

# **837 Health Care Claim: Institutional**

HIPAA/V4010X096A1/837: 837 Health Care Claim: Institutional

**Version: 6.6 Final**

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# 837 Health Care Claim: Institutional

Functional Group=HC

## Not Defined:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	ISA	Interchange Control Header	M	1			Required
	GS	Functional Group Header	M	1			Required

## Heading:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
005	ST	Transaction Set Header	M	1			Required
010	BHT	Beginning of Hierarchical Transaction	M	1			Required
015	REF	Transmission Type Identification	O	1			Required

<u>LOOP ID - 1000A</u>					<u>1</u>	<u>N1/020L</u>	
020	NM1	Submitter Name	O	1		N1/020	Required
045	PER	Submitter EDI Contact Information	O	2			Required

<u>LOOP ID - 1000B</u>					<u>1</u>	<u>N1/020L</u>	
020	NM1	Receiver Name	O	1		N1/020	Required

## Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
<u>LOOP ID - 2000A</u>					<u>&gt;1</u>		
001	HL	Billing/Pay-To Provider Hierarchical Level	M	1			Required

<u>LOOP ID - 2010AA</u>					<u>1</u>	<u>N2/015L</u>	
015	NM1	Billing Provider Name	O	1		N2/015	Required
025	N3	Billing Provider Address	O	1			Required
030	N4	Billing Provider City/State/ZIP Code	O	1			Required
035	REF	Billing Provider Secondary Identification	O	8			Situational

<u>LOOP ID - 2010AB</u>					<u>1</u>	<u>N2/015L</u>	
015	NM1	Pay-To Provider Name	O	1		N2/015	Required
025	N3	Pay-To Provider Address	O	1			Required
030	N4	Pay-To Provider City/State/ZIP Code	O	1			Required
035	REF	Pay-To Provider Secondary Identification	O	5			Situational

<u>LOOP ID - 2000B</u>					<u>&gt;1</u>		
001	HL	Subscriber Hierarchical Level	M	1			Required
005	SBR	Subscriber Information	O	1			Required

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
<b>LOOP ID - 2010BA</b>					<b><u>1</u></b>	<b><u>N2/015L</u></b>	
015	NM1	Subscriber Name	O	1		N2/015	Required
025	N3	Subscriber Address	O	1			Required
030	N4	Subscriber City/State/ZIP Code	O	1			Required
032	DMG	Subscriber Demographic Information	O	1			Required
035	REF	Subscriber Secondary Identification	O	4			Situational
<b>LOOP ID - 2010BC</b>					<b><u>1</u></b>	<b><u>N2/015L</u></b>	
015	NM1	Payer Name	O	1		N2/015	Required
<b>LOOP ID - 2300</b>					<b><u>100</u></b>		
130	CLM	Claim information	O	1			Required
135	DTP	Discharge Hour	O	1			Situational
135	DTP	Statement Dates	O	1			Required
135	DTP	Admission Date/Hour	O	1			Situational
140	CL1	Institutional Claim Code	O	1			Situational
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational
190	NTE	Claim Note	O	10			Situational
190	NTE	Billing Note	O	1			Required
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	O	1			Situational
231	HI	Diagnosis Related Group (DRG) Information	O	1			Situational
231	HI	Other Diagnosis Information	O	2			Situational
231	HI	Principal Procedure Information	O	1			Situational
231	HI	Other Procedure Information	O	2			Situational
231	HI	Occurrence Span Information	O	2			Situational
231	HI	Occurrence Information	O	2			Situational
231	HI	Value Information	O	2			Situational
231	HI	Condition Information	O	2			Situational
231	HI	Treatment Code Information	O	2			Situational
240	QTY	Claim Quantity	O	4			Situational
<b>LOOP ID - 2310A</b>					<b><u>1</u></b>	<b><u>N2/250L</u></b>	
250	NM1	Attending Physician Name	O	1		N2/250	Required
271	REF	Attending Physician Secondary Identification	O	5			Situational
<b>LOOP ID - 2310B</b>					<b><u>1</u></b>	<b><u>N2/250L</u></b>	
250	NM1	Operating Physician Name	O	1		N2/250	Required
271	REF	Operating Physician Secondary Identification	O	5			Situational

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
<b>LOOP ID - 2310C</b>					<b><u>1</u></b>	<b><u>N2/250L</u></b>	
250	NM1	Other Provider Name	O	1		N2/250	Required
271	REF	Other Provider Secondary Identification	O	5			Situational
<b>LOOP ID - 2310E</b>					<b><u>1</u></b>	<b><u>N2/250L</u></b>	
250	NM1	Service Facility Name	O	1		N2/250	Required
265	N3	Service Facility Address	O	1			Required
270	N4	Service Facility City/State/Zip Code	O	1			Required
271	REF	Service Facility Secondary Identification	O	5			Situational
<b>LOOP ID - 2320</b>					<b><u>10</u></b>	<b><u>N2/290L</u></b>	
290	SBR	Other Subscriber Information	O	1		N2/290	Required
295	CAS	Claim Level Adjustment	O	5			Required
300	AMT	Payer Prior Payment	O	1			Required
300	AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	O	1			Situational
310	OI	Other Insurance Coverage Information	O	1			Required
<b>LOOP ID - 2330A</b>					<b><u>1</u></b>	<b><u>N2/325L</u></b>	
325	NM1	Other Subscriber Name	O	1		N2/325	Required
332	N3	Other Subscriber Address	O	1			Required
340	N4	Other Subscriber City/State/ZIP Code	O	1			Required
355	REF	Other Subscriber Secondary Information	O	3			Situational
<b>LOOP ID - 2330B</b>					<b><u>1</u></b>	<b><u>N2/325L</u></b>	
325	NM1	Other Payer Name	O	1		N2/325	Required
332	N3	Other Payer Address	O	1			Required
340	N4	Other Payer City/State/ZIP Code	O	1			Required
350	DTP	Claim Adjudication Date	O	1			Required
355	REF	Other Payer Secondary Identification and Reference Number	O	2			Required
<b>LOOP ID - 2400</b>					<b><u>999</u></b>	<b><u>N2/365L</u></b>	
365	LX	Service Line Number	O	1		N2/365	Required
375	SV2	Institutional Service Line	O	1			Required
455	DTP	Service Line Date	O	1			Required
<b>LOOP ID - 2420A</b>					<b><u>1</u></b>	<b><u>N2/500L</u></b>	
500	NM1	Attending Physician Name	O	1		N2/500	Required
525	REF	Attending Physician Secondary Identification	O	1			Situational
<b>LOOP ID - 2420B</b>					<b><u>1</u></b>	<b><u>N2/500L</u></b>	
500	NM1	Operating Physician Name	O	1		N2/500	Required

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
525	REF	Operating Physician Secondary Identification	O	1			Situational
<b>LOOP ID - 2420C</b>					<b><u>1</u></b>	<b><u>N2/500L</u></b>	
500	NM1	Other Provider Name	O	1		N2/500	Required
525	REF	Other Provider Secondary Identification	O	1			Situational
<b>LOOP ID - 2430</b>					<b><u>25</u></b>		
540	SVD	Service Line Adjudication Information	O	1			Required
545	CAS	Service Line Adjustment	O	99			Required
550	DTP	Service Adjudication Date	O	1			Situational
555	SE	Transaction Set Trailer	M	1			Required

**Not Defined:**

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

**Notes:**

1. The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy will use the 837 more efficiently because information that applies to all lower levels in the hierarchy will not have to be repeated within the transaction.
2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, regulatory entities and Community Health Information Networks.

# ISA Interchange Control Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 16

User Option (Usage): Required

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
ISA01	I01	Authorization Information Qualifier	M	ID	2/2	Required

**Description:** Code to identify the type of information in the Authorization Information

**Code Name**

- 00 No Authorization Information Present (No Meaningful Information in I02)
- 03 Additional Data Identification

ISA02	I02	Authorization Information	M	AN	10/10	Required
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**Description:** Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)

ISA03	I03	Security Information Qualifier	M	ID	2/2	Required
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**Description:** Code to identify the type of information in the Security Information

**Code Name**

- 00 No Security Information Present (No Meaningful Information in I04)
- 01 Password

ISA04	I04	Security Information	M	AN	10/10	Required
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**Description:** This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

ISA05	I05	Interchange ID Qualifier	M	ID	2/2	Required
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**Description:** Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

**Notes:** This ID qualifies the Sender in ISA06.

**Code Name**

- ZZ Mutually Defined  
Submitter ID

ISA06	I06	Interchange Sender ID	M	AN	15/15	Required
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**Description:** Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element

**All Programs:** This is the Submitter ID, a single value supplied to the business entity (plan) by HHSC.

ISA07	I05	Interchange ID Qualifier	M	ID	2/2	Required
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**Description:** Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

**Notes:** This ID qualifies the Receiver in ISA08.

		<u>Code</u>	<u>Name</u>				
		ZZ	Mutually Defined Receiver ID				
ISA08	I07	<b>Interchange Receiver ID</b>		M	AN	15/15	Required
		<b>Description:</b> Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them					
		<b>All Programs:</b> 617591011TEDT (Test); 617591011TEDP (Production)					
ISA09	I08	<b>Interchange Date</b>		M	DT	6/6	Required
		<b>Description:</b> Date of the interchange					
		<b>Notes:</b> The date format is YYMMDD.					
ISA10	I09	<b>Interchange Time</b>		M	TM	4/4	Required
		<b>Description:</b> Time of the interchange					
		<b>Notes:</b> The time format is HHMM.					
ISA11	I10	<b>Interchange Control Standards Identifier</b>		M	ID	1/1	Required
		<b>Description:</b> Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer					
		<u>Code</u>	<u>Name</u>				
		U	U.S. EDI Community of ASC X12, TDCC, and UCS				
ISA12	I11	<b>Interchange Control Version Number</b>		M	ID	5/5	Required
		<b>Description:</b> Code specifying the version number of the interchange control segments					
		<u>Code</u>	<u>Name</u>				
		00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997				
ISA13	I12	<b>Interchange Control Number</b>		M	NO	9/9	Required
		<b>Description:</b> A control number assigned by the interchange sender					
		<b>Notes:</b> The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.					
ISA14	I13	<b>Acknowledgment Requested</b>		M	ID	1/1	Required
		<b>Description:</b> Code sent by the sender to request an interchange acknowledgment (TA1)					
		<u>Code</u>	<u>Name</u>				
		0	No Acknowledgment Requested				
		1	Interchange Acknowledgment Requested				
ISA15	I14	<b>Usage Indicator</b>		M	ID	1/1	Required
		<b>Description:</b> Code to indicate whether data enclosed by this interchange envelope is test, production or information					
		<u>Code</u>	<u>Name</u>				
		P	Production Data				
ISA16	I15	<b>Component Element Separator</b>		M		1/1	Required
		<b>Description:</b> Type is not applicable; the component element separator is a delimiter and not					

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator				

**Notes:**

The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by '.' for clarity.

**Example:**

ISA\*00\* .....\*01\*SECRET....\*ZZ\*SUBMITTERS.ID..\*ZZ\*RECEIVERS.ID...\*930602\*1253\*U\*00401\*000000905\*1  
\*P\*::~

# GS Functional Group Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 8

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS01	479	<b>Functional Identifier Code</b>	M	ID	2/2	Required
<p><b>Description:</b> Code identifying a group of application related transaction sets</p> <p><b>Code Name</b>                      HC Health Care Claim (837)</p>						
GS02	142	<b>Application Sender's Code</b>	M	AN	2/15	Required
<p><b>Description:</b> Code identifying party sending transmission; codes agreed to by trading partners</p> <p><b>Notes:</b> Use this code to identify the unit sending the information.</p> <p><b>All Programs:</b> Submitter ID</p>						
GS03	124	<b>Application Receiver's Code</b>	M	AN	2/15	Required
<p><b>Description:</b> Code identifying party receiving transmission; codes agreed to by trading partners</p> <p><b>Notes:</b> Use this code to identify the unit receiving the information.</p> <p><b>All Programs:</b> 617591011TEDT (Test); 617591011TEDP (Production)</p>						
GS04	373	<b>Date</b>	M	DT	8/8	Required
<p><b>Description:</b> Date expressed as CCYYMMDD</p> <p><b>Notes:</b> Use this date for the functional group creation date.</p>						
GS05	337	<b>Time</b>	M	TM	4/8	Required
<p><b>Description:</b> Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)</p> <p><b>Notes:</b> Use this time for the creation time. The recommended format is HHMM.</p>						
GS06	28	<b>Group Control Number</b>	M	N0	1/9	Required
<p><b>Description:</b> Assigned number originated and maintained by the sender</p>						
GS07	455	<b>Responsible Agency Code</b>	M	ID	1/2	Required
<p><b>Description:</b> Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480</p> <p><b>Code Name</b>                      X Accredited Standards Committee X12</p>						
GS08	480	<b>Version / Release / Industry Identifier Code</b>	M	AN	1/12	Required
<p><b>Description:</b> Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the</p>						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user); if code in DE455 in GS segment is T, then other formats are allowed				
		<u>Code</u>	<u>Name</u>			
		004010X096	Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.			
		A1				

**Semantics:**

1. GS04 is the group date.
2. GS05 is the group time.
3. The data interchange control number GS06 in this header must be identical to the same data element in the associated functional group trailer, GE02.

**Comments:**

1. A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

**Example:**

GS\*HC\*SENDER CODE\*RECEIVER CODE\*19940331\*0802\*1\*X\*004010X096~

# ST Transaction Set Header

Pos: 005	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	Transaction Set Identifier Code	M	ID	3/3	Required

**Description:** Code uniquely identifying a Transaction Set

**Code Name**

837 Health Care Claim

ST02	329	Transaction Set Control Number	M	AN	4/9	Required
------	-----	--------------------------------	---	----	-----	----------

**Description:** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

**Notes:** The Transaction Set Control Number in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could be 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.

## Semantics:

1. 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).

## Example:

ST\*837\*987654~

# BHT Beginning of Hierarchical Transaction

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 6

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
BHT01	1005	Hierarchical Structure Code	M	ID	4/4	Required

**Description:** Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set

**Code Name**

0019 Information Source, Subscriber, Dependent

BHT02	353	Transaction Set Purpose Code	M	ID	2/2	Required
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**Description:** Code identifying purpose of transaction set

**Code Name**

00 Original

BHT03	127	Reference Identification	O	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Use this reference identifier to identify the inventory file number of the tape or transmission assigned by the submitter's system.

