Health Care Claim Payment/Advice (835) for HCSC Shared Claims Processing (SCP) Partners

Version 11.0

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Health Care Service Corporation (HCSC) Shared Claims Processing 835 Companion Guide

Introduction

Scope of Companion Document

For the health care industry to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical. This Companion Guide for Health Care Service Corporation (HCSC) Shared Claims Processing (SCP) Partners is based on the ASCX12N Implementation Guides adopted under HIPAA will clarify and specify the data content when exchanging repriced claims electronically with HCSC. Transmissions based on this companion document, used in tandem with the ANSI X12N Implementation Guides, are compliant with both the X12 syntax and those guidelines. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA.

This implementation guide provides a detailed explanation of the transaction set by defining data content, identifying valid code tables, and specifying values that are applicable for electronic claims payment. This implementation guide is designed to assist those who send and/or receive Electronic Remittance Advice (ERA) and/or payments in the 837/835 format.

Exchange of Claim Data

Claims are sent to Shared Claims partners in ANSI 837-5010 and returned in ANSI 835-5010 HIPAA claims formats. This manual explains the use of business-specific fields for the benefit of payers receiving electronic claims from our networks. All medical claims will be received by BCBSIL since most providers will electronically submit their claims directly to BCBSIL. Claims data will be sent to the Fund via the 837 Record. Once the Fund has adjudicated the claims, they will be returned to BCBSIL via the 835 Record.

Version Information

This Companion Guide is based on the October 2003 ASC X12 standards, referred to as Version 5, Release 1, Sub-release 0 (005010). The unique Version/Release/Industry Identifier Code for transaction sets that are defined by this implementation guide is 005010X221A1.

The two-character Functional Identifier Code for the transaction set included in this implementation guide:

- **HP Health Care Claim Payment/Advice (835)**

The Version/Release/Industry Identifier Code and the applicable Functional Identifier Code must be transmitted in the Functional Group Header (GS segment) that begins a functional group of these transaction sets.

Revision History

Date	Version	Description of Changes	Author
Dec 2011	Version 10.0	NO CHANGES	SCP Labor Team
April 2012	Version 11.0	• Updated Appendix A for Ineligible Reason Codes • Included Appendix B for Institutional 835 claim samples • Included Appendix C for Professional 835 claim samples	SCP Labor Team

835 Health Care Claim Payment/Advice

Functional Group ID=HP

Introduction:

This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Heading:

Page No.	Pos. No.	Seg. ID	Name	SCP Usage	Max.Use	Loop Repeat	Notes and Comments
162	0100	ST	Transaction Set Header	M	1		
165	0200	BPR	Financial Information	M	1		
167	0400	TRN	Reassociation Trace Number	M	1		
168	0500	CUR	Foreign Currency Information	O	1		
17	0600	REF	Receiver Identification	O	1		
18	0600	REF	Version Identification	O	1		
19	0700	DTM	Production Date	O	1		
			LOOP ID - 1000A			1	
20	0800	N1	Payer Identification	M	1		
22	1000	N3	Payer Address	M	1		
23	1100	N4	Payer City, State, ZIP Code	M	1		
25	1200	REF	Additional Payer Identification	O	4		
27	1300	PER	Payer Business Contact Information	O	1		
30	1300	PER	Payer Technical Contact Information	M	>1		
32	1300	PER	Payer WEB Site	O	1		
			LOOP ID - 1000B			1	
33	0800	N1	Payee Identification	M	1		
35	1000	N3	Payee Address	O	1		
36	1100	N4	Payee City, State, ZIP Code	O	1		
38	1200	REF	Payee Additional Identification	M	>1		
40	1400	RDM	Remittance Delivery Method	O	1		

Detail:

Page No.	Pos. No.	Seg. ID	Name	SCP Usage	Max.Use	Loop Repeat	Notes and Comments
			LOOP ID - 2000			>1	
42	0030	LX	Header Number	O	1		
43	0050	TS3	Provider Summary Information	O	1		
47	0070	TS2	Provider Supplemental Summary	O	1		

			Information				
			LOOP ID - 2100			>1	
52	0100	CLP	Claim Payment Information	M	1		
58	0200	CAS	Claims Adjustment	O	99		
64	0300	NM1	Patient Name	M	1		
67	0300	NM1	Insured Name	O	1		
70	0300	NM1	Corrected Patient/Insured Name	O	1		
72	0300	NM1	Service Provider Name	O	1		
75	0300	NM1	Crossover Carrier Name	O	1		
77	0300	NM1	Corrected Priority Payer Name	O	1		
79	0300	NM1	Other Subscriber Name	O	1		
81	0330	MIA	Inpatient Adjudication Information	O	1		
87	0350	MOA	Outpatient Adjudication Information	O	1		
90	0400	REF	Other Claim Related Identification	M	5		
92	0400	REF	Other Claim Related Identification	M	5		
95	0400	REF	Other Claim Related Identification	O	5		
96	0400	REF	Rendering Provider Identification	M	1		
98	0500	DTM	Statement From or To Date	O	2		
100	0500	DTM	Coverage Expiration Date	O	1		
101	0500	DTM	Claim Received Date	O	1		
102	0600	PER	Claim Contact Information	O	2		
104	0620	AMT	Claim Supplemental Information	O	13		
106	0640	QTY	Claim Supplemental Information Quantity	O	14		
			LOOP ID - 2110			999	
108	0700	SVC	Service Payment Information	M	1		
115	0800	DTM	Service Date	O	2		n3
117	0900	CAS	Service Adjustment Revision 10.1.2011	O	99		n4
124	1000	REF	Service Identification	O	2		
126	1000	REF	Line Item Control Number	O	1		
127	1000	REF	Rendering Provider Information	O	10		
129	1000	REF	HealthCare Policy Identification	O	5		
131	1100	AMT	Service Supplemental Amount	M	1		
133	1200	QTY	Service Supplemental Quantity	O	6		
134	1300	LQ	Health Care Remark Codes	O	99		

Summary:

Page No.	Pos. No.	Seg. ID	Name	X12 Usage	SCP Usage	Max.Use	Loop Repeat	Notes and Comments
135	0100	PLB	Provider Adjustment	O	O	>1		
159	0200	SE	Transaction Set Trailer	M	M	1		

Transaction Set Notes

1. The LX segment is used to provide a looping structure and logical grouping of claim payment information.

2. The CAS segment is used to reflect changes to amounts within Table 2.

3. The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.
4. The CAS segment is used to reflect changes to amounts within Table 2.

Transaction Set Comments

1. The TRN segment is used to uniquely identify a claim payment and advice.
2. The CUR segment does not initiate a foreign exchange transaction.
3. The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

Segment: **ST** **Transaction Set Header**
Position: 0100
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes:

1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).

2 The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.

Comments:
Notes: TR3 Example: ST*835*1234~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
ST01	**143**	**Transaction Set Identifier Code**	**M**	**1**	**ID 3/3**	**M**
		Code uniquely identifying a Transaction Set OD: 835W1__ST01__TransactionSetIdentifierCode The only valid value within this transaction set for ST01 is 835. 835 Health Care Claim Payment/Advice				
ST02	**329**	**Transaction Set Control Number**	**M**	**1**	**AN 4/9**	**M**
		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: 835W1__ST02__TransactionSetControlNumber The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example 0001, and increment from there. This number must be unique within a specific group and interchange, but it can be repeated in other groups and interchanges.				

Segment: **BPR** **Financial Information**
Position: 0200
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur

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

Semantic Notes:
1 BPR02 specifies the payment amount.
2 When using this transaction set to initiate a payment, all or some of BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used.
BPR06 and BPR07 relate to the originating depository financial institution (ODFI).
3 BPR08 is a code identifying the type of bank account or other financial asset.
4 BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.
5 BPR10 shall be mutually established between the originating depository financial institution (ODFI) and the company originating the payment.
6 BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).
7 BPR14 is a code identifying the type of bank account or other financial asset.
8 BPR15 is the account number of the receiving company to be debited or credited with the payment order.
9 BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).
10 BPR17 is a code identifying the business reason for this payment.
11 BPR18, BPR19, BPR20 and BPR21, if used, identify a third bank identification number and account to be used for return items only.
12 BPR20 is a code identifying the type of bank account or other financial asset.

Comments:
Notes: TR3 Notes: 1. Use the BPR to address a single payment to a single payee. A payee
may represent a single provider, a provider group, or multiple providers in a chain. The BPR contains mandatory information, even when it is not being used to move funds electronically.

TR3 Example:
BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456*1512345678*
999999999*01*999988880*DA*98765*20030901~

Data Element Summary

Ref.	Data	Base	User

Des.	Element	Name	Attributes			
BPR01	**305**	**Transaction Handling Code**	**M**	**1**	**ID 1/2**	**M**

Code designating the action to be taken by all parties

OD: 835W1__BPR01__TransactionHandlingCode

C — Payment Accompanies Remittance Advice
Use this code to instruct your third party processor to move both funds and remittance detail together through the banking system.

D — Make Payment Only
Use this code to instruct your third party processor to move only funds through the banking system and to ignore any remittance information.

H — Notification Only
Use this code when the actual provider payment (BPR02) is zero and the transaction is not being used for Prenotification of Future Transfers. This indicates remittance information without any associated payment.

I — Remittance Information Only
Use this code to indicate to the payee that the remittance detail is moving separately from the payment.

P — Prenotification of Future Transfers
This code is used only by the payer and the banking system to initially validate account numbers before beginning an EFT relationship. Contact your VAB for additional information.

U — Split Payment and Remittance
Use this code to instruct the third party processor to split the payment and remittance detail, and send each on a separate path.

X — Handling Party's Option to Split Payment and Remittance
Use this code to instruct the third party processor to move the payment and remittance detail, either together or separately, based upon end point requests or capabilities.

Des.	Element	Name	Attributes			
BPR02	**782**	**Monetary Amount**	**M**	**1**	**R 1/18**	**M**

Monetary amount

OD: 835W1__BPR02__TotalActualProviderPaymentAmount

IMPLEMENTATION NAME: Total Actual Provider Payment Amount

Use BPR02 for the total payment amount for this 835. The total payment amount for this 835 cannot exceed eleven characters, including decimals (9999999999.99). Although the value can be zero, the 835 cannot be issued for less than zero dollars.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point).

Shared Claims Processing Notes:

The amount to be paid to the provider for services rendered.

EDF2 Notes:

EDF2-CLM-CURRENT-DRAFT-AMT

The total amount to be paid to both provider and member

BPR03	**478**	**Credit/Debit Flag Code**	**M**	**1**	**ID 1/1**	**M**

Code indicating whether amount is a credit or debit

OD: 835W1__BPR03__CreditorDebitFlagCode

IMPLEMENTATION NAME: Credit or Debit Flag Code

C — Credit

Use this code to indicate a credit to the provider's account and a debit to the payer's account, initiated by the payer. In the case of an EFT, no additional action is required of the provider. Also use this code when a check is issued for the payment.

D — Debit

Use this code to indicate a debit to the payer's account and a credit to the provider's account,
initiated by the provider at the instruction of the payer.
Extreme caution must be used when using Debit transactions.
Contact your VAB for information about debit transactions.
The rest of
this segment and document assumes that a credit payment is being used.

BPR04	**591**	**Payment Method Code**	**M**	**1**	**ID 3/3**	**M**

Code identifying the method for the movement of payment instructions

OD: 835W1__BPR04__PaymentMethodCode

ACH — Automated Clearing House (ACH)

Use this code to move money electronically through the ACH, or to notify the provider that an ACH transfer was requested. When this code is used, see BPR05 through BPR15 for additional requirements.

BOP — Financial Institution Option

Use this code to indicate that the third party processor will choose the method of payment based upon end point requests or capabilities. When this code is used, see BPR05 through BPR15 for additional requirements.

CHK — Check

Use this code to indicate that a check has been issued for payment.

FWT — Federal Reserve Funds/Wire Transfer - Nonrepetitive

Use this code to indicate that the funds were sent through the wire system. When this code is used, see BPR05 through BPR15 for additional requirements.

NON — Non-Payment Data

Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.

BPR05	**812**	**Payment Format Code**	**O**	**1**	**ID 1/10**	**O**

Code identifying the payment format to be used

SITUATIONAL RULE: Required when BPR04 is ACH. If not required by this implementation guide, do not send.

OD: 835W1__BPR05__PaymentFormatCode

CCP — Cash Concentration/Disbursement plus Addenda (CCD+) (ACH)

Use the CCD+ format to move money and up to 80 characters of data, enough to reassociate dollars and data when the dollars are sent through the ACH and the data is sent on a separate path. The addenda must contain a copy of the TRN segment.

CTX — Corporate Trade Exchange (CTX) (ACH)

Use the CTX format to move dollars and data through the ACH. The CTX format can contain up to 9,999 addenda records of 80 characters each. The CTX encapsulates the complete 835 and all envelope segments.

BPR06 506 (DFI) ID Number Qualifier X 1 ID 2/2 O

Code identifying the type of identification number of Depository Financial Institution (DFI)

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD:
835W1__BPR06__DepositoryFinancialInstitutionDFIIdentificationNumberQualifier

IMPLEMENTATION NAME: Depository Financial Institution (DFI) Identification Number Qualifier

BPR06 through BPR09 relate to the originating financial institution and the originator’s account (payer).

01 — ABA Transit Routing Number Including Check Digits (9 digits)

The ABA transit routing number is a unique number identifying every bank in the United States.

CODE SOURCE 4: ABA Routing Number

04 — Canadian Bank Branch and Institution Number

CODE SOURCE 91: Canadian Financial Institution Branch and Institution Number

BPR07 507 (DFI) Identification Number X 1 AN 3/12 O

Depository Financial Institution (DFI) identification number

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR07__SenderDFIIdentifier

IMPLEMENTATION NAME: Sender DFI Identifier

CODE SOURCE 60: (DFI) Identification Number

Use this number for the identifying number of the financial institution sending the transaction into the applicable network.

BPR08 569 Account Number Qualifier O 1 ID 1/3 O

Code indicating the type of account

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR08__AccountNumberQualifier

Use this code to identify the type of account in BPR09.

DA — Demand Deposit

BPR09 508 Account Number X 1 AN 1/35 O

Account number assigned

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR09__SenderBankAccountNumber

IMPLEMENTATION NAME: Sender Bank Account Number

Use this number for the originator's account number at the financial institution.

BPR10 509 Originating Company Identifier O 1 AN 10/10 O

A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR10__PayerIdentifier

IMPLEMENTATION NAME: Payer Identifier

BPR11 510 Originating Company Supplemental Code O 1 AN 9/9 O

A code defined between the originating company and the originating depository financial institution (ODFI) that uniquely identifies the company initiating the transfer instructions

SITUATIONAL RULE: Required when BPR10 is present and the payee has a business need to receive further identification of the source of the payment (such as identification of the payer by division or region). If not required by this implementation guide, do not send.

OD: 835W1__BPR11__OriginatingCompanySupplementalCode

Use this code to further identify the payer by division or region. The element must be left justified and space filled to meet the minimum element size requirements. If used, this code must be identical to TRN04, excluding trailing spaces.

BPR12 506 (DFI) ID Number Qualifier X 1 ID 2/2 O

Code identifying the type of identification number of Depository Financial Institution (DFI)

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD:
835W1__BPR12__DepositoryFinancialInstitutionDFIIdentificationNumberQualifier

IMPLEMENTATION NAME: Depository Financial Institution (DFI) Identification Number Qualifier

BPR12 through BPR15 relate to the receiving financial institution and the receiver's account.

- 01 ABA Transit Routing Number Including Check Digits (9 digits)

  The ABA transit routing number is a unique number identifying every bank in the United States.

  CODE SOURCE 4: ABA Routing Number
- 04 Canadian Bank Branch and Institution Number

  CODE SOURCE 91: Canadian Financial Institution Branch and Institution Number

BPR13 507 (DFI) Identification Number X 1 AN 3/12 O

Depository Financial Institution (DFI) identification number

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR13__ReceiverorProviderBankIDNumber

IMPLEMENTATION NAME: Receiver or Provider Bank ID Number

CODE SOURCE 60: (DFI) Identification Number

Use this number for the identifying number of the financial institution receiving the transaction from the applicable network.

BPR14 569 Account Number Qualifier O 1 ID 1/3 O

Code indicating the type of account

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR14__AccountNumberQualifier

Use this code to identify the type of account in BPR15.

DA	Demand Deposit
SG	Savings

BPR15 508 Account Number X 1 AN 1/35 O

Account number assigned

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR15__ReceiverorProviderAccountNumber

IMPLEMENTATION NAME: Receiver or Provider Account Number

Use this number for the receiver’s account number at the financial institution.

BPR16 373 Date O 1 DT 8/8 M

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

OD: 835W1__BPR16__CheckIssueorEFTEffectiveDate

IMPLEMENTATION NAME: Check Issue or EFT Effective Date

Use this for the effective entry date. If BPR04 is ACH, this is the date that the money moves from the payer and is available to the payee. If BPR04 is CHK, this is the check issuance date. If BPR04 is FWT, this is the date that the payer anticipates the money to move. As long as the effective date is a business day, this is the settlement date. If BPR04 is ‘NON’, enter the date of the 835.

Segment: **TRN** **Reassociation Trace Number**
Position: 0400
Loop:
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes:
1 TRN02 provides unique identification for the transaction.
2 TRN03 identifies an organization.
3 TRN04 identifies a further subdivision within the organization.

Comments:
Notes: TR3 Notes: 1. This segment's purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.
TR3 Example: TRN*1*12345*1512345678*999999999~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
TRN01	**481**	**Trace Type Code**	**M**	**1**	**ID 1/2**	**M**
		Code identifying which transaction is being referenced OD: 835W1__TRN01__TraceTypeCode 1 Current Transaction Trace Numbers				
TRN02	**127**	**Reference Identification**	**M**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1__TRN02__CheckorEFTTraceNumber IMPLEMENTATION NAME: Check or EFT Trace Number This number must be unique within the sender/receiver relationship. The number is assigned by the sender. If payment is made by check, this must be the check number. If payment is made by EFT, this must be the EFT reference number. If this is a nonpayment 835, this must be a unique remittance advice identification number. See 1.10.2.3, Reassociation of Dollars and Data, for additional information.				
TRN03	**509**	**Originating Company Identifier**	**O**	**1**	**AN 10/10**	**M**
		A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification. OD: 835W1__TRN03__PayerIdentifier IMPLEMENTATION NAME: Payer Identifier This must be a 1 followed by the payer's EIN (or TIN).				
TRN04	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment. If not required by this implementation guide, do not send.				

OD: 835W1__TRN04__OriginatingCompanySupplementalCode

IMPLEMENTATION NAME: Originating Company Supplemental Code

If both TRN04 and BPR11 are used, they must be identical, excluding trailing spaces. Since BPR11 has a min/max value of 9/9, whenever both are used, this element is restricted to a maximum size of 9.

Segment: **CUR** **Foreign Currency Information**
Position: 0500
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify the currency (dollars, pounds, francs, etc.) used in a transaction
Syntax Notes:
1 If CUR08 is present, then CUR07 is required.
2 If CUR09 is present, then CUR07 is required.
3 If CUR10 is present, then at least one of CUR11 or CUR12 is required.
4 If CUR11 is present, then CUR10 is required.
5 If CUR12 is present, then CUR10 is required.
6 If CUR13 is present, then at least one of CUR14 or CUR15 is required.
7 If CUR14 is present, then CUR13 is required.
8 If CUR15 is present, then CUR13 is required.
9 If CUR16 is present, then at least one of CUR17 or CUR18 is required.
10 If CUR17 is present, then CUR16 is required.
11 If CUR18 is present, then CUR16 is required.
12 If CUR19 is present, then at least one of CUR20 or CUR21 is required.
13 If CUR20 is present, then CUR19 is required.
14 If CUR21 is present, then CUR19 is required.

Semantic Notes:
Comments:
1 See Figures Appendix for examples detailing the use of the CUR segment.

Notes: Situational Rule: Required when the payment is not being made in US dollars. If not required by this implementation guide, do not send.

TR3 Notes: 1. When the CUR segment is not present, the currency of payment is defined as US dollars.
TR3 Example: CUR*PR*CAD~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CUR01	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1__CUR01__EntityIdentifierCode PR Payer				
CUR02	**100**	**Currency Code**	**M**	**1**	**ID 3/3**	**M**
		Code (Standard ISO) for country in whose currency the charges are specified OD: 835W1__CUR02__CurrencyCode CODE SOURCE 5: Countries, Currencies and Funds This is the currency code for the payment currency.				

Segment:	**REF** **Receiver Identification**
Position:	0600
Loop:	
Level:	Heading
Usage:	Optional
Max Use:	1
Purpose:	To specify identifying information
Syntax Notes:	**1** At least one of REF02 or REF03 is required. **2** If either C04003 or C04004 is present, then the other is required. **3** If either C04005 or C04006 is present, then the other is required.
Semantic Notes:	**1** REF04 contains data relating to the value cited in REF02.
Comments:	
Notes:	Situational Rule: Required when the receiver of the transaction is other than the payee (e.g., a clearinghouse or billing service). If not required by this implementation guide, may be provided at sender’s discretion, but cannot be required by the receiver. TR3 Notes: 1. This is the business identification information for the transaction receiver. This may be different than the EDI address or identifier of the receiver. This is the initial receiver of the transaction. This information must not be updated if the transaction is routed through multiple intermediaries, such as clearinghouses, before reaching the payee. TR3 Example: REF*EV*1235678~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification OD: 835W1__REF01__ReferenceIdentificationQualifier EV — Receiver Identification Number A unique number identifying the organization/site location designated to receive the current transmitted transaction set	**M**	**1**	**ID 2/3**	**M**
REF02	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1__REF02__ReceiverIdentifier IMPLEMENTATION NAME: Receiver Identifier ALIAS: Receiver Identification **Shared Claims Processing Notes:** Unique ID assigned to each Fund by BCBSIL (i.e. LABOR999)	**X**	**1**	**AN 1/50**	**M**

Segment: **REF** **Version Identification**
Position: 0600
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when necessary to report the version number of the adjudication system that generated the claim payments in order for the payer to resolve customer service questions from the payee. If not required by this implementation guide, do not send.

TR3 Notes: 1. Update this reference number whenever a change in the version or release number affects the 835. (This is not the ANSI ASCX12 version number as reported in the GS segment.)

TR3 Example: REF*F2*FS3.21~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification OD: 835W1__REF01__ReferenceIdentificationQualifier F2 — Version Code - Local Identifies the release of a set of information or requirements to distinguish from the previous or future sets that may differ; the release in question is on the local level				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1__REF02__VersionIdentificationCode IMPLEMENTATION NAME: Version Identification Code				

Segment: **DTM** **Production Date**
Position: 0700
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes:
1 At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the cut off date of the adjudication system remittance run is different from the date of the 835 as identified in the related GS04 element. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. If your adjudication cycle completed on Thursday and your 835 is produced on Saturday, you are required to populate this segment with Thursday's date.
TR3 Example: DTM*405*20020317~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
DTM01	**374**	**Date/Time Qualifier**	**M**	**1**	**ID 3/3**	**M**
		Code specifying type of date or time, or both date and time OD: 835W1__DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier 405 Production Used to identify dates and times that operations or processes were performed				
DTM02	**373**	**Date**	**X**	**1**	**DT 8/8**	**M**
		Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1__DTM02__ProductionDate IMPLEMENTATION NAME: Production Date Report the end date for the adjudication production cycle for claims included in this 835.				

Segment: **N1** **Payer Identification**
Position: 0800
Loop: 1000A
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes:
1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.

Semantic Notes:
Comments:
1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.

Notes: TR3 Notes: 1. Use this N1 loop to provide the name/address information for the payer.

