, a provider may also have provided or participated in some aspect of the health care services described in the transaction as a billing provider, referring provider, supervising provider, etc.

Regulatory Agency

A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Secondary Payer

The secondary payer is a payer other than the primary payer and may be secondary, tertiary or even quaternary.

Submitter and Receiver

The submitter is the entity who initially formats the claim data into the transaction and begins the transmission chain, even though there is a provider who “submits” information in the form of paper or some other non-standard EDI transaction to the “submitter”. The receiver is the entity who receives the claim transmission on behalf of one or many payer organizations (e.g., a Preferred Provider Organization (PPO), a reprinter, or any of several other payer-associated entities that can perform a variety of functions for the payer such as Value-Added Networks or Automated Clearing Houses. The submitter defines, by trading partner agreement, who the claim receiver is.

Providers function as submitters when they format their own claim data into a claim transmission package; when a provider uses another entity to format its claim data that entity is the submitter, not the provider.

Subscriber

The subscriber is an individual eligible for coverage because of his or her association with a sponsor. His or her name is listed in the health insurance policy. Synonyms include “member” and “insured”. The subscriber may or may not be the patient. Examples of subscribers include the following: employees; union members; and individuals covered under government programs, such as Medicare and Medicaid.



Transmission intermediary

The transmission intermediary is the entity that handles the transaction between the provider (originator of the claim/encounter transmission) and the destination payer. The term “intermediary” is not used to convey a specific Medicare contractor type.

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.

For example, while a payer who does not pay claims with certain home health information must still be able to electronically accept a claim transaction with home health data, the payer is not required to bring that data into its adjudication system, and can ignore such data within the data set. Trading partners should specify the data they are able to “process” or act upon most efficiently and the data they require or would prefer to have in order to efficiently adjudicate a claim. This “subset” of data must not contain any loops, segments, elements or codes that are not included in the HIPAA implementation guide and the order of data must not be changed.

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”

Professional claims span an enormous variety of health care professional specialties and payment situations. Because of this, it is difficult to set a single list of data elements that are required for all types of professional health care claims. To meet the divergent needs of professional claim submitters, many data segments and elements included in the implementation guide are marked “situational” and have notes specifying when they should be used. Some elements (e.g., procedure code modifiers) are used at the discretion of the claim submitter — their use is based on the specific health care provided.

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.

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 Health Care Claim (837) transactions generally function in a batch mode with the possible exception of preadjudication or predetermination of benefits situations (determined by trading partner agreements).



Interactions with Other Transactions

The Health Care Claim: Professional transaction interacts with other transactions including the following:

- Functional Acknowledgment (997) which is used as the first response to receiving an 837, informing the 837 submitter that the transmission arrived.
- Unsolicited Claim Status (277) which may be used as the second response to receiving an 837 and indicates which claims in an 837 batch were received electronically but not yet accepted into the adjudication system, which were accepted into the adjudication system (i.e., which claims passed the front-end edits) and which claims were rejected before entering the adjudication system.
- Unsolicited Claim Status (277) which is not part of HIPAA but may be used by trading partners to automate the front-end accept-reject report process.
- Remittance Advice (835) which is generated by the payer's adjudication system.





V. List of External Code Sources Needed for this Transaction

- 5 Countries, Currencies and Funds
- 22 States and Outlying Areas of the U.S.
- 41 Universal Product Code
- 51 ZIP Code
- 77 X12 Directories
- 121 Health Industry
- 130 Health Care Financing Administration Common Procedural Coding System
- 131 International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
- 139 Claim Adjustment Reason Code
- 235 Claim Frequency Type Code
- 237 Place of Service from Health Care Financing
- 240 National Drug Code by Format
- 245 National Association of Insurance Commissioners (NAIC) Code
- 411 Remittance Remark Codes
- 513 Home Infusion EDI Coalition (HIEC) Product/Service Code List
- 522 Health Industry Labeler Identification Code
- 540 Health Care Financing Administration National PlanID