BHT04	373	Date	O	DT	8/8	Required
-------	-----	------	---	----	-----	----------

**Description:** Date expressed as CCYYMMDD

**Notes:** Transaction Set Creation Date

BHT05	337	Time	O	TM	4/8	Required
-------	-----	------	---	----	-----	----------

**Description:** 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)

**Notes:** Transaction Set Creation Time

BHT06	640	Transaction Type Code	O	ID	2/2	Required
-------	-----	-----------------------	---	----	-----	----------

**Description:** Code specifying the type of transaction

**Notes:** Claim or Encounter Identifier

**All Programs:** Use RP when the entire ST-SE envelope contains encounter transmissions.

**Code Name**

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.

**Semantics:**

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

**Example:**

BHT\*0019\*00\*0123\*19960618\*0932\*RP~

**All Programs:**

It is understood that some transactions in the file were received by your organization as claims. However, all transactions sent from your organization to TMHP are defined as encounters.

# REF Transmission Type Identification

Pos: 015	Max: 1
Heading - Optional	
Loop: N/A	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

87 Functional Category

REF02	127	Reference Identification	C	AN	1/30	Required
-------	-----	--------------------------	---	----	------	----------

**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** This value is the designation of the 837 Institutional Transaction that is being used to submit encounters.

**All Programs:** When sending the transaction set in a production mode, this value is 004010X096A1.

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Example:

REF\*87\*004010X096A1~

# Loop 1000A

Pos: 020	Repeat: 1
Optional	
Loop: 1000A	Elements: N/A

**User Option (Usage):** Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
020	NM1	Submitter Name	O	1		Required
045	PER	Submitter EDI Contact Information	O	2		Required

## Semantics:

- NM102 qualifies NM103.

## Notes:

The name of the entity submitting the file to TMHP. The entity is either the plan itself or an entity representing the plan.

## Example:

NM1\*41\*2\*SouthCentral Texas HMO Inc\*\*\*\*\*46\*99999999~

# NM1 Submitter Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 9

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
41 Submitter						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
1 Person						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> The name of the plan submitting the file to TMHP						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
46 Electronic Transmitter Identification Number (ETIN) Established by a trading partner agreement						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> MCO Submitter ID assigned by TMHP						
<b>All Programs:</b> TMHP assigned Submitter ID						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Example:

NM1\*41\*2\*SouthCentral Texas HMO Inc\*\*\*\*\*46\*999999999~

# PER Submitter EDI Contact Information

Pos: 045	Max: 2
Heading - Optional	
Loop: 1000A	Elements: 9

User Option (Usage): Required

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
PER01	366	Contact Function Code	M	ID	2/2	Required
<p><b>Description:</b> Code identifying the major duty or responsibility of the person or group named</p> <p><b>Code Name</b> IC Information Contact</p>						
PER02	93	Name	O	AN	1/60	Required
<p><b>Description:</b> Free-form name</p> <p><b>Notes:</b> Submitter Contact Name</p>						
PER03	365	Communication Number Qualifier	C	ID	2/2	Required
<p><b>Description:</b> Code identifying the type of communication number</p> <p><b>Code Name</b> TE Telephone</p>						
PER04	364	Communication Number	C	AN	1/80	Required
<p><b>Description:</b> Complete communications number including country or area code when applicable</p>						

## Syntax Rules:

1. P0304 - If either PER03 or PER04 is present, then the other is required.

## Notes:

1. 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.
2. The telephone number should always include the area code.

## Example:

PER\*IC\*JANE DOE\*TE\*900555555~

# Loop 1000B

Pos: 020	Repeat: 1
Optional	
Loop: 1000B	Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
020	NM1	Receiver Name	O	1		Required

## Semantics:

- NM102 qualifies NM103.

## Notes:

The entity receiving the transmission

## Example:

NM1\*40\*2\*TMHP\*\*\*\*\*46\*617591011TEDP~

## All Programs:

"TMHP" expected in this loop.

# NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 9

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
40 Receiver						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>All Programs:</b> "TMHP" is expected in this field.						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Notes:</b> Information Receiver Identification Number						
<b>Code Name</b>						
46 Electronic Transmitter Identification Number (ETIN)						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>All Programs:</b> 617591011TEDP (Production)						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Example:

NM1\*40\*2\*TMHP\*\*\*\*\*46\*617591011TEDP~

## All Programs:

"TMHP" is expected in this segment.

# Loop 2000A

Pos: 001	Repeat: >1
Mandatory	
Loop: 2000A	Elements: N/A

**User Option (Usage):** Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
001	HL	Billing/Pay-To Provider Hierarchical Level	M	1		Required
015		Loop 2010AA	O		1	Required
015		Loop 2010AB	O		1	Situational

## Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. 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.
4. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
5. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

## Notes:

1. Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the plan. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
2. 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.
3. 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.
4. 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. TMHP file size limit is 75 MB.

## Example:

HL\*1\*\*20\*1~

# HL Billing/Pay-To Provider Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000A	Elements: 3

User Option (Usage): Required

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
HL01	628	Hierarchical ID Number	M	AN	1/12	Required
<p><b>Description:</b> A unique number assigned by the sender to identify a particular data segment in a hierarchical structure</p> <p><b>Notes:</b> 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.</p>						
HL03	735	Hierarchical Level Code	M	ID	1/2	Required
<p><b>Description:</b> Code defining the characteristic of a level in a hierarchical structure</p> <p><b>Code Name</b></p> <p>20 Information Source</p>						
HL04	736	Hierarchical Child Code	O	ID	1/1	Required
<p><b>Description:</b> Code indicating if there are hierarchical child data segments subordinate to the level being described</p> <p><b>Notes:</b> The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).</p> <p><b>Code Name</b></p> <p>1 Additional Subordinate HL Data Segment in This Hierarchical Structure.</p>						

## Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. 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.
4. HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
5. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

## Notes:

1. Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the plan. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.
2. 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.
3. 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.
4. 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. TMHP file size limit is 75MB.

**Example:**

HL\*1\*\*20\*1~

# Loop 2010AA

Pos: 015	Repeat: 1
Optional	
Loop: 2010AA	Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Billing Provider Name	O	1		Required
025	N3	Billing Provider Address	O	1		Required
030	N4	Billing Provider City/State/ZIP Code	O	1		Required
035	REF	Billing Provider Secondary Identification	O	8		Situational

## Semantics:

- NM102 qualifies NM103

## Notes:

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.

## Example:

NM1\*85\*2\*ELLIS HOSPITAL\*\*\*\*\*24\*123456789~

# NM1 Billing Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 9

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
85 Billing Provider						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Billing Provider Last or Organizational Name						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Notes:</b> 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.						
<b>Code Name</b>						
24 Employer's Identification Number						
34 Social Security Number						
XX Health Care Financing Administration National Provider Identifier						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Billing Provider Primary Identifier						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Notes:

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.

**Example:**

NM1\*85\*2\*ELLIS HOSPITAL\*\*\*\*\*24\*123456789~

# N3 Billing Provider Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b>	M	AN	1/55	Required
		<b>Description:</b> Address information				
		<b>Notes:</b> Billing Provider Address Line 1				
N302	166	<b>Address Information</b>	O	AN	1/55	Situational
		<b>Description:</b> Address information				
		<b>Notes:</b> Billing Provider Address Line 2				

## Example:

N3\*225 MAIN STREET BARKLEY BUILDING~

# N4 Billing Provider City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 4

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b>	O	AN	2/30	Required
		<b>Description:</b> Free-form text for city name				
		<b>Notes:</b> Billing Provider City Name				
N402	156	<b>State or Province Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency				
		<b>Notes:</b> Billing Provider State				
N403	116	<b>Postal Code</b>	O	ID	3/15	Required
		<b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)				
		<b>Notes:</b> Billing Provider ZIP Code				
N404	26	<b>Country Code</b>	O	ID	2/3	Situational
		<b>Description:</b> Code identifying the country				
		<b>Notes:</b> Billing Provider Country Code				
		<b>All Programs:</b> This data element is required when the address is outside of the U.S.				

## Comments:

1. N402 is required only if city name (N401) is in the U.S. or Canada.

## Example:

N4\*CENTERVILLE\*PA\*17111~

# REF Billing Provider Secondary Identification

Pos: 035	Max: 8
Detail - Optional	
Loop: 2010AA	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- 1J Facility ID Number
- EI Employer's Identification Number
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Billing Provider Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
2. If "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 8 times.

## Example:

REF\*0B\*A8765~

# Loop 2010AB

Pos: 015	Repeat: 1
Optional	
Loop: 2010AB	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Pay-To Provider Name	O	1		Required
025	N3	Pay-To Provider Address	O	1		Required
030	N4	Pay-To Provider City/State/ZIP Code	O	1		Required
035	REF	Pay-To Provider Secondary Identification	O	5		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. Required if the Pay-to Provider is a different entity than the Billing Provider.
2. A common scenario for requiring the "Pay-to-Provider" loop is when the "Billing Provider" loop contains information about a billing service.

## Example:

NM1\*87\*2\*ELLIS HOSPITAL\*\*\*\*\*24\*123456789~

# NM1 Pay-To Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AB	Elements: 9

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
87 Pay-to Provider						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Pay-to Provider Last or Organizational Name						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Notes:</b> If "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.						
<b>Code Name</b>						
24 Employer's Identification Number						
34 Social Security Number						
XX Health Care Financing Administration National Provider Identifier						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Pay-to Provider Primary Identifier						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. Required if the Pay-to Provider is a different entity than the Billing Provider.
2. A common scenario for requiring the "Pay-to-Provider" loop is when the "Billing Provider" loop contains information about a billing service.
3. Another common scenario for requiring the "Pay-to-Provider" loop is when the "Billing Provider" loop contains information about a medical group and there is the need to supply information about an individual physician.

**Example:**

NM1\*87\*2\*ELLIS HOSPITAL\*\*\*\*\*24\*123456789~

# N3 Pay-To Provider Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010AB	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b>	M	AN	1/55	Required
		<b>Description:</b> Address information				
		<b>Notes:</b> Pay-to Provider Address Line 1				
N302	166	<b>Address Information</b>	O	AN	1/55	Situational
		<b>Description:</b> Address information				
		<b>Notes:</b> Pay-to Provider Address Line 2				

## Example:

N3\*2216 N. MAIN STREET\*COLDER BUILDING~

# N4 Pay-To Provider City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010AB	Elements: 4

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b>	O	AN	2/30	Required
		<b>Description:</b> Free-form text for city name				
		<b>Notes:</b> Pay-to Provider City				
N402	156	<b>State or Province Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency				
		<b>Notes:</b> Pay-to Provider State Code				
N403	116	<b>Postal Code</b>	O	ID	3/15	Required
		<b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)				
		<b>Notes:</b> Pay-to Provider ZIP Code				
N404	26	<b>Country Code</b>	O	ID	2/3	Situational
		<b>Description:</b> Code identifying the country				
		<b>Notes:</b> Pay-to Provider Country Code				
		<b>All Programs:</b> This data element is required when the address is outside the U.S.				

## Comments:

1. N402 is required only if city name (N401) is in the U.S. or Canada.

## Example:

N4\*MADISON\*NY\*18298~

# REF Pay-To Provider Secondary Identification

Pos: 035	Max: 5
Detail - Optional	
Loop: 2010AB	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- 1J Facility ID Number
- EI Employer's Identification Number
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Pay-to Provider Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
2. If "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.

## Example:

REF\*EI\*987652311~

<h1 style="margin: 0;">Loop 2000B</h1>	<b>Pos: 001</b> <b>Repeat: &gt;1</b> <b>Mandatory</b> <b>Loop: 2000B</b> <b>Elements: N/A</b>
--	---

**User Option (Usage):** Required

**Loop Summary:**

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
001	HL	Subscriber Hierarchical Level	M	1		Required
005	SBR	Subscriber Information	O	1		Required
015		Loop 2010BA	O		1	Required
015		Loop 2010BC	O		1	Required
130		Loop 2300	O		100	Required

**Comments:**

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. 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.
4. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
5. 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.
6. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

**Notes:**

1. Since the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. 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 Subscriber Hierarchical Level loops, there is an implied maximum of 5000. TMHP file size limit is 75MB.

**Example:**

HL\*124\*123\*22\*1~

# HL Subscriber Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000B	Elements: 4

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL01	628	<b>Hierarchical ID Number</b>	M	AN	1/12	Required
<b>Description:</b> A unique number assigned by the sender to identify a particular data segment in a hierarchical structure						
HL02	734	<b>Hierarchical Parent ID Number</b>	O	AN	1/12	Required
<b>Description:</b> Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to						
HL03	735	<b>Hierarchical Level Code</b>	M	ID	1/2	Required
<b>Description:</b> Code defining the characteristic of a level in a hierarchical structure						
<b>Code Name</b>						
22 Subscriber						
HL04	736	<b>Hierarchical Child Code</b>	O	ID	1/1	Required
<b>Description:</b> Code indicating if there are hierarchical child data segments subordinate to the level being described						
<b>Notes:</b> 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.						
<b>Code Name</b>						
0 No Subordinate HL Segment in This Hierarchical Structure.						
1 Additional Subordinate HL Data Segment in This Hierarchical Structure.						

## Comments:

1. The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.
2. The HL segment defines a top-down/left-right ordered structure.
3. 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.
4. HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
5. 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.
6. HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

## Notes:

1. Since the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.

2. 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 Subscriber Hierarchical Level loops, there is an implied maximum of 5000. TMHP file size limit is 75MB.