2. The payer’s secondary identifying reference number is provided in N104, if necessary.

TR3 Example: N1*PR*INSURANCE COMPANY OF TIMBUCKTU*XV*8888888888~

Data Element Summary

Ref. Des. Attributes	Data Element	Name	Base Attributes			User
N101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_1000A_N101__EntityIdentifierCode PR Payer				
N102	**93**	**Name**	**X**	**1**	**AN 1/60**	**M**
		Free-form name OD: 835W1_1000A_N102__PayerName IMPLEMENTATION NAME: Payer Name				
N103	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**	**O**
		Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when the National PlanID is mandated for use. If not required by this implementation guide, may be provided at the sender’s discretion, but cannot be required by the receiver. OD: 835W1_1000A_N103__IdentificationCodeQualifier XV Centers for Medicare and Medicaid Services PlanID Required if the National PlanID is mandated for use. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID				
N104	**67**	**Identification Code**	**X**	**1**	**AN 2/80**	**O**
		Code identifying a party or other code SITUATIONAL RULE: Required when the National PlanID is mandated for use. If				

not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

OD: 835W1_1000A_N104__PayerIdentifier

IMPLEMENTATION NAME: Payer Identifier

Segment: **N3** **Payer Address**
Position: 1000
Loop: 1000A
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: TR3 Example: N3*100 MAIN STREET~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
N301	**166**	**Address Information** Address information OD: 835W1_1000A_N301__PayerAddressLine IMPLEMENTATION NAME: Payer Address Line	**M**	**1**	**AN 1/55**	**M**
N302	**166**	**Address Information** Address information SITUATIONAL RULE: Required when a second address line exists. If not required by this implementation guide, do not send. OD: 835W1_1000A_N302__PayerAddressLine IMPLEMENTATION NAME: Payer Address Line	**O**	**1**	**AN 1/55**	**O**

Segment: **N4** **Payer City, State, ZIP Code**
Position: 1100
Loop: 1000A
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
1 Only one of N402 or N407 may be present.
2 If N406 is present, then N405 is required.
3 If N407 is present, then N404 is required.
Semantic Notes:
Comments:
1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2 N402 is required only if city name (N401) is in the U.S. or Canada.
Notes: TR3 Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
N401	**19**	**City Name** Free-form text for city name OD: 835W1_1000A_N401__PayerCityName IMPLEMENTATION NAME: Payer City Name	**O**	**1**	**AN 2/30**	**M**
N402	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send. OD: 835W1_1000A_N402__PayerStateCode IMPLEMENTATION NAME: Payer State Code CODE SOURCE 22: States and Provinces	**X**	**1**	**ID 2/2**	**O**
N403	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send. OD: 835W1_1000A_N403__PayerPostalZoneorZIPCode IMPLEMENTATION NAME: Payer Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	**O**	**1**	**ID 3/15**	**O**
N404	**26**	**Country Code** Code identifying the country SITUATIONAL RULE: Required when the address is outside the United States of America. If not required by this implementation guide, do not send.	**X**	**1**	**ID 2/3**	**O**

OD: 835W1_1000A_N404__CountryCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the alpha-2 country codes from Part 1 of ISO 3166.

N407 1715 Country Subdivision Code X 1 ID 1/3 O

Code identifying the country subdivision

SITUATIONAL RULE: Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.

OD: 835W1_1000A_N407__CountrySubdivisionCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

Segment: **REF** **Additional Payer Identification**
Position: 1200
Loop: 1000A
Level: Heading
Usage: Optional
Max Use: 4
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional payer identification numbers beyond those in the TRN and Payer N1 segments are needed. If not required by this implementation guide, do not send.

TR3 Notes: 1. The ID available in the TRN and N1 segments must be used before using the REF segment.
TR3 Example: REF*2U*98765~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification				
		OD: 835W1_1000A_REF01__ReferenceIdentificationQualifier				
		2U — Payer Identification Number For Medicare carriers or intermediaries, use this qualifier for the Medicare carrier or intermediary ID number. For Blue Cross and Blue Shield Plans, use this qualifier for the Blue Cross Blue Shield association plan code.				
		EO — Submitter Identification Number A unique number identifying the submitter of the transaction set This is required when the original transaction sender is not the payer or is identified by an identifier other than those already provided. This is not updated by third parties between the payer and the payee. An example of a use for this qualifier is when identifying a clearinghouse that created the 835 when the health plan sent a proprietary format to the clearinghouse.				
		HI — Health Industry Number (HIN) CODE SOURCE 121: Health Industry Number				
		NF — National Association of Insurance Commissioners (NAIC) Code A unique number assigned to each insurance company This is the preferred value when identifying the payer. CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified				

by the Reference Identification Qualifier
OD: 835W1_1000A_REF02__AdditionalPayerIdentifier

IMPLEMENTATION NAME: Additional Payer Identifier

Segment: **PER** **Payer Business Contact Information**
Position: 1300
Loop: 1000A
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when there is a business contact area that would apply to this remittance and all the claims. If not required by this implementation guide, do not send.

TR3 Notes: 1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number always includes the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (800) 555-1212 would be represented as 8005551212). The extension number, when applicable, is identified in the next element pair (Communications Number Qualifier and Communication Number) immediately after the telephone number.

TR3 Example: PER*CX*JOHN WAYNE*TE*8005551212~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
PER01	**366**	**Contact Function Code**	**M**	**1**	**ID 2/2**	**M**
		Code identifying the major duty or responsibility of the person or group named				
		OD: 835W1_1000A_PER01__ContactFunctionCode				
		CX — Payers Claim Office Location responsible for paying bills related to medical care received				
PER02	**93**	**Name**	**O**	**1**	**AN 1/60**	**O**
		Free-form name				
		SITUATIONAL RULE: Required when it is necessary to identify an individual or other contact point to discuss information related to this transaction. If not required by this implementation guide, do not send.				
		OD: 835W1_1000A_PER02__PayerContactName				
		IMPLEMENTATION NAME: Payer Contact Name				
		Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).				
PER03	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**	**O**
		Code identifying the type of communication number				

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER03__CommunicationNumberQualifier

EM	Electronic Mail
FX	Facsimile
TE	Telephone

PER04 **364** **Communication Number** **X** **1** **AN 1/256** **O**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER04__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER05 **365** **Communication Number Qualifier** **X** **1** **ID 2/2** **O**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER05__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension When used, the value following this code is the extension for the preceding communications contact number.
FX	Facsimile
TE	Telephone

PER06 **364** **Communication Number** **X** **1** **AN 1/256** **O**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER06__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER07 **365** **Communication Number Qualifier** **X** **1** **ID 2/2** **O**

Code identifying the type of communication number

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER07__CommunicationNumberQualifier

EX	Telephone Extension

PER08 **364** **Communication Number** **X** **1** **AN 1/256** **O**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER08__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

Segment: **PER** **Payer Technical Contact Information**
Position: 1300
Loop: 1000A
Level: Heading
Usage: Mandatory
Max Use: >1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: TR3 Notes: 1. Required to report technical contact information for this remittance advice.
TR3 Example: PER*BL*JOHN WAYNE*TE*8005551212*EX*123~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
PER01	**366**	**Contact Function Code**	**M**	**1**	**ID 2/2**	**M**
		Code identifying the major duty or responsibility of the person or group named OD: 835W1_1000A_PER01__ContactFunctionCode BL Technical Department				
PER02	**93**	**Name**	**O**	**1**	**AN 1/60**	**O**
		Free-form name SITUATIONAL RULE: Required when it is necessary to identify an individual or other contact point to discuss technical information related to this transaction. If not required by this implementation guide, do not send. OD: 835W1_1000A_PER02__PayerTechnicalContactName IMPLEMENTATION NAME: Payer Technical Contact Name Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).				
PER03	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**	**O**
		Code identifying the type of communication number SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send. OD: 835W1_1000A_PER03__CommunicationNumberQualifier EM Electronic Mail TE Telephone Recommended UR Uniform Resource Locator (URL) Use only when there is no central telephone number for the payer entity.				
PER04	**364**	**Communication Number**	**X**	**1**	**AN 1/256**	**O**
		Complete communications number including country or area code when applicable				

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER04__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER05 365 Communication Number Qualifier X 1 ID 2/2 O

Code identifying the type of communication number

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER05__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension When used, the value following this code is the extension for the preceding communications contact number.
FX	Facsimile
TE	Telephone
UR	Uniform Resource Locator (URL)

PER06 364 Communication Number X 1 AN 1/256 O

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER06__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER07 365 Communication Number Qualifier X 1 ID 2/2 O

Code identifying the type of communication number

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER07__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension When used, the value following this code is the extension for the preceding communications contact number.
FX	Facsimile
UR	Uniform Resource Locator (URL)

PER08 364 Communication Number X 1 AN 1/256 O

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER08__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

Segment: **PER** **Payer WEB Site**
Position: 1300
Loop: 1000A
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the payer has a WEB site that contains appeal, complaint, medical or other policies that may apply to this remittance advice and the Payee can not be reasonably expected to know the current site location. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
TR3 Example: PER*IC**UR*www.anyhealthplan.com/policies.html~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
PER01	**366**	**Contact Function Code**	**M**	**1**	**ID 2/2**	**M**
		Code identifying the major duty or responsibility of the person or group named				
		OD: 835W1_1000A_PER01__ContactFunctionCode				
		IC — Information Contact				
PER03	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**	**M**
		Code identifying the type of communication number				
		OD: 835W1_1000A_PER03__CommunicationNumberQualifier				
		UR — Uniform Resource Locator (URL)				
PER04	**364**	**Communication Number**	**X**	**1**	**AN 1/256**	**M**
		Complete communications number including country or area code when applicable				
		OD: 835W1_1000A_PER04__CommunicationNumber				
		This is the payer's WEB site URL where providers can find policy and other related information.				

Segment: **N1** **Payee Identification**
Position: 0800
Loop: 1000B
Level: Heading
Usage: Mandatory
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes:
1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments:
1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: TR3 Notes: 1. Use this N1 loop to provide the name/address information of the payee. The identifying reference number is provided in N104.

TR3 Example: N1*PE*MID-STATE MENTAL HOSPITAL*XX*12345678~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
N101	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_1000B_N101__EntityIdentifierCode PE — Payee	**M**	**1**	**ID 2/3**	**M**
N102	**93**	**Name** Free-form name OD: 835W1_1000B_N102__PayeeName IMPLEMENTATION NAME: Payee Name	**X**	**1**	**AN 1/60**	**M**
N103	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_1000B_N103__IdentificationCodeQualifier FI — Federal Taxpayer's Identification Number Required if provider is not mandated by NPI. For individual providers as payees, use this qualifier to represent the Social Security Number. XV — Centers for Medicare and Medicaid Services PlanID This is REQUIRED when the National Health Plan Identifier is mandated for use and the payee is a health plan. This only applies in cases of post payment recovery. See section 1.10.2.16 (Post Payment Recovery) for further information. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID XX — Centers for Medicare and Medicaid Services National Provider Identifier	**X**	**1**	**ID 1/2**	**M**

This is REQUIRED when the National Provider Identifier is mandated for use and the payee is a covered health care provider under the mandate.

CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier

N104	**67**	**Identification Code**	**X**	**1**	**AN 2/80**	**M**

Code identifying a party or other code

OD: 835W1_1000B_N104__PayeeIdentificationCode

IMPLEMENTATION NAME: Payee Identification Code

Segment: **N3** **Payee Address**
Position: 1000
Loop: 1000B
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the sender needs to communicate the payee address to a transaction receiver, e.g., a VAN or a clearinghouse. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
TR3 Example: N3*SUITE 200*1000 MAIN STREET~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
N301	**166**	**Address Information** Address information OD: 835W1_1000B_N301__PayeeAddressLine IMPLEMENTATION NAME: Payee Address Line	**M**	**1**	**AN 1/55**	**M**
N302	**166**	**Address Information** Address information SITUATIONAL RULE: Required when a second address line exists. If not required by this implementation guide, do not send. OD: 835W1_1000B_N302__PayeeAddressLine IMPLEMENTATION NAME: Payee Address Line	**O**	**1**	**AN 1/55**	**O**

Segment: **N4** **Payee City, State, ZIP Code**
Position: 1100
Loop: 1000B
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
1 Only one of N402 or N407 may be present.
2 If N406 is present, then N405 is required.
3 If N407 is present, then N404 is required.

Semantic Notes:
Comments:
1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2 N402 is required only if city name (N401) is in the U.S. or Canada.

Notes: Situational: Required when the sender needs to communicate the payee address to a transaction receiver, e.g., a VAN or a clearinghouse. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
N401	**19**	**City Name** Free-form text for city name OD: 835W1_1000B_N401__PayeeCityName IMPLEMENTATION NAME: Payee City Name	**O**	**1**	**AN 2/30**	**M**
N402	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send. OD: 835W1_1000B_N402__PayeeStateCode IMPLEMENTATION NAME: Payee State Code CODE SOURCE 22: States and Provinces	**X**	**1**	**ID 2/2**	**O**
N403	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send. OD: 835W1_1000B_N403__PayeePostalZoneorZIPCode IMPLEMENTATION NAME: Payee Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	**O**	**1**	**ID 3/15**	**O**

N404	**26**	**Country Code**	**X**	**1**	**ID 2/3**	**O**
		Code identifying the country SITUATIONAL RULE: Required when the address is outside the United States of America. If not required by this implementation guide, do not send. OD: 835W1_1000B_N404__CountryCode CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.				
N407	**1715**	**Country Subdivision Code**	**X**	**1**	**ID 1/3**	**O**
		Code identifying the country subdivision SITUATIONAL RULE: Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send. OD: 835W1_1000B_N407__CountrySubdivisionCode CODE SOURCE 5: Countries, Currencies and Funds Use the country subdivision codes from Part 2 of ISO 3166.				

Segment: **REF** **Payee Additional Identification**
Position: 1200
Loop: 1000B
Level: Heading
Usage: Mandatory
Max Use: >1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when identification of the payee is dependent upon an identification number beyond that supplied in the N1 segment. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Example: REF*TJ*12345678~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**

REF01

Code qualifying the Reference Identification

OD: 835W1_1000B_REF01__ReferenceIdentificationQualifier

Shared Claims Processing Notes:

=TJ

0B	State License Number
D3	National Council for Prescription Drug Programs Pharmacy Number CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number
PQ	Payee Identification
TJ	Federal Taxpayer's Identification Number This information must be in the N1 segment unless the National Provider ID or the National Health Plan Identifier was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number. TJ also represents the Employer Identification Number (EIN). According to the IRS, TIN and EIN can be used interchangeably.

REF02

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1_1000B_REF02__AdditionalPayeeIdentifier

IMPLEMENTATION NAME: Additional Payee Identifier

Shared Claims Processing Notes:

Federally assigned Tax Identification Number of the billing provider. This can be either the Employer Identification number or the Social Security Number of the provider.

EDF2 Notes:

EDF2-PROVIDER-TAX-ID

Federally assigned Tax Identification Number of the billing provider. This can be either the Employer Identification number or the Social Security Number of the provider.

Segment: **RDM** **Remittance Delivery Method**
Position: 1400
Loop: 1000B
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To identify remittance delivery when remittance is separate from payment
Syntax Notes:
1 If either C04003 or C04004 is present, then the other is required.
2 If either C04005 or C04006 is present, then the other is required.
3 If either C04003 or C04004 is present, then the other is required.
4 If either C04005 or C04006 is present, then the other is required.

Semantic Notes:
Comments:
1 RDM02 is used to contain the name of a third party processor if needed, who would be the first recipient of the remittance.
2 RDM03 contains the operative communication number for the delivery method specified in RDM01 (i.e. fax phone number and mail address).
3 RDM04 and RDM05 allow for additional room to convey further routing information beyond what is given in RDM03.

Notes: Situational Rule: Required when BPR01 = U or X; and the remittance is to be sent separately from the payment. The payer is responsible to provide the bank with the instructions on how to deliver the remittance information, if not required by this implementation guide, do not send.

TR3 Notes: 1. Payer should coordinate this process with their Originating Depository Financial Institution (ODFI).

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
RDM01	**756**	**Report Transmission Code**	**M**	**1**	**ID 1/2**	**M**
		Code defining timing, transmission method or format by which reports are to be sent OD: 835W1_1000B_RDM01__ReportTransmissionCode				
		BM — By Mail When used, RDM02 must be used. When BM is used, the remittance information will be mailed to the payee at the address identified in this 1000B loop.				
		EM — E-Mail Use with encrypted e-mail.				
		FT — File Transfer Use with FTP communications.				
		OL — On-Line Use with secured hosted or other electronic delivery.				
RDM02	**93**	**Name**	**O**	**1**	**AN 1/60**	**O**
		Free-form name SITUATIONAL RULE: Required when RDM01 = BM. If not required by this implementation guide, do not send. OD: 835W1_1000B_RDM02__Name				

		When BM is used, the remittance information will be mailed to the attention of this person at the payee’s address identified in this 1000B loop.				
RDM03	**364**	**Communication Number**	**O**	**1**	**AN 1/256**	**O**
		Complete communications number including country or area code when applicable				
		SITUATIONAL RULE: Required when RDM01 equals EM, FT, or OL. If not required by this implementation guide, do not send. OD: 835W1_1000B_RDM03__CommunicationNumber Contains URL web address or e-mail address.				

Segment: **LX** **Header Number**
Position: 0030
Loop: 2000
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To reference a line number in a transaction set
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when claim/service information is being provided in the transaction. If not required by this implementation guide, do not send.

TR3 Notes: 1. The purpose of LX01 is to provide an identification of a particular grouping of claims for sorting purposes.

2. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments. This number is intended to be unique within each transaction.
TR3 Example: LX*1~
TR3 Example: LX*110210~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
LX01	**554**	**Assigned Number**	**M**	**1**	**N0 1/6**	**M**
		Number assigned for differentiation within a transaction set OD: 835W1_2000_LX01__AssignedNumber				

Segment: **TS3** **Provider Summary Information**
Position: 0050
Loop: 2000
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply provider-level control information
Syntax Notes:
Semantic Notes:

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

Comments:
Notes: Situational Rule: Required for Medicare Part A or when payers and payees outside the Medicare Part A community need to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity [i.e., the corporate office of a hospital chain]. If not required by this implementation guide, do not send.

TR3 Notes: 1. TS301 identifies the subsidiary provider.

2. The remaining mandatory elements (TS302 through TS305) must be valid with appropriate data, as defined by the TS3 segment.

3. Only Medicare Part A uses data elements TS313, TS315, TS317, TS318 and TS320 through TS324. Each monetary amount element is for that provider for this facility type code for loop 2000.

TR3 Example: TS3*123456*11*20021031*10*130957.66~

Data Element Summary

Ref. **Data** **Base** **User**

Des. Attributes	Element	Name	Attributes			
TS301	**127**	**Reference Identification**	**M**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2000_TS301__ProviderIdentifier IMPLEMENTATION NAME: Provider Identifier This is the provider number.				
TS302	**1331**	**Facility Code Value**	**M**	**1**	**AN 1/2**	**M**
		Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. OD: 835W1_2000_TS302__FacilityTypeCode IMPLEMENTATION NAME: Facility Type Code When reporting a TS3 segment for professional claims and the claims are not all for the same place of service, report a place of service of 11 (Office) as the default value. When reporting a TS3 segment for pharmaceutical claims and the claims are not all for the same place of service, report a place of service of 99 (Other unlisted facility) as the default value.				
TS303	**373**	**Date**	**M**	**1**	**DT 8/8**	**M**
		Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1_2000_TS303__FiscalPeriodDate IMPLEMENTATION NAME: Fiscal Period Date Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, use December 31st of the current year.				
TS304	**380**	**Quantity**	**M**	**1**	**R 1/15**	**M**
		Numeric value of quantity OD: 835W1_2000_TS304__TotalClaimCount IMPLEMENTATION NAME: Total Claim Count This is the total number of claims.				
TS305	**782**	**Monetary Amount**	**M**	**1**	**R 1/18**	**M**
		Monetary amount OD: 835W1_2000_TS305__TotalClaimChargeAmount IMPLEMENTATION NAME: Total Claim Charge Amount This is the total reported charges for all claims. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all 782 elements.				
TS313	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when the Total MSP Payer Amount is not zero. If not required by this implementation guide, do not send.				

		OD: 835W1_2000_TS313__TotalMSPPayerAmount IMPLEMENTATION NAME: Total MSP Payer Amount See TR3 note 3.				
TS315	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the Total Non-Lab charge amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS315__TotalNonLabChargeAmount IMPLEMENTATION NAME: Total Non-Lab Charge Amount See TR3 note 3.	**O**	**1**	**R 1/18**	**O**
TS317	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the Total HCPCS Reported Charge Amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS317__TotalHCPCSReportedChargeAmount IMPLEMENTATION NAME: Total HCPCS Reported Charge Amount See TR3 note 3.	**O**	**1**	**R 1/18**	**O**
TS318	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the total HCPCS payable amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS318__TotalHCPCSPayableAmount IMPLEMENTATION NAME: Total HCPCS Payable Amount See TR3 note 3.	**O**	**1**	**R 1/18**	**O**
TS320	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the total professional component amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS320__TotalProfessionalComponentAmount IMPLEMENTATION NAME: Total Professional Component Amount The professional component amount must also be reported in the CAS segment with a Claim Adjustment Reason Code value of 89. See TR3 note 3.	**O**	**1**	**R 1/18**	**O**
TS321	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the total MSP patient liability met is not zero. If not required by this implementation guide, do not send.	**O**	**1**	**R 1/18**	**O**

OD: 835W1_2000_TS321__TotalMSPPatientLiabilityMetAmount

IMPLEMENTATION NAME: Total MSP Patient Liability Met Amount

See TR3 note 3.

TS322 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when the total patient reimbursement is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS322__TotalPatientReimbursementAmount

IMPLEMENTATION NAME: Total Patient Reimbursement Amount

See TR3 note 3.

TS323 380 Quantity O 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when the Total PIP Claim Count is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS323__TotalPIPClaimCount

IMPLEMENTATION NAME: Total PIP Claim Count

See TR3 note 3.

TS324 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when the total PIP adjustment amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS324__TotalPIPAdjustmentAmount

IMPLEMENTATION NAME: Total PIP Adjustment Amount

See TR3 note 3.

Segment: **TS2** **Provider Supplemental Summary Information**
Position: 0070
Loop: 2000
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To provide supplemental summary control information by provider fiscal year and bill type
Syntax Notes:
Semantic Notes:

1 TS201 is the total diagnosis related group (DRG) amount.
2 TS202 is the total federal specific amount.
3 TS203 is the total hospital specific amount.
4 TS204 is the total disproportionate share amount.
5 TS205 is the total capital amount.
6 TS206 is the total indirect medical education amount.
7 TS207 is the total number of outlier days.
8 TS208 is the total day outlier amount.
9 TS209 is the total cost outlier amount.
10 TS210 is the diagnosis related group (DRG) average length of stay.
11 TS211 is the total number of discharges.
12 TS212 is the total number of cost report days.
13 TS213 is the total number of covered days.
14 TS214 is total number of non-covered days.
15 TS215 is the total Medicare Secondary Payer (MSP) pass- through amount calculated for a non-Medicare payer.
16 TS216 is the average diagnosis-related group (DRG) weight.
17 TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.
18 TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount.
19 TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.

Comments:
Notes: Situational Rule: Required for Medicare Part A. If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment provides summary information specific to an iteration of the LX loop (Table 2).

2. Each element represents the total value for the provider/bill type combination in this loop 2000 iteration.
TR3 Example: TS2*59786*55375.77~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
TS201	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when the value of the Total DRG amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS201__TotalDRGAmount

IMPLEMENTATION NAME: Total DRG Amount

This includes: operating federal-specific amount, operating hospital-specific amount, operating Indirect Medical Education amount, and operating Disproportionate Share Hospital amount. It does not include any operating outlier amount.

See TR3 note 2.

TS202	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when total federal specific amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS202__TotalFederalSpecificAmount

IMPLEMENTATION NAME: Total Federal Specific Amount

See TR3 note 2.

TS203	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when total hospital specific amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS203__TotalHospitalSpecificAmount

IMPLEMENTATION NAME: Total Hospital Specific Amount

See TR3 note 2.

TS204	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when total disproportionate share amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS204__TotalDisproportionateShareAmount

IMPLEMENTATION NAME: Total Disproportionate Share Amount

See TR3 note 2.

TS205	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when total capital amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS205__TotalCapitalAmount

IMPLEMENTATION NAME: Total Capital Amount

This includes: capital federal-specific amount, hospital federal specfic amount, hold harmless amount, Indirect Medical Education amount, Disproportionate Share Hospital amount, and the exception amount. It does not include any capital outlier amount.

See TR3 note 2.

TS206	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when total indirect medical education amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS206__TotalIndirectMedicalEducationAmount IMPLEMENTATION NAME: Total Indirect Medical Education Amount See TR3 note 2.				
TS207	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required when total outlier day count is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS207__TotalOutlierDayCount IMPLEMENTATION NAME: Total Outlier Day Count See TR3 note 2.				
TS208	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when the value of the total day outlier amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS208__TotalDayOutlierAmount IMPLEMENTATION NAME: Total Day Outlier Amount See TR3 note 2.				
TS209	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when the value of the total cost outlier amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS209__TotalCostOutlierAmount IMPLEMENTATION NAME: Total Cost Outlier Amount See TR3 note 2.				
TS210	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required when the value of the average DRG length of stay is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS210__AverageDRGLengthofStay IMPLEMENTATION NAME: Average DRG Length of Stay See TR3 note 2.				
TS211	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required when the value of the total discharge count is not				

zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS211__TotalDischargeCount

IMPLEMENTATION NAME: Total Discharge Count

This is the discharge count produced by PPS PRICER SOFTWARE.

See TR3 note 2.

TS212	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when the value of the total cost report day count is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS212__TotalCostReportDayCount

IMPLEMENTATION NAME: Total Cost Report Day Count

See TR3 note 2.

TS213	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when the value of the total covered day count is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS213__TotalCoveredDayCount

IMPLEMENTATION NAME: Total Covered Day Count

See TR3 note 2.

TS214	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when the value of the total noncovered day count is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS214__TotalNoncoveredDayCount

IMPLEMENTATION NAME: Total Noncovered Day Count

See TR3 note 2.

TS215	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when the value of the total MSP Passthrough amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS215__TotalMSPPassThroughAmount

IMPLEMENTATION NAME: Total MSP Pass-Through Amount

See TR3 note 2.