**Example:**

HL\*124\*123\*22\*1~

# SBR Subscriber Information

Pos: 005	Max: 1
Detail - Optional	
Loop: 2000B	Elements: 5

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SBR01	1138	<b>Payer Responsibility Sequence Number Code</b>	M	ID	1/1	Required
		<b>Description:</b> Code identifying the insurance carrier's level of responsibility for a payment of a claim				
		<b>Code Name</b>				
		P		Primary		
SBR02	1069	<b>Individual Relationship Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code indicating the relationship between two individuals or entities				
		<b>Notes:</b> Patients Relationship to Insured				
		<b>Code Name</b>				
		18		Self		
SBR09	1032	<b>Claim Filing Indicator Code</b>	O	ID	1/2	Required
		<b>Description:</b> Code identifying type of claim				
		<b>Notes:</b> Required prior to mandated used of PlanID. Not used after PlanID is mandated.				
		<b>Star-specific:</b> Use "MC"				
		<b>Chip-specific:</b> Use "11"				
		<b>STAR+Plus-specific:</b> Use "MC"				
		<b>NorthSTAR:</b> Use "MC" for Medicaid population and "11" for non-Medicaid population				
		<b>Code Name</b>				
		11		Other Non-Federal Programs		
		MC		Medicaid		

## Semantics:

1. SBR02 specifies the relationship to the person insured.

## Example:

SBR\*P\*18\*\*\*\*\*MC~

# Loop 2010BA

Pos: 015	Repeat: 1
Optional	
Loop: 2010BA	Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Subscriber Name	O	1		Required
025	N3	Subscriber Address	O	1		Required
030	N4	Subscriber City/State/ZIP Code	O	1		Required
032	DMG	Subscriber Demographic Information	O	1		Required
035	REF	Subscriber Secondary Identification	O	4		Situational

## Semantics:

- NM102 qualifies NM103.

## Notes:

The name of the enrolled member. Subscriber in this setting is the member/client/recipient.

## Example:

NM1\*IL\*1\*DOE\*JOHN\*T\*\*\*MI\*739004273~

# NM1 Subscriber Name

<b>Pos:</b> 015	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2010BA	<b>Elements:</b> 8

**User Option (Usage):** Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
IL Insured or Subscriber						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
1 Person						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Subscriber Last Name						
NM104	1036	<b>Name First</b>	O	AN	1/25	Required
<b>Description:</b> Individual first name						
<b>Notes:</b> Subscriber First Name						
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
<b>Description:</b> Individual middle name or initial						
<b>Notes:</b> Subscriber Middle Name						
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
<b>Description:</b> Suffix to individual name						
<b>Notes:</b> Subscriber Name Suffix						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
MI Member Identification Number						
The code MI is intended to be the subscriber's identification number as assigned by the program, such as the Medicaid ID or the NorthSTAR ID.						
In the event that a Social Security Number is also available, put the SSN in the REF02.						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Subscriber Primary Identifier						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Star-specific:</b> TMHP expects the Texas Medicaid ID.				
		<b>Chip-specific:</b> TMHP expects the CHIP program-issued ID.				
		<b>STAR+Plus-specific:</b> TMHP expects the Texas Medicaid ID.				
		<b>NorthSTAR:</b> TMHP expects the NorthSTAR program-issued ID.				

### Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

### Semantics:

1. NM102 qualifies NM103.

### Example:

NM1\*IL\*1\*DOE\*JOHN\*T\*\*\*MI\*739004273~

# N3 Subscriber Address

Pos: 025	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b>	M	AN	1/55	Required
		<b>Description:</b> Address information				
		<b>Notes:</b> Subscriber Address Line 1				
N302	166	<b>Address Information</b>	O	AN	1/55	Situational
		<b>Description:</b> Address information				
		<b>Notes:</b> Subscriber Address Line 2				

## Example:

N3\*125 CITY AVENUE~

# N4 Subscriber City/State/ZIP Code

Pos: 030	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 3

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b>	O	AN	2/30	Required
		<b>Description:</b> Free-form text for city name				
		<b>Notes:</b> Subscriber City				
N402	156	<b>State or Province Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency				
		<b>Notes:</b> Subscriber State Code				
N403	116	<b>Postal Code</b>	O	ID	3/15	Required
		<b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)				
		<b>Notes:</b> Subscriber ZIP Code				

## Comments:

- N402 is required only if city name (N401) is in the U.S. or Canada.

## Example:

N4\*CENTERVILLE\*PA\*17111~

# DMG Subscriber Demographic Information

Pos: 032	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 3

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DMG01	1250	Date Time Period Format Qualifier	C	ID	2/3	Required
<b>Description:</b> Code indicating the date format, time format, or date and time format						
<b>Code Name</b>						
D8 Date Expressed in Format CCYYMMDD						
DMG02	1251	Date Time Period	C	AN	1/35	Required
<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times						
<b>Notes:</b> Subscriber Birth Date						
DMG03	1068	Gender Code	O	ID	1/1	Required
<b>Description:</b> Code indicating the sex of the individual						
<b>Notes:</b> Subscriber Gender Code						
<b>Code Name</b>						
F Female						
M Male						
U Unknown						

## Syntax Rules:

1. P0102 - If either DMG01 or DMG02 is present, then the other is required.

## Semantics:

1. DMG02 is the date of birth.

## Example:

DMG\*D8\*19290730\*M~

# REF Subscriber Secondary Identification

Pos: 035	Max: 4
Detail - Optional	
Loop: 2010BA	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

SY Social Security Number

The social security number may not be used for Medicare.

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Subscriber Secondary Identifier

**Star-specific:** If used, TMHP expects the member's SSN.

**Chip-specific:** If used, TMHP expects the member's SSN.

**STAR+Plus-specific:** If used, TMHP expects the member's SSN.

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.

## Example:

REF\*SY\*030385074~

# Loop 2010BC

Pos: 015	Repeat: 1
Optional	
Loop: 2010BC	Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
015	NM1	Payer Name	O	1		Required

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. This is the destination payer, which in this case is TMHP. When the transaction arrived at the plan, this loop would have been populated with information about the plan. Now that the plan has adjudicated the transaction and is sending the encounter to TMHP, TMHP is shown here.
2. The plan is now listed as an "Other Payer" in loop 2330B.

## Example:

NM1\*PR\*2\*TMHP\*\*\*\*\*PI\*123456789~

# NM1 Payer Name

<b>Pos:</b> 015	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2010BC	<b>Elements:</b> 5

**User Option (Usage):** Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
PR Payer						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Payer Name						
<b>All Programs:</b> "TMHP" is expected in this field.						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
PI Payor Identification						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Payer Identifier						
<b>All Programs:</b> All plans will populate this field with "617591011TEDP"						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Notes:

"TMHP" is expected in this segment.

## Example:

NM1\*PR\*2\*TMHP\*\*\*\*\*PI\*123456789~

# Loop 2300

Pos: 130	Repeat: 100
Optional	
Loop: 2300	Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
130	CLM	Claim information	O	1		Required
135	DTP	Discharge Hour	O	1		Situational
135	DTP	Statement Dates	O	1		Required
135	DTP	Admission Date/Hour	O	1		Situational
140	CL1	Institutional Claim Code	O	1		Situational
180	REF	Original Reference Number (ICN/DCN)	O	1		Situational
190	NTE	Claim Note	O	10		Situational
190	NTE	Billing Note	O	1		Required
231	HI	Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information	O	1		Situational
231	HI	Diagnosis Related Group (DRG) Information	O	1		Situational
231	HI	Other Diagnosis Information	O	2		Situational
231	HI	Principal Procedure Information	O	1		Situational
231	HI	Other Procedure Information	O	2		Situational
231	HI	Occurrence Span Information	O	2		Situational
231	HI	Occurrence Information	O	2		Situational
231	HI	Value Information	O	2		Situational
231	HI	Condition Information	O	2		Situational
231	HI	Treatment Code Information	O	2		Situational
240	QTY	Claim Quantity	O	4		Situational
250		Loop 2310A	O		1	Situational
250		Loop 2310B	O		1	Situational
250		Loop 2310C	O		1	Situational
250		Loop 2310E	O		1	Situational
290		Loop 2320	O		10	Required
365		Loop 2400	O		999	Required

## Semantics:

1. CLM02 is the total amount of all submitted charges of service segments for this claim.
2. CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
3. CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

## Notes:

1. The information supplied in Loop ID-2300 applies to all service lines within Loop ID-2400 unless a segment occurs in Loop ID-2400 with the same segment description and is populated. In that case, the Loop ID-2400 information overrides the Loop ID-2300 information for that service line only.
2. The developers of this implementation guide recommend that trading partners limit the size of the transaction (SE-ST 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. TMHP file size limit is 75MB.

**Example:**

CLM\*01319300001\*500\*\*\*11:A:1\*Y\*A\*Y\*Y\*\*AA~

# CLM Claim information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 8

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CLM01	1028	<b>Claim Submitter's Identifier</b>	M	AN	1/38	Required

**Description:** Identifier used to track a claim from creation by the health care provider through payment

**Notes:** Patient Account Number

**All Programs:** 1. This is the value assigned to the transaction by the provider.  
 2. The ICN assigned to the transaction by the plan is located in 2330B/REF/REF02.  
 3. 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 any 837-receiving system.

CLM02	782	<b>Monetary Amount</b>	O	R	1/18	Required
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**Description:** Monetary amount

**Notes:** Total Claim Charge Amount

**All Programs:** Use this element to indicate the total amount of all submitted charges of service segments for this claim. Zero may be a valid amount.

CLM05	C023	<b>Health Care Service Location Information</b>	O	Comp		Required
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**Description:** 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

**Notes:** This is one of the most important composite fields in the transaction. From this composite field, information such as: "Place of Service", "Bill Type" and "Original/Adjustment/Void"

1331		<b>Facility Code Value</b>	M	AN	1/2	Required
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**Description:** 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

**Notes:** Facility Type Code

**All Programs:** Positions 1-2 (Type of Bill)

**ExternalCodeList**

**Name:** 236

**Description:** Uniform Billing Claim Form Bill Type

1332		<b>Facility Code Qualifier</b>	O	ID	1/2	Required
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**Description:** Code identifying the type of facility referenced

**Code Name**

A Uniform Billing Claim Form Bill Type

**CODE SOURCE:**

236: Uniform Billing Claim Form Bill Type

1325		<b>Claim Frequency Type Code</b>	O	ID	1/1	Required
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<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p><b>Description:</b> Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type</p> <p><b>Notes:</b> Claim Frequency Code</p> <p><b>All Programs:</b> Position 3 (Type of Bill)</p> <p>This value, among other things, identifies if the transaction is an original (1), adjustment (7) or a void (8).</p> <p><b>ExternalCodeList</b></p> <p><b>Name:</b> 235</p> <p><b>Description:</b> Claim Frequency Type Code</p>				
CLM06	1073	<b>Yes/No Condition or Response Code</b>	O	ID	1/1	Required
		<p><b>Description:</b> Code indicating a Yes or No condition or response</p> <p><b>Notes:</b> Provider or Supplier Signature Indicator</p> <p><b>Code Name</b></p> <p>N No</p> <p>Y Yes</p>				
CLM07	1359	<b>Provider Accept Assignment Code</b>	O	ID	1/1	Situational
		<p><b>Description:</b> Code indicating whether the provider accepts assignment</p> <p><b>Notes:</b> Medicare Assignment Code</p> <p><b>Code Name</b></p> <p>A Assigned</p> <p>C Not Assigned</p>				
CLM08	1073	<b>Yes/No Condition or Response Code</b>	O	ID	1/1	Required
		<p><b>Description:</b> Code indicating a Yes or No condition or response</p> <p><b>Notes:</b> Benefits Assignment Certification Indicator</p> <p><b>Code Name</b></p> <p>N No</p> <p>Y Yes</p>				
CLM09	1363	<b>Release of Information Code</b>	O	ID	1/1	Required
		<p><b>Description:</b> Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations</p> <p><b>Notes:</b> Release of Information Code</p> <p><b>Code Name</b></p> <p>A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization</p> <p>I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes</p> <p>M The Provider has Limited or Restricted Ability to Release Data Related to a Claim</p> <p>N No, Provider is Not Allowed to Release Data</p> <p>O On file at Payor or at Plan Sponsor</p> <p>Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim</p>				
CLM18	1073	<b>Yes/No Condition or Response Code</b>	O	ID	1/1	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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**Description:** Code indicating a Yes or No condition or response

**Notes:** Explanation of Benefits Indicator

<u>Code</u>	<u>Name</u>
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N	No
Y	Yes

**Semantics:**

1. CLM02 is the total amount of all submitted charges of service segments for this claim.
2. CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
3. CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

**Notes:**

1. The information supplied in Loop ID-2300 applies to all service lines within Loop ID-2400 unless a segment occurs in Loop ID-2400 with the same segment description and is populated. In that case, the Loop ID-2400 information overrides the Loop ID-2300 information for that service line only.
2. The developers of this implementation guide recommend that trading partners limit the size of the transaction (SE-ST 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. TMHP file size limit is 75MB.

**Example:**

CLM\*01319300001\*500\*\*\*11:A:1\*Y\*A\*Y\*A\*\*\*\*\*Y~

# DTP Discharge Hour

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	<b>Date/Time Qualifier</b>	M	ID	3/3	Required
<b>Description:</b> Code specifying type of date or time, or both date and time						
<b>Notes:</b> Date Time Qualifier						
		<b>Code Name</b>				
		096 Discharge				
DTP02	1250	<b>Date Time Period Format Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code indicating the date format, time format, or date and time format						
		<b>Code Name</b>				
		TM Time Expressed in Format HHMM				
DTP03	1251	<b>Date Time Period</b>	M	AN	1/35	Required
<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times						
<b>Notes:</b> Discharge Hour						

## Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

## Notes:

1. This segment is required on all final inpatient claims/encounters.
2. The 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.

## Example:

DTP\*096\*TM\*1130~

# DTP Statement Dates

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	<b>Date/Time Qualifier</b>	M	ID	3/3	Required
<b>Description:</b> Code specifying type of date or time, or both date and time						
<b>Notes:</b> Date Time Qualifier						
		<b>Code Name</b>				
		434 Statement				
DTP02	1250	<b>Date Time Period Format Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code indicating the date format, time format, or date and time format						
		<b>Code Name</b>				
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
DTP03	1251	<b>Date Time Period</b>	M	AN	1/35	Required
<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times						
<b>Notes:</b> Statement From or To Date						

## Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

## Notes:

1. The statement date is used to indicate the discharge date of an admission, unless the transaction is an interim bill.
2. If 2300/CL1/CL103 does not equal "30", the statement dates is the discharge date.

## Example:

DTP\*434\*RD8\*19981209-19981214~

# DTP Admission Date/Hour

Pos: 135	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
<p><b>Description:</b> Code specifying type of date or time, or both date and time</p> <p><b>Notes:</b> Date Time Qualifier</p> <p><b>Code Name</b> 435 Admission</p>						
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
<p><b>Description:</b> Code indicating the date format, time format, or date and time format</p> <p><b>Code Name</b> DT Date and Time Expressed in Format CCYYMMDDHHMM</p>						
DTP03	1251	Date Time Period	M	AN	1/35	Required
<p><b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times</p> <p><b>Notes:</b> Admission Date and Hour</p>						

## Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

## Notes:

1. This segment is required on all inpatient claims.
2. The 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.

## Example:

DTP\*435\*DT\*200601131242~

# CL1 Institutional Claim Code

Pos: 140	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CL101	1315	<b>Admission Type Code</b>	O	ID	1/1	Situational
		<b>Description:</b> Code indicating the priority of this admission				
		<b><u>ExternalCodeList</u></b>				
		<b>Name:</b> 231				
		<b>Description:</b> Admission Type Code				
CL102	1314	<b>Admission Source Code</b>	O	ID	1/1	Situational
		<b>Description:</b> Code indicating the source of this admission				
		<b><u>ExternalCodeList</u></b>				
		<b>Name:</b> 230				
		<b>Description:</b> Admission Source Code				
CL103	1352	<b>Patient Status Code</b>	O	ID	1/2	Situational
		<b>Description:</b> Code indicating patient status as of the "statement covers through date"				
		<b><u>ExternalCodeList</u></b>				
		<b>Name:</b> 239				
		<b>Description:</b> Patient Status Code				

## Notes:

This segment is required when reporting hospital based admission on claims/encounters.

## Example:

CL1\*1\*7\*30~

# REF Original Reference Number (ICN/DCN)

Pos: 180	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

F8 Original Reference Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Claim Original Reference Number

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

1. Required when CLM05-3 (Claim Submission Reason code) = "7" or "8".
2. This is the ICN assigned by the plan to a transaction that has already been transmitted to TMHP.
3. The Original ICN is a concatenated value: "Plan ICN" and "Sequence Number". Unless both values are supplied, the system will be unable to confirm the value supplied in CLM05-3, resulting in an error being generated.

## Example:

REF\*F8\*0007693022991~

# NTE Claim Note

Pos: 190	Max: 10
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NTE01	363	Note Reference Code	O	ID	3/3	Required

**Description:** Code identifying the functional area or purpose for which the note applies

**Code Name**

ALG Allergies

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48517

DCP Goals, Rehabilitation Potential, or Discharge Plans

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48522

DGN Diagnosis Description

DME Durable Medical Equipment (DME) and Supplies

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48514

MED Medications

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48510

NTR Nutritional Requirements

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48516

ODT Orders for Disciplines and Treatments

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48521

RHB Functional Limitations, Reason Homebound, or Both

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48617

RLH Reasons Patient Leaves Home

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48621

RNH Times and Reasons Patient Not at Home

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48620

SET Unusual Home, Social Environment, or Both

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48619

SFM Safety Measures

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48515

SPT Supplementary Plan of Treatment

**Code Name**

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48521

UPI Updated Information

**EMC v.6.0 Reference:**

Record Type 73 Field No. 5 Code 48616

NTE02	352	<b>Description</b>	M	AN	1/80	Required
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**Description:** A free-form description to clarify the related data elements and their content

**Notes:** Transaction Receipt Date

**Example:** NTE\*ADD\*RCT20060114~

**All Programs:** The value supplied is the date the transaction was received by the plan.

**Notes:**

The first iteration should be the date the transaction was received by the plan.

**Example:**

# NTE Billing Note

Pos: 190	Max: 1
Detail - Optional	
Loop: 2300	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NTE01	363	Note Reference Code	O	ID	3/3	Required

**Description:** Code identifying the functional area or purpose for which the note applies

**Code Name**

ADD Additional Information

NTE02	352	Description	M	AN	1/80	Required
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**Description:** A free-form description to clarify the related data elements and their content

**Notes:** Billing Note Text

**Example:** NTE\*ADD\*19970114~

**All Programs:** 84 [Remarks]

**Star-specific:** Record Type 90 Field No. 4, 17

## Comments:

1. The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processable. The use of the NTE segment should therefore be avoided, if at all possible, in an automated environment.

## Notes:

1. This segment is used to convey additional information necessary to adjudicate the claim.
2. 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.

## Example:

NTE\*ADD\*RCT19970114~

# HI Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BK Principal Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 131D				
		<b>Description:</b> International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Required for all unscheduled outpatient visits or upon the patient's admission to the hospital.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BJ Admitting Diagnosis				
		ZZ Mutually Defined				
		ZZ used to indicate the "Patient Reason For Visit." See Code Source 131.				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 131D				
		<b>Description:</b> International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BN United States Department of Health and Human Services, Office of Vital Statistics E-code				
1271		<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 131D				
		<b>Description:</b> International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis				

**Notes:**

1. The Admitting Diagnosis is required on all inpatient admission claims and encounters.
2. An E-Code diagnosis is required whenever a diagnosis is needed to describe an injury, poisoning or adverse effect.
3. The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits.

**Example:**

HI\*BK:9976~

# HI Diagnosis Related Group (DRG) Information

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		DR Diagnosis Related Group (DRG)				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Diagnosis Related Group (DRG) Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 229				
		<b>Description:</b> Diagnosis Related Group Number (DRG)				

## Notes:

DRG Information is required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.

## Example:

HI\*DR:123~

## All Programs:

If your organization pays by DRG, it is expected that you will supply the DRG.

# HI Other Diagnosis Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BF Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Other Diagnosis				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 131D				
		<b>Description:</b> International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BF Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Other Diagnosis				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BF Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Other Diagnosis				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BF Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Other Diagnosis				
HI05	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BF Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Other Diagnosis				
HI06	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BF Diagnosis				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Other Diagnosis				

**Notes:**

1. Required when other condition(s) co-exists with the principal diagnosis, co-exists at the time of admission or develops subsequently during the patient's treatment.
2. All codes are ICD-9-CM

**Example:**

HI\*BF:V9782~

# HI Principal Procedure Information

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 1

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BP	Health Care Financing Administration Common Procedural Coding System Principal Procedure			
		BR	International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure			
		<b>CODE SOURCE:</b>				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Principal Procedure Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 130				
		<b>Description:</b> Health Care Financing Administration Common Procedural Coding System				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 131P				
		<b>Description:</b> International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Situational
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8	Date Expressed in Format CCYYMMDD			
	1251	<b>Date Time Period</b>	C	AN	1/35	Situational
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				

## Notes:

Required on inpatient claims or encounters when a procedure was performed.

## Example:

HI\*BR:92795:D8:19980321~

# HI Other Procedure Information

Pos: 231                      Max: 2  
 Detail - Optional  
 Loop: 2300                Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BO Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		<b>CODE SOURCE:</b>				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Procedure Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Situational
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8 Date Expressed in Format CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Situational
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Procedure Date				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BO Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		<b>CODE SOURCE:</b>				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Procedure Code				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Situational
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8	Date Expressed in Format CCYYMMDD			
	1251	<b>Date Time Period</b>	C	AN	1/35	Situational
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Procedure Date				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BO	Health Care Financing Administration Common Procedural Coding System			
		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure			
		<b>CODE SOURCE:</b>				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Procedure Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Situational
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8	Date Expressed in Format CCYYMMDD			
	1251	<b>Date Time Period</b>	C	AN	1/35	Situational
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Procedure Date				
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BO	Health Care Financing Administration Common Procedural Coding System			
		BQ	International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure			
		<b>CODE SOURCE:</b>				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Procedure Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Situational
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8 Date Expressed in Format CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Situational
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Procedure Date				
HI05	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BO Health Care Financing Administration Common Procedural Coding System				
		BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure				
		<b>CODE SOURCE:</b>				
		131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Procedure Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Situational
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8 Date Expressed in Format CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Situational
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Procedure Date				
HI06	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BO Health Care Financing Administration Common Procedural Coding System				

**Code Name**

BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

**CODE SOURCE:**

131: International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure

1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list

**Notes:** Procedure Code

1250 **Date Time Period Format Qualifier** C ID 2/3 Situational

**Description:** Code indicating the date format, time format, or date and time format

**Code Name**

D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Situational

**Description:** Expression of a date, a time, or range of dates, times or dates and times

**Notes:** Procedure Date

**Notes:**

Required on inpatient claims or encounters when additional procedures must be reported.

**Example:**

HI\*BQ:92795:D8:19980321~

# HI Occurrence Span Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BI	Occurrence Span			
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Span Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 132				
		<b>Description:</b> National Uniform Billing Committee (NUBC) Codes				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD			
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BI	Occurrence Span			
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Span Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b><u>Code Name</u></b> RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times <b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities <b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b><u>Code Name</u></b> BI Occurrence Span				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list <b>Notes:</b> Occurrence Span Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b><u>Code Name</u></b> RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times <b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities <b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b><u>Code Name</u></b> BI Occurrence Span				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list <b>Notes:</b> Occurrence Span Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b><u>Code Name</u></b> RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI05	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BI Occurrence Span				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Span Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI06	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BI Occurrence Span				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Span Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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**Notes:**

Required when occurrence span information applies to the claim or encounter.

**Example:**

HI\*BI:70:RD8:19981202-19981212~

# HI Occurrence Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BH Occurrence				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 132				
		<b>Description:</b> National Uniform Billing Committee (NUBC) Codes				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b>				
		D8 Date Expressed in Format CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BH Occurrence				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b> D8 Date Expressed in Format CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b> BH Occurrence				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				
		<b>Code Name</b> D8 Date Expressed in Format CCYYMMDD				
	1251	<b>Date Time Period</b>	C	AN	1/35	Required
		<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times				
		<b>Notes:</b> Occurrence or Occurrence Span Code Associated Date				
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b> BH Occurrence				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Occurrence Code				
	1250	<b>Date Time Period Format Qualifier</b>	C	ID	2/3	Required
		<b>Description:</b> Code indicating the date format, time format, or date and time format				

**Code Name**

D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required

**Description:** Expression of a date, a time, or range of dates, times or dates and times

**Notes:** Occurrence or Occurrence Span Code Associated  
Date

HI05 C022 **Health Care Code Information** O Comp Situational

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

**Notes:** Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required

**Description:** Code identifying a specific industry code list

**Code Name**

BH Occurrence

1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list

**Notes:** Occurrence Code

1250 **Date Time Period Format Qualifier** C ID 2/3 Required

**Description:** Code indicating the date format, time format, or date and time format

**Code Name**

D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required

**Description:** Expression of a date, a time, or range of dates, times or dates and times

**Notes:** Occurrence or Occurrence Span Code Associated  
Date

HI06 C022 **Health Care Code Information** O Comp Situational

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

**Notes:** Used when necessary to report multiple additional co-existing conditions.

1270 **Code List Qualifier Code** M ID 1/3 Required

**Description:** Code identifying a specific industry code list

**Code Name**

BH Occurrence

1271 **Industry Code** M AN 1/30 Required

**Description:** Code indicating a code from a specific industry code list

**Notes:** Occurrence Code

1250 **Date Time Period Format Qualifier** C ID 2/3 Required

**Description:** Code indicating the date format, time format, or date and time format

**Code Name**

D8 Date Expressed in Format CCYYMMDD

1251 **Date Time Period** C AN 1/35 Required

**Description:** Expression of a date, a time, or range of dates, times or dates and times

**Notes:** Occurrence or Occurrence Span Code Associated  
Date

**Notes:**

Required when occurrence information applies to the claim or encounter.

**Example:**

HI\*BH:42:D8:19981208~

# HI Value Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BE		Value		
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Value Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 132				
		<b>Description:</b> National Uniform Billing Committee (NUBC) Codes				
	782	<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Value Code Associated Amount				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BE		Value		
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Value Code				
	782	<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Value Code Associated Amount				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BE		Value		
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Value Code				
	782	<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Value Code Associated Amount				
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BE		Value		
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Value Code				
	782	<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Value Code Associated Amount				
HI05	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BE		Value		
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Value Code				
	782	<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Value Code Associated Amount				
HI06	C022	<b>Health Care Code Information</b>	O	Comp		Situational

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities <b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
1270		<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b> BE Value				
1271		<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list <b>Notes:</b> Value Code				
782		<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount <b>Notes:</b> Value Code Associated Amount				

**Notes:**

Required when value information applies to the claim or encounter.

**Example:**

HI\*BE:0001:1740~

# HI Condition Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BG Condition				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Condition Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 132				
		<b>Description:</b> National Uniform Billing Committee (NUBC) Codes				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BG Condition				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Condition Code				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BG Condition				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Notes:</b> Condition Code				
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BG Condition				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Condition Code				
HI05	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BG Condition				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Condition Code				
HI06	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		BG Condition				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Condition Code				

**Notes:**

Required when condition information applies to the claim or encounter.

**Example:**

HI\*BG:67~

# HI Treatment Code Information

Pos: 231	Max: 2
Detail - Optional	
Loop: 2300	Elements: 6

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	<b>Health Care Code Information</b>	M	Comp		Required
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		TC Treatment Codes				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Treatment Code				
		<b>ExternalCodeList</b>				
		<b>Name:</b> 359				
		<b>Description:</b> Treatment Codes				
HI02	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		TC Treatment Codes				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Treatment Code				
HI03	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		TC Treatment Codes				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Notes:</b> Treatment Code				
HI04	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		TC Treatment Codes				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Treatment Code				
HI05	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		TC Treatment Codes				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Treatment Code				
HI06	C022	<b>Health Care Code Information</b>	O	Comp		Situational
		<b>Description:</b> To send health care codes and their associated dates, amounts and quantities				
		<b>Notes:</b> Used when necessary to report multiple additional co-existing conditions.				
	1270	<b>Code List Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code identifying a specific industry code list				
		<b>Code Name</b>				
		TC Treatment Codes				
	1271	<b>Industry Code</b>	M	AN	1/30	Required
		<b>Description:</b> Code indicating a code from a specific industry code list				
		<b>Notes:</b> Treatment Code				

**Notes:**

Required when Home Health Agencies need to report Plan of Treatment information under various payer contracts.

**Example:**

HI\*TC:A01~

# QTY Claim Quantity

Pos: 240	Max: 4
Detail - Optional	
Loop: 2300	Elements: 3

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
QTY01	673	<b>Quantity Qualifier</b>	M	ID	2/2	Required
<b>Description:</b> Code specifying the type of quantity						
<b>Code Name</b>						
CA Covered - Actual						
CD Co-insured - Actual						
LA Life-time Reserve - Actual						
NA Number of Non-covered Days						
QTY02	380	<b>Quantity</b>	C	R	1/15	Required
<b>Description:</b> Numeric value of quantity						
<b>Notes:</b> Claim Days Count						
QTY03	C001	<b>Composite Unit of Measure</b>	O	Comp		Required
<b>Description:</b> To identify a composite unit of measure(See Figures Appendix for examples of use)						
	355	<b>Unit or Basis for Measurement Code</b>	M	ID	2/2	Required
<b>Description:</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken						
<b>Code Name</b>						
DA Days						

## Syntax Rules:

1. R0204 - At least one of QTY02 or QTY04 is required.
2. E0204 - Only one of QTY02 or QTY04 may be present.

## Notes:

1. Use the Quantity segment at the claim level Loop ID-2300 to transmit quantities that apply to the entire claim.
2. Required on Inpatient claims or encounters when covered, co-insured, life-time reserved or non-covered days are being reported.