TS216	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when the value of the average DRG Weight is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS216__AverageDRGweight

IMPLEMENTATION NAME: Average DRG weight

See TR3 note 2.

TS217	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when the value of the total PPS capital FSP (Federal-specific Portion) DRG amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS217__TotalPPSCapitalFSPDRGAmount

IMPLEMENTATION NAME: Total PPS Capital FSP DRG Amount

See TR3 note 2.

TS218	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when the value of the total PPS Capital HSP (Hospital-specific Portion) DRG Amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS218__TotalPPSCapitalHSPDRGAmount

IMPLEMENTATION NAME: Total PPS Capital HSP DRG Amount

See TR3 note 2.

TS219	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when the value of the Total PPS Capital DSH (Disproportionate Share, Hospital) DRG amount is not zero. If not required by this implementation guide, do not send.

OD: 835W1_2000_TS219__TotalPPSDSHDRGAmount

IMPLEMENTATION NAME: Total PPS DSH DRG Amount

See TR3 note 2.

Segment: **CLP** **Claim Payment Information**
Position: 0100
Loop: 2100
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply information common to all services of a claim
Syntax Notes:
Semantic Notes:
1 CLP03 is the amount of submitted charges this claim.
2 CLP04 is the amount paid this claim.
3 CLP05 is the patient responsibility amount.
4 CLP07 is the payer's internal control number.
5 CLP12 is the diagnosis-related group (DRG) weight.
6 CLP13 is the discharge fraction.
7 CLP14 is the patient authorization to coordinate benefits. A "Y" indicates that the authorization exists; an "N" indicates that the authorization does not exist.

Comments:
Notes: TR3 Notes: 1. For CLP segment occurrence limitations, see section 1.3.2, Other Usage Limitations.
R3 Example:
CLP*7722337*1*211366.97*138018.4**12*0201027431240940C00~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CLP01	**1028**	**Claim Submitter's Identifier**	**M**	**1**	**AN 1/38**	**M**

Identifier used to track a claim from creation by the health care provider through payment
OD: 835W1_2100_CLP01__PatientControlNumber

IMPLEMENTATION NAME: Patient Control Number

Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter a single zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database. In the case of pharmacy claims, this is the prescription reference number (field 402-02 in the NCPDP 5.1 format).

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CLP02	**1029**	**Claim Status Code**	**M**	**1**	**ID 1/2**	**M**

Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization
OD: 835W1_2100_CLP02__ClaimStatusCode

To determine the full claim status reference Claim adjustment reason codes in the CAS segment in conjunction with this claim status code.

1 Processed as Primary
Use this code if the claim was adjudicated by the current payer as primary regardless of whether any part of the claim was paid.

2 Processed as Secondary
Use this code if the claim was adjudicated by the current

			payer as secondary regardless of whether any part of the claim was paid.
		3	Processed as Tertiary Use this code if the claim was adjudicated by the current payer as tertiary (or subsequent) regardless of whether any part of the claim was paid.
		4	Denied Usage of this code would apply if the Patient/Subscriber is not recognized, and the claim was not forwarded to another payer.
		19	Processed as Primary, Forwarded to Additional Payer(s) When this code is used, the Crossover Carrier Name NM1 segment is required.
		20	Processed as Secondary, Forwarded to Additional Payer(s) When this code is used, the Crossover Carrier Name NM1 segment is required.
		21	Processed as Tertiary, Forwarded to Additional Payer(s) When this code is used, the Crossover Carrier Name NM1 segment is required.
		22	Reversal of Previous Payment See section 1.10.2.8 for usage information.
		23	Not Our Claim, Forwarded to Additional Payer(s) Usage of this code would apply if the patient/subscriber is not recognized, the claim was not adjudicated by the payer, but other payers are known and the claim has been forwarded to another payer. When this code is used, the Crossover Carrier Name NM1 segment is required.
		25	Predetermination Pricing Only - No Payment

CLP03 **782** **Monetary Amount** **M** **1** **R 1/18** **M**

Monetary amount

OD: 835W1_2100_CLP03__TotalClaimChargeAmount

IMPLEMENTATION NAME: Total Claim Charge Amount

See 1.10.2.1, Balancing, in this implementation guide for additional information.

Use this monetary amount for the submitted charges for this claim. The amount can be positive, zero or negative. An example of a situation with a negative charge is a reversal claim. See section 1.10.2.8 for additional information.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claims Processing Notes:

The total charge for services rendered.

EDF2 Notes:

EDF2-KEY-TOTAL-PROVIDER-CHARGE

The total charge for services rendered.

CLP04 **782** **Monetary Amount** **M** **1** **R 1/18** **M**

Monetary amount

OD: 835W1_2100_CLP04__ClaimPaymentAmount

IMPLEMENTATION NAME: Claim Payment Amount

See 1.10.2.1, Balancing, in this implementation guide for additional information. See section 1.10.2.9 for information about interest considerations.

Use this monetary amount for the amount paid for this claim. It can be positive, zero or negative, but the value in BPR02 may not be negative.

Shared Claims Processing Notes:

The amount to be paid to the provider for the service rendered.

EDF2 Notes:

EDF2-CLM-PROV-PAYMENT-AMT

The amount to be paid to the provider for the service rendered.

CLP05 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when the patient's responsibility is greater than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_CLP05__PatientResponsibilityAmount

IMPLEMENTATION NAME: Patient Responsibility Amount

Amounts in CLP05 must have supporting adjustments reflected in CAS segments at the 2100 (CLP) or 2110 (SVC) loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility).

Use this monetary amount for the payer's statement of the patient responsibility amount for this claim, which can include such items as deductible, non-covered services, co-pay and co-insurance. This is not used for reversals. See section 1.10.2.8, Reversals and Corrections, for additional information.

CLP06 1032 Claim Filing Indicator Code O 1 ID 1/2 M

Code identifying type of claim

OD: 835W1_2100_CLP06__ClaimFilingIndicatorCode

For many providers to electronically post the 835 remittance data to their patient accounting systems without human intervention, a unique, provider-specific insurance plan code is needed. This code allows the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider. Because most payers maintain the same Originating Company Identifier in the TRN03 or BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03 or BPR10 to identify the unique, provider-specific insurance plan code needed to post the payment without human intervention. The value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value as assigned or edited by the payer. For example the BL from the SBR09 in the 837 would be returned as 12, 13, 15, in the 835 when more details are known. The 837 SBR09 code CI (Commercial Insurance) is generic, if through adjudication the specific type of plan is obtained a more specific code must be returned in the 835.

The 837 and 835 transaction code lists for this element are not identical by design. There are some business differences between the two transactions. When a code from the 837 is not available in the 835 another valid code from the 835 must be assigned by the payer.

12	Preferred Provider Organization (PPO)
	This code is also used for Blue Cross/Blue Shield participating provider arrangements.
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
	This code is also used for Blue Cross/Blue Shield non-participating provider arrangements.
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
CH	Champus
DS	Disability
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
	Use this code for the Black Lung Program.
TV	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

CLP07 127 Reference Identification O 1 AN 1/50 M

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1_2100_CLP07__PayerClaimControlNumber

IMPLEMENTATION NAME: Payer Claim Control Number

Use this number for the payer's internal control number. This number must apply to the entire claim.

Shared Claims Processing Notes:

BCBSIL's document control number and the number of adjustments on the claim. Field includes reason for adjustment when the adjustment number is 01 thru 99.

Field Position:
01 - 17 = BCBSIL's document control number
18 - 19 = Claim suffix: Values = 00 - 99

EDF2 Notes:

EDF2-KEY-CLM-DCN-PREFIX: Position 1-4

EDF2-KEY-CLM-DCN-YEAR: Position 5

EDF2-KEY-CLM-DCN-DATE: Position 6-8

EDF2-KEY-CLAIM-DCN-ROLL-NO: Position 10

EDF2-KEY-CLM-DCN-BATCH-NO: Position 11-13

EDF2-KEY-CLM-DCN-ITEM-CT: Position 14-15

EDF2-KEY-CLM-DCN-INCR: Position 16

EDF2-KEY-CLM-DCN-LOCATION: Position 17

BCBSIL's document control number.

EDF2-KEY-CLAIM-ADJ-SUFFIX: Position 18-19

Indicates the number of adjustments on the claim.

CLP08 1331 Facility Code Value O 1 AN 1/2 O

Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services.
SITUATIONAL RULE: Required when the information was received on the original claim. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

OD: 835W1_2100_CLP08__FacilityTypeCode

IMPLEMENTATION NAME: Facility Type Code

Since professional or dental claims can have different place of service codes for services within a single claim, default to the place of service of the first service line when the service lines are not all for the same place of service.

This number was received in CLM05-1 of the 837 claim.

CLP09 1325 Claim Frequency Type Code O 1 ID 1/1 O

Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type
SITUATIONAL RULE: Required when the information was received on the original claim. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

OD: 835W1_2100_CLP09__ClaimFrequencyCode

IMPLEMENTATION NAME: Claim Frequency Code

CODE SOURCE 235: Claim Frequency Type Code

This number was received in CLM05-3 of the 837 Claim.

CLP11 1354 Diagnosis Related Group (DRG) Code O 1 ID 1/4 O

Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems
SITUATIONAL RULE: Required for institutional claims when the claim was adjudicated using a DRG. If not required by this implementation guide, do not send.

OD: 835W1_2100_CLP11__DiagnosisRelatedGroupDRGCode

		CODE SOURCE 229: Diagnosis Related Group Number (DRG)				
CLP12	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required for institutional claims when the claim was adjudicated using a DRG. If not required by this implementation guide, do not send. OD: 835W1_2100_CLP12__DiagnosisRelatedGroupDRGWeight IMPLEMENTATION NAME: Diagnosis Related Group (DRG) Weight This is the adjudicated DRG Weight.				
CLP13	**954**	**Percentage as Decimal**	**O**	**1**	**R 1/10**	**O**
		Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%) SITUATIONAL RULE: Required when a discharge fraction was applied in the adjudication process. If not required by this implementation guide, do not send. OD: 835W1_2100_CLP13__DischargeFraction IMPLEMENTATION NAME: Discharge Fraction This is the adjudicated discharge fraction.				

Segment: **CAS** **Claims Adjustment**
Position: 0200
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 99
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

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

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

Comments:
1 Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

Notes: Situational Rule: Required when dollar amounts and/or quantities are being adjusted at the claim level. If not required by this implementation guide, do not send.

TR3 Notes: 1. Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged. See 1.10.2.1, Balancing, and 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.

2. See the SVC TR3 Note #1 for details about per diem adjustments.

3. A single CAS segment contains six repetitions of the "adjustment trio"

composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a specific Claim Adjustment Group Code (CAS01). The six iterations (trios) of the Adjustment Reason Code related to the Specific Adjustment Group Code must be exhausted before repeating a second iteration of the CAS segment using the same Adjustment Group Code. The first adjustment must be the first on-zero adjustment and is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

TR3 Example: CAS*PR*100*15

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CAS01	**1033**	**Claim Adjustment Group Code**	**M**	**1**	**ID 1/2**	**M**

Code identifying the general category of payment adjustment

OD: 835W1_2100_CAS01__ClaimAdjustmentGroupCode

Evaluate the usage of group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, OA. See 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)

Shared Claims Processing Notes:

= PR

CO	Contractual Obligations Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.
OA	Other adjustments Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.
PI	Payor Initiated Reductions Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).
PR	Patient Responsibility

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CAS02	**1034**	**Claim Adjustment Reason Code**	**M**	**1**	**ID 1/5**	**M**

Code identifying the detailed reason the adjustment was made

OD: 835W1_2100_CAS02__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

Required to report a non-zero adjustment applied at the claim level for the claim adjustment group code reported in CAS01.

Shared Claims Processing Notes:

= 100 (Payment made to patient/insured/responsible party)

CAS03 **782** **Monetary Amount** **M** **1** **R 1/18** **M**

Monetary amount

OD: 835W1_2100_CAS03__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claims Processing Notes:

Amount returned by the provider on credit adjustments. This field is required when the claim involves a credit amount.

EDF2 Notes:

EDF2-CLM-SUB-PAYMENT-AMT

The amount to be paid to the member who had submitted the claim for application.

CAS04 **380** **Quantity** **O** **1** **R 1/15** **O**

Numeric value of quantity

SITUATIONAL RULE: Required when the CAS02 adjustment reason code is related to non-covered days. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS04__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See section 1.10.2.4.1 for additional information.

A positive value decreases the covered days, and a negative number increases the covered days.

CAS05 **1034** **Claim Adjustment Reason Code** **X** **1** **ID 1/5** **O**

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS05__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

CAS06 **782** **Monetary Amount** **X** **1** **R 1/18** **O**

Monetary amount

SITUATIONAL RULE: Required when CAS05 is present. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS06__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

		See CAS03.				
CAS07	**380**	**Quantity**	**X**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required when CAS05 is present and is related to non-covered days. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS07__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.				
CAS08	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**	**O**
		Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS08__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code				
CAS09	**782**	**Monetary Amount**	**X**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when CAS08 is present. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS09__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.				
CAS10	**380**	**Quantity**	**X**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required when CAS08 is present and is related to non-covered days. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS10__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.				
CAS11	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**	**O**
		Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS11__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code				
CAS12	**782**	**Monetary Amount**	**X**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when CAS11 is present. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS12__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS13	**380**	**Quantity**	**X**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when CAS11 is present and is related to non-covered days. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS13__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04

CAS14	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**	**O**

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS14__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

CAS15	**782**	**Monetary Amount**	**X**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when CAS14 is present. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS15__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS16	**380**	**Quantity**	**X**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when CAS14 is present and is related to non-covered days. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS16__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

CAS17	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**	**O**

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS17__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

CAS18 **782** **Monetary Amount** **X** **1** **R 1/18** **O**

Monetary amount

SITUATIONAL RULE: Required when CAS17 is present. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS18__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS19 **380** **Quantity** **X** **1** **R 1/15** **O**

Numeric value of quantity

SITUATIONAL RULE: Required when CAS17 is present and is related to non-covered days. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS19__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

Segment: **NM1** **Patient Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: TR3 Notes: 1. Provide the patient’s identification number in NM109.

2. When used and the information was submitted with the original claim, this segment must provide the information from the original claim. The Corrected Patient/Insured Name NM1 segment identifies the adjudicated Insured name and ID information if different than what was submitted on the claim.
TR3 Example: NM1*QC*1*SHEPHARD*SAM*O***HN*666666666A~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode QC Patient Individual receiving medical care				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 1 Person				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**M**
		Individual last name or organizational name SITUATIONAL RULE: Required for all claims that are not Retail Pharmacy claims or for Retail Pharmacy claims when the information is known. If not required by this implementation guide, do not send. OD: 835W1_2100_NM103__PatientLastName IMPLEMENTATION NAME: Patient Last Name **Shared Claims Processing Notes:** Last name of the actual patient **EDF2 Notes:** EDF2-PAT-PATIENT-LAST-NAME Last name of the actual patient.				
NM104	**1036**	**Name First**	**O**	**1**	**AN 1/35**	**O**
		Individual first name				

SITUATIONAL RULE: Required when the patient has a first name and it is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM104__PatientFirstName

IMPLEMENTATION NAME: Patient First Name

Shared Claims Processing Notes:

First name of the actual patient

EDF2 Notes:

EDF2-PAT-PATIENT-FIRST-NAME

First name of the actual patient

NM105	**1037**	**Name Middle**	**O**	**1**	**AN 1/25**	**O**

Individual middle name or initial

SITUATIONAL RULE: Required when the patient has a middle name or initial and it is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM105__PatientMiddleNameorInitial

IMPLEMENTATION NAME: Patient Middle Name or Initial

If this data element is used and contains only one character, it is assumed to represent the middle initial.

Shared Claims Processing Notes:

Middle initial of the actual patient

EDF2 Notes:

EDF2-PAT-PATIENT-M-INITIAL

Middle initial of the actual patient

NM107	**1039**	**Name Suffix**	**O**	**1**	**AN 1/10**	**O**

Suffix to individual name

SITUATIONAL RULE: Required when this information is necessary for identification of the individual. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM107__PatientNameSuffix

IMPLEMENTATION NAME: Patient Name Suffix

An example of this is when a Junior and Senior are covered under the same subscriber.

NM108	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**	**M**

Code designating the system/method of code structure used for Identification Code (67)

SITUATIONAL RULE: Required when the patient identifier (NM109) is known or was reported on the healthcare claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM108__IdentificationCodeQualifier

Shared Claims Processing Notes:

=MI

34	Social Security Number
HN	Health Insurance Claim (HIC) Number

			Unique number assigned to individual for submitting claims covered by Medicare benefits				
		II	Standard Unique Health Identifier for each Individual in the United States Use this code if mandated in a final Federal Rule.				
		MI	Member Identification Number				
		MR	Medicaid Recipient Identification Number Unique identification number assigned to each member covered under a subscriber's contract				
NM109	**67**	**Identification Code**		**X**	**1**	**AN 2/80**	**M**

Code identifying a party or other code

SITUATIONAL RULE: Required when the patient identifier is known or was reported on the health care claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM109__PatientIdentifier

IMPLEMENTATION NAME: Patient Identifier

Shared Claims Processing Notes:

Insured Member ID which must match the number sent by BCBSIL on the ETR3 layout.

EDF2 Notes:

EDF2-BCBSIL-MEMBER-NO

Insured Member ID which must match the number sent by BCBSIL on the ETR3 layout.

Segment: **NM1 Insured Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when the insured or subscriber is different from the patient. If not required by this implementation guide, do not send.

TR3 Notes: 1. In the case of Medicare and Medicaid, the insured patient is always the subscriber and this segment is not used.

2. When the patient is the subscriber and the information was submitted with the original claim, this segment must provide the information from the original claim. When the patient is the subscriber, the Corrected Patient/Insured Name NM1 segment identifies the adjudicated Patient name and ID information if different than what was submitted on the claim.

TR3 Example: NM1*IL*1*SHEPARD*JESSICA****MI*999887777A~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual				
		OD: 835W1_2100_NM101__EntityIdentifierCode				
		IL — Insured or Subscriber				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity				
		OD: 835W1_2100_NM102__EntityTypeQualifier				
		Shared Claims Processing Notes:				
		= 1 (Person)				
		1 — Person				
		2 — Non-Person Entity				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**O**
		Individual last name or organizational name				
		SITUATIONAL RULE: Required when the last name (NM102=1) or organization name (NM102=2) is known. If not required by this implementation guide, do not send.				
		OD: 835W1_2100_NM103__SubscriberLastName				
		IMPLEMENTATION NAME: Subscriber Last Name				
NM104	**1036**	**Name First**	**O**	**1**	**AN 1/35**	**O**

Individual first name

SITUATIONAL RULE: Required when the subscriber is a person (NM102=1) and the first name is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM104__SubscriberFirstName

IMPLEMENTATION NAME: Subscriber First Name

NM105 1037 Name Middle O 1 AN 1/25 O

Individual middle name or initial

SITUATIONAL RULE: Required when the subscriber is a person (NM102=1) and the middle name or initial is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM105__SubscriberMiddleNameorInitial

IMPLEMENTATION NAME: Subscriber Middle Name or Initial

If this data element is used and contains only one character, it is assumed to represent the middle initial.

NM107 1039 Name Suffix O 1 AN 1/10 O

Suffix to individual name

SITUATIONAL RULE: Required when the subscriber is a person (NM102=1), the information is known and this information is necessary for identification of the individual. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM107__SubscriberNameSuffix

IMPLEMENTATION NAME: Subscriber Name Suffix

For example, use when necessary to differentiate between a Junior and Senior under the same contract.

NM108 66 Identification Code Qualifier X 1 ID 1/2 M

Code designating the system/method of code structure used for Identification Code (67)

OD: 835W1_2100_NM108__IdentificationCodeQualifier

Shared Claims Processing Notes:

= MI

FI	Federal Taxpayer's Identification Number Not Used when NM102=1
II	Standard Unique Health Identifier for each Individual in the United States Use this code if mandated in a final Federal Rule.
MI	Member Identification Number The code MI is intended to identify that the subscriber’s identification number as assigned by the payer will be conveyed in NM109. Payers use different terminology to convey the same number, therefore, the 835 workgroup recommends using MI (Member Identification number) to convey the same categories of numbers as represented in the 837 IGs for the inbound claims.

NM109 67 Identification Code X 1 AN 2/80 M

Code identifying a party or other code

OD: 835W1_2100_NM109__SubscriberIdentifier

IMPLEMENTATION NAME: Subscriber Identifier

EDF2 Notes:

EDF2-MEMBER-NO

Insured member ID which must match the number sent by BCBSIL on the ETR3 layout.

Segment: **NM1** **Corrected Patient/Insured Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when needed to provide corrected information about the patient or insured. If not required by this implementation guide, do not send.

TR3 Notes: 1. Since the patient is always the insured for Medicare and Medicaid, this segment always provides corrected patient information for Medicare and Medicaid. For other carriers, this will always be the corrected insured information.
TR3 Example: NM1*74*1*SHEPARD*SAMUEL*O***C*666666666A~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode 74 Corrected Insured				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier **Shared Claims Processing Notes:** = 1 (Person) 1 Person 2 Non-Person Entity				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**M**
		Individual last name or organizational name SITUATIONAL RULE: Required when the insured is a person (NM102=1) AND the submitted vs adjudicated data is different. If not required by this implementation guide, do not send. OD: 835W1_2100_NM103__CorrectedPatientorInsuredLastName IMPLEMENTATION NAME: Corrected Patient or Insured Last Name				
NM104	**1036**	**Name First**	**O**	**1**	**AN 1/35**	**O**
		Individual first name SITUATIONAL RULE: Required when the insured is a person (NM102=1) AND the submitted vs adjudicated data is different. If not required by this implementation guide, do not send.				

OD: 835W1_2100_NM104__CorrectedPatientorInsuredFirstName

IMPLEMENTATION NAME: Corrected Patient or Insured First Name

NM105 **1037** **Name Middle** **O** **1** **AN 1/25** **O**

Individual middle name or initial

SITUATIONAL RULE: Required when the insured is a person (NM102=1) AND the submitted vs adjudicated data is different AND the information is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM105__CorrectedPatientorInsuredMiddleName

IMPLEMENTATION NAME: Corrected Patient or Insured Middle Name

If this data element is used and contains only one character, it is assumed to represent the middle initial.

NM107 **1039** **Name Suffix** **O** **1** **AN 1/10** **O**

Suffix to individual name

SITUATIONAL RULE: Required when the insured is a person (NM102=1) and corrected information for the insured is available and this information is necessary for identification of the individual. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM107__CorrectedPatientorInsuredNameSuffix

IMPLEMENTATION NAME: Corrected Patient or Insured Name Suffix

NM108 **66** **Identification Code Qualifier** **X** **1** **ID 1/2** **M**

Code designating the system/method of code structure used for Identification Code (67)

SITUATIONAL RULE: Required when a value is reported in NM109. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM108__IdentificationCodeQualifier

C Insured's Changed Unique Identification Number

NM109 **67** **Identification Code** **X** **1** **AN 2/80** **M**

Code identifying a party or other code

SITUATIONAL RULE: Required when the adjudicated patient/insured identification number is different than the identification submitted on the claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM109__CorrectedInsuredIdentificationIndicator

IMPLEMENTATION NAME: Corrected Insured Identification Indicator

Shared Claims Processing Notes:

Insured Member ID which must match the number sent by BCBSIL on the ETR3 layout.

EDF2 Notes:

EDF2-MEMBER-NO

Insured Member ID which must match the number sent by BCBSIL on the ETR3 layout.

Segment: **NM1** **Service Provider Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when the rendering provider is different from the payee. If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment provides information about the rendering provider. An identification number is provided in NM109.

2. This information is provided to facilitate identification of the claim within a payee's system. Other providers (e.g., Referring provider, supervising provider) related to the claim but not directly related to the payment are not supported and are not necessary for claim identification.

TR3 Example: NM1*82*2******XX*12345678~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode 82 Rendering Provider				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 1 Person 2 Non-Person Entity				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**O**
		Individual last name or organizational name SITUATIONAL RULE: Required when a unique name is necessary for identification of the provider identified in NM109. If not required, may be provided at sender's discretion, but cannot be required by the receiver. OD: 835W1_2100_NM103__RenderingProviderLastorOrganizationName IMPLEMENTATION NAME: Rendering Provider Last or Organization Name				
NM104	**1036**	**Name First**	**O**	**1**	**AN 1/35**	**O**
		Individual first name SITUATIONAL RULE: Required when the Servicing Provider is a person (NM102=1), NM103 is used AND the information is known from systems of the				

sender. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM104__RenderingProviderFirstName

IMPLEMENTATION NAME: Rendering Provider First Name

NM105 1037 Name Middle O 1 AN 1/25 O

Individual middle name or initial

SITUATIONAL RULE: Required when the Servicing Provider is a person (NM102=1), NM103 is used AND the information is known from systems of the sender. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM105__RenderingProviderMiddleNameorInitial

IMPLEMENTATION NAME: Rendering Provider Middle Name or Initial

If this data element is used and contains only one character, it represents the middle initial.