## Example:

QTY\*LA\*20\*DA~

# Loop 2310A

Pos: 250	Repeat: 1
Optional	
Loop: 2310A	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Attending Physician Name	O	1		Required
271	REF	Attending Physician Secondary Identification	O	5		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.
2. Required on all inpatient claims or encounters.

## Example:

NM1\*71\*1\*JONES\*JOHN\*\*\*\*XX\*1234567890~

# NM1 Attending Physician Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 9

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<p><b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual</p> <p><b>Notes:</b> The entity identifier in NM101 applies to all segments in Loop ID-2310.</p> <p><b>Code Name</b></p> <p>71 Attending Physician</p>						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<p><b>Description:</b> Code qualifying the type of entity</p> <p><b>Code Name</b></p> <p>1 Person</p> <p>2 Non-Person Entity</p>						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<p><b>Description:</b> Individual last name or organizational name</p> <p><b>Notes:</b> Attending Physician Last Name</p>						
NM104	1036	<b>Name First</b>	O	AN	1/25	Situational
<p><b>Description:</b> Individual first name</p> <p><b>Notes:</b> Attending Physician First Name</p>						
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
<p><b>Description:</b> Individual middle name or initial</p> <p><b>Notes:</b> Attending Physician Middle Name</p>						
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
<p><b>Description:</b> Suffix to individual name</p> <p><b>Notes:</b> Attending Physician Name Suffix</p>						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<p><b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)</p> <p><b>Code Name</b></p> <p>24 Employer's Identification Number</p> <p>34 Social Security Number</p> <p>XX Health Care Financing Administration National Provider Identifier</p>						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<p><b>Description:</b> Code identifying a party or other code</p>						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Notes:</b> Attending Physician Primary Identifier				

### Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

### Semantics:

1. NM102 qualifies NM103.

### Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.
2. Required on all inpatient claims or encounters.

### Example:

NM1\*71\*1\*JONES\*JOHN\*\*\*\*XX\*1234567890~

# REF Attending Physician Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310A	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider ID
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Attending Physician Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

## Example:

REF\*0B\*A12345~

# Loop 2310B

Pos: 250	Repeat: 1
Optional	
Loop: 2310B	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Operating Physician Name	O	1		Required
271	REF	Operating Physician Secondary Identification	O	5		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. This segment is required when any surgical procedure code is listed on this claim.
2. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

## Example:

NM1\*72\*1\*MEYERS\*JANE\*\*\*\*XX\*1234567890~

# NM1 Operating Physician Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 9

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
		<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual				
		<b>Code Name</b>				
		72		Operating Physician		
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
		<b>Description:</b> Code qualifying the type of entity				
		<b>Code Name</b>				
		1		Person		
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
		<b>Description:</b> Individual last name or organizational name				
		<b>Notes:</b> Operating Physician Last Name				
NM104	1036	<b>Name First</b>	O	AN	1/25	Required
		<b>Description:</b> Individual first name				
		<b>Notes:</b> Operating Physician First Name				
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
		<b>Description:</b> Individual middle name or initial				
		<b>Notes:</b> Operating Physican Middle Name				
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
		<b>Description:</b> Suffix to individual name				
		<b>Notes:</b> Operating Physician Name Suffix				
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
		<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)				
		<b>Code Name</b>				
		24		Employer's Identification Number		
		34		Social Security Number		
		XX		Health Care Financing Administration National Provider Identifier		
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
		<b>Description:</b> Code identifying a party or other code				
		<b>Notes:</b> Operating Physician Primary Identifier				

**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.

**Semantics:**

1. NM102 qualifies NM103.

**Notes:**

1. This segment is required when any surgical procedure code is listed on this claim.
2. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.

**Example:**

NM1\*72\*1\*MEYERS\*JANE\*\*\*\*XX\*1234567890~

# REF Operating Physician Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310B	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider ID
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Operating Physician Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

## Example:

REF\*0B\*A12345~

# Loop 2310C

Pos: 250	Repeat: 1
Optional	
Loop: 2310C	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Other Provider Name	O	1		Required
271	REF	Other Provider Secondary Identification	O	5		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.

## Example:

NM1\*73\*1\*DOE\*JOHN\*A\*\*\*34\*201749586~

# NM1 Other Provider Name

<b>Pos: 250</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2310C</b>	<b>Elements: 9</b>

**User Option (Usage):** Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
		<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual				
		<b>Code Name</b>				
		73		Other Physician		
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
		<b>Description:</b> Code qualifying the type of entity				
		<b>Code Name</b>				
		1		Person		
		2		Non-Person Entity		
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
		<b>Description:</b> Individual last name or organizational name				
		<b>Notes:</b> Other Physician Last Name				
NM104	1036	<b>Name First</b>	O	AN	1/25	Situational
		<b>Description:</b> Individual first name				
		<b>Notes:</b> Other Physician First Name				
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
		<b>Description:</b> Individual middle name or initial				
		<b>Notes:</b> Other Provider Middle Name				
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
		<b>Description:</b> Suffix to individual name				
		<b>Notes:</b> Other Provider Name Suffix				
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
		<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)				
		<b>Code Name</b>				
		24		Employer's Identification Number		
		34		Social Security Number		
		XX		Health Care Financing Administration National Provider Identifier		
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
		<b>Description:</b> Code identifying a party or other code				
		<b>Notes:</b> Other Physician Primary Identifier				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.

**Semantics:**

1. NM102 qualifies NM103.

**Notes:**

1. Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101.

**Example:**

NM1\*73\*1\*DOE\*JOHN\*A\*\*\*34\*201749586~

# REF Other Provider Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310C	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider Identifier
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Other Provider Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

## Example:

REF\*0B\*12345~

# Loop 2310E

Pos: 250	Repeat: 1
Optional	
Loop: 2310E	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
250	NM1	Service Facility Name	O	1		Required
265	N3	Service Facility Address	O	1		Required
270	N4	Service Facility City/State/Zip Code	O	1		Required
271	REF	Service Facility Secondary Identification	O	5		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. 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.
2. 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.

## Example:

NM1\*FA\*2\*Rehab Facility\*\*\*\*\*XX\*12345678~

# NM1 Service Facility Name

<b>Pos:</b> 250	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2310E	<b>Elements:</b> 9

**User Option (Usage):** Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
FA Facility						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Laboratory or Facility Name						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Situational
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
24 Employer's Identification Number						
34 Social Security Number						
XX Health Care Financing Administration National Provider Identifier						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Situational
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Laboratory or Facility Primary Identifier						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. 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.
2. 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.

**Example:**

NM1\*FA\*2\*Rehab Facility\*\*\*\*XX\*1234567890~

# N3 Service Facility Address

Pos: 265	Max: 1
Detail - Optional	
Loop: 2310E	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b>	M	AN	1/55	Required
		<b>Description:</b> Address information				
		<b>Notes:</b> Laboratory or Facility Address Line 1				
N302	166	<b>Address Information</b>	O	AN	1/55	Situational
		<b>Description:</b> Address information				
		<b>Notes:</b> Laboratory or Facility Address Line 2				

## Example:

N3\*123 MAIN STREET~

# N4 Service Facility City/State/Zip Code

Pos: 270	Max: 1
Detail - Optional	
Loop: 2310E	Elements: 4

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b>	O	AN	2/30	Required
		<b>Description:</b> Free-form text for city name				
		<b>Notes:</b> Laboratory or Facility City Name				
N402	156	<b>State or Province Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency				
		<b>Notes:</b> Laboratory or Facility State Code				
N403	116	<b>Postal Code</b>	O	ID	3/15	Required
		<b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)				
		<b>Notes:</b> Laboratory or Facility ZIP Code				
N404	26	<b>Country Code</b>	O	ID	2/3	Situational
		<b>Description:</b> Code identifying the country				

## Comments:

1. N402 is required only if city name (N401) is in the U.S. or Canada.

## Example:

N4\*LONGVIEW\*TX\*75123~

# REF Service Facility Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310E	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- 1J Facility ID Number
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider Identifier

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Laboratory or Facility Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

## Example:

REF\*0B\*A12345~

# Loop 2320

<b>Pos: 290</b>	<b>Repeat: 10</b>
<b>Optional</b>	
<b>Loop: 2320 Elements: N/A</b>	

**User Option (Usage):** Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
290	SBR	Other Subscriber Information	O	1		Required
295	CAS	Claim Level Adjustment	O	5		Required
300	AMT	Payer Prior Payment	O	1		Required
300	AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	O	1		Situational
310	OI	Other Insurance Coverage Information	O	1		Required
325		Loop 2330A	O		1	Required
325		Loop 2330B	O		1	Required

## Semantics:

1. SBR02 specifies the relationship to the person insured.
2. SBR03 is policy or group number.

## Notes:

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 transmitted, a second 2320 Loop is required, as well as the associated loops (2330A and 2330B).

## Example:

SBR\*S\*18\*\*\*\*\*11~

## All Programs:

1. All transactions submitted must contain at least one 2320 loop. The plan must complete a 2320 loop to provide HHSC with information regarding their adjudication activities.
2. The number of required 2320 loops is equal to the number of entities that participated in the payment of the transaction. As an example, if another insurance company has already adjudicated the transaction prior to the plan adjudicating the transaction, it is expected that two 2320 loops will be included.
3. The 2320 loop contains summary payment information: amount of monies paid by the entity, the reason(s) for adjustments to charged amounts and quantities.

# SBR Other Subscriber Information

Pos: 290	Max: 1
Detail - Optional	
Loop: 2320	Elements: 5

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SBR01	1138	<b>Payer Responsibility Sequence Number Code</b>	M	ID	1/1	Required
<p><b>Description:</b> Code identifying the insurance carrier's level of responsibility for a payment of a claim</p> <p><b>Code Name</b></p> <p>S Secondary</p> <p>T Tertiary</p> <p>Used to indicate "payer of last resort".</p>						
SBR02	1069	<b>Individual Relationship Code</b>	O	ID	2/2	Required
<p><b>Description:</b> Code indicating the relationship between two individuals or entities</p> <p><b>Code Name</b></p> <p>18 Self</p>						
SBR03	127	<b>Reference Identification</b>	O	AN	1/30	Situational
<p><b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier</p> <p><b>Notes:</b> Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber. The subscriber's number should be carried in NM109. Using code IL in NM101 identifies the number in NM109 as the insured's Identification Number.</p>						
SBR09	1032	<b>Claim Filing Indicator Code</b>	O	ID	1/2	Required
<p><b>Description:</b> Code identifying type of claim</p> <p><b>Notes:</b> Required prior to mandated used of PlanID. Not used after PlanID is mandated.</p> <p><b>Code Name</b></p> <p>11 Other Non-Federal Programs</p> <p>MC Medicaid</p>						

## Semantics:

1. SBR02 specifies the relationship to the person insured.
2. SBR03 is policy or group number.

## Notes:

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 transmitted, a second 2320 Loop is required, as well as the associated loops (2330A and 2330B).

## Example:

SBR\*S\*18\*\*\*\*\*11~

**All Programs:**

1. All transactions submitted must contain at least one 2320 loop. The plan must complete a 2320 loop to provide HHSC with information regarding their adjudication activities.
2. The number of required 2320 loops is equal to the number of entities that participated in the payment of the transaction. As an example, if another insurance company has already adjudicated the transaction prior to the plan adjudicating the transaction, it is expected that two 2320 loops will be included.
3. The 2320 loop contains summary payment information: amount of monies paid by the entity, the reason(s) for adjustments to charged amounts and quantities.

# CAS Claim Level Adjustment

Pos: 295	Max: 5
Detail - Optional	
Loop: 2320	Elements: 19

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CAS01	1033	<b>Claim Adjustment Group Code</b>	M	ID	1/2	Required
<b>Description:</b> Code identifying the general category of payment adjustment						
<b>Code Name</b>						
CO Contractual Obligations						
CR Correction and Reversals						
OA Other adjustments						
PI Payor Initiated Reductions						
PR Patient Responsibility						
CAS02	1034	<b>Claim Adjustment Reason Code</b>	M	ID	1/5	Required
<b>Description:</b> Code identifying the detailed reason the adjustment was made						
<b>Notes:</b> Adjustment Reason Code						
<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.						
<b>ExternalCodeList</b>						
<b>Name:</b> 139						
<b>Description:</b> Claim Adjustment Reason Code						
CAS03	782	<b>Monetary Amount</b>	M	R	1/18	Required
<b>Description:</b> Monetary amount						
<b>Notes:</b> Adjustment Amount						
CAS04	380	<b>Quantity</b>	O	R	1/15	Situational
<b>Description:</b> Numeric value of quantity						
<b>Notes:</b> Adjustment Quantity						
CAS05	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
<b>Description:</b> Code identifying the detailed reason the adjustment was made						
<b>Notes:</b> Used when additional adjustment information applies to claim.						
<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.						
CAS06	782	<b>Monetary Amount</b>	C	R	1/18	Situational
<b>Description:</b> Monetary amount						
<b>Notes:</b> Adjustment Amount						
CAS07	380	<b>Quantity</b>	C	R	1/15	Situational
<b>Description:</b> Numeric value of quantity						
<b>Notes:</b> Adjustment Quantity						
CAS08	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
<b>Description:</b> Code identifying the detailed reason the adjustment was made						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Notes:</b> Used when additional adjustment information applies to claim. <b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.				
CAS09	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Notes:</b> Adjustment Amount	C	R	1/18	Situational
CAS10	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Notes:</b> Adjustment Quantity	C	R	1/15	Situational
CAS11	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Notes:</b> Used when additional adjustment information applies to claim. <b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.	C	ID	1/5	Situational
CAS12	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Notes:</b> Adjustment Amount	C	R	1/18	Situational
CAS13	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Notes:</b> Adjustment Quantity	C	R	1/15	Situational
CAS14	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Notes:</b> Used when additional adjustment information applies to claim. <b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.	C	ID	1/5	Situational
CAS15	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Notes:</b> Adjustment Amount	C	R	1/18	Situational
CAS16	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Notes:</b> Adjustment Quantity	C	R	1/15	Situational
CAS17	1034	<b>Claim Adjustment Reason Code</b> <b>Description:</b> Code identifying the detailed reason the adjustment was made <b>Notes:</b> Used when additional adjustment information applies to claim. <b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.	C	ID	1/5	Situational
CAS18	782	<b>Monetary Amount</b> <b>Description:</b> Monetary amount <b>Notes:</b> Adjustment Amount	C	R	1/18	Situational
CAS19	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Notes:</b> Adjustment Quantity	C	R	1/15	Situational

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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### Syntax Rules:

1. L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2. C0605 - If CAS06 is present, then CAS05 is required.
3. C0705 - If CAS07 is present, then CAS05 is required.
4. L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5. C0908 - If CAS09 is present, then CAS08 is required.
6. C1008 - If CAS10 is present, then CAS08 is required.
7. L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8. C1211 - If CAS12 is present, then CAS11 is required.
9. C1311 - If CAS13 is present, then CAS11 is required.
10. L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11. C1514 - If CAS15 is present, then CAS14 is required.
12. C1614 - If CAS16 is present, then CAS14 is required.
13. L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14. C1817 - If CAS18 is present, then CAS17 is required.
15. C1917 - If CAS19 is present, then CAS17 is required.