NM107 1039 Name Suffix O 1 AN 1/10 O

Suffix to individual name

SITUATIONAL RULE: Required when the Servicing Provider is a person (NM102=1), NM103 is used and this information is necessary for identification of the individual, for instance when a Junior and Senior are both providers in the same practice. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM107__RenderingProviderNameSuffix

IMPLEMENTATION NAME: Rendering Provider Name Suffix

NM108 66 Identification Code Qualifier X 1 ID 1/2 M

Code designating the system/method of code structure used for Identification Code (67)

OD: 835W1_2100_NM108__IdentificationCodeQualifier

BD	Blue Cross Provider Number Number assigned by Blue Cross Plan to a provider of services
BS	Blue Shield Provider Number Number assigned by Blue Shield Plan to a provider of services
FI	Federal Taxpayer's Identification Number This is the preferred ID until the National Provider ID is mandated and applicable. For individual providers as payees, use this qualifier to represent the Social Security Number.
MC	Medicaid Provider Number Number assigned to a health care provider for submitting claims covered by Medicaid benefits
PC	Provider Commercial Number Unique number assigned to the provider for submitting claims to commercial insurance carriers
SL	State License Number Number uniquely issued to provider by state licensing board
UP	Unique Physician Identification Number (UPIN) Number assigned to the provider by the National Registry for Medicare identification purposes
XX	Centers for Medicare and Medicaid Services National Provider Identifier

Required value if the National Provider ID is mandated for use and the provider is a covered
health care provider under the mandate. Otherwise, one of the other listed codes may be used.

CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier

NM109 67 Identification Code X 1 AN 2/80 M

Code identifying a party or other code

OD: 835W1_2100_NM109__RenderingProviderIdentifier

IMPLEMENTATION NAME: Rendering Provider Identifier

Segment: **NM1 Crossover Carrier Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when the claim is transferred to another carrier or coverage (CLP02 equals 19, 20, 21 or 23). If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment provides information about the crossover carrier. Provide any reference numbers in NM109. The crossover carrier is defined as any payer to which the claim is transferred for further payment after being finalized by the current payer.
TR3 Example: NM1*TT*2*ACME INSURANCE*****XV*123456789~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode				
		TT — Transfer To				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier				
		2 — Non-Person Entity				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**M**
		Individual last name or organizational name OD: 835W1_2100_NM103__CoordinationofBenefitsCarrierName IMPLEMENTATION NAME: Coordination of Benefits Carrier Name Name of the crossover carrier associated with this claim.				
NM108	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**	**M**
		Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_2100_NM108__IdentificationCodeQualifier				
		AD — Blue Cross Blue Shield Association Plan Code Unique 3-digit number assigned to independent Blue Cross or Blue Shield plans by Blue Cross/Blue Shield Association				
		FI — Federal Taxpayer's Identification Number				
		NI — National Association of Insurance Commissioners (NAIC)				

		Identification This is the preferred ID until the National Plan ID is mandated and applicable.					
	PI	Payor Identification					
	PP	Pharmacy Processor Number Unique number assigned to each pharmacy for submitting claims					
	XV	Centers for Medicare and Medicaid Services PlanID Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID					
NM109	**67**	**Identification Code**	**X**	**1**	**AN**	**2/80**	**M**

Code identifying a party or other code

OD: 835W1_2100_NM109__CoordinationofBenefitsCarrierIdentifier

IMPLEMENTATION NAME: Coordination of Benefits Carrier Identifier

Segment: **NM1** **Corrected Priority Payer Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when current payer believes that another payer has priority for making a payment and the claim is not being automatically transferred to that payer. If not required by this implementation guide, do not send.

TR3 Notes: 1. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. Do not use this segment when the Crossover Carrier NM1 segment is used.
TR3 Example: NM1*PR*2*ACME INSURANCE*****XV*123456789~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode PR Payer				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 2 Non-Person Entity				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**M**
		Individual last name or organizational name OD: 835W1_2100_NM103__CorrectedPriorityPayerName IMPLEMENTATION NAME: Corrected Priority Payer Name				
NM108	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**	**M**
		Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_2100_NM108__IdentificationCodeQualifier AD Blue Cross Blue Shield Association Plan Code Unique 3-digit number assigned to independent Blue Cross or Blue Shield plans by Blue Cross/Blue Shield Association FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification This is the preferred ID until the National Plan ID is mandated and applicable.				

		PI	Payor Identification				
		PP	Pharmacy Processor Number Unique number assigned to each pharmacy for submitting claims				
		XV	Centers for Medicare and Medicaid Services PlanID Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID				
NM109	**67**	**Identification Code**		**X**	**1**	**AN 2/80**	**M**

Code identifying a party or other code

OD: 835W1_2100_NM109__CorrectedPriorityPayerIdentificationNumber

IMPLEMENTATION NAME: Corrected Priority Payer Identification Number

Segment: **NM1** **Other Subscriber Name**
Position: 0300
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when a corrected priority payer has been identified in another NM1 segment AND the name or ID of the other subscriber is known. If not required by this implementation guide, do not send.

TR3 Notes: 1. This is the name and ID number of the other subscriber when a corrected priority payer has been identified. When used, either the name or ID must be supplied.
TR3 Example: NM1*GB*Smith*Jane~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
NM101	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**	**M**
		Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode GB Other Insured				
NM102	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**	**M**
		Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 1 Person 2 Non-Person Entity				
NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**	**O**
		Individual last name or organizational name SITUATIONAL RULE: Required when known or when NM109 is not present. If not required by this implementation guide, do not send. OD: 835W1_2100_NM103__OtherSubscriberLastName IMPLEMENTATION NAME: Other Subscriber Last Name At least one of NM103 or NM109 must be present.				
NM104	**1036**	**Name First**	**O**	**1**	**AN 1/35**	**O**
		Individual first name SITUATIONAL RULE: Required when the Other Subscriber is a person (NM102=1), NM103 is present and the first name is known. If not required by this implementation guide, do not send.				

OD: 835W1_2100_NM104__OtherSubscriberFirstName

IMPLEMENTATION NAME: Other Subscriber First Name

NM105 1037 Name Middle O 1 AN 1/25 O

Individual middle name or initial

SITUATIONAL RULE: Required when the Other Subscriber is a person (NM102=1) and the middle name or initial is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM105__OtherSubscriberMiddleNameorInitial

IMPLEMENTATION NAME: Other Subscriber Middle Name or Initial

When only one character is present this is assumed to be the middle initial.

NM107 1039 Name Suffix O 1 AN 1/10 O

Suffix to individual name

SITUATIONAL RULE: Required when the Other Subscriber is a person (NM102=1), the information is known and this information is necessary for identification of the individual. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM107__OtherSubscriberNameSuffix

IMPLEMENTATION NAME: Other Subscriber Name Suffix

NM108 66 Identification Code Qualifier X 1 ID 1/2 O

Code designating the system/method of code structure used for Identification Code (67)

SITUATIONAL RULE: Required when NM109 is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM108__IdentificationCodeQualifier

FI	Federal Taxpayer's Identification Number Not Used when NM102=1.
II	Standard Unique Health Identifier for each Individual in the United States Use this code if mandated in a final Federal Rule.
MI	Member Identification Number Use this code when supplying the number used for identification of the subscriber in NM109.

NM109 67 Identification Code X 1 AN 2/80 O

Code identifying a party or other code

SITUATIONAL RULE: Required when known or when NM103 is not present. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM109__OtherSubscriberIdentifier

IMPLEMENTATION NAME: Other Subscriber Identifier

At least one of NM103 or NM109 must be present.

Segment: **MIA** **Inpatient Adjudication Information**
Position: 0330
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims
Syntax Notes:
Semantic Notes:

1 MIA01 is the covered days.
2 MIA02 is the Prospective Payment System (PPS) Operating Outlier amount.
3 MIA03 is the lifetime psychiatric days.
4 MIA04 is the Diagnosis Related Group (DRG) amount.
5 MIA05 is the Claim Payment Remark Code. See Code Source 411.
6 MIA06 is the disproportionate share amount.
7 MIA07 is the Medicare Secondary Payer (MSP) pass-through amount.
8 MIA08 is the total Prospective Payment System (PPS) capital amount.
9 MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.
10 MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount.
11 MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.
12 MIA12 is the old capital amount.
13 MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.
14 MIA14 is hospital specific Diagnosis Related Group (DRG) Amount.
15 MIA15 is the cost report days.
16 MIA16 is the federal specific Diagnosis Related Group (DRG) amount.
17 MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.
18 MIA18 is the indirect teaching amount.
19 MIA19 is the professional component amount billed but not payable.
20 MIA20 is the Claim Payment Remark Code. See Code Source 411.
21 MIA21 is the Claim Payment Remark Code. See Code Source 411.
22 MIA22 is the Claim Payment Remark Code. See Code Source 411.
23 MIA23 is the Claim Payment Remark Code. See Code Source 411.
24 MIA24 is the capital exception amount.

Comments:
Notes: Situational Rule: Required for all inpatient claims when there is a need to report Remittance Advice Remark Codes at the claim level or, the claim is paid by Medicare or Medicaid under the Prospective Payment System (PPS). If not required by this implementation guide, do not send.

TR3 Notes: 1. When used outside of the Medicare and Medicaid community only MIA01, 05, 20, 21, 22 and 23 may be used.

2. Either MIA or MOA may appear, but not both.

3. This segment must not be used for covered days or lifetime reserve days. For

covered or lifetime reserve days, use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop.

4. All situational quantities and/or monetary amounts in this segment are required when the value of the item is different than zero.

MIA*0***138018.4~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
MIA01	**380**	**Quantity**	**M**	**1**	**R 1/15**	**M**
		Numeric value of quantity OD: 835W1_2100_MIA01__CoveredDaysorVisitsCount IMPLEMENTATION NAME: Covered Days or Visits Count Implementers utilizing the MIA segment always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.				
MIA02	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when an additional payment is made for excessive cost incurred by the provider when the payer is Medicare or Medicaid and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA02__PPSOperatingOutlierAmount IMPLEMENTATION NAME: PPS Operating Outlier Amount See TR3 note 4. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.				
MIA03	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**
		Numeric value of quantity SITUATIONAL RULE: Required for psychiatric claims when the payer is Medicare or Medicaid and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA03__LifetimePsychiatricDaysCount IMPLEMENTATION NAME: Lifetime Psychiatric Days Count				
MIA04	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required for claims paid under a Diagnostic Related Group when the payer is Medicare or Medicaid and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA04__ClaimDRGAmount IMPLEMENTATION NAME: Claim DRG Amount				
MIA05	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when a claim level Claim Payment Remark Code applies to this claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA05__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code				
MIA06	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA06__ClaimDisproportionateShareAmount IMPLEMENTATION NAME: Claim Disproportionate Share Amount				
MIA07	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA07__ClaimMSPPassthroughAmount IMPLEMENTATION NAME: Claim MSP Pass-through Amount				
MIA08	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA08__ClaimPPSCapitalAmount IMPLEMENTATION NAME: Claim PPS Capital Amount				
MIA09	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA09__PPSCapitalFSPDRGAmount IMPLEMENTATION NAME: PPS-Capital FSP DRG Amount				
MIA10	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA10__PPSCapitalHSPDRGAmount IMPLEMENTATION NAME: PPS-Capital HSP DRG Amount				
MIA11	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA11__PPSCapitalDSHDRGAmount

IMPLEMENTATION NAME: PPS-Capital DSH DRG Amount

MIA12 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA12__OldCapitalAmount

IMPLEMENTATION NAME: Old Capital Amount

MIA13 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA13__PPSCapitalIMEamount

IMPLEMENTATION NAME: PPS-Capital IME amount

MIA14 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA14__PPSOperatingHospitalSpecificDRGAmount

IMPLEMENTATION NAME: PPS-Operating Hospital Specific DRG Amount

MIA15 380 Quantity O 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA15__CostReportDayCount

IMPLEMENTATION NAME: Cost Report Day Count

MIA16 782 Monetary Amount O 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA16__PPSOperatingFederalSpecificDRGAmount

IMPLEMENTATION NAME: PPS-Operating Federal Specific DRG Amount

MIA17	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA17__ClaimPPSCapitalOutlierAmount IMPLEMENTATION NAME: Claim PPS Capital Outlier Amount				
MIA18	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA18__ClaimIndirectTeachingAmount IMPLEMENTATION NAME: Claim Indirect Teaching Amount				
MIA19	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA19__NonpayableProfessionalComponentAmount IMPLEMENTATION NAME: Nonpayable Professional Component Amount				
MIA20	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA20__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code				
MIA21	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA21__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code				
MIA22	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.				

OD: 835W1_2100_MIA22__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MIA23	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

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

SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA23__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MIA24	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send.

OD: 835W1_2100_MIA24__PPSCapitalExceptionAmount

IMPLEMENTATION NAME: PPS-Capital Exception Amount

Segment: **MOA** **Outpatient Adjudication Information**
Position: 0350
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting
Syntax Notes:
Semantic Notes:
1 MOA01 is the reimbursement rate.
2 MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
3 MOA03 is the Claim Payment Remark Code. See Code Source 411.
4 MOA04 is the Claim Payment Remark Code. See Code Source 411.
5 MOA05 is the Claim Payment Remark Code. See Code Source 411.
6 MOA06 is the Claim Payment Remark Code. See Code Source 411.
7 MOA07 is the Claim Payment Remark Code. See Code Source 411.
8 MOA08 is the End Stage Renal Disease (ESRD) payment amount.
9 MOA09 is the professional component amount billed but not payable.

Comments:
Notes: Situational Rule: Required for outpatient/professional claims where there is a need to report a Remittance Advice Remark Code at the claim level or when the payer is Medicare or Medicaid and MOA01, 02, 08 or 09 are non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Either MIA or MOA may appear, but not both.

2. All situational quantities and/or monetary amounts in this segment are required when the value of the item is different than zero.

TR3 Example: MOA***MA01~

Data Element Summary

Ref. Des. Attributes	Data Element	Name	Base Attributes			User
MOA01	**954**	**Percentage as Decimal**	**O**	**1**	**R 1/10**	**O**
		Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%) SITUATIONAL RULE: Required when the outpatient institutional claim reimbursement rate is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA01__ReimbursementRate IMPLEMENTATION NAME: Reimbursement Rate				
MOA02	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when the outpatient institutional claim HCPCS Payable Amount is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA02__ClaimHCPCSPayableAmount IMPLEMENTATION NAME: Claim HCPCS Payable Amount				

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

MOA03	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when a Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_MOA03__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MOA04	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_MOA04__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MOA05	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_MOA05__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MOA06	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_MOA06__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MOA07	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**	**O**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_MOA07__ClaimPaymentRemarkCode

IMPLEMENTATION NAME: Claim Payment Remark Code

MOA08	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**

		Monetary amount SITUATIONAL RULE: Required when the outpatient institutional claim ESRD Payment Amount is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA08__ClaimESRDPaymentAmount IMPLEMENTATION NAME: Claim ESRD Payment Amount				
MOA09	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when the outpatient institutional claim Nonpayable Professional Component Amount is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA09__NonpayableProfessionalComponentAmount IMPLEMENTATION NAME: Nonpayable Professional Component Amount				

Segment: **REF** **Other Claim Related Identification**
Position: 0400
Loop: 2100
Level: Detail
Usage: Mandatory
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional reference numbers specific to the claim in the CLP segment are provided to identify information used in the process of adjudicating this claim. If not required by this implementation guide, do not send.

TR3 Example:
REF*1L*000P12568~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**

Code qualifying the Reference Identification

OD: 835W1_2100_REF01__ReferenceIdentificationQualifier

Shared Claims Processing Notes:

= 1L

1L	Group or Policy Number Use this code when conveying the Group Number in REF02.
1W	Member Identification Number Unique identification number assigned to each member under a subscriber's contract
28	Employee Identification Number
6P	Group Number This is the Other Insured Group Number. This is required when a Corrected Priority Payer is identified in the NM1 segment and the Group Number of the other insured for that payer is known.
9A	Repriced Claim Reference Number
9C	Adjusted Repriced Claim Reference Number
BB	Authorization Number Proves that permission was obtained to provide a service Use this qualifier only when supplying an authorization number that was assigned by the adjudication process and was not provided prior to the services. Do not use this qualifier when reporting the same number as reported in the claim as the prior authorization or re-authorization number.
CE	Class of Contract Code See section 1.10.2.15 for information on the use of Class of

			Contract Code.
		EA	Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records
		F8	Original Reference Number When this is a correction claim and CLP07 does not equal the CLP07 value from the original claim payment, one iteration of this REF segment using this qualifier is REQUIRED to identify the original claim CLP07 value in REF02. See section 1.10.2.8, Reversals and Corrections, for additional information.
		G1	Prior Authorization Number An authorization number acquired prior to the submission of a claim Use this qualifier when reporting the number received with the original claim as a preauthorization number (in the 837 that was at table 2, position 180, REF segment, using the same qualifier of G1).
		G3	Predetermination of Benefits Identification Number A number assigned by a third-party payer identifying the pre-treatment estimate
		IG	Insurance Policy Number Use this code when conveying the Policy Number in REF02.
		SY	Social Security Number

REF02 **127** **Reference Identification** **X** **1** **AN 1/50** **M**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1_2100_REF02__OtherClaimRelatedIdentifier

IMPLEMENTATION NAME: Other Claim Related Identifier

Shared Claims Processing Notes:

Identification number assigned by the payer to the group or plan through which insurance is provided.

EDF2 Notes:

EDF2-KEY-GROUP-NO
REF01 = 1L

Identification number assigned by the payer to the group or plan through which insurance is provided.

Segment: **REF** **Other Claim Related Identification**
Position: 0400
Loop: 2100
Level: Detail
Usage: Mandatory
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional reference numbers specific to the claim in the CLP segment are provided to identify information used in the process of adjudicating this claim. If not required by this implementation guide, do not send.

TR3 Example:
REF*CE*1006~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**

Code qualifying the Reference Identification

OD: 835W1_2100_REF01__ReferenceIdentificationQualifier

Shared Claims Processing Notes:

= CE

1L	Group or Policy Number Use this code when conveying the Group Number in REF02.
1W	Member Identification Number Unique identification number assigned to each member under a subscriber's contract
28	Employee Identification Number
6P	Group Number This is the Other Insured Group Number. This is required when a Corrected Priority Payer is identified in the NM1 segment and the Group Number of the other insured for that payer is known.
9A	Repriced Claim Reference Number
9C	Adjusted Repriced Claim Reference Number
BB	Authorization Number Proves that permission was obtained to provide a service Use this qualifier only when supplying an authorization number that was assigned by the adjudication process and was not provided prior to the services. Do not use this qualifier when reporting the same number as reported in the claim as the prior authorization or re-authorization number.
CE	Class of Contract Code See section 1.10.2.15 for information on the use of Class of

			Contract Code.
		EA	Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records
		F8	Original Reference Number When this is a correction claim and CLP07 does not equal the CLP07 value from the original claim payment, one iteration of this REF segment using this qualifier is REQUIRED to identify the original claim CLP07 value in REF02. See section 1.10.2.8, Reversals and Corrections, for additional information.
		G1	Prior Authorization Number An authorization number acquired prior to the submission of a claim Use this qualifier when reporting the number received with the original claim as a preauthorization number (in the 837 that was at table 2, position 180, REF segment, using the same qualifier of G1).
		G3	Predetermination of Benefits Identification Number A number assigned by a third-party payer identifying the pre-treatment estimate
		IG	Insurance Policy Number Use this code when conveying the Policy Number in REF02.
		SY	Social Security Number

REF02 **127** **Reference Identification** **X** **1** **AN 1/50** **M**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1_2100_REF02__OtherClaimRelatedIdentifier

IMPLEMENTATION NAME: Other Claim Related Identifier

Shared Claims Processing Notes:

Field Position:
1 = Disposition Type: Identifies what type of record was sent to BCBSIL on the Disposition File
2-6 = RFI Letter Code (1): The reason why the fund has pended processing of a claim
7-11 = RFI Letter Code (2): The reason why the fund has pended processing of a claim
12-16 = RFI Letter Code (3): The reason why the fund has pended processing of a claim
17-21 = RFI Letter Code (4): The reason why the fund has pended processing of a claim
22-26 = Reject Reason Code: The code corresponding to the reason as to why the claim was rejected by BCBSIL
27-29 = Adjustment Reason Code - This field is for R06 Adjustment only

EDF2 Notes:

EDF2-RECORD-TYPE: Position 1

Identifies what type of record was sent to BCBSIL on the Disposition File

EDF2-RFI-LETTER: Position 2-6
EDF2-RFI-LETTER: Position 7-11
EDF2-RFI-LETTER: Position 12-16
EDF2-RFI-LETTER: Position 17-21

The reason why the fund has pended process of a claim (4 occurrences).

EDF2-REJECT-RSN-CD: Position 22-26

The code corresponding to the reason as to why the claim was rejected by BCBSIL.

EDF2-ADJ-RSN-CD: Position 27-29

This field is for R06 Adjustment only.

Segment: **REF** **Other Claim Related Identification**
Position: 0400
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional reference numbers specific to the claim in the CLP segment are provided to identify information used in the process of adjudicating this claim. If not required by this implementation guide, do not send.

TR3 Example:
REF*F8*01020103140448591~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification OD: 835W1_2100_REF01__ReferenceIdentificationQualifier **Shared Claims Processing Notes:** = F8 Refer to 005010X221A1 Data Element Dictionary for acceptable code values.				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2100_REF02__OtherClaimRelatedIdentifier IMPLEMENTATION NAME: Other Claim Related Identifier **Shared Claims Processing Notes:** Unique control number assigned when a claim enters the ITS process **EDF2 Notes:** EDF2-CLM-SCCF-SERIAL-NO Unique control number assigned when a claim enters the ITS process.				

Segment: **REF** **Rendering Provider Identification**
Position: 0400
Loop: 2100
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional rendering provider identification numbers not already reported in the Provider NM1 segment for this claim were submitted on the original claim and impacted adjudication. If not required by this implementation guide, do not send.

TR3 Notes: 1. The NM1 segment always contains the primary reference number.
TR3 Example: REF*1A*12345678~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification OD: 835W1_2100_REF01__ReferenceIdentificationQualifier **Shared Claims Processing Notes:** = 1A, 1B				
		0B State License Number				
		1A Blue Cross Provider Number				
		1B Blue Shield Provider Number				
		1C Medicare Provider Number				
		1D Medicaid Provider Number				
		1G Provider UPIN Number				
		1H CHAMPUS Identification Number				
		1J Facility ID Number				
		D3 National Council for Prescription Drug Programs Pharmacy Number CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number				
		G2 Provider Commercial Number A unique number assigned to a provider by a commercial insurer				
		LU Location Number				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2100_REF02__RenderingProviderSecondaryIdentifier IMPLEMENTATION NAME: Rendering Provider Secondary Identifier				

Shared Claims Processing Notes:

The number assigned to the provider for EMC identification purposes by the payer/receiver.

EDF2 Notes:

EDF2-PROVIDER-NO

The number assigned to the provider for EMC identification purposes by the payer/receiver.

Segment: **DTM** **Statement From or To Date**
Position: 0500
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify pertinent dates and times
Syntax Notes:
1 At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the "Statement From or To Dates" are not supplied at the service (2110 loop) level. If not required by this implementation guide, may be provided at sender’s discretion, but cannot be required by the receiver.

TR3 Notes: 1. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear.

2. When claim dates are not provided, service dates are required for every service line.

3. When claim dates are provided, service dates are not required, but if used they override the claim dates for individual service lines.

4. For retail pharmacy claims, the Claim Statement Period Start Date is equivalent to the prescription filled date.

5. For predeterminations, where there is no service date, the value of DTM02 must be 19000101. Use only when the CLP02 value is 25 - Predetermination Pricing Only - No Payment.

6. When payment is being made in advance of services, the use of future dates is allowed.

TR3 Example: DTM*233*20020916~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
DTM01	**374**	**Date/Time Qualifier**	**M**	**1**	**ID 3/3**	**M**

Code specifying type of date or time, or both date and time

OD: 835W1_2100_DTM01__DateTimeQualifier

IMPLEMENTATION NAME: Date Time Qualifier

232 Claim Statement Period Start

If the claim statement period start date is conveyed without a subsequent claim statement period end date, the end date is assumed to be the same as the start date. This date or code 233 is required when service level dates are not provided in the remittance advice.

233 Claim Statement Period End

If a claim statement period end date is conveyed without a claim statement period start date, then the start date is assumed to be different from the end date but not conveyed at the payer's discretion. See the note on code 232.

DTM02	**373**	**Date**	**X**	**1**	**DT 8/8**	**M**

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year
OD: 835W1_2100_DTM02__ClaimDate

IMPLEMENTATION NAME: Claim Date

Segment: **DTM** **Coverage Expiration Date**
Position: 0500
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes:
1 At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when payment is denied because of the expiration of coverage.
If not required by this implementation guide, do not send.
TR3 Example: DTM*036*20011001~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
DTM01	**374**	**Date/Time Qualifier**	**M**	**1**	**ID 3/3**	**M**
		Code specifying type of date or time, or both date and time OD: 835W1_2100_DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier 036 Expiration Date coverage expires				
DTM02	**373**	**Date**	**X**	**1**	**DT 8/8**	**M**
		Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1_2100_DTM02__Date This is the expiration date of the patient’s coverage.				