### Semantics:

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

### Comments:

1. Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
2. When the submitted charges are paid in full, the value for CAS03 should be "0".

### Notes:

1. Payers use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged.
2. When the submitted charges are paid in full, the value for CAS03 should be "0".
3. 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.

### Example:

CAS\*CO\*96\*555.52~

# AMT Payer Prior Payment

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	<b>Amount Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code to qualify amount				
		<b>Code Name</b>				
		C4 Prior Payment - Actual				
AMT02	782	<b>Monetary Amount</b>	M	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Payer Paid Amount				

## Notes:

This segment is required for STAR and CHIP participating plans. The first iteration is the total amount of money that the plan has paid on this transaction.

## Example:

AMT\*C4\*150~

## All Programs:

1. This is the total amount of money that the plan has paid on this transaction.
2. This value is the summation of all detail paid amounts in Loop 2430.
3. It is acceptable to show "0" amount paid.

# AMT Coordination of Benefits (COB) Total Medicare Paid Amount

Pos: 300	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
AMT01	522	<b>Amount Qualifier Code</b>	M	ID	1/3	Required
		<b>Description:</b> Code to qualify amount				
		<b>Code Name</b>				
		N1		Net Worth		
AMT02	782	<b>Monetary Amount</b>	M	R	1/18	Required
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Total Medicare Paid Amount				

## Notes:

This segment is used to convey the COB Total Medicare Paid Amount applicable to this claim when known.

## Example:

AMT\*N1\*873.4~

# OI Other Insurance Coverage Information

Pos: 310	Max: 1
Detail - Optional	
Loop: 2320	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
OI03	1073	Yes/No Condition or Response Code	O	ID	1/1	Required

**Description:** Code indicating a Yes or No condition or response

**Notes:** Benefits Assignment Certification Indicator

### Code Name

N No

Y Yes

OI06	1363	Release of Information Code	O	ID	1/1	Required
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**Description:** Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations

### Code Name

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

#### **EMC v.6.0 Reference:**

N No, Provider is Not Allowed to Release Data

#### **EMC v.6.0 Reference:**

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

## Semantics:

- 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.

## Notes:

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.

## Example:

OI\*\*\*Y\*\*\*Y~

# Loop 2330A

Pos: 325	Repeat: 1
Optional	
Loop: 2330A	Elements: N/A

**User Option (Usage):** Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
325	NM1	Other Subscriber Name	O	1		Required
332	N3	Other Subscriber Address	O	1		Required
340	N4	Other Subscriber City/State/ZIP Code	O	1		Required
355	REF	Other Subscriber Secondary Information	O	3		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. The first instance of this loop must always be populated with the plan information, as opposed to other subscribers like other insurance companies.
2. 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 transmitted, a second 2320 Loop is required, as well as the associated loops (2330A and 2330B).

## Example:

NM1\*IL\*2\*GHC\*\*\*\*\*MI\*123456789~

## All Programs:

1. All transactions submitted must contain at least one 2320 loop. The plan must complete a 2320 loop to provide HHSC with information regarding their adjudication activities.
2. The number of required 2320 loops is equal to the number of entities that participated in the payment of the transaction. As an example, if another insurance company has already adjudicated the transaction prior to the plan adjudicating the transaction, it is expected that two 2320 loops will be included.
3. The 2320 loop contains summary payment information: amount of monies paid by the entity, the reason(s) for adjustments to charged amounts and quantities.

# NM1 Other Subscriber Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 8

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
IL Insured or Subscriber						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
1 Person						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Other Insured Last Name						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
MI Member Identification Number						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>All Programs:</b> This is the Plan ID.						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. The first instance of this loop must always be populated with the plan information, as opposed to other subscribers like other insurance companies.
2. Submitters are required to send information on all known other subscribers in Loop 2320 and 2330B.

## Example:

NM1\*IL\*2\*GHC\*\*\*\*\*MI\*123456789~

# N3 Other Subscriber Address

Pos: 332	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b>	M	AN	1/55	Required
		<b>Description:</b> Address information				
		<b>Notes:</b> Other Insured Address Line 1				
N302	166	<b>Address Information</b>	O	AN	1/55	Situational
		<b>Description:</b> Address information				
		<b>Notes:</b> Other Insured Address Line 2				

## Notes:

Required when reporting information about an entity other than the plan and the information is available.

## Example:

N3\*4320 WASHINGTON ST SUITE 100~

# N4 Other Subscriber City/State/ZIP Code

Pos: 340	Max: 1
Detail - Optional	
Loop: 2330A	Elements: 3

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b>	O	AN	2/30	Required
		<b>Description:</b> Free-form text for city name				
		<b>Notes:</b> Other Insured City Name				
N402	156	<b>State or Province Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency				
		<b>Notes:</b> Other Insured State Code				
N403	116	<b>Postal Code</b>	O	ID	3/15	Required
		<b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)				
		<b>Notes:</b> Other Insured ZIP Code				

## Comments:

1. N402 is required only if city name (N401) is in the U.S. or Canada.

## Example:

N4\*PALISADES\*OR\*23119~

# REF Other Subscriber Secondary Information

Pos: 355	Max: 3
Detail - Optional	
Loop: 2330A	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Other Insured Additional Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

This segment is required when additional identification numbers are required.

## Example:

REF\*SY\*030385074~

# Loop 2330B

Pos: 325	Repeat: 1
Optional	
Loop: 2330B	Elements: N/A

**User Option (Usage):** Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
325	NM1	Other Payer Name	O	1		Required
332	N3	Other Payer Address	O	1		Required
340	N4	Other Payer City/State/ZIP Code	O	1		Required
350	DTP	Claim Adjudication Date	O	1		Required
355	REF	Other Payer Secondary Identification and Reference Number	O	2		Required

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. The first instance of this loop must always be populated with the plan information, as opposed to other subscribers like other insurance companies.
2. 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 transmitted, a second 2320 Loop is required, as well as the associated loops (2330A and 2330B).

## Example:

NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*PI\*43140~

## All Programs:

This loop is intended to report the following key pieces of information: the plan's ICN and/or ISN-sequence number and date adjudicated.

# NM1 Other Payer Name

Pos: 325	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 5

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
PR Payer						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Other Payer Organization Name						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
PI Payor Identification						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>All Programs:</b> This value is the "Plan Code".						
This is the location used to determine the participating plan.						
If additional loops are used, this value won't be a plan ID as defined by HHSC.						

## Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.

## Semantics:

1. NM102 qualifies NM103.

## Example:

NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*PI\*43140~

# N3 Other Payer Address

Pos: 332	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N301	166	<b>Address Information</b>	M	AN	1/55	Required
		<b>Description:</b> Address information				
		<b>Notes:</b> Other Payer Address Line 1				
N302	166	<b>Address Information</b>	O	AN	1/55	Situational
		<b>Description:</b> Address information				
		<b>Notes:</b> Other Payer Address Line 2				

## Example:

N3\*4320 WASHINGTON ST SUITE 100~

# N4 Other Payer City/State/ZIP Code

Pos: 340	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 4

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
N401	19	<b>City Name</b>	O	AN	2/30	Required
		<b>Description:</b> Free-form text for city name				
		<b>Notes:</b> Other Payer City				
N402	156	<b>State or Province Code</b>	O	ID	2/2	Required
		<b>Description:</b> Code (Standard State/Province) as defined by appropriate government agency				
		<b>Notes:</b> Other Payer State Code				
N403	116	<b>Postal Code</b>	O	ID	3/15	Required
		<b>Description:</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States)				
		<b>Notes:</b> Other Payer ZIP Code				
N404	26	<b>Country Code</b>	O	ID	2/3	Situational
		<b>Description:</b> Code identifying the country				
		<b>Notes:</b> Payer Country Code				

## Comments:

1. N402 is required only if city name (N401) is in the U.S. or Canada.

## Example:

N4\*PALISADES\*OR\*23119~

# DTP Claim Adjudication Date

Pos: 350	Max: 1
Detail - Optional	
Loop: 2330B	Elements: 3

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required
<b>Description:</b> Code specifying type of date or time, or both date and time						
<b>Notes:</b> Date Time Qualifier						
		<b>Code Name</b>				
		573 Date Claim Paid				
DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
<b>Description:</b> Code indicating the date format, time format, or date and time format						
		<b>Code Name</b>				
		D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	Date Time Period	M	AN	1/35	Required
<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times						
<b>Notes:</b> Adjudication Date						

## Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

## Notes:

Date Adjudicated

## Example:

DTP\*573\*D8\*20061226~

## All Programs:

This is the date the plan actually transmitted final adjudication information to provider.

# REF Other Payer Secondary Identification and Reference Number

Pos: 355	Max: 2
Detail - Optional	
Loop: 2330B	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Notes:** Use code F8 to indicate the payer's claim number assigned to this claim by the payer referenced in this iteration of Loop ID - 2330B.

**Code Name**

F8 Original Reference Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Other Payer Secondary Identifier

**All Programs:** Plan's ICN

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

1. This segment carries the ICN that the plan applied to this transaction.
2. Positions 1,2,3,4 are reserved for the sequence number. All four positions must be populated (0001) as opposed to ( 1).
3. If plan does use a sequence number in its processing, enter four zeros (0000).

## Example:

REF\*F8\*00001435261708~

# Loop 2400

Pos: 365      Repeat: 999  
 Optional  
 Loop: 2400 Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
365	LX	Service Line Number	O	1		Required
375	SV2	Institutional Service Line	O	1		Required
455	DTP	Service Line Date	O	1		Required
500		Loop 2420A	O		1	Situational
500		Loop 2420B	O		1	Situational
500		Loop 2420C	O		1	Situational
540		Loop 2430	O		25	Required

## Notes:

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.

## Example:

LX\*1~

# LX Service Line Number

Pos: 365	Max: 1
Detail - Optional	
Loop: 2400	Elements: 1

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LX01	554	Assigned Number	M	N0	1/6	Required

**Description:** Number assigned for differentiation within a transaction set

**Notes:** This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.

## Notes:

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.

## Example:

LX\*1~

# SV2 Institutional Service Line

Pos: 375	Max: 1
Detail - Optional	
Loop: 2400	Elements: 6

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SV201	234	<b>Product/Service ID</b>	C	AN	1/48	Required
<p><b>Description:</b> Identifying number for a product or service</p> <p><b>Notes:</b> Service Line Revenue Code</p> <p><b>ExternalCodeList</b></p> <p><b>Name:</b> 132</p> <p><b>Description:</b> National Uniform Billing Committee (NUBC) Codes</p>						
SV202	C003	<b>Composite Medical Procedure Identifier</b>	C	Comp		Situational
<p><b>Description:</b> To identify a medical procedure by its standardized codes and applicable modifiers</p> <p><b>Notes:</b> This data element required for outpatient claims when an appropriate HCPCS exists for the service line item.</p>						
	235	<b>Product/Service ID Qualifier</b>	M	ID	2/2	Required
<p><b>Description:</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234)</p> <p><b>Code Name</b></p> <p>HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes</p> <p>Because the AMA's CPT codes are also level 1 HCPCS codes, they are reported under HC.</p> <p>ZZ Mutually Defined</p> <p>Limited to STAR+Plus and NorthSTAR program</p>						
	234	<b>Product/Service ID</b>	M	AN	1/48	Required
<p><b>Description:</b> Identifying number for a product or service</p> <p><b>Notes:</b> Procedure Code</p> <p><b>ExternalCodeList</b></p> <p><b>Name:</b> 130</p> <p><b>Description:</b> Health Care Financing Administration Common Procedural Coding System</p>						
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
<p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>All Programs:</b> Use this modifier for the first procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>						
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
<p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p>						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>All Programs:</b> Use this modifier for the second procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
		<b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <b>All Programs:</b> Use this modifier for the third procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
		<b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <b>All Programs:</b> Use this modifier for the fourth procedure code modifier. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
SV203	782	<b>Monetary Amount</b>	O	R	1/18	Required
		<b>Description:</b> Monetary amount <b>Notes:</b> Line Item Charge Amount				
SV204	355	<b>Unit or Basis for Measurement Code</b>	C	ID	2/2	Required
		<b>Description:</b> Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken  <b>Code Name</b> DA Days UN Unit				
SV205	380	<b>Quantity</b>	C	R	1/15	Required
		<b>Description:</b> Numeric value of quantity <b>Notes:</b> Service Unit Count				
SV206	1371	<b>Unit Rate</b>	O	R	1/10	Situational
		<b>Description:</b> The rate per unit of associate revenue for hospital accommodation <b>Notes:</b> This data element is required when the associated revenue code is 100-219.				

**Syntax Rules:**

1. R0102 - At least one of SV201 or SV202 is required.
2. P0405 - If either SV204 or SV205 is present, then the other is required.

**Semantics:**

1. SV201 is the revenue code.
2. SV203 is a submitted charge amount.

**Notes:**

This segment is required for inpatient claims or outpatient claims or other claims that require procedure information to be reported for claim adjudication.

**Example:**

SV2\*300\*HC:80019\*73.42\*UN\*1~  
SV2\*120\*\*1500\*DA\*5\*300~

# DTP Service Line Date

Pos: 455	Max: 1
Detail - Optional	
Loop: 2400	Elements: 3

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	<b>Date/Time Qualifier</b>	M	ID	3/3	Required
<b>Description:</b> Code specifying type of date or time, or both date and time						
<b>Notes:</b> Date Time Qualifier						
		<u>Code</u> <u>Name</u>				
		472 Service				
DTP02	1250	<b>Date Time Period Format Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code indicating the date format, time format, or date and time format						
		<u>Code</u> <u>Name</u>				
		D8 Date Expressed in Format CCYYMMDD				
		RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD				
DTP03	1251	<b>Date Time Period</b>	M	AN	1/35	Required
<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times						
<b>Notes:</b> Service Date						

## Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

## Notes:

1. Required on outpatient claims when revenue, procedure or drug codes are reported in the SV2 segment.
2. 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.
3. 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).

## Example:

DTP\*472\*D8\*19960819~

# Loop 2420A

Pos: 500	Repeat: 1
Optional	
Loop: 2420A	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
500	NM1	Attending Physician Name	O	1		Required
525	REF	Attending Physician Secondary Identification	O	1		Situational

## Semantics:

- NM102 qualifies NM103.

## Notes:

Required if the Attending Provider NM1 information is different than that carried in the 2310A loop.

## Example:

NM1\*71\*1\*JONES\*JOHN\*\*\*SR\*24\*123456789~

# NM1 Attending Physician Name

<b>Pos:</b> 500	<b>Max:</b> 1
Detail - Optional	
<b>Loop:</b> 2420A	<b>Elements:</b> 8

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
71 Attending Physician						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
1 Person						
2 Non-Person Entity						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Attending Physician Last Name						
NM104	1036	<b>Name First</b>	O	AN	1/25	Required
<b>Description:</b> Individual first name						
<b>Notes:</b> Attending Physician First Name						
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
<b>Description:</b> Individual middle name or initial						
<b>Notes:</b> Attending Physician Middle Name						
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
<b>Description:</b> Suffix to individual name						
<b>Notes:</b> Attending Physician Name Suffix						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
24 Employer's Identification Number						
34 Social Security Number						
XX Health Care Financing Administration National Provider Identifier						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Attending Physician Primary Identifier						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.

**Semantics:**

1. NM102 qualifies NM103.

**Notes:**

Required if the Attending Provider NM1 information is different than that carried in the 2310A loop.

**Example:**

NM1\*71\*1\*JONES\*JOHN\*\*\*SR\*24\*123456789~

# REF Attending Physician Secondary Identification

Pos: 525	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
Stat of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider Identifier
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Attending Physician Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

## Example:

REF\*1D\*123456789~

# Loop 2420B

Pos: 500	Repeat: 1
Optional	
Loop: 2420B	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
500	NM1	Operating Physician Name	O	1		Required
525	REF	Operating Physician Secondary Identification	O	1		Situational

## Semantics:

- NM102 qualifies NM103.

## Notes:

Required if the Operating Provider NM1 information is different than that carried in the 2310B loop.

## Example:

NM1\*72\*1\*MEYERS\*JANE\*I\*\*\*34\*129847263~

# NM1 Operating Physician Name

<b>Pos:</b> 500	<b>Max:</b> 1
<b>Detail - Optional</b>	
<b>Loop:</b> 2420B	<b>Elements:</b> 8

**User Option (Usage):** Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual						
<b>Code Name</b>						
72 Operating Physician						
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
<b>Description:</b> Code qualifying the type of entity						
<b>Code Name</b>						
1 Person						
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
<b>Description:</b> Individual last name or organizational name						
<b>Notes:</b> Operating Physician Last Name						
NM104	1036	<b>Name First</b>	O	AN	1/25	Required
<b>Description:</b> Individual first name						
<b>Notes:</b> Operating Physician First Name						
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
<b>Description:</b> Individual middle name or initial						
<b>Notes:</b> Operating Physican Middle Name						
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
<b>Description:</b> Suffix to individual name						
<b>Notes:</b> Operating Physician Name Suffix						
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)						
<b>Code Name</b>						
24 Employer's Identification Number						
34 Social Security Number						
XX Health Care Financing Administration National Provider Identifier						
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
<b>Description:</b> Code identifying a party or other code						
<b>Notes:</b> Operating Physician Primary Identifier						

**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.

**Semantics:**

1. NM102 qualifies NM103.

**Notes:**

Required if the Operating Provider NM1 information is different than that carried in the 2310B loop.

**Example:**

NM1\*72\*1\*MEYERS\*JANE\*I\*\*\*34\*129847263~

# REF Operating Physician Secondary Identification

Pos: 525	Max: 1
Detail - Optional	
Loop: 2420B	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider Identifier
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Operating Physician Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.

## Example:

REF\*1D\*123456789~

# Loop 2420C

Pos: 500	Repeat: 1
Optional	
Loop: 2420C	Elements: N/A

User Option (Usage): Situational

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
500	NM1	Other Provider Name	O	1		Required
525	REF	Other Provider Secondary Identification	O	1		Situational

## Semantics:

1. NM102 qualifies NM103.

## Notes:

1. Required if the Other Provider NM1 information is different than that carried in the 2310C loop.
2. Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.

## Example:

NM1\*73\*1\*JONES\*JOHN\*\*\*SR\*24\*123456789~

# NM1 Other Provider Name

<b>Pos: 500</b>	<b>Max: 1</b>
<b>Detail - Optional</b>	
<b>Loop: 2420C</b>	<b>Elements: 8</b>

**User Option (Usage):** Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	<b>Entity Identifier Code</b>	M	ID	2/3	Required
		<b>Description:</b> Code identifying an organizational entity, a physical location, property or an individual				
		<b>Code Name</b>				
		73		Other Physician		
NM102	1065	<b>Entity Type Qualifier</b>	M	ID	1/1	Required
		<b>Description:</b> Code qualifying the type of entity				
		<b>Code Name</b>				
		1		Person		
		2		Non-Person Entity		
NM103	1035	<b>Name Last or Organization Name</b>	O	AN	1/35	Required
		<b>Description:</b> Individual last name or organizational name				
		<b>Notes:</b> Other Physician Last Name				
NM104	1036	<b>Name First</b>	O	AN	1/25	Situational
		<b>Description:</b> Individual first name				
		<b>Notes:</b> Other Physician First Name				
NM105	1037	<b>Name Middle</b>	O	AN	1/25	Situational
		<b>Description:</b> Individual middle name or initial				
		<b>Notes:</b> Other Provider Middle Name				
NM107	1039	<b>Name Suffix</b>	O	AN	1/10	Situational
		<b>Description:</b> Suffix to individual name				
		<b>Notes:</b> Other Provider Name Suffix				
NM108	66	<b>Identification Code Qualifier</b>	C	ID	1/2	Required
		<b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)				
		<b>Code Name</b>				
		24		Employer's Identification Number		
		34		Social Security Number		
		XX		Health Care Financing Administration National Provider Identifier		
NM109	67	<b>Identification Code</b>	C	AN	2/80	Required
		<b>Description:</b> Code identifying a party or other code				
		<b>Notes:</b> Other Provider Identifier				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.

**Semantics:**

1. NM102 qualifies NM103.

**Notes:**

1. Required if the Other Provider NM1 information is different than that carried in the 2310C loop.
2. Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider, etc.

**Example:**

NM1\*73\*1\*JONES\*JOHN\*\*\*SR\*24\*123456789~

# REF Other Provider Secondary Identification

Pos: 525	Max: 1
Detail - Optional	
Loop: 2420C	Elements: 2

User Option (Usage): Situational

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	Reference Identification Qualifier	M	ID	2/3	Required

**Description:** Code qualifying the Reference Identification

**Code Name**

- 0B State License Number  
State of Texas Medical License
- 1D Medicaid Provider Number  
Texas Provider Identifier (TPI)
- EI Employer's Identification Number
- N5 Provider Plan Network Identification Number  
CHIP Plan-assigned Provider Identifier
- SY Social Security Number

REF02	127	Reference Identification	C	AN	1/30	Required
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**Description:** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**Notes:** Other Provider Secondary Identifier

## Syntax Rules:

1. R0203 - At least one of REF02 or REF03 is required.

## Notes:

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.

## Example:

REF\*0B\*A12345~

# Loop 2430

Pos: 540      Repeat: 25  
 Optional  
 Loop: 2430 Elements: N/A

User Option (Usage): Required

## Loop Summary:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Usage</u>
540	SVD	Service Line Adjudication Information	O	1		Required
545	CAS	Service Line Adjustment	O	99		Required
550	DTP	Service Adjudication Date	O	1		Situational

## Notes:

1. The 2430 loop contains the payment and adjustment information for each detail line.

## Example:

SVD\*99\*50.5\*HC:0305\*013\*1~

# SVD Service Line Adjudication Information

Pos: 540	Max: 1
Detail - Optional	
Loop: 2430	Elements: 6

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SVD01	67	<b>Identification Code</b>	M	AN	2/80	Required
		<b>Description:</b> Code identifying a party or other code <b>Notes:</b> Other Payer Primary Identifier				
SVD02	782	<b>Monetary Amount</b>	M	R	1/18	Required
		<b>Description:</b> Monetary amount <b>Notes:</b> Service Line Paid Amount				
SVD03	C003	<b>Composite Medical Procedure Identifier</b>	O	Comp		Situational
		<b>Description:</b> To identify a medical procedure by its standardized codes and applicable modifiers				
	235	<b>Product/Service ID Qualifier</b>	M	ID	2/2	Required
		<b>Description:</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234) <b>Notes:</b> Product or Service ID Qualifier				
		<b>Code Name</b> 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. ZZ Mutually Defined STAR+Plus and NorthSTAR programs only				
	234	<b>Product/Service ID</b>	M	AN	1/48	Required
		<b>Description:</b> Identifying number for a product or service <b>Notes:</b> Procedure Code				
		<b>ExternalCodeList</b> <b>Name:</b> 130 <b>Description:</b> Health Care Financing Administration Common Procedural Coding System				
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
		<b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <b>All Programs:</b> 1. Use this modifier for the first procedure code modifier. 2. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.				
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
		<b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p><b>All Programs:</b> 1. Use this modifier for the second procedure code modifier. 2. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>				
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
		<p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>All Programs:</b> 1. Use this modifier for the third procedure code modifier. 2. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>				
	1339	<b>Procedure Modifier</b>	O	AN	2/2	Situational
		<p><b>Description:</b> This identifies special circumstances related to the performance of the service, as defined by trading partners</p> <p><b>All Programs:</b> 1. Use this modifier for the fourth procedure code modifier. 2. Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.</p>				
	352	<b>Description</b>	O	AN	1/80	Situational
		<p><b>Description:</b> A free-form description to clarify the related data elements and their content</p> <p><b>Notes:</b> Procedure Code Description</p>				
SVD04	234	<b>Product/Service ID</b>	O	AN	1/48	Required
		<p><b>Description:</b> Identifying number for a product or service</p> <p><b>Notes:</b> Service Line Revenue Code</p> <p><b>ExternalCodeList</b> <b>Name:</b> 132 <b>Description:</b> National Uniform Billing Committee (NUBC) Codes</p>				
SVD05	380	<b>Quantity</b>	O	R	1/15	Required
		<p><b>Description:</b> Numeric value of quantity</p> <p><b>Notes:</b> Paid Quantity</p>				
SVD06	554	<b>Assigned Number</b>	O	NO	1/6	Situational
		<p><b>Description:</b> Number assigned for differentiation within a transaction set</p> <p><b>Notes:</b> Bundled or Unbundled Line Number</p>				

**Semantics:**

1. SVD01 is the payer identification code.
2. SVD02 is the amount paid for this service line.
3. SVD04 is the revenue code.
4. SVD05 is the paid units of service.

**Comments:**

1. SVD03 represents the medical procedure code upon which adjudication of this service line was based. This may be different than the submitted medical procedure code.
2. 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.

**Notes:**

1. The SVD segment contains the payment information for each detail line.
2. This segment is required for STAR and CHIP participating plans. The first iteration is the amount of money that the plan has paid on this detail.

**Example:**

SVD\*99\*50.5\*HC:0305\*013\*1~

# CAS Service Line Adjustment

Pos: 545	Max: 99
Detail - Optional	
Loop: 2430	Elements: 19

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CAS01	1033	<b>Claim Adjustment Group Code</b>	M	ID	1/2	Required
<b>Description:</b> Code identifying the general category of payment adjustment						
<b>Code Name</b>						
CO Contractual Obligations						
CR Correction and Reversals						
OA Other adjustments						
PI Payor Initiated Reductions						
PR Patient Responsibility						
CAS02	1034	<b>Claim Adjustment Reason Code</b>	M	ID	1/5	Required
<b>Description:</b> Code identifying the detailed reason the adjustment was made						
<b>Notes:</b> Adjustment Reason Code						
<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.						
<b>ExternalCodeList</b>						
<b>Name:</b> 139						
<b>Description:</b> Claim Adjustment Reason Code						
CAS03	782	<b>Monetary Amount</b>	M	R	1/18	Required
<b>Description:</b> Monetary amount						
<b>Notes:</b> Adjustment Amount						
CAS04	380	<b>Quantity</b>	O	R	1/15	Situational
<b>Description:</b> Numeric value of quantity						
<b>Notes:</b> Adjustment Quantity						
<b>All Programs:</b> This is the quantity (number of units) being adjusted.						
CAS05	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
<b>Description:</b> Code identifying the detailed reason the adjustment was made						
<b>Notes:</b> Adjustment Reason Code						
<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.						
CAS06	782	<b>Monetary Amount</b>	C	R	1/18	Situational
<b>Description:</b> Monetary amount						
<b>Notes:</b> Adjustment Amount						
CAS07	380	<b>Quantity</b>	C	R	1/15	Situational
<b>Description:</b> Numeric value of quantity						
<b>Notes:</b> Adjustment Quantity						
<b>All Programs:</b> This is the quantity (number of units) being adjusted.						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CAS08	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
		<b>Description:</b> Code identifying the detailed reason the adjustment was made				
		<b>Notes:</b> Adjustment Reason Code				
		<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.				
CAS09	782	<b>Monetary Amount</b>	C	R	1/18	Situational
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Adjustment Amount				
CAS10	380	<b>Quantity</b>	C	R	1/15	Situational
		<b>Description:</b> Numeric value of quantity				
		<b>Notes:</b> Adjustment Quantity				
		<b>All Programs:</b> This is the quantity (number of units) being adjusted.				
CAS11	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
		<b>Description:</b> Code identifying the detailed reason the adjustment was made				
		<b>Notes:</b> Adjustment Reason Code				
		<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.				
CAS12	782	<b>Monetary Amount</b>	C	R	1/18	Situational
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Adjustment Amount				
CAS13	380	<b>Quantity</b>	C	R	1/15	Situational
		<b>Description:</b> Numeric value of quantity				
		<b>Notes:</b> Adjustment Quantity				
		<b>All Programs:</b> This is the quantity (number of units) being adjusted.				
CAS14	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
		<b>Description:</b> Code identifying the detailed reason the adjustment was made				
		<b>Notes:</b> Adjustment Reason Code				
		<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.				
CAS15	782	<b>Monetary Amount</b>	C	R	1/18	Situational
		<b>Description:</b> Monetary amount				
		<b>Notes:</b> Adjustment Amount				
CAS16	380	<b>Quantity</b>	C	R	1/15	Situational
		<b>Description:</b> Numeric value of quantity				
		<b>Notes:</b> Adjustment Quantity				
		<b>All Programs:</b> This is the quantity (number of units) being adjusted.				
CAS17	1034	<b>Claim Adjustment Reason Code</b>	C	ID	1/5	Situational
		<b>Description:</b> Code identifying the detailed reason the adjustment was made				
		<b>Notes:</b> Adjustment Reason Code				
		<b>All Programs:</b> This is commonly thought of as the "Explanation of Benefit" code.				
CAS18	782	<b>Monetary Amount</b>	C	R	1/18	Situational