Segment: **DTM** **Claim Received Date**
Position: 0500
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes:
1 At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required whenever state or federal regulations or the provider contract mandate interest payment or prompt payment discounts based upon the receipt date of the claim by the payer. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.
TR3 Example: DTM*050*20011124~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
DTM01	**374**	**Date/Time Qualifier**	**M**	**1**	**ID 3/3**	**M**
		Code specifying type of date or time, or both date and time OD: 835W1_2100_DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier 050 Received				
DTM02	**373**	**Date**	**X**	**1**	**DT 8/8**	**M**
		Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1_2100_DTM02__Date This is the date that the claim was received by the payer.				

Segment: **PER** **Claim Contact Information**
Position: 0600
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when there is a claim specific communications contact. If not required by this implementation guide, do not send.

TR3 Notes: 1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number always includes the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (800)555-1212 would be represented as 8005551212). The extension number, when applicable, is identified in the next element pair (Communications Number Qualifier and Communication Number) immediately after the telephone number.
TR3 Example: PER*CX**TE*8005551212~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
PER01	**366**	**Contact Function Code**	**M**	**1**	**ID 2/2**	**M**
		Code identifying the major duty or responsibility of the person or group named				
		OD: 835W1_2100_PER01__ContactFunctionCode				
		CX — Payers Claim Office Location responsible for paying bills related to medical care received				
PER02	**93**	**Name**	**O**	**1**	**AN 1/60**	**O**
		Free-form name				
		SITUATIONAL RULE: Required when the name of the individual to contact is not already defined or is different than the name within the prior contact segment (PER). If not required by this implementation guide, do not send. OD: 835W1_2100_PER02__ClaimContactName IMPLEMENTATION NAME: Claim Contact Name				
PER03	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**	**M**
		Code identifying the type of communication number				
		OD: 835W1_2100_PER03__CommunicationNumberQualifier				
		EM — Electronic Mail FX — Facsimile TE — Telephone				

PER04	**364**	**Communication Number**	**X**	**1**	**AN 1/256**	**M**

Complete communications number including country or area code when applicable

OD: 835W1_2100_PER04__ClaimContactCommunicationsNumber

IMPLEMENTATION NAME: Claim Contact Communications Number

PER05	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**	**O**

Code identifying the type of communication number

SITUATIONAL RULE: Required when required per ASC X12 syntax when PER06 is sent. If not required by this implementation guide, do not send.

OD: 835W1_2100_PER05__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension When used, the value following this code is the extension for the preceding communications contact number.
FX	Facsimile
TE	Telephone

PER06	**364**	**Communication Number**	**X**	**1**	**AN 1/256**	**O**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a second claim specific communications contact number exists. If not required by this implementation guide, do not send.

OD: 835W1_2100_PER06__ClaimContactCommunicationsNumber

IMPLEMENTATION NAME: Claim Contact Communications Number

PER07	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**	**O**

Code identifying the type of communication number

SITUATIONAL RULE: Required when required per ASC X12 syntax when PER08 is sent. If not required by this implementation guide, do not send.

OD: 835W1_2100_PER07__CommunicationNumberQualifier

EX	Telephone Extension

PER08	**364**	**Communication Number**	**X**	**1**	**AN 1/256**	**O**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_2100_PER08__CommunicationNumberExtension

IMPLEMENTATION NAME: Communication Number Extension

Segment: **AMT** **Claim Supplemental Information**
Position: 0620
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 13
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.

2. Send/receive one AMT for each applicable non-zero value. Do not report any zero values.

TR3 Example: AMT*T*49~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
AMT01	**522**	**Amount Qualifier Code**	**M**	**1**	**ID 1/3**	**M**

Code to qualify amount

OD: 835W1_2100_AMT01__AmountQualifierCode

AU Coverage Amount

The dollar amount of property coverage provided by a specific policy contract

Use this monetary amount to report the total covered charges.

This is the sum of the original submitted provider charges that are considered for payment under the benefit provisions of the health plan. This excludes charges considered not covered (i.e. per day television or telephone charges) but includes reductions to payments of covered services (i.e. reductions for amounts over fee schedule and patient deductibles).

D8 Discount Amount

A reduction from the usual price

Prompt Pay Discount Amount

See section 1.10.2.9 for additional information.

DY Per Day Limit

F5 Patient Amount Paid

Monetary amount value already paid by one receiving medical care

Use this monetary amount for the amount the patient has already paid.

I Interest

See section 1.10.2.9 for additional information.

		NL	Negative Ledger Balance Used only by Medicare Part A and Medicare Part B.
		T	Tax
		T2	Total Claim Before Taxes The total monies requested for a single claim before any taxes were included Used only when tax also applies to the claim.
		ZK	Federal Medicare or Medicaid Payment Mandate - Category 1
		ZL	Federal Medicare or Medicaid Payment Mandate - Category 2
		ZM	Federal Medicare or Medicaid Payment Mandate - Category 3
		ZN	Federal Medicare or Medicaid Payment Mandate - Category 4
		ZO	Federal Medicare or Medicaid Payment Mandate - Category 5

AMT02	**782**	**Monetary Amount**	**M**	**1**	**R 1/18**	**M**

Monetary amount

OD: 835W1_2100_AMT02__ClaimSupplementalInformationAmount

IMPLEMENTATION NAME: Claim Supplemental Information Amount

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claims Processing Notes:

The amount to be paid to a member who had submitted the claim for adjudication. This payment was not made through BCBSIL; payment was made directly by the Fund. This is a required field when payment is made to the member.

Segment: **QTY** **Claim Supplemental Information Quantity**
Position: 0640
Loop: 2100
Level: Detail
Usage: Optional
Max Use: 14
Purpose: To specify quantity information
Syntax Notes:
1 At least one of QTY02 or QTY04 is required.
2 Only one of QTY02 or QTY04 may be present.
Semantic Notes:
1 QTY04 is used when the quantity is non-numeric.
Comments:
Notes: Situational Rule: Required when the value of a specific quantity identified by the QTY01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.

2. Send one QTY for each non-zero value. Do not report any zero values.
TR3 Example: QTY*ZK*3~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
QTY01	**673**	**Quantity Qualifier**	**M**	**1**	**ID 2/2**	**M**

Code specifying the type of quantity
OD: 835W1_2100_QTY01__QuantityQualifier

Code	Definition
CA	Covered - Actual Days covered on this service
CD	Co-insured - Actual
LA	Life-time Reserve - Actual Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve
LE	Life-time Reserve - Estimated Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is an estimate of the number of days in reserve
NE	Non-Covered - Estimated
NR	Not Replaced Blood Units
OU	Outlier Days
PS	Prescription
VS	Visits
ZK	Federal Medicare or Medicaid Payment Mandate - Category 1
ZL	Federal Medicare or Medicaid Payment Mandate - Category 2
ZM	Federal Medicare or Medicaid Payment Mandate - Category 3
ZN	Federal Medicare or Medicaid Payment Mandate - Category 4
ZO	Federal Medicare or Medicaid Payment Mandate - Category 5

QTY02	**380**	**Quantity**	**X**	**1**	**R 1/15**	**M**

Numeric value of quantity

OD: 835W1_2100_QTY02__ClaimSupplementalInformationQuantity

IMPLEMENTATION NAME: Claim Supplemental Information Quantity

Segment: **SVC** **Service Payment Information**
Position: 0700
Loop: 2110
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To supply payment and control information to a provider for a particular service
Syntax Notes:
Semantic Notes:
1 SVC01 is the medical procedure upon which adjudication is based.
2 SVC02 is the submitted service charge.
3 SVC03 is the amount paid this service.
4 SVC04 is the National Uniform Billing Committee Revenue Code.
5 SVC05 is the paid units of service.
6 SVC06 is the original submitted medical procedure.
7 SVC07 is the original submitted units of service.

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

Notes: Situational Rule: Required for all service lines in a professional, dental or outpatient claim priced at the service line level or whenever payment for any service line of the claim is different than the original submitted charges due to service line specific adjustments (excluding cases where the only service specific adjustment is for room per diem). If not required by this implementation guide, do not send.

TR3 Notes: 1. See section 1.10.2.1.1 (Service Line Balancing) for additional information.

2. The exception to the situational rule occurs with institutional claims when the room per diem is the only service line adjustment. In this instance, a claim level CAS adjustment to the per diem is appropriate (i.e., CAS*CO*78*25~). See section 1.10.2.4.1 for additional information.

3. See 1.10.2.6, Procedure Code Bundling and Unbundling, and section 1.10.2.1.1, Service Line Balancing, for important SVC segment usage information.

TR3 Example: SVC*HC:99214*100*80~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
SVC01	**C003**	**Composite Medical Procedure Identifier**	**M**	**1**		**M**
		To identify a medical procedure by its standardized codes and applicable modifiers OD: 835W1_2110_SVC01_C003 This is the adjudicated medical procedure information. This code is a composite data structure.				
C00301	**235**	**Product/Service ID Qualifier**	**M**		**ID 2/2**	**M**
		Code identifying the type/source of the descriptive number used in Product/Service ID (234)				

835W1_2110_SVC01_C00301_ProductorServiceIDQualifier

IMPLEMENTATION NAME: Product or Service ID Qualifier

The value in SVC01-1 qualifies the values in SVC01-2, SVC01-3, SVC01-4, SVC01-5, SVC01-6 and SVC01-7.
Shared Claims Processing Notes:

= HC, NU

AD	American Dental Association Codes This association's membership consists of U.S. dentists. It sets standards for the dental profession CODE SOURCE 135: American Dental Association
ER	Jurisdiction Specific Procedure and Supply Codes CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. CODE SOURCE 130: Healthcare Common Procedural Coding System
HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code Medicare uses this code to reflect the Skilled Nursing Facility Group as well as the Home Health Agency Outpatient Prospective Payment System. CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List
N4	National Drug Code in 5-4-2 Format 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size CODE SOURCE 240: National Drug Code by Format
N6	National Health Related Item Code in 4-6 Format This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names National Health Related Item Code in 4-6 Format Codes as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under

HIPAA.

CODE SOURCE 240: National Drug Code by Format

NU National Uniform Billing Committee (NUBC) UB92 Codes

CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes

UI U.P.C. Consumer Package Code (1-5-5)

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names U.P.C. Consumer Package Code (1-5-5) Codes as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.

WK Advanced Billing Concepts (ABC) Codes

This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used in transactions covered under HIPAA by parties registered in the pilot project and their trading partners.

CODE SOURCE 843: Advanced Billing Concepts (ABC) Codes

C00302 234 Product/Service ID M AN 1/48 M

Identifying number for a product or service

OD: 835W1_2110_SVC01_C00302_AdjudicatedProcedureCode

IMPLEMENTATION NAME: Adjudicated Procedure Code

This is the adjudicated procedure code or revenue code as identified by the qualifier in SVC01-1.

C00303 1339 Procedure Modifier O AN 2/2 O

This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL RULE: Required when a procedure code modifier applies to this service. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC01_C00303_ProcedureModifier

C00304 1339 Procedure Modifier O AN 2/2 O

This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL RULE: Required when a second procedure code modifier applies to this service. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC01_C00304_ProcedureModifier

C00305 1339 Procedure Modifier O AN 2/2 O

This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL RULE: Required when a third procedure code modifier applies to this service. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC01_C00305_ProcedureModifier

C00306 1339 Procedure Modifier O AN 2/2 O

This identifies special circumstances related to the performance of the service, as defined by trading partners

SITUATIONAL RULE: Required when a fourth procedure code modifier applies to this service. If not required by this implementation guide, do not send.

		OD: 835W1_2110_SVC01_C00306_ProcedureModifier				
SVC02	**782**	**Line Item Charge Amount**	**M**	**1**	**R 1/18**	**M**

Monetary amount

OD: 835W1_2110_SVC02__LineItemChargeAmount

IMPLEMENTATION NAME: Line Item Charge Amount

Use this monetary amount for the submitted service charge amount.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claims Processing Notes:

The charge, as specified, by a provider, for a particular service

EDF2 Notes:

EDF2-SVC-PROV-CHARGE

The charge, as specified, by a provider, for a particular service

SVC03	**782**	**Line Item Provider Payment**	**O**	**1**	**R 1/18**	**M**

Monetary amount

OD: 835W1_2110_SVC03__LineItemProviderPaymentAmount

IMPLEMENTATION NAME: Line Item Provider Payment Amount

Use this number for the service amount paid. The value in SVC03 must equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop. See 1.10.2.1, Balancing, for additional information.

Shared Claims Processing Notes:

The payable amount for this service line. This field is required if either the provider or member paid.

EDF2 Notes:

EDF2-SVC-PAYABLE-AMT

The payable amount for this service line. This field is required if either the provider or member paid.

SVC04	**234**	**NUBC Revenue Code**	**O**	**1**	**AN 1/48**	**O**

Identifying number for a product or service

SITUATIONAL RULE: Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC04__NationalUniformBillingCommitteeRevenueCode

IMPLEMENTATION NAME: National Uniform Billing Committee Revenue Code

If the original claim and adjudication only referenced an NUBC revenue code that is supplied in SVC01 and this element is not used.

SVC05	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when the paid units of service are different than one. If not required by this implementation guide, may be provided at sender’s discretion, but cannot be required by the receiver.

OD: 835W1_2110_SVC05__UnitsofServicePaidCount

IMPLEMENTATION NAME: Units of Service Paid Count

If not present, the value is assumed to be one.

SVC06 **C003** **Composite Medical Procedure Identifier** **O** **1** **O**

To identify a medical procedure by its standardized codes and applicable modifiers

SITUATIONAL RULE: Required when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC06_C003

This code is a composite data structure.

This is the Submitted Procedure Code information.

C00301 **235** **Product/Service ID Qualifier** **M** **ID 2/2** **M**

Code identifying the type/source of the descriptive number used in Product/Service ID (234)

OD: 835W1_2110_SVC06_C00301_ProductorServiceIDQualifier

IMPLEMENTATION NAME: Product or Service ID Qualifier

The value in SVC06-1 qualifies the value in SVC06-2, SVC06-3, SVC06-4, SVC06-5, SVC06-6 and SVC06-7.

AD	American Dental Association Codes This association's membership consists of U.S. dentists. It sets standards for the dental profession CODE SOURCE 135: American Dental Association
ER	Jurisdiction Specific Procedure and Supply Codes CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes
HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. CODE SOURCE 130: Healthcare Common Procedural Coding System
HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code Medicare uses this code to reflect the Skilled Nursing Facility Group as well as the Home Health Agency Outpatient Prospective Payment System. CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code

			This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List			
		N4	National Drug Code in 5-4-2 Format 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size CODE SOURCE 240: National Drug Code by Format			
		NU	National Uniform Billing Committee (NUBC) UB92 Codes CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes			
		WK	Advanced Billing Concepts (ABC) Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names Complimentary, Alternative, or Holistic Procedure Codes as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 843: Complimentary, Alternative, or Holistic Procedure Codes			
C00302	**234**	**Product/Service ID** Identifying number for a product or service OD: 835W1_2110_SVC06_C00302_ProcedureCode IMPLEMENTATION NAME: Procedure Code		**M**	**AN 1/48**	**M**
C00303	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00303_ProcedureModifier		**O**	**AN 2/2**	**O**
C00304	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a second procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00304_ProcedureModifier		**O**	**AN 2/2**	**O**
C00305	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a third procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00305_ProcedureModifier		**O**	**AN 2/2**	**O**
C00306	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners		**O**	**AN 2/2**	**O**

SITUATIONAL RULE: Required when a fourth procedure code modifier applies to this service. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC06_C00306_ProcedureModifier

C00307	**352**	**Description**	**O**		**AN 1/80**	**O**

A free-form description to clarify the related data elements and their content

SITUATIONAL RULE: Required when a description was received on the original service for a not otherwise classified procedure code. If not required by this implementation guide, do not
send.

OD: 835W1_2110_SVC06_C00307_ProcedureCodeDescription

IMPLEMENTATION NAME: Procedure Code Description

SVC07	**380**	**Quantity**	**O**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. If not required by this implementation guide, do not send.

OD: 835W1_2110_SVC07__OriginalUnitsofServiceCount

IMPLEMENTATION NAME: Original Units of Service Count

Segment: **DTM** **Service Date**
Position: 0800
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify pertinent dates and times
Syntax Notes:
1 At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when claim level Statement From or Through Dates are not supplied or the service dates are not the same as reported at the claim level. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. Dates at the service line level apply only to the service line where they appear.

2. If used for inpatient claims and no service date was provided on the claim then report the through date from the claim level.

3. When claim dates are not provided, service dates are required for every service line.

4. When claim dates are provided, service dates are not required, but if used they override the claim dates for individual service lines.

5. For retail pharmacy claims, the service date is equivalent to the prescription filled date.

6. For predeterminations, where there is no service date, the value of DTM02 must be 19000101. Use only when the CLP02 value is 25 - Predetermination Pricing Only - No Payment.

7. When payment is being made in advance of services, the use of future dates is allowed.

TR3 Example: DTM*472*20021031~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
DTM01	**374**	**Date/Time Qualifier**	**M**	**1**	**ID 3/3**	**M**

Code specifying type of date or time, or both date and time

OD: 835W1_2110_DTM01__DateTimeQualifier

IMPLEMENTATION NAME: Date Time Qualifier

150	Service Period Start This qualifier is required for reporting the beginning of multi-day services. If not required by this implementation guide, do not send.
151	Service Period End

		472	This qualifier is required for reporting the end of multi-day services. If not required by this implementation guide, do not send. Service Begin and end dates of the service being rendered This qualifier is required to indicate a single day service. If not required by this implementation guide, do not send.			
DTM02	**373**	**Date**		**X**	**1**	**DT 8/8**	**M**

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year
OD: 835W1_2110_DTM02__ServiceDate

IMPLEMENTATION NAME: Service Date

Segment: **CAS** **Service Adjustment**
Position: 0900
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 99
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Syntax Notes:

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

Semantic Notes:

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

Comments:

1 Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

Notes: Situational Rule: Required when dollar amounts are being adjusted specific to the service or when the paid amount for a service line (SVC03) is different than the original submitted charge amount for the service (SVC02). If not required by this implementation guide, do not send.

TR3 Notes: 1. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See sections 1.10.2.1, Balancing, and 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.

2. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment

quantity. These six adjustment trios are used to report up to six adjustments related to a specific Claim Adjustment Group Code (CAS01). The six iterations (trios) of the Adjustment Reason Code related to the Specific Adjustment Group Code must be exhausted before repeating a second iteration of the CAS segment using the same Adjustment Group Code. The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05- CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

TR3 Example: CAS*PR*1*15**2*10~
CAS*CO*45*2~
CAS*OA*22*150~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CAS01	**1033**	**Claim Adjustment Group Code**	**M**	**1**	**ID 1/2**	**M**

Code identifying the general category of payment adjustment

OD: 835W1_2110_CAS01__ClaimAdjustmentGroupCode

Evaluate the usage of group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, OA. See 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)

Shared Claims Processing Notes:

= CO, OA, PR

CO	Contractual Obligations Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.
OA	Other adjustments Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.
PI	Payor Initiated Reductions Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).
PR	Patient Responsibility

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
CAS02	**1034**	**Claim Adjustment Reason Code**	**M**	**1**	**ID 1/5**	**M**

Code identifying the detailed reason the adjustment was made

OD: 835W1_2110_CAS02__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

Required to report a non-zero adjustment applied at the service level for the claim adjustment group code reported in CAS01.

Shared Claims Processing Notes:

Appendix B - Ineligible/Adjustment/Remittance/Group Code Guide

EDF2 Notes:

CAS02 = 45 mapped to EDF2-SVC-INTERIM-DISCNT-AMT

Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

CAS02 = 1 mapped to EDF2-SVC-DEDUCTIBLE-AMT

The amount which must be paid by the insured toward his/her own medical expenses before benefits under his/her contract will be paid.

CAS02 = 2 mapped to EDF2-SVC-COINS-AMT

The out-of-pocket expenses that the member will pay on the claim. This is considered a saving to the Fund.

CAS02 = 3 mapped to Co Pay-AMT (Revised 10.1.2011)

CAS02 = 22 mapped to EDF2-SVC-OI-SAVING-AMT

The amount paid by another insurance carrier.

CAS02 = 23 mapped to EDF2-SVC-MCARE-SAVINGS-AMT (Revised 10.1.2011)

The amount paid by Medicare on the claim.

CAS02 = 201 mapped to EDF2-SVC-WCOMP-SAVINGS-AMOUNT

The amount paid by Workers Compensation on the claim.

CAS03	**782**	**Monetary Amount**	**M**	**1**	**R 1/18**	**M**

Monetary amount

OD: 835W1_2110_CAS03__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claim Processing Notes:

SCP Accounts must pass Service Line Ineligible Amount when applicable or claims will reject for missing amount. (Revised 10.1.2011)

EDF2 Notes:

EDF2-SVC-INTERIM-DISCNT AMT

For institutional claims, the discounted amount of each line of service based on the ETR3 svc-discount percent field supplied by BCBSIL on the Funds transmission record. This field is required if a percentage is supplied and the Fund is the primary payer.

EDF2-SVC-DEDUCTIBLE-AMT

The amount which must be paid by the insured toward his/her own medical expenses before benefits under his/her contract will be paid.

EDF2-SVC-COINS-AMT

The out-of-pocket expenses that the member will pay on the claim. This is considered a saving to the Fund.

EDF2-SVC-OI-SAVING-AMT

The amount paid by another insurance carrier.

EDF2-SVC-MCARE-SAVINGS-AMT

The amount paid by Medicare on the claim.

EDF2-SVC-WCOMP-SAVINGS AMOUNT

The amount paid by Workers Compensation on the claim.

CAS04 380 Quantity O 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when units of service are being adjusted. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS04__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

A positive number decreases paid units, and a negative value increases paid units.

CAS05 1034 Claim Adjustment Reason Code X 1 ID 1/5 O

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS05__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

See CAS02.

CAS06 782 Monetary Amount X 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when CAS05 is present. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS06__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS07 380 Quantity X 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when CAS05 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS07__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

CAS08 1034 Claim Adjustment Reason Code X 1 ID 1/5 O

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS08__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

See CAS02.

CAS09 782 Monetary Amount X 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when CAS08 is present. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS09__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS10 380 Quantity X 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when CAS08 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS10__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

CAS11 1034 Claim Adjustment Reason Code X 1 ID 1/5 O

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS11__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

See CAS02.

CAS12 782 Monetary Amount X 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when CAS11 is present. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS12__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS13 380 Quantity X 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when CAS11 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS13__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

CAS14 1034 Claim Adjustment Reason Code X 1 ID 1/5 O

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS14__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

See CAS02.

CAS15 782 Monetary Amount X 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when CAS14 is present. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS15__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS16 380 Quantity X 1 R 1/15 O

Numeric value of quantity

SITUATIONAL RULE: Required when CAS14 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS16__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

CAS17	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**	**O**

Code identifying the detailed reason the adjustment was made

SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS17__AdjustmentReasonCode

IMPLEMENTATION NAME: Adjustment Reason Code

CODE SOURCE 139: Claim Adjustment Reason Code

See CAS02.

CAS18	**782**	**Monetary Amount**	**X**	**1**	**R 1/18**	**O**

Monetary amount

SITUATIONAL RULE: Required when CAS17 is present. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS18__AdjustmentAmount

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS19	**380**	**Quantity**	**X**	**1**	**R 1/15**	**O**

Numeric value of quantity

SITUATIONAL RULE: Required when CAS17 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send.

OD: 835W1_2110_CAS19__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

Segment: **REF** **Service Identification**
Position: 1000
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when related service specific reference identifiers were used in the process of adjudicating this service. If not required by this implementation guide, do not send.
TR3 Example: REF*RB*100~

Data Element Summary

Ref. Des. Attributes	Data Element	Name	Base Attributes			User
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**

Code qualifying the Reference Identification
OD: 835W1_2110_REF01__ReferenceIdentificationQualifier
Shared Claims Processing Notes:
= RB

Code	Definition
1S	Ambulatory Patient Group (APG) Number
APC	Ambulatory Payment Classification CODE SOURCE 468: Ambulatory Payment Classification
BB	Authorization Number Proves that permission was obtained to provide a service
E9	Attachment Code Supplementary reference information
G1	Prior Authorization Number An authorization number acquired prior to the submission of a claim
G3	Predetermination of Benefits Identification Number A number assigned by a third-party payer identifying the pre-treatment estimate
LU	Location Number This is the Payer’s identification for the provider location. This is REQUIRED when the specific site of service affected the payment of the claim.
RB	Rate code number Rate Code Number reflects Ambulatory Surgical Center (ASC) rate for Medicare, either 0, 50, 100 or 150%.

Ref. Des.	Data Element	Name	Base Attributes			User
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1_2110_REF02__ProviderIdentifier

IMPLEMENTATION NAME: Provider Identifier

Shared Claims Processing Notes:

The code indicating the reason why the fund deemed a service ineligible.

EDF2 Notes:

EDF2-SVC-NON-PYMT-RSN-CD (up to 2 occurrences)

The code indicating the reason why the fund deemed a service ineligible.

Segment: **REF** **Line Item Control Number**
Position: 1000
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes:
Situational Rule: Required when a Line Item Control Number was received on the original claim or when claim or service line splitting has occurred. If not required by this implementation guide, do not send.

TR3 Notes: 1. This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes. See section 1.10.2.11 and 1.10.2.14.1 for additional information on usage with split claims or services. Note - the value in REF02 can include alpha characters.
TR3 Example: REF*6R*A78910~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification OD: 835W1_2110_REF01__ReferenceIdentificationQualifier 6R — Provider Control Number Number assigned by information provider company for tracking and billing purposes				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2110_REF02__LineItemControlNumber IMPLEMENTATION NAME: Line Item Control Number				

Segment: **REF** **Rendering Provider Information**
Position: 1000
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 10
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when the rendering provider for this service is different than the rendering provider applicable at the claim level. If not required by this implementation guide, do not send.
TR3 Example: REF*HPI*1234567891~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification OD: 835W1_2110_REF01__ReferenceIdentificationQualifier				
		0B — State License Number				
		1A — Blue Cross Provider Number				
		1B — Blue Shield Provider Number				
		1C — Medicare Provider Number				
		1D — Medicaid Provider Number				
		1G — Provider UPIN Number				
		1H — CHAMPUS Identification Number				
		1J — Facility ID Number				
		D3 — National Council for Prescription Drug Programs Pharmacy Number CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number				
		G2 — Provider Commercial Number A unique number assigned to a provider by a commercial insurer				
		HPI — Centers for Medicare and Medicaid Services National Provider Identifier This qualifier is REQUIRED when the National Provider Identifier is mandated for use and the provider is a covered health care provider under that mandate. CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier				
		SY — Social Security Number				
		TJ — Federal Taxpayer's Identification Number				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				

OD: 835W1_2110_REF02__RenderingProviderIdentifier

IMPLEMENTATION NAME: Rendering Provider Identifier

Segment: **REF** **HealthCare Policy Identification**
Position: 1000
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when;
* The payment is adjusted in accordance with the Payer's published Healthcare Policy Code list and
* A Claim Adjustment Reason Code identified by the notation, "refer to 835 Healthcare Policy identification segment", in the Claim Adjustment Reason Code List is present in a related CAS segment and
* The payer has a published enumerated healthcare policy code list available to healthcare providers via an un-secure public website. If not required by this implementation guide, do not send.

TR3 Notes: 1. Healthcare Policy - A clinical/statutory rule use to determine claim adjudication that cannot be explained by the sole use of a claim adjustment reason code in the CAS segment and Remittance Advise Remark code when appropriate.

2. The term Healthcare Policy is intended to include Medical Review Policy, Dental Policy Review, Property and Casualty Policies, Workers Comp Policies and Pharmacy Policies for example Medicare LMRP's.(Local Medicare Review policies) and NCD (National Coverage
Determinations).

3. This policy segment must not be used to provide a proprietary explanation code or reason for adjustment.

4. Supply the Healthcare policy identifier in REF02 as provided by the payer's published Healthcare policy code list. This policy code will be used to explain the policy used to process the claim which resulted in the adjusted payment.

5. If this segment is used, the PER (Payer Web Site) segment is required to provide an un-secure WEB contact point where the provider can access the payer's enumerated, published healthcare policy.
TR3 Example: REF*0K*L12345678910~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
REF01	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**	**M**
		Code qualifying the Reference Identification				
		OD: 835W1_2110_REF01__ReferenceIdentificationQualifier				
		0K Policy Form Identifying Number				
REF02	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**	**M**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1_2110_REF02__HealthcarePolicyIdentification

IMPLEMENTATION NAME: Healthcare Policy Identification

Segment: **AMT** **Service Supplemental Amount**
Position: 1100
Loop: 2110
Level: Detail
Usage: Mandatory
Max Use: 1
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment is used to convey information only. It is not part of the financial balancing of the 835.
TR3 Example: AMT*B6*425~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
AMT01	**522**	**Amount Qualifier Code**	**M**	**1**	**ID 1/3**	**M**
		Code to qualify amount OD: 835W1_2110_AMT01__AmountQualifierCode **Shared Claims Processing Notes:** = B6				
		B6 — Allowed - Actual Amount considered for payment under the provisions of the contract Allowed amount is the amount the payer deems payable prior to considering patient responsibility.				
		KH — Deduction Amount Late Filing Reduction				
		T — Tax				
		T2 — Total Claim Before Taxes The total monies requested for a single claim before any taxes were included Use this monetary amount for the service charge before taxes. This is only used when there is an applicable tax amount on this service.				
		ZK — Federal Medicare or Medicaid Payment Mandate - Category 1				
		ZL — Federal Medicare or Medicaid Payment Mandate - Category 2				
		ZM — Federal Medicare or Medicaid Payment Mandate - Category 3				
		ZN — Federal Medicare or Medicaid Payment Mandate - Category 4				
		ZO — Federal Medicare or Medicaid Payment Mandate - Category 5				
AMT02	**782**	**Service Supplemental Amount**	**M**	**1**	**R 1/18**	**M**
		Monetary amount OD: 835W1_2110_AMT02__ServiceSupplementalAmount IMPLEMENTATION NAME: Service Supplemental Amount				

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claims Processing Notes:

Eligible amount is the amount of the provider charge for a service that is covered under the group's contract and eligible for payment.

EDF2 Notes:

EDF2-SVC-ELIGIBLE-AMT

Eligible amount is the amount of the provider charge for a service that is covered under the group's contract and eligible for payment.

Segment: **QTY** **Service Supplemental Quantity**
Position: 1200
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 6
Purpose: To specify quantity information
Syntax Notes:
1 At least one of QTY02 or QTY04 is required.
2 Only one of QTY02 or QTY04 may be present.
Semantic Notes:
1 QTY04 is used when the quantity is non-numeric.
Comments:
Notes: Situational Rule: Required when new Federal Medicare or Medicaid mandates require Quantity counts and value of specific quantities identified in the QTY01 qualifier are non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.
TR3 Example: QTY*ZL*3.75~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
QTY01	**673**	**Quantity Qualifier**	**M**	**1**	**ID 2/2**	**M**
		Code specifying the type of quantity				
		OD: 835W1_2110_QTY01__QuantityQualifier				
		ZK Federal Medicare or Medicaid Payment Mandate - Category 1				
		ZL Federal Medicare or Medicaid Payment Mandate - Category 2				
		ZM Federal Medicare or Medicaid Payment Mandate - Category 3				
		ZN Federal Medicare or Medicaid Payment Mandate - Category 4				
		ZO Federal Medicare or Medicaid Payment Mandate - Category 5				
QTY02	**380**	**Quantity**	**X**	**1**	**R 1/15**	**M**
		Numeric value of quantity				
		OD: 835W1_2110_QTY02__ServiceSupplementalQuantityCount				
		IMPLEMENTATION NAME: Service Supplemental Quantity Count				

Segment: **LQ** **Health Care Remark Codes**
Position: 1300
Loop: 2110
Level: Detail
Usage: Optional
Max Use: 99
Purpose: To identify standard industry codes
Syntax Notes: **1** If LQ01 is present, then LQ02 is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when remark codes or NCPDP Reject/Payment codes are
necessary for the provider to fully understand the adjudication message for a given service line. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. Use this segment to provide informational remarks only. This segment has no impact on the actual payment. Changes in claim payment amounts are provided in the CAS segments.
TR3 Example: LQ*HE*12345~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
LQ01	**1270**	**Code List Qualifier Code**	**O**	**1**	**ID 1/3**	**M**
LQ02	**1271**	**Industry Code**	**X**	**1**	**AN 1/30**	**M**

LQ01 — Code List Qualifier Code

Code identifying a specific industry code list
OD: 835W1_2110_LQ01__CodeListQualifierCode
Shared Claims Processing Notes:
= HE

HE	Claim Payment Remark Codes CODE SOURCE 411: Codes for Medicare and Medicaid Services
RX	National Council for Prescription Drug Programs Reject/Payment Codes CODE SOURCE 530: National Council for Prescription Drug Programs Reject/Payment Codes

LQ02 — Industry Code

Code indicating a code from a specific industry code list
OD: 835W1_2110_LQ02__RemarkCode

IMPLEMENTATION NAME: Remark Code
Shared Claims Processing Notes:
The reason why BCBSIL deem a claim or service line invalid.
EDF2 Notes:
EDF2-SVC-REJECT-RSN-CD

The reason why BCBSIL deem a claim or service line invalid.

Segment: **PLB** **Provider Adjustment**
Position: 0100
Loop:
Level: Summary
Usage: Optional
Max Use: >1
Purpose: To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service

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

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

Comments:

Notes: Situational Rule: Required when reporting adjustments to the actual payment that are NOT
specific to a particular claim or service. If not required by this implementation guide, do not send.

TR3 Notes: 1. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Zero dollar adjustments are not allowed. Some examples of PLB adjustments are a Periodic Interim Payment (loans and loan repayment) or a capitation payment. Multiple adjustments can be placed in one PLB segment, grouped by the provider identified in PLB01 and the period identified in PLB02. Although the PLB reference numbers are not standardized, refer to 1.10.2.9 (Interest and Prompt Payment Discounts), 1.10.2.10 (Capitation and Related Payments or Adjustments), 1.10.2.12 (Balance Forward Processing), 1.10.2.16 (Post Payment Recovery) and 1.10.2.17 (Claim Overpayment Recovery) for code suggestions and usage guidelines.

2. The codes and notations under PLB03 and its components apply equally to PLB05, 07, 09, 11 and 13.

TR3 Example:
PLB*020102115096x580x01*20111231*72:PR020102115096X580X01*0

Data Element Summary

Ref.	Data	Base	User

Des.	Element	Name	Attributes			
PLB01	**127**	**Reference Identification**	**M**	**1**	**AN 1/50**	**M**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
OD: 835W1__PLB01__ProviderIdentifier

IMPLEMENTATION NAME: Provider Identifier

When the National Provider Identifier (NPI) is mandated and the provider is a covered health care provider under that mandate, this must be the NPI assigned to the provider.

Until the NPI is mandated, this is the provider identifier as assigned by the payer.

Des.	Element	Name	Attributes			
PLB02	**373**	**Date**	**M**	**1**	**DT 8/8**	**M**

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year
OD: 835W1__PLB02__FiscalPeriodDate

IMPLEMENTATION NAME: Fiscal Period Date

This is the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31st of the current year.

Des.	Element	Name	Attributes			
PLB03	**C042**	**Adjustment Identifier**	**M**	**1**		**M**

To provide the category and identifying reference information for an adjustment
OD: 835W1__PLB03_C042

This identifier is a composite data structure. The composite identifies the reason and identifying information for the related adjustment dollar amount (PLB04 for PLB03).

Des.	Element	Name	Attributes			
C04201	**426**	**Adjustment Reason Code**	**M**		**ID 2/2**	**M**

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment
OD: 835W1__PLB03_C04201_AdjustmentReasonCode

Shared Claims Processing Notes:

= 72

50	Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge This is the interest assessment for late filing.
72	Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee

	This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits
	This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.
CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding

	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning

of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive).

This payment and recoupment is effectively a loan to the provider and loan repayment.

See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.

PL	Payment Final This is the final settlement.
RA	Retro-activity Adjustment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
RE	Return on Equity
SL	Student Loan Repayment
TL	Third Party Liability This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
WO	Overpayment Recovery This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.
WU	Unspecified Recovery Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).

C04202 127 Reference Identification O AN 1/50 O

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send.

OD: 835W1__PLB03_C04202_ProviderAdjustmentIdentifier

IMPLEMENTATION NAME: Provider Adjustment Identifier

Use when necessary to assist the receiver in identifying, tracking or reconciling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information.

Shared Claims Processing Notes:

= PR (Patient Responsibility) & 2100 CLP CLP07 - Document Control Number

PLB04 782 Monetary Amount M 1 R 1/18 M

Monetary amount

OD: 835W1__PLB04__ProviderAdjustmentAmount

IMPLEMENTATION NAME: Provider Adjustment Amount

This is the adjustment amount for the preceding adjustment reason.

Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.

Shared Claims Processing Notes:

Amount returned by the provider on credit adjustment

EDF2 Notes:

EDF2-CLM-RFCR-AMT

Amount returned by the provider on credit adjustment

PLB05	**C042**	**Adjustment Identifier**	**X**	**1**	**O**

To provide the category and identifying reference information for an adjustment

SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send.

OD: 835W1__PLB05_C042

See PLB03 for details.

C04201	**426**	**Adjustment Reason Code**	**M**	**ID 2/2**	**M**

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

OD: 835W1__PLB05_C04201_AdjustmentReasonCode

50	Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge This is the interest assessment for late filing.
72	Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.

AP	Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment This is the bad debt passthrough.
BN	Bonus This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance This is the tentative adjustment.
CR	Capitation Interest This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment Provide supporting identification information in PLB03-2.
CT	Capitation Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.

FC	Fund Allocation This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement This is the interim rate lump sum adjustment.
J1	Nonreimbursable This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty The dollar value of the penalty assessed a business entity for a past due debt This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed The dollar value of interest owed a business entity for a past due payment This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy IRS Levy
LS	Lump Sum This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive).

			This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.			
		PL	Payment Final This is the final settlement.			
		RA	Retro-activity Adjustment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		RE	Return on Equity			
		SL	Student Loan Repayment			
		TL	Third Party Liability This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		WO	Overpayment Recovery This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.			
		WU	Unspecified Recovery Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).			
C04202	**127**	**Reference Identification**		**O**	**AN 1/50**	**O**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB05_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier				
PLB06	**782**	**Monetary Amount**		**X 1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when PLB05 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB06__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.				
PLB07	**C042**	**Adjustment Identifier**		**X 1**		**O**
		To provide the category and identifying reference information for an adjustment SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send. OD: 835W1__PLB07_C042 See PLB03 for details.				
C04201	**426**	**Adjustment Reason Code**		**M**	**ID 2/2**	**M**

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment
OD: 835W1__PLB07_C04201_AdjustmentReasonCode

50	Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge This is the interest assessment for late filing.
72	Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.

BD	Bad Debt Adjustment This is the bad debt passthrough.
BN	Bonus This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance This is the tentative adjustment.
CR	Capitation Interest This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment Provide supporting identification information in PLB03-2.
CT	Capitation Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement This is the interim rate lump sum adjustment.
J1	Nonreimbursable This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty The dollar value of the penalty assessed a business entity for a past due debt This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed

	The dollar value of interest owed a business entity for a past due payment This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy IRS Levy
LS	Lump Sum This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.
PL	Payment Final This is the final settlement.
RA	Retro-activity Adjustment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
RE	Return on Equity
SL	Student Loan Repayment
TL	Third Party Liability This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
WO	Overpayment Recovery This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.
WU	Unspecified Recovery Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).

C04202	**127**	**Reference Identification**	**O**	**AN 1/50**	**O**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier
SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send.

OD: 835W1__PLB07_C04202_ProviderAdjustmentIdentifier

IMPLEMENTATION NAME: Provider Adjustment Identifier

PLB08	**782**	**Monetary Amount**	**X 1**	**R 1/18**	**O**

Monetary amount
SITUATIONAL RULE: Required when PLB07 is used. If not required by this implementation guide, do not send.

OD: 835W1__PLB08__ProviderAdjustmentAmount

IMPLEMENTATION NAME: Provider Adjustment Amount

This is the adjustment amount for the preceding adjustment reason.

PLB09	**C042**	**Adjustment Identifier**	**X 1**		**O**

To provide the category and identifying reference information for an adjustment
SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send.

OD: 835W1__PLB09_C042

See PLB03 for details.

C04201	**426**	**Adjustment Reason Code**	**M**	**ID 2/2**	**M**

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment
OD: 835W1__PLB09_C04201_AdjustmentReasonCode

50	Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge This is the interest assessment for late filing.
72	Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.

AM	Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment This is the bad debt passthrough.
BN	Bonus This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance This is the tentative adjustment.
CR	Capitation Interest This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment Provide supporting identification information in PLB03-2.
CT	Capitation Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance

	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment,

			claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.				
		PL	Payment Final This is the final settlement.				
		RA	Retro-activity Adjustment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.				
		RE	Return on Equity				
		SL	Student Loan Repayment				
		TL	Third Party Liability This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.				
		WO	Overpayment Recovery This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.				
		WU	Unspecified Recovery Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).				
C04202	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB09_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier		**O**		**AN 1/50**	**O**
PLB10	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when PLB09 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB10__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.		**X**	**1**	**R 1/18**	**O**
PLB11	**C042**	**Adjustment Identifier** To provide the category and identifying reference information for an adjustment SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation		**X**	**1**		**O**

guide, do not send.

OD: 835W1__PLB11_C042

See PLB03 for details.

C04201 **426** **Adjustment Reason Code** **M** **ID 2/2** **M**

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment
OD: 835W1__PLB11_C04201_AdjustmentReasonCode

50	Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge This is the interest assessment for late filing.
72	Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance This represents the check received from the provider for overpayments generated by payments

	from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment This is the bad debt passthrough.
BN	Bonus This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance This is the tentative adjustment.
CR	Capitation Interest This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment Provide supporting identification information in PLB03-2.
CT	Capitation Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement This is the interim rate lump sum adjustment.
J1	Nonreimbursable This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty

	The dollar value of the penalty assessed a business entity for a past due debt This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.
PL	Payment Final
	This is the final settlement.
RA	Retro-activity Adjustment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
RE	Return on Equity
SL	Student Loan Repayment
TL	Third Party Liability
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
WO	Overpayment Recovery
	This is the recovery of previous overpayment. An identifying

number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.

WU Unspecified Recovery

Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).

C04202 127 Reference Identification O AN 1/50 O

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

SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send.

OD: 835W1__PLB11_C04202_ProviderAdjustmentIdentifier

IMPLEMENTATION NAME: Provider Adjustment Identifier

PLB12 782 Monetary Amount X 1 R 1/18 O

Monetary amount

SITUATIONAL RULE: Required when PLB11 is used. If not required by this implementation guide, do not send.

OD: 835W1__PLB12__ProviderAdjustmentAmount

IMPLEMENTATION NAME: Provider Adjustment Amount

This is the adjustment amount for the preceding adjustment reason.

PLB13 C042 Adjustment Identifier X 1 O

To provide the category and identifying reference information for an adjustment

SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send.

OD: 835W1__PLB13_C042

See PLB03 for details.

C04201 426 Adjustment Reason Code M ID 2/2 M

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

OD: 835W1__PLB13_C04201_AdjustmentReasonCode

50 Late Charge

This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.

51 Interest Penalty Charge

This is the interest assessment for late filing.

72 Authorized Return

This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code

	must be directly offset.
90	Early Payment Allowance
AH	Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment This is the bad debt passthrough.
BN	Bonus This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance This is the tentative adjustment.
CR	Capitation Interest This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment Provide supporting identification information in PLB03-2.
CT	Capitation Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru

CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement This is the interim rate lump sum adjustment.
J1	Nonreimbursable This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty The dollar value of the penalty assessed a business entity for a past due debt This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed The dollar value of interest owed a business entity for a past due payment This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy IRS Levy
LS	Lump Sum This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers Identification of the affiliated providers must be made on PLB03-2.

		PI	Periodic Interim Payment This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.			
		PL	Payment Final This is the final settlement.			
		RA	Retro-activity Adjustment This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		RE	Return on Equity			
		SL	Student Loan Repayment			
		TL	Third Party Liability This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		WO	Overpayment Recovery This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.			
		WU	Unspecified Recovery Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).			
C04202	**127**	**Reference Identification**		**O**	**AN 1/50**	**O**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB13_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier				
PLB14	**782**	**Monetary Amount**		**X 1**	**R 1/18**	**O**
		Monetary amount SITUATIONAL RULE: Required when PLB13 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB14__ProviderAdjustmentAmount				

IMPLEMENTATION NAME: Provider Adjustment Amount

This is the adjustment amount for the preceding adjustment reason.

Segment: **SE** **Transaction Set Trailer**
Position: 0200
Loop:
Level: Summary
Usage: Mandatory
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)
Syntax Notes:
Semantic Notes:
Comments: **1** SE is the last segment of each transaction set.
Notes: TR3 Example: SE*45*1234~

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
SE01	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments OD: 835W1__SE01__TransactionSegmentCount IMPLEMENTATION NAME: Transaction Segment Count	**M**	**1**	**N0 1/10**	**M**
SE02	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: 835W1__SE02__TransactionSetControlNumber The Transaction Set Control Numbers in ST02 and SE02 must be identical. The originator assigns the Transaction Set Control Number, which must be unique within a functional group (GS-GE). This unique number also aids in error resolution research.	**M**	**1**	**AN 4/9**	**M**

A EDI Control Directory

Control Segments

- **ISA**
  Interchange Control Header Segment
- **GS**
  Functional Group Header Segment
- **GE**
  Functional Group Trailer Segment
- **IEA**
  Interchange Control Trailer Segment

ICS Interchange Control Structures

Functional Group ID=

Introduction:

The purpose of this standard is to define the control structures for the electronic interchange of one or more encoded business transactions including the EDI (Electronic Data Interchange) encoded transactions of Accredited Standards Committee X12. This standard provides the interchange envelope of a header and trailer for the electronic interchange through a data transmission, and it provides a structure to acknowledge the receipt and processing of this envelope.

Page No.	Pos. No.	Seg. ID	Name	X12 Usage	SCP Usage	Max.Use	Loop Repeat	Notes and Comments
162	0010	ISA	Interchange Control Header	M	M	1		
165	0020	GS	Functional Group Header	M	M	1		
167	0030	GE	Functional Group Trailer	M	M	1		
168	0040	IEA	Interchange Control Trailer	M	M	1		

Segment: **ISA** **Interchange Control Header**
Position: 0010
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
ISA01	**I01**	**Authorization Information Qualifier**	**M**	**1**	**ID 2/2**	**M**
		Code identifying the type of information in the Authorization Information				
		Shared Claims Processing Notes:				
		= 00				
		Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA02	**I02**	**Authorization Information**	**M**	**1**	**AN 10/10**	**M**
		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**	**1**	**ID 2/2**	**M**
		Code identifying the type of information in the Security Information				
		Shared Claims Processing Notes:				
		= 00				
		Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA04	**I04**	**Security Information**	**M**	**1**	**AN 10/10**	**M**
		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**	**1**	**ID 2/2**	**M**
		Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified				
		Shared Claims Processing Notes:				
		= ZZ				
		Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA06	**I06**	**Interchange Sender ID**	**M**	**1**	**AN 15/15**	**M**
		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				
		Shared Claims Processing Notes:				
		= Adjudication Identification Number assigned to Group				
		EDF2 Notes:				
		EDF2-CLM-EXT-ADJUD-ID Unique ID assigned to each Fund by BCBSIL.				

ISA07	**I05**	**Interchange ID Qualifier**	**M**	**1**	**ID 2/2**	**M**
		Code indicating the system/method of code structure used to designate the sender or receiver ID element being qualified **Shared Claims Processing Notes:** = ZZ (Mutually Defined) Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA08	**I07**	**Interchange Receiver ID**	**M**	**1**	**AN 15/15**	**M**
		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 **Shared Claims Processing Notes:** = HCSCLABOR				
ISA09	**I08**	**Interchange Date**	**M**	**1**	**DT 6/6**	**M**
		Date of the interchange				
ISA10	**I09**	**Interchange Time**	**M**	**1**	**TM 4/4**	**M**
		Time of the interchange **Shared Claims Processing Notes:** The time format is HHMM				
ISA11	**I65**	**Repetition Separator**	**M**	**1**	**AN 1/1**	**M**
		Type is not applicable; the repetition separator is a delimiter and not a data element; this field provides the delimiter used to separate repeated occurrences of a simple data element or a composite data structure; this value must be different than the data element separator, component element separator, and the segment terminator **Shared Claims Processing Notes:** = ^				
ISA12	**I11**	**Interchange Control Version Number**	**M**	**1**	**ID 5/5**	**M**
		Code specifying the version number of the interchange control segments **Shared Claims Processing Notes:** 00501 Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA13	**I12**	**Interchange Control Number**	**M**	**1**	**N0 9/9**	**M**
		A control number assigned by the interchange sender **Shared Claims Processing Notes:** = Unique Control Number				
ISA14	**I13**	**Acknowledgment Requested**	**M**	**1**	**ID 1/1**	**M**
		Code indicating sender's request for an interchange acknowledgment **Shared Claims Processing Notes:** = 0 Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA15	**I14**	**Interchange Usage Indicator**	**M**	**1**	**ID 1/1**	**M**
		Code indicating whether data enclosed by this interchange envelope is test, production or information **Shared Claims Processing Notes:** = P (Production Data) = T (Test Data) Refer to 005010 Data Element Dictionary for acceptable code values.				
ISA16	**I15**	**Component Element Separator**	**M**	**1**	**AN 1/1**	**M**
		Type is not applicable; the component element separator is a delimiter and not 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

Shared Claims Processing Notes:

= :

Segment: **GS** **Functional Group Header**
Position: 0020
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the beginning of a functional group and to provide control information
Syntax Notes:
Semantic Notes:
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.