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<b>Description:</b> Monetary amount <b>Notes:</b> Adjustment Amount				
CAS19	380	<b>Quantity</b> <b>Description:</b> Numeric value of quantity <b>Notes:</b> Adjustment Quantity <b>All Programs:</b> This is the quantity (number of units) being adjusted.	C	R	1/15	Situational

### Syntax Rules:

1. L050607 - If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2. C0605 - If CAS06 is present, then CAS05 is required.
3. C0705 - If CAS07 is present, then CAS05 is required.
4. L080910 - If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5. C0908 - If CAS09 is present, then CAS08 is required.
6. C1008 - If CAS10 is present, then CAS08 is required.
7. L111213 - If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8. C1211 - If CAS12 is present, then CAS11 is required.
9. C1311 - If CAS13 is present, then CAS11 is required.
10. L141516 - If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11. C1514 - If CAS15 is present, then CAS14 is required.
12. C1614 - If CAS16 is present, then CAS14 is required.
13. L171819 - If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14. C1817 - If CAS18 is present, then CAS17 is required.
15. C1917 - If CAS19 is present, then CAS17 is required.

### Semantics:

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

### Comments:

1. Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
2. When the submitted charges are paid in full, the value for CAS03 should be "0".

### Notes:

1. Payers use this CAS segment to report line level adjustments from prior payments which cause the amount paid to differ from the amount originally charged.

2. When the submitted charges are paid in full, the value for CAS03 should be "0".

**Example:**

CAS\*CO\*024\*25~

# DTP Service Adjudication Date

Pos: 550	Max: 1
Detail - Optional	
Loop: 2430	Elements: 3

User Option (Usage): Situational

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	<b>Date/Time Qualifier</b>	M	ID	3/3	Required
<b>Description:</b> Code specifying type of date or time, or both date and time						
<b>Notes:</b> Date Time Qualifier						
		<b><u>Code</u> <u>Name</u></b>				
		573 Date Claim Paid				
DTP02	1250	<b>Date Time Period Format Qualifier</b>	M	ID	2/3	Required
<b>Description:</b> Code indicating the date format, time format, or date and time format						
		<b><u>Code</u> <u>Name</u></b>				
		D8 Date Expressed in Format CCYYMMDD				
DTP03	1251	<b>Date Time Period</b>	M	AN	1/35	Required
<b>Description:</b> Expression of a date, a time, or range of dates, times or dates and times						
<b>Notes:</b> Service Adjudication Date						

## Semantics:

1. DTP02 is the date or time or period format that will appear in DTP03.

## Notes:

This segment is only used when the "Service Adjudication Date" is different than 2330B/DTP "Claim Adjudication Date".

## Example:

DTP\*573\*D8\*19981226~

# SE Transaction Set Trailer

Pos: 555	Max: 1
Detail - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SE01	96	<b>Number of Included Segments</b>	M	NO	1/10	Required
<p><b>Description:</b> Total number of segments included in a transaction set including ST and SE segments</p> <p><b>Notes:</b> Transaction Segment Count</p>						
SE02	329	<b>Transaction Set Control Number</b>	M	AN	4/9	Required
<p><b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set</p> <p><b>Notes:</b> SE02 must match ST02.</p>						

## Comments:

1. SE is the last segment of each transaction set.

## Example:

SE\*1230\*987654~

# GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GE01	97	<b>Number of Transaction Sets Included</b>	M	N0	1/6	Required
<b>Description:</b> Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element						
GE02	28	<b>Group Control Number</b>	M	N0	1/9	Required
<b>Description:</b> Assigned number originated and maintained by the sender						

## Semantics:

1. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

## Comments:

1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

## Example:

GE\*5\*1~

# IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

User Option (Usage): Required

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
IEA01	I16	<b>Number of Included Functional Groups</b>	M	N0	1/5	Required
		<b>Description:</b> A count of the number of functional groups included in an interchange				
IEA02	I12	<b>Interchange Control Number</b>	M	N0	9/9	Required
		<b>Description:</b> A control number assigned by the interchange sender				

## Example:

IEA\*1\*000000905~

## TMHP 837I Companion Guide Change Log

Change Date	Reference	Description
2/9/06	GS	Example changed
2/9/06	BHT	Example changed
2/9/06	Loop 1000B	"All Programs" note changed
2/9/06	Loop 1000B NM1	"All Programs" note changed
2/9/06	Loop 1000B NM103	"All Programs" note changed
2/9/06	Loop 2010AA	Example changed
2/9/06	Loop 2010AA NM1	Example changed
2/9/06	Loop 2010AB REF	Example changed
2/9/06	Loop 2010BA	Example changed
2/9/06	Loop 2010BC	Example changed
2/9/06	Loop 2010BC NM1	Example changed
2/9/06	Loop 2010BC NM109	"All Programs" note changed
2/9/06	Loop 2300	Example changed
2/9/06	Loop 2300 CLM	Example changed
2/9/06	Loop 2300 DTP	Example changed
2/9/06	Loop 2300 NTE and NTE02	Example changed
2/9/06	Loop 2320	Example added; Semantics #4 removed
2/9/06	Loop 2320 SBR	Example changed
2/9/06	Loop 2330A	Example changed
2/9/06	Loop 2330A	Example changed
2/9/06	Loop 2330A REF	Example changed
2/9/06	Loop 2330B REF	Notes changed
2/9/06	Loop 2420C REF	Example changed
2/9/06	GE	Example added
3/1/06	Global	Removed extraneous "External Code List" references
3/1/06	ISA	Example changed
3/1/06	ISA15	Removed the "T"
3/1/06	REF02	"All Programs" note changed
3/1/06	NM109	Notes changed
3/1/06	Loop 1000B	"All Programs" note changed Example changed
3/1/06	Loop 1000B NM1	"All Programs" note changed; Example changed
3/1/06	Loop 1000B NM103	"All Programs" note changed
3/1/06	Loop 1000B NM109	"All Programs" note changed
3/1/06	Loop 2000A	Notes changed
3/1/06	Loop 2000A HL	Notes changed
3/1/06	Loop 2000A PRV	Elements changed
3/1/06	Loop 2010AA NM108	Notes changed
3/1/06	Loop 2010AA REF	Notes changed ; Example changed
3/1/06	Loop 2010AB NM108	Notes changed
3/1/06	Loop 2010AB N4	Example changed

<b>Change Date</b>	<b>Reference</b>	<b>Description</b>
3/1/06	Loop 2010AB REF	Notes changed
3/1/06	Loop 2000B	Notes changed
3/1/06	Loop 2000B HL	Notes changed
3/1/06	Loop 2010BA NM109	Notes changed
3/1/06	Loop 2010BA REF02	Notes changed
3/1/06	Loop 2010BC	Example changed
3/1/06	Loop 2010BC NM1	Notes changed; Example changed
3/1/06	Loop 2010BC NM103	"All Programs" note changed
3/1/06	Loop 2010BC NM109	"All Programs" note changed; Removed code set
3/1/06	Loop 2300	Notes changed
3/1/06	Loop 2300 CLM	Notes changed
3/1/06	Loop 2300 CLM01	"All programs" changed
3/1/06	Loop 2300 CLM05-3	"All programs" changed
3/1/06	Loop 2300 REF	Purpose changed
3/1/06	Loop 2300 NTE	Notes changed
3/1/06	Loop 2300 HI – Other Diagnosis	Notes changed
3/1/06	Loop 2300 HI01-3; -4 -Principal Procedure Information	Fields changed to "Situational"
3/1/06	Loop 2300 HI – Value Information	Example changed
3/1/06	Loop 2310AB	Example changed
3/1/06	Loop 2310AB REF	Example changed
3/1/06	Loop 2310AB NM1	Example changed
3/1/06	Loop 2310B	Example changed
3/1/06	Loop 2310B NM1	Example changed
3/1/06	Loop 2310B REF	Example removed
3/1/06	Loop 2310C REF	Example changed
3/1/06	Loop 2310E NM1	Example changed
3/1/06	Loop 2310E REF	Example changed
3/1/06	Loop 2310E REF01	Notes changed
3/1/06	Loop 2320 CAS	Notes, comments, purpose changed
3/1/06	Loop 2320 AMT	Notes changed
3/1/06	Loop 2330 N4	Note removed
3/1/06	Loop 2330B REF02	"All Programs" note changed
3/1/06	Loop 2400 SV2	Purpose changed
3/1/06	Loop 2400 DTP	Notes changed
3/1/06	Loop 2420A	Example changed
3/1/06	Loop 2420A NM1	Example changed
3/1/06	Loop 2420A REF	Example changed
3/1/06	Loop 2420B REF	Example changed
3/1/06	Loop 2420C	Example changed
3/1/06	Loop 2420C NM1	Example changed
3/1/06	Loop 2430	Example changed
3/1/06	Loop 2430 SVD	Notes changed

<b>Change Date</b>	<b>Reference</b>	<b>Description</b>
3/1/06	Loop 2430 SVD03	Changed segment to "required"
3/1/06	Loop 2430 CAS	Notes, comments, purpose changed
4/27/06	Loop 2010AA REF01	Qualifiers updated
4/27/06	Loop 2010AB REF01	Qualifiers updated
4/27/06	Loop 2310A REF01	Qualifiers updated
4/27/06	Loop 2310B REF01	Qualifiers updated
4/27/06	Loop 2310C REF01	Qualifiers updated
4/27/06	Loop 2310E REF01	Qualifiers updated
4/27/06	Loop 2420A REF01	Qualifiers updated
4/27/06	Loop 2420B REF01	Qualifiers updated
4/27/06	Loop 2420C REF01	Qualifiers updated
4/27/06	Loop 2300 CLM09	Changed segment to "required"
4/27/06	Loop 2300 CLM11	Changed segment to "excluded"
4/27/06	Loop 2300 CLM12	Changed segment to "excluded"
4/27/06	Loop 2310D NM101	Qualifiers updated
4/27/06	Loop 2320 OI	Changed segment to "required"
4/27/06	Loop 2400 SV203	Changed segment to "required"
4/27/06	Loop 2010AA NM102	Qualifiers updated
4/27/06	Loop 2010AB NM102	Qualifiers updated
4/27/06	Loop 1000A NM108	Qualifier updated
5/18/06	Loop 2430 SVD03	Changed segment to "situational"
6/12/06	Loop 2000A PRV	Removed requirement for Provider Taxonomy Codes
6/12/06	Loop 2000B SBR01	Removed S and T qualifier for clarity
6/12/06	Loop 2010AA NM104-07	Changed fields to "Not Used"
6/12/06	Loop 2010AB NM104-07	Changed fields to "Not Used"
6/12/06	Loop 2300 CLM18	Changed field to "Required"
6/12/06	Loop 2300 NTE	Updated qualifiers
6/12/06	Loop 2300 HI01-3 and 4, other procedure code	Changed fields to "Situational"
6/12/06	Loop 2300 HI02-3 and 4, other procedure code	Changed fields to "Situational"
6/12/06	Loop 2300 HI03-3 and 4, other procedure code	Changed fields to "Situational"
6/12/06	Loop 2300 HI04-3 and 4, other procedure code	Changed fields to "Situational"
6/12/06	Loop 2300 HI05-3 and 4, other procedure code	Changed fields to "Situational"
6/12/06	Loop 2300 HI06-3 and 4, other procedure code	Changed fields to "Situational"
6/12/06	Loop 2310A NM108-09	Changed field to "Required"
6/12/06	Loop 2310A REF01	Changed qualifiers to eliminate 1J
6/12/06	Loop 2310B NM108-09	Changed fields to "Required"
6/12/06	Loop 2310C NM108-09	Changed fields to "Required"

<b>Change Date</b>	<b>Reference</b>	<b>Description</b>
6/12/06	Loop 2320 SBR01	Removed P qualifier for clarity
6/12/06	Loop 2320 AMT, Payer Prior Payment (HMO)	Changed to "Required"
6/12/06	Loop 2320 AMT01-02, Total submitted amount	Changed fields to "Not recommended" (no longer printed in CG)
6/12/06	Loop 2330A REF01	Removed qualifiers 0B, 1B, 1E, 1J, EI, NS, and TJ (SY only valid value)
6/12/06	Loop 2330B NM108-09	Changed fields to "Required"
6/12/06	Loop 2420A NM108-09	Changed fields to "Required"
6/12/06	Loop 2420B NM108-09	Changed fields to "Required"
6/12/06	Loop 2420C NM108-09	Changed fields to "Required"
6/21/06	Loop 2300, CLM18	Updated example
6/21/06	Loop 2400, 2300 NTE	Updated example
6/21/06	Loop 2010BA N3	Changed segment to "Required"