Data Element Summary

Ref. Des. Attributes	Data Element	Name	Base Attributes			User
GS01	**479**	**Functional Identifier Code**	**M**	**1**	**ID 2/2**	**M**
		Code identifying a group of application related transaction sets				
		Shared Claims Processing Notes:				
		= HP for Health Payment (835)				
		Refer to 005010 Data Element Dictionary for acceptable code values.				
GS02	**142**	**Application Sender's Code**	**M**	**1**	**AN 2/15**	**M**
		Code identifying party sending transmission; codes agreed to by trading partners				
		Shared Claims Processing Notes:				
		= Adjudication Identification Number assigned to Group				
		EDF2 Notes:				
		EDF2-CLM-EXT-ADJUD-ID Unique ID assigned to each Fund by BCBSIL.				
GS03	**124**	**Application Receiver's Code**	**M**	**1**	**AN 2/15**	**M**
		Code identifying party receiving transmission; codes agreed to by trading partners				
		Shared Claims Processing Notes:				
		= HCSCLABOR				
GS04	**373**	**Date**	**M**	**1**	**DT 8/8**	**M**
		Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year				
		Shared Claims Processing Notes:				
		Use this date for the functional group creation date. Format is CCYYMMDD.				
GS05	**337**	**Time**	**M**	**1**	**TM 4/8**	**M**
		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)				
		Shared Claims Processing Notes:				

		Use this time for the creation time. The recommended format is HHMM.				
GS06	**28**	**Group Control Number**	**M**	**1**	**N0 1/9**	**M**
		Assigned number originated and maintained by the sender **Shared Claims Processing Notes:** = Unique Control Number				
GS07	**455**	**Responsible Agency Code**	**M**	**1**	**ID 1/2**	**M**
		Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480 **Shared Claims Processing Notes:** = XX Refer to 005010 Data Element Dictionary for acceptable code values.				
GS08	**480**	**Version / Release / Industry Identifier Code**	**M**	**1**	**AN 1/12**	**M**
		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 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 **Shared Claims Processing Notes:** = 00501X221A1 Refer to 005010 Data Element Dictionary for acceptable code values.				

Segment: **GE** **Functional Group Trailer**
Position: 0030
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To indicate the end of a functional group and to provide control information
Syntax Notes:
Semantic Notes: **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.

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
GE01	**97**	**Number of Transaction Sets Included**	**M**	**1**	**N0 1/6**	**M**
		Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element				
GE02	**28**	**Group Control Number**	**M**	**1**	**N0 1/9**	**M**
		Assigned number originated and maintained by the sender				

Segment: **IEA** **Interchange Control Trailer**
Position: 0040
Loop:
Level:
Usage: Mandatory
Max Use: 1
Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments
Syntax Notes:
Semantic Notes:
Comments:

Data Element Summary

Ref. Des.	Data Element	Name	Base Attributes			User Attributes
IEA01	**I16**	**Number of Included Functional Groups** A count of the number of functional groups included in an interchange	**M**	**1**	**N0 1/5**	**M**
IEA02	**I12**	**Interchange Control Number** A control number assigned by the interchange sender	**M**	**1**	**N0 9/9**	**M**

A. Ineligible/Adjustment/Remittance/Group Code Guide

Revision: Effective 04.23.2012

Bluechip Ineligible Reason Code	ANSI Group Code	ANSI Claim Adjustment RSN Code	Remittance Remark Code	Bluechip Ineligible Reason Code Description
N/A	**CO**	**45**		**INTERIM DISCOUNT AMOUNT (INSTITUTIONAL CLAIMS). Note: No Bluechip Ineligible Reason Code req.**
N/A	**PR**	**1**		**LABOR DEDUCTIBLE**
N/A	**PR**	**2**		**LABOR COINSURANCE**
N/A	**PR**	**3**		**LABOR COPAY AMT**
N/A	**OA**	**22**		**OTHER CARRIER SAVING AMT**
N/A	**OA**	**201**		**WORMAN COMP SAVING AMOUNT**
N/A	**OA**	**23**		**MEDICARE SAVING AMOUNT**
503	**CO**	**45**		**CHARGES EXCEED PPO ALLOWANCE (PROFESSIONAL CLAIMS)**
52	OA	B11		CHARGES FORWARDED TO THE INFERTILITY NETWORK PROVIDER
53	OA	B11		CHARGES FORWARDED TO WOMAN'S PRINCIPLE HEALTHCARE PROVIDER
56	OA	B11		OUTPATIENT PROF SERVICE RELATED TO IN-AREA TREAT, EMERGENCY INELIGIBLE
57	OA	B11		OUTPATIENT PROF SERVICE RELATED TO IN-AREA TREAT, EMERGENCY INELIGIBLE
100	PR	14		ADMISSION DATE IS PRIOR TO PATIENT'S DATE OF BIRTH.
101	PR	13		ADMISSION/BILL FROM DATE IS AFTER PATIENT'S EXPIRED DATE.
102	PR	13		DISCHARGE/BILL TO DATE IS AFTER PATIENT'S EXPIRED DATE.
103	CO	16	M67	PROCEDURE NOT INDICATED ON BILL/CLAIM
104	PR	16	N203	ANESTHESIA TIME NOT INDICATED ON BILL/CLAIM.
105	PR	16	M76	DIAGNOSIS NOT INDICATED ON BILL/CLAIM.
106	PR	16	M54	SERVICE CHARGE(S) NOT INDICATED ON BILL/CLAIM.
107	PR	5		INVALID PLACE OF TREATMENT FOR TYPE OF PROCEDURE PERFORMED
108	CO	11		Invalid procedure for type of diagnosis indicated
109	PR	16	N29	TRANSMITTAL RECORD NOT ON FILE
110	PR	27		SERVICE AFTER MM/DD/YY DISAPPROVED
111	PR	16	N225	TRANSMITTAL RECORD NOT CURRENT-UPDATE REQUIRED
112	CO	8		Invalid provider for type of procedure indicated
113	CO	16	N305	DATE OF ACCIDENT/INJURY NOT INDICATED ON THE BILL.
114	CO	7		Invalid procedure for patient's sex type
115	PR	16	N34	LIFETIME RESERVE DAYS BILLED ON ECF/SNF CLAIMS.
116	PR	16	N15	BABY'S CHARGES MUST BE SEPARATE FROM MOTHER'S CLAIM.
117	PR	31		BLUE CROSS ONLY COVERAGE.

118	PR	31		BLUE SHIELD ONLY COVERAGE.
119	PR	32		NO COVERAGE FOR OVERAGED DEPENDENT
120	PR	32		NO COVERAGE FOR OVERAGED DEPENDENT-AGE XX
121	PR	32		NO COVERAGE FOR OVERAGED DEPENDENT- END OF MONTH FOR AGE XX
122	PR	32		NO COVERAGE FOR OVERAGED DEPENDENT- END OF YR IN WHICH REACH AGE XX
123	PR	32		NO COVERAGE FOR OVERAGED STUDENT-AGE XX
124	PR	32		NO COVERAGE FOR OVERAGED STUDENT DEPENDENT-END OF MONTH FOR AGE XX
125	PR	32		NO COVERAGE FOR OVERAGED STUDENT DEPEND- END OF YR IN WHICH REACH AGE XX
126	PR	32		NO COVERAGE FOR OVERAGED STUDENT DEPENDENT
127	PR	31		PATIENT IS AN INELIGIBLE MEMBER OR SPOUSE PER MEMBER/SPOUSE INELIG CODE
128	OA	18		DUPLICATE CONTINUOUS STAY BILLING.
129	OA	18		THIS CHARGE IS A DUPLICATE OF A PREVIOUSLY PROCESSED CLAIM.
130	CO	16	M22	AMBULANCE MILES REQUIRED.
131	CO	170		THIS PROVIDER IS NOT ELIGIBLE TO BILL FOR THESE SERVICES.
132	PR	26		SERVICE PRIOR TO START UP AGREEMENT/EFFECTIVE DATE
133	PR	27		SERVICE AFTER CONTRACT TERMINATION DATE.
134	PR	96	N130	SERVICES FOR FUTURE DATES ARE NOT COVERED
135	PR	96	N128	SERVICE PRIOR TO CONTRACT CONVERSION
136	PR	96	N130	MAJOR MEDICAL COVERAGE ONLY.
137	PR	27		Member not covered for these dates of services due to lapse in coverage
138	PR	96		DENTAL COVERAGE ONLY.
139	PR	32		PATIENT IS AN INELIGIBLE DEPENDENT.
140	PR	27		GROUP DID NOT APPROVE EXTENSION OF BENEFITS.
141	PR	32		STUDENT DEPENDENT NOT COVERED AFTER GRADUATION DATE.
142	PR	23		THIS CHARGE WAS PROCESSED BY THE PREVIOUS HEALTH INSURANCE CARRIER.
144	PR	6		INVALID CPT CODE FOR PAT AGE. PROVIDER CONTACTED FOR VERIFICATION.
145	PR	16	N202	SURGICAL PROCEDURE NOT INDICATED ON CLAIM. PROVIDER CONTACTED FOR INFO.
146	PR	B11		INVALID CPT CODE: REFERRED TO PAR PLAN
147	PR	B11		ADDITIONAL PRICING INFO REQUESTED FROM PAR PLAN.
148	PR	B11		CLAIM SUBMITTED BY PAR THROUGH ITS/ACES. PAR PLAN CONTACTED
150	PR	96	N130	CONTRACT DOES NOT COVER THIS TYPE OF OUTPATIENT HOSPITAL SERVICE.
151	CO	89		CHARGE REPORTED SHOULD BE BILLED TO BLUE SHIELD ON HCFA 1500 FORM.
152	PR	96	N130	BLUE CROSS AND MAJOR MEDICAL COVERAGE ONLY.
153	PR	96	N130	THIS AMBULANCE SERVICE IS NOT COVERED
200	PR	B11		CLAIM FORWARDED TO CONTROL PLAN FOR PROCESSING.

201	PR	16	N149	NORMAL NEWBORN CHARGES MUST BE BILLED ON MOTHER'S CLAIM.
202	PR	152		NEWBORN/BABY'S STAY OVER 15 DAY MAXIMUM
203	PR	34		NORMAL NEWBORN CARE IS NOT IN BENEFIT.
204	PR	197		MD CERTIFICATION REQUIRED FOR TRANSSEXUAL SURGERY.
205	PR	B5		COORDINATED HOME CARE REQUIREMENTS NOT FULFILLED.
206	PR	B5		DAY PSYCHIATRIC PROGRAM REQUIREMENTS NOT FULFILLED.
207	PR	B5		NIGHT PSYCHIATRIC PROGRAM REQUIREMENTS NOT FULFILLED.
208	PR	B5		CARDIAC REHABILITATION PROGRAM REQUIREMENTS NOT FULFILLED.
209	PR	B5		O/P ALCOHOL ABUSE PROGRAM REQUIREMENTS NOT FULFILLED.
210	PR	B5		O/P DRUG ABUSE PROGRAM REQUIREMENTS NOT FULFILLED.
211	PR	109		CLAIM FORWARDED TO EMPLOYEE'S GROUP FOR PROCESSING.
214	PR	16	N179	STUDENT HEALTH OFFICES MUST VERIFY SERVICES.
215	PR	38		MEDICAL GROUP APPROVAL REQUIRED.
216	PR	197		GROUP RECERTIFICATION REQUIRED FOR THIS BENEFIT.
217	PR	197		RECERTIFICATION FOR EACH CONFINEMENT/SERVICE/XX # OF DAYS WAS NOT DONE.
218	PR	B5		PRIOR ADMISSION DID NOT HAVE SAME CONDITION REQUIRED FOR THIS SERVICE
219	PR	35		MAXIMUM STAY FOR THIS CONDITION REACHED.
220	PR	B11		CLAIM HAS BEEN FORWARDED TO CONTROL PLAN FOR PROCESSING.
221	PR	B11		CLAIM HAS BEEN FORWARDED TO CONTROL PLAN FOR PROCESSING.
222	PR	B11		CLAIM HAS BEEN FORWARDED TO CONTROL PLAN FOR PROCESSING.
223	PR	22		REPAIR/REPLACEMENT: MA Y BE COVERED BY OTHER INSURANCE.
224	PR	16		REPLACEMENT: INFO NEEDED, IS SERVICE DUE TO ILLNESS/INJURY?
226	PR	49		ROUTINE PHYSICAL EXAMINATION NOT COVERED.
227	PR	89		PHYSICIAN'S CHARGES MUST BE BILLED SEPARATELY.
228	PR	B5		SERVICE NOT COVERED. PRIOR ADMISSION INELIGIBLE.
229	PR	96	N130	SERVICE NOT COVERED.
230	PR	B5		ADMISSION DATE WAS NOT WITHIN DAY REQUIREMENT.
231	PR	109		AMBULANCE SERVICE HANDLED BY HEALTH SERVICE INCORPORATED.
232	PR	B5		REPAIR/REPLACEMENT MUST BE BILLED BY HOSPITAL.
233	PR	B5		REPAIR/REPLCMNT INEL FOR DENTAL APPL/CATARACT LENSES IF NOT RX CHANGE.
234	PR	173		REPAIR/REPLACEMENT MUST BE MD PRESCRIBED.

235	PR	B5		ECF/SNF PRIOR ADMISSION QUALIFICATION NOT MET.
236	PR	32		NORMAL NEWBORN NOT COVERED: MOTHER IS DEPENDENT.
237	PR	34		NORMAL NEWBORN NOT COVERED: MOTHER IS NOT ELIGIBLE.
238	PR	177		NORMAL NEWBORN NOT COVERED: MEMBER NOT COVERED 270 DAYS PRIOR DELIVERY
239	PR	B22		OB NOT COVERED: MOTHER NOT ELIGIBLE FOR OB.
240	PR	B5		OB NOT COVERED: PREGNANCY OCCURRED PRIOR TO THE EFFECTIVE DATE.
241	PR	B5		CONCURRENT MENTAL AND MEDICAL CARE ONLY THE HIGHER CHARGE ELIGIBLE.
242	PR	B5		CONCURRENT RADIATION AND MEDICAL CARE ONLY THE HIGHER CHARGE COVERED.
243	PR	B5		SERVICES PRIOR ADMISSION QUALIFICATIONS NOT MET.
244	PR	B5		ACCUPUNCTURE IS NOT ELIGIBLE FOR THIS SERVICE.
245	PR	96	N130	ADMISSION HISTORY EXAMINATION IS NOT A BENEFIT.
246	PR	B5		ANESTHESIA IS NOT COVERED FOR THIS PROCEDURE.
247	PR	49		ONLY ANNUAL PHYSICAL EXAM COVERED.
248	PR	54		ASSISTANT SURGEON IS NOT COVERED FOR THIS PROCEDURE.
249	PR	96	N130	SERVICE NOT COVERED.
250	PR	96	N130	SERVICE NOT COVERED FOR THIS DIAGNOSIS.
251	PR	96	N130	THIS METHOD OF CHEMOTHERAPY ADMINISTRATION IS NOT COVERED.
252	PR	B20		INELIGIBLE: CONCURRENT MEDICAL FOR DIFFERENT PHYSICIAN.
253	PR	B14		INELIBIBLE: CONCURRENT MEDICAL FOR SAME PHYSICIAN.
254	PR	51		CONGENITAL SURGERY NOT COVERED FOR PRE-EXISTING CONDITION.
255	PR	96	N130	THIS TYPE OF CONGENITAL SURGERY/SERVICE NOT COVERED
256	PR	B5		COSMETIC SURGERY-SERV DUE TO ILL/ACC OCCURRING PRIOR TO EFFECT DATE
257	PR	B5		COSMETIC SURGERY-SERV NOT RELATED TO A COVERED CONDITION
258	PR	B5		COSMETIC SURGERY-SERV NOT DUE TO A COVERED CONDITION
259	PR	96	N130	THIS TYPE OF COSMETIC SURG/SERVICE NOT COVERED
260	PR	B5		COSMETIC SURG/SERVICE NOT DUE TO AN ACCIDENT
261	PR	B5		DAY PSYCH NOT PERFORMED FOR A MENTAL CONDITION
262	PR	38		DAY PSYCH NOT PERFORMED BY PARTICIPATING PROVIDER
269	PR	B22		SERVICE NOT COVERED FOR THIS DIAGNOSIS
270	PR	B5		ECF/SNF ADMISSION IS NOT COVERED FOR OB OR MENTAL CONDITION
271	PR	B5		ECF/SNF ADMISSION IS NOT COVERED FOR TB CONDITION

272	PR	197		SERVICE NOT A COVERED BENEFIT UNLESS IT IS MD CERTIFIED
273	PR	172		SERVICE NOT COVERED BY CONTRACT FOR THIS TYPE OF PROVIDER
274	PR	49		ONLY EMPLOYMENT PHYSICAL EXAMS ARE COVERED
275	PR	B5		FAMILY COUNSELING IS NOT COVERED UNLESS THE PATIENT IS PRESENT
276	PR	158		FOREIGN CLAIMS NOT COVERED BY THIS CONTRACT
277	PR	96	N130	THIS METHOD OF ANESTHESIA IS NOT COVERED
278	PR	96	N130	HAIR TRANSPLANT IS NOT A BENEFIT
279	PR	197		INPATIENT DENTAL ADMISSION REQUIRES MD CERTIFICATION
280	PR	5		PROCEDURE CODE IS NOT VALID FOR PLACE OF TREATMENT
281	OA	16	N4	THIS SERVICE REQUIRES THE MEDICARE EXPLANATION OF BENEFITS TO PROCESS
282	PR	B5		NIGHT PSYCH NOT PERFORMED FOR A MENTAL CONDITION
283	PR	38		NIGHT PSYCH NOT PERFORMED BY A PARTICIPATING PROVIDER
284	PR	96	N130	PROCEDURE NOT A CORPORATELY COVERED PROCEDURE
285	PR	167		SERVICE DUE TO OB CONDITION, NOT COVERED
286	PR	167		OB NOT COVERED FOR SINGLE COVERAGE
287	PR	167		OB FOR NORMAL DELIVERY NOT A BENEFIT
288	PR	167		OB FOR OTHER THAN ELECTIVE ABORTION IS NOT A BENEFIT
289	PR	179		OB WAITING PERIOD NOT MET
290	PR	B5		ONSET DATE PRIOR TO MEMBERS' EFFECTIVE DATE
291	PR	B5		ONSET DATE PRIOR TO PATIENT'S EFFECTIVE DATE
292	PR	96	N130	OP SURGERY - FOLLOW UP IS NOT A BENEFIT
293	PR	167		PATIENT IS NOT ELIGIBLE FOR OB BENEFITS
294	PR	B5		PATIENT HAS EXCEEDED THE AGE LIMIT FOR THIS SERVICE
295	PR	58		SERVICES ARE NOT COVERED BY THE CONTRACT FOR THIS PLACE OF TREATMENT
296	PR	49		ONLY PRE-MARITAL PHYSICAL EXAMS ARE COVERED
297	PR	96	N130	PRE AND POST NATAL CARE IS NOT A BENEFIT
298	PR	49		ROUTINE EXAM IS NOT A BENEFIT
299	PR	96	N130	SERVICE IS NOT A BENEFIT OF THE CONTRACT (PROVISION IS NOT COVERED)
300	PR	B5		REPAIR/REPLACEMENT: NOT COVERED BECAUSE NOT DUE TO DAMAGE
301	PR	B5		REPAIR/REPLACEMENT: NOT COVERED BECAUSE NOT DUE TO GROWTH
302	PR	B5		REPAIR/REPLACEMENT: NOT COVERED BECAUSE CONDITION DOES NOT WARRANT IT
303	PR	B5		REPLACEMENT:NOT COVERED BECAUSE NOT DUE TO ACCIDENT.
304	PR	B5		SAME PROVIDER: BILLING SURG & ANES. ANES NOT COVERED.

305	PR	B5		SAME PROVIDER: BILLING SURG & ASST SURG. ASST SURG NOT COVERED.
306	PR	B5		SAME PROVIDER: BILLING MEDICAL CARE & CHEMO. MEDICAL CARE NOT COVERED.
307	PR	B14		SAME PROVIDER: BILLING MEDICAL & CONSULTATION. CONSULT NOT COVERED.
308	PR	B5		SAME PROVIDER: BILLING CONSULTATION & SURGERY. CONSULT NOT COVERED.
309	PR	B5		SAME PROVIDER: BILLING EST & EST ANES EST ANES NOT COVERED 01
310	PR	B5		SAME PROVIDER: BILNG SURG, ANEST & ASST SURG ANEST & ASST SURG NOT 0
311	PR	B5		SAME PROVIDER: BILLING IP MEDICAL & RAD THPY. MED VISIT NOT COVERED.
312	PR	B5		SAME PROVIDER: BILLING CHEMOTHERAPY & MEDICAL. MEDICAL NOT COVERED.
313	PR	B5		SAME PROVIDER: BILLING MENTAL & MEDICAL CARE. MEDICAL NOT COVERED.
314	PR	B5		SAME PROVIDER: BILNG DEL, NORM NWBRN &/ANES. NORM NWBRN & ANES NOT COV.
315	PR	B5		SAME PROVIDER: BILLING THE DELIVERY & PRENATAL CARE. PRENATAL NOT COV.
316	PR	49		ONLY SCHOOL PHYSICAL EXAMS ARE COVERED.
317	PR	B5		SURGERY DATE IS NOT WITHIN SERVICE DATES.
318	PR	58		SERVICES IN A STUDENT HEALTH FACILITY ARE NOT A BENEFIT.
319	PR	49		ONLY SUBSTANCE ABUSE PHYSICAL EXAMS ARE COVERED.
320	PR	96	N130	SUPPLEMENTAL ACCIDENT CARE IS NOT A BENEFIT.
321	PR	96	N130	SURGERY, NOT COVERED
322	PR	197		SURGERY NOT COV UNLESS MD CERTIFIED SERVICE
323	PR	96	N227	HOSPITAL CERTIFICATION REQUIRED FOR A PRIVATE ROOM.
324	PR	96	N130	PROCEDURE IS NOT COVERED BY THIS CONTRACT.
325	PR	27		PATIENT'S DATE OF BIRTH IS PRIOR TO MEMBER'S EFFECTIVE DATE.
326	PR	B5		BENEFITS CANNOT BEGIN UNTIL DAY REQUIREMENT IS MET.
327	PR	197		MD CERTIFICATION FOR PRIVATE DUTY NURSING CARE REQUIRED.
328	PR	197		MD CERTIFICATION FOR DURABLE MEDICAL EQUIPMENT REQUIRED.
329	PR	197		MD CERTIFICATION FOR AMBULANCE REQUIRED.
330	PR	197		MD CERTIFICATION REQUIRED-ALL OTHER
331	PR	B5		SERVICES NOT WITHIN DAY REQUIREMENT.
332	PR	38		FACILITY NOT APPROVED FOR CARDIAC REHABILATATION.
333	PR	16	N47	OUTPATIENT SERVICES ARE BEING BILLED DURING AN INPATIENT STAY.
334	PR	55		EXPERIMENTAL PROCEDURE NOT COVERED.
335	PR	119		INTERVAL DAYS EXCEED TREATMENT TIME FACTOR.
336	PR	167		PATIENT NOT ELIGIBLE TO RECEIVE TREATMENT FOR ALCOHOLISM.

337	PR	167		PATIENT NOT ELIGIBLE TO RECEIVE TREATMENT FOR DRUG ABUSE.
338	PR	39		PRE-ADMISSION REVIEW OBTAINED BUT NOT APPROVED.
339	PR	197		PRE-ADMISSION REVIEW WAS NOT OBTAINED.
340	PR	B5		EMERGENCY SERVICES BEYOND HOUR LIMIT.
341	CO	16	N79	PRE-X QUESTIONNAIRE TO MEMB, PROVIDER OR FACILITY-WAIT PERIOD NOT MET
342	CO	16	N79	PRE-X QUESTIONNAIRE TO MEM,PROV OR FAC-EXPENSE FREE WAIT PERIOD NOT MET
343	CO	16	MA04	THIS HOSPITAL CLAIM REQUIRES MEDICARE'S PAID AMOUNT TO PROCESS.
344	PR	B5		MD CERTIFICATION REQUIRED:MANDATORY OUTPATIENT SURGERY PROC PERFORMED IP
345	PR	96	N130	PROCEDURE NOT COVERED BY CONTRACT FOR ORGAN TRANSPLANT.
346	PR	197		MEDICAL/SURGICAL ADVISOR WAS NOT CONTACTED PRIOR TO TREATMENT
347	PR	39		MEDICAL/SURGICAL ADVISOR CONTACTED BUT DID NOT APPROVE.
348	PR	B5		WEEKEND ADMISSION: ROOM & BOARD CHARGES INELIGIBLE FOR FRIDAY & SATUDAY.
349	PR	B5		WEEKEND ADMISSION: ALL SERVICES INELIGIBLE.
350	PR	B5		WEEKEND ADMISSION: ROOM & BOARD CHARGES INELIGIBLE FOR ENTIRE STAY.
351	PR	B5		WEEKEND ADMISSION: ALL SERVICES FOR ENTIRE STAY INELIGIBLE.
352	PR	B5		FRIDAY/SATURDAY ADMISSION: ROOM & BOARD FOR SATURDAY/SUNDAY INELIGIBLE.
353	PR	16	N179	DATE OF SURGERY REQUIRED TO PROCESS CLAIM.
354	PR	16	N232	ITEMIZED CHARGE BREAKDOWN PER DAY REQUIRED.
355	PR	50		MEDICAL NECESSITY DENIAL-INPATIENT SERVICE
356	PR	50		MEDICAL NECESSITY DENIAL- HOSPITAL CARE NOT REQUIRED
357	PR	50		MEDICAL NECESSITY DENIAL-EXCESSIVE PASSES
358	PR	50		MEDICAL NECESSITY DENIAL- LENGTH OF STAY
359	PR	B5		ROUND TRIP AMBULANCE FEE INELIGIBLE WHEN ADMITTING PROV CAN PERFORM SVC.
360	CO	16	M127	Medical records required
361	PR	96	N130	SERVICE DETERMINED TO BE INELIGIBLE AFTER REVIEW.
362	PR	B5		ALL CHGS FOR FRI/SAT PRECEDING MON DISCHARGE INEL UNLESS MD CERTIFIED.
363	PR	96	N130	MEMBER IS NOT COVERED UNDER THE ADDITIONAL TRANSPLANT COVERAGE PROGRAM
364	PR	96	N202	MEDICAL DEPARTMENT APPRVD FACILITY, BUT NOT THE ACTUAL ORGAN TRANSPLANT.
365	PR	58		MEDICAL DEPARTMENT HAS NOT APPRVD FACILITY, BUT HAS APPRVD ORGAN TRANSPL
366	PR	96	N202	MEDICAL DEPARTMENT HAS NOT APPRVD THE FACILITY OR THE ORGAN TRANSPLANT.
367	PR	B5		SERV NOT COVERED ELIGIBILITY CRITERIA FOR ADDITIONAL TRANSPLANT NOT MET

368	PR	61		SECOND SURGICAL OPINION REQUIRED FOR THIS PROCEDURE.
369	PR	B5		ROOM & BOARD CHARGES NOT COVERED FOR MANDATORY OP SERVICE RENDERED I/P
370	PR	B5		BEREAVEMENT COUNSELING NOT WITHIN DAY LIMIT.
371	PR	B5		WEEKEND ADMISSION-1ST DAYS ROOM & BOARD INELIGIBLE UNLESS MD CERTIFIED
373	PR	B5		CHC MUST BE RECERTIFIED EVERY 15 DAYS.
374	PR	B5		ECF MUST BE RECERTIFIED EVERY 30 DAYS.
376	PR	B5		ELIGIBLE ONLY IF PERFORMED AS PART OF APPROVED HOSPICE PROGRAM.
377	PR	B5		ELIGIBLE ONLY IF APPROVED BY EMPLOYEE ASSISTANCE PROGRAM COORDINATOR.
378	PR	107		SERVICES COVERED ONLY WHEN BILLED WITH OP PSYCH OR HOME DIALYSIS.
379	PR	B5		SERVICE COVERED ONLY FOR PRE SCHOOL IMMUNIZATIONS.
380	PR	B5		SERVICE COVERED ONLY WHEN MD CERTIFIED OR ICU NOT AVAILABLE.
381	PR	B5		SERVICE COVERED ONLY "FROM AGE" AS SPECIFIED IN MEMBER'S POLICY.
382	PR	B5		SERVICE COVERED ONLY "TO AGE" AS SPECIFIED IN MEMBER'S POLICY.
383	PR	B5		COV ONLY FOR EAR EXAM BY MD,TEST ORDERD BY MD/CONSULT W/MD WHO PERF EXAM
384	PR	35		SERVICE COV ONLY WHEN BLUE SHIELD DAYS ARE AVAILABLE FOR MENTAL CARE
385	PR	35		SERVICE COVERED ONLY WHEN BLUE CROSS INPATIENT DAYS ARE AVAILABLE.
386	PR	B5		WEEKEND ADMISSION-ALL FRIDAY, SATURDAY AND SUNDAY SERVICES INELIGIBLE.
390	PR	59		SAME PROVIDER BILLING ANES & SURG.ANES CHGS OVER U&C FOR SURG IS NOT COV
391	PR	38		BENEFITS ARE NOT PROVIDED FOR SERVICES OBTAINED FROM NON-PAR PROV.
392	PR	B5		BENEFIT PAYABLE ONLY IF WITHIN 1 MONTH OF RELATED SURGERY OR IP ADMIT
393	PR	B5		BENEFIT PAYABLE ONLY IF BY SAME MD THAT DELIVERED THE CHILD.
394	PR	179		PREEXISTING WAITING PERIOD HAS NOT BEEN MET.
395	PR	179		PREEXISIING EXPENSE FREE WAITING PERIOD HAS NOT BEEN MET.
396	PR	B5		SAME PROV BILLING DELVERY,NORM NEWBORN&ANES.NORM NEWBORN CARE NOT COVERD
397	PR	B5		SAME PROV BILLING DELIVERY, NORM NEWBORN & ANES. ANES. NOT COVERED.
398	PR	16	N153	ADDITONAL INFO REQUEST TO THE PROVIDER REQUESTING ROOM & BOARD CHARGES.
399	PR	96	N130	SERVICES ARE NOT COVERED.
400	PR	119		MAXIMUM BENEFIT AVAILABLE FOR THIS SERVICE HAS BEEN PAID.
401	PR	45		CHARGE EXCEEDS AVERAGE SEMI PRIVATE ROOM RATE.
402	PR	45		CHARGE EXCEEDS AVERAGE SEMI PRIVATE ROOM RATE PLUS AN ADD'L $ AMT.

403	PR	45		CHARGE EXCEEDS EXCEPTION SCHEDULE ALLOWANCE.
404	PR	45		CHARGE EXCEEDS THE FLAT RATE.
405	PR	45		CHARGE EXCEEDS THE FLAT RATE PLUS AN ADDITIONAL $ AMOUNT.
406	PR	45		CHARGE EXCEEDS MOST COMMON SEMI PRIVATE ROOM RATE.
407	PR	45		CHARGE EXCEEDS MOST COMMON SEMI PRIVATE ROOM RATE PLUS AN ADD'L $ AMT
408	OA	23		CHARGE EXCEEDS MEDICARE'S ALLOWABLE AMT.
409	CO	45		CHARGE EXCEEDS PAYMENT FACTORING ALLOWANCE.
410	CO	45		CHARGE EXCEEDS SCHEDULED ALLOWANCE.
411	CO	45		CHARGE EXCEEDS USUAL & CUSTOMARY.
412	CO	45		CHARGE EXCEEDS USUAL.
413	PR	45		CHARGE EXCEEDS PSYCHIATRIC GLOBAL BILLING PARAMETERS.
414	PR	45		CHARGE EXCEEDS A PERCENT OF AVERAGE SEMI PRIVATE ROOM RATE.
415	PR	45		CHARGE EXCEEDS A PERCENT OF BILLED AMOUNT.
416	PR	45		CHARGE EXCEEDS A PERCENT OF MOST COMMON SEMI PRIVATE ROOM RATE.
417	CO	45		CHARGE EXCEEDS A PERCENT OF THE USUAL & CUSTOMARY.
418	CO	45		CHARGE EXCEEDS A PERCENT OF USUAL.
419	CO	45		INDEMNITY SCHEDULE ALLOWANCE IS ZERO DOLLARS.
420	CO	16	M29	ADDITIONAL PRICING INFORMATION REQUESTED. E.G. OPERATIVE REPORT.
421	CO	45		CHARGE EXCEEDS MEDICARE DEDUCTIBLE.
422	PR	45		CHARGE EXCEEDS MEDICARE COINSURANCE.
423	CO	22		CHGE EXCEEDS MEDICARE LIFETIME RESERVE DAILY COPAYMENT AMT
424	OA	23		MEDICARE PAID THIS AMOUNT
425	CO	45		THIS AMOUNT IS OVER DRG.
426	PR	16	MA04	ADDITIONAL MEDICARE INFORMATION REQUESTED.
427	PR	35		MAXIMUM CCP BENEFIT AVAILABLE FOR THIS SERVICE HAS BEEN MET.
428	PR	45		MAXIMUM MEDICARE COINSURANCE DAYS HAVE BEEN MET/EXCEEDED.
429	PR	35		MAXIMUM MEDICARE LIFETIME RESERVE DAYS HAVE BEEN MET/EXCEEDED.
430	PR	45		CHARGE EXCEEDS FLAT RATE PLUS % OF AVG SEMI PRIVATE ROOM RATE.
431	PR	45		CHARGE EXCEEDS FLAT RATE PLUS % OF MOST COMMON SEMI PRIVATE ROOM RATE.
432	PR	45		MEDICAL DEPT. HAS NOT APPROVED OVER MAX AMOUNT.
433	PR	45		DIFFERENT SUBSTANCE ABUSE COURSE OF TREATMENT MAX MET.
434	PR	45		GROUP DETERMINED MAXIMUM HAS BEEN MET.
435	PR	45		GROUP DETERMINED ADDITIONAL BENEFITS NOT AVAILABLE FOR THIS MAXIMUM.
437	CO	94		RDG (DRG) LINE ADDED FOR BAL OF CLM WHEN DRG IS GREATER THAN AMT BILLED

438	PR	45		MAXIMUM BENEFIT FOR COORDINATED HOME CARE (CHC) HAS BEEN MET/PAID.
439	PR	45		CHARGES EXCEED ALLOWANCE PAYABLE.
440	PR	45		PT MAX REACHED. NOT RENEWABLE AS DID NOT FOLLW SURG FOR SAME COND/INJ.
441	PR	23		ECF DAYS PAID BY MEDICARE.
442	PR	35		ECF SUPPLEMENTAL DAYS EXHAUSTED
443	CO	59		CONCURRENT MEDICAL WITH SURG OVER U&C-SURG CHGE PD IN FULL
451	PR	45		NON PART PROV: CHGS OVR MCNP SCHED OF ALL. PAT RESP FOR CHGS OVR THE ALL
452	CO	45		NETWRK PROV: CHGS OVR MCNP SCHED OF ALL. PAT NOT RESP FOR CHGS OVR ALLOW
453	CO	45		CHARGES EXCEEDS MEDICARE'S LIMITING CHARGE.
454	PR	45		NON-PAR BEHAVORAL HLTH NETWRK PROV:CHGS OVR MAX.PT RESP CHGS OVR ALLOW.
455	CO	45		PART BEHAV HLTH NTWRK PROV:CHGS OVR MAX.PAT NOT RESP FOR CHGS OVR ALLOW.
456	CO	45		CHARGE FOR SERVICES EXCEED MAXIMUM ALLOWANCE
457	CO	45		CHG EXCEEDS NTWRK AMT NEGOTIATED W/MAGELLAN PAT NOT RESP
458	CO	45		CHARGES EXCEED PER DIEM NEG W/MAGELLAN. PAT'S IS NOT RESPONSIBLE
459	CO	45		CHARGE EXCEEDS HEALTHCHOICE OF CONNECTICUT'S MAXIMUM ALLOWANCE.
460	CO	45		PAYMENT REDUCED BY AMOUNT NEGOTIATED W/HEALTHCHOICE OF CONNECTICUT.
461	CO	45		MAX BEN PAYABLE FOR SKILLED NURSING CARE HAS BEEN PAID.
473	PR	35		BENEFIT MAXIMUM HAS BEEN REACHED.CHGS EXCEED DAILY LIFETIME RESERVE
475	PR	45		PROV NON PPO,CHGS EXCEED HIAA SCHE. OF ALLOW PAT RES FOR CHGS OVER ALLOW
478	CO	45		SOLID ORGAN TRANSPLANT-CHGE EXCEED SCH PROV BLUE QUALITY CTR, NO BILL PT
479	CO	45		SOLID ORGAN TRANSPLANT-CHGE INCLUDE IN PMT MADE PROV IN BQCT, NO BILL PT
486	PR	197		NATIONAL HLTH SRV ADVISOR CONTACTED,PORTION OF STAY EXCEEDS APPRÆD LNGTH
487	PR	39		NATIONAL HLTH SRV ADVISOR CONTACTED BUT DID NOT APPROVE TREAT/SERV
488	PR	197		NATIONAL HLTH SRV ADVISOR NOT CONTACTED PRIOR TO TREATMENT
489	PR	38		NATIONAL HLTH SRV(NHS) ADVISOR NOT CONTACTED TIMELY;IE LATE NOTIFICATION
494	PR	78		Charges exceed private room rate.
496	PR	16	N465	Physical therapy maximum has been met. Additional information will be requested from your provider. You
497				Invalid Provider for type of procedure indicated (PPO)
498				Invalid Provider for type of procedure indicated (Non PPO)
500	PR	125	M53	CONTINUOUS STAY DATES OUT OF SEQUENCE.

501	PR	16	N179	CONTROL PLAN MUST REVIEW CLAIM FOR ORGAN TRANSPLANT.
504	PR	B8		LPN NOT COVERED SINCE RN WAS AVAILABLE FOR THIS SERVICE.
505	CO	45		CHARGES OVER U&C AND PPO ALLOWANCE NOT COVERED.
506	CO	B15		PRE-NATAL CHARGES MUST BE ROLLED INTO DELIVERY CHARGE.
507	PR	B5		SERVICE NOT ELIGIBLE. FAILED TO MEET GROUP GUIDELINES.
508	PR	16	N202	INVESTIGATION TO DETERMINE IF STAFF MD AVALABLE
509	PR	38		MEDICAL GROUP DID NOT APPROVE (CATASTROPHIC).
510	PR	38		MEDICAL GROUP DID NOT APPROVE. (ALL OTHER)
511	PR	152		LATE DISCHARGE NOT AUTHORIZED.
512	PR	96		VISION SERVICE NOT COVERED.
513	PR	160		PHYSICAL EXAMINATION IS NOT COVERED BY CONTRACT.
514	PR	96	N130	SELF INFLICTED INJURY NOT COVERED
515	PR	108		DME NOT COV SINCE NOT GIVEN FOR OXYGEN.
516	PR	40		CHARGES DO NOT MEET QUALIFICATIONS FOR OUT-OF-AREA NON-EMERGENCY CARE
517	PR	167		SERVICE NOT COVERED, CONDITION WAS NOT FOR AN ECTOPIC PREGNANCY
518	PR	B5		SERVICE NOT COVERED, PATIENT WAS NOT DISABLED
519	PR	B5		PROVISION COVERED ONLY IF PRESCRIBED AS A RESULT OF ACCIDENT/INJURY.
520	PR	40		ER ROOM & RELATED SVCS NOT COVERED, NOT RELATED TO ACC/INJ/SEVERE EMER
521	PR	167		INFERTILITY SERVICES/TREATMENT NOT COVERED.
522	PR	B5		NEWBORN SERVICES INELIGIBLE: BABY DID NOT MEET ENROLLMENT REQUIREMENTS.
523	PR	16	N202	ADDITIONAL INFO REQUIRED: IF ACCIDENT/INJURY SELF INFLICTED.
524	PR	27		PATIENT DID NOT HAVE CONTINUOUS COVERAGE UP TO TIME OF DELIVERY.
525	PR	B5		TREATMENT COVERED ONLY IF TREATMENT BEGAN W/I 30 DAYS AFTER ACCIDENT.
526	PR	B5		OBESITY NOT COVERED UNLESS EXOGENEOUS WITH A MEDICAL COMPLICATION.
527	PR	58		FACILITY NOT APPROVED FOR SUBSTANCE ABUSE.
528	PR	58		ECF/SNF ADMISSION FOR ALCOHOL, DRUG OR TB CONDITION NOT COVERED.
529	PR	39		PRE-ADMISSION REVIEW OBTAINED, HOWEVER, PORTION OF THE STAY NOT APPROVED
530	PR	96	N130	SURGERY CARE NOT COVERED SERVICES
531	PR	B5		IMMUNIZATIONS RELATED TO TRAVEL NOT COVERED.
532	PR	B5		SERVICES ARE NOT COVERED UNLESS TREATMENT IS FOR FOLLOW-UP ACCIDENT.
533	PR	B5		MEDICAL EMERGENCY DID NOT MEET GROUP GUIDELINES.

534	PR	B5		INITIAL ACCIDENT CARE NOT W/I TIME LIMIT, FOLLOW-UP CARE INELIGIBLE.
535	PR	B5		FOLLOW-UP CHEMO VISIT WAS NOT W/I DAY LIMIT OF LAST CHEMO TREATMENT.
536	PR	B5		PT TREATMENT NOT W/I DAY LIMIT OF SURGERY/HOSPITAL DISCHARGE.
537	PR	B5		SERVICE INELIGIBLE: CONDITION NOT DUE TO BACTERIAL INFECTION/ACCIDENT
538	PR	B5		SERVICE INELIGIBLE: CONDITION NOT DUE TO DISEASE/INJURY.
539	PR	B5		CHIROPRACTOR SERVICES LIMITED TO X-RAYS OF THE SPINE.
540	PR	B5		ONLY SURFACE AMBULANCE SERVICES ARE COVERED.
541	PR	B5		ONLY AIR AMBULANCE SERVICES ARE COVERED.
542	PR	179		SERVICE INEL: ILL/INJ PRIOR TO EFF DATE & WAITING PERIOD NOT MET.
543	PR	39		PRE-ADMISSION REVIEW OBTAINED BUT NOT APPROVED. ALL RM & BRD CHGS INEL.
544	PR	B5		NON-ER SURG ADMISSION: ROOM & BOARD INEL WHEN PRE-ADM TESTING NOT DONE.
546	PR	B5		SERVICE COVERED ONLY WHEN RELATED TO SURGERY.
547	PR	B5		SOCIAL WORKER SERVICES COVERED ONLY WHEN UNDER THE DIRECTION OF PHYS.
548	PR	B5		SOCIAL WORKER SERVICES COVERED ONLY IF SUBMTD W/GRP APPROVAL & FORM.
549	PR	B5		HOME HEALTH AIDE IS NOT COVERED AS PART OF THE CHC PROGRAM.
550	PR	B5		SRVC COV ONLY IF RELATED TO COV I/P SURG OR O/P DISLOC/FRACTURE.
551	PR	B5		SERVICE COVERED ONLY IF RELATED TO COVERED I/P SURGERY.
552	PR	B5		MEDICAL SOCIAL WORKER SVCS COVERED ONLY IF SPECIFIC GROUP GUIDLINES MET.
553	PR	B5		THIS SERVICE IS COVERED ONLY IF RELATED TO AN ACCIDENT.
554	PR	19		CHARGES ELIGIBLE UNDER "WORKERS' COMPENSATION" NOT COVERED.
555	PR	20		CHARGES ELIGIBLE UNDER "REIMBURSEMENT" NOT COVERED.
556	PR	22		CHARGES ELIGIBLE UNDER "WORKERS' COMP" & "REIMBURSEMENT" NOT COVERED.
557	PR	22		CHARGES ELIGIBLE UNDER "WORKERS' COMP" & "MEDICARE" NOT COVERED.
558	PR	22		CHARGES ELIGIBLE UNDER "REIMBURSEMENT" AND "MEDICARE" NOT COVERED.
559	PR	22		CHRGS ELIG UNDER "WORKERS' COMP, REIMBURSEMENT & MEDICARE" NOT COVERED.
560	PR	16	N4	MEDICARE'S PAYMENT ESTIMATED - CHARGES NOT COVERED.
561	PR	197		ADVISOR CONTACTED, HOWEVER, PORTION OF STAY EXCEEDS LENGTH APPROVED.
562	PR	197		ADVISOR NOT CONTACTED AND PORTION OF STAY EXCEEDS CONTRACT LIMIT.
564	PR	1		MEDICARE B DEDUCTIBLE NOT COVERED UNDER THE TERMS OF THIS CONTRACT.

565	PR	23		CHARGES NOT COVERED WHEN DENIED BY MEDICARE.
566	PR	108		RNTL CHG OVR PURCH PRC OF DME/COST FOR PURCH PRICE PD ON PREV CLAIM.
567	PR	B5		ONLY SCHOOL PHYS EXAMS FOR 1ST, 5TH, 7TH GRD, HIGH SCHL & REQ SPORTS COV
568	PR	B5		INHOS SRVCS PROVIDED BY NON-PART PROV COV ONLY IF REL TO ER ACC/MED CARE
569	PR	197		MED/SURG ADVISOR REVIEW NOT OBTAINED FOR THIS TYPE OF ADMISSION.
570	PR	39		MED/SURG ADVISOR REVIEWED ADMISSION, BUT DID NOT APPROVE.
571	PR	177		PAT DID NOT MEET ENROLMENT REQRMNT FOR THIS SERVICE TO BE COVERED.
572	PR	39		MED/SURG ADVISOR DID NOT APPROVE ADMISSION. 1ST DAY ROOM & BOARD DENIED.
573	PR	8		CONDITION NOT COVERED FOR THIS PROVIDER TYPE.
574	PR	109		SVCS FOR THE COND REPORTED HANDLED BY OTHER INSURANCE CARRIER.
575	CO	45		PRENATAL CHGS COVRD ONLY UP TO U & C OF THE DELIVERY CHARGE.
576	PR	38		SERVICE COVERED ONLY IF PERFORMED OR RECEIVED BY A PPO PROVIDER.
577	PR	B5		ELIGIBLE ONLY WHEN PROVIDED AS PART OF A TOTAL PHYSICAL THERAPY PROGRAM.
579	PR	109		ELIGIBLE UNDER THE EXTENDED MENTAL HEALTH COVERAGE.
580	PR	38		ELIBIGLE ONLY IF PROVIDED/ORDERED BY PRIMARY CARE PHYSICIAN/MEDICAL GRP
581	PR	96		TYPE OF TINT USED CONSIDERED SUNGLASSES. SUNGLASSES ARE NOT ELIGIBLE.
583	PR	167		SVCS NOT COV IF DIAG/TREAT IS FOR INFERTILITY,MATERNITY, MNTL/SUBS ABUSE
584	PR	167		SVCS NOT COV IF DIAG/TREAT IS FOR INFERTILITY,MENTAL/SUBSTANCE ABUSE.
585	PR	167		SVCS NOT COV IF DIAG/TREAT IS FOR MENTAL/SUBSTANCE ABUSE, ALCOHOL ABUSE.
586	PR	167		SVCS NOT COV IF DIAG/TREAT IS FOR SUBSTANCE ABUSE.
588	PR	96	N130	CHARGES BILLED BY HOSPITAL AS NON-COVERED ON UB92.
589	PR	197		MNTL HLTH ADV APP NOT OBT PRIOR TO REC TREAT FOR MENT/SUBS ABUSE TRTMENT
590	PR	172		COVERED OUT-OF-NETWORK ONLY IF PROVIDED BY A PSYCHOLOGIST/PSYCHIATRIST.
591	PR	16		GROUP BEING CONTACTED FOR ADDITIONAL MEMBERSHIP INFORMATION.
592	PR	197		APPROVAL/CERTIFICATION OBTAINED BUT PORTION OF STAY NOT APPROVED.
593	PR	108		MEDICAL ADVISOR DID NOT APPROVE DME RENTAL/PURCHASE.
594	PR	109		VISION CARE SERVICES ARE HANDLED BY AN OUTSIDE VENDOR.
595	PR	B5		ER CARE OUTSIDE THE U. S. COVERED IF PROVIDED W/IN 60 DAYS OF TRIP.
596	CO	277	N366	MEMBER HAS NOT RESPONDED TO MODIFIED REIMBURSEMENT QUESTIONNAIRE.

598	CO	22		SVC CAN'T BE CONSIDERED FOR BEN IF DENIED BY MEDICARE FOR INSUF CLM INFO
599	CO	18		MEDICARE DENIED AS DUPLICATE; NEED MEDICARE PAID AMOUNT TO PROCESS.
601	PR	96	N130	COSMETIC:PROCEDURE NOT COVERED.
602	PR	96	N130	CONGENTIAL:PROCEDURE NOT COVERED.
605	PR	B5		CONGENITAL:NOT DUE TO AN ACCIDENT.
606	PR	B5		COSMETIC: SERVICE NOT COVERED
608	PR	B5		CONGENITAL: ACCIDENT PRIOR TO COVERAGE DATE
610	PR	B5		COSMETIC: NOT DUE TO ACCIDENT, SCARS, TUMORS OR DISEASES
611	PR	B5		CONGENITAL: NOT DUE TO ACCIDENT, SCARS, TUMORS OR DISEASES
613	PR	B5		COSMETIC: SERVICE NOT COVERED.
614	PR	B5		CONGENITAL: ACCIDENT OR SCARS,TUMORS AND DISEASE PRIOR TO COVERAGE DATE
616	PR	B5		COSMETIC: ACCIDENT PRIOR TO EFF. DATE AND NOT MD CERTIFIED
617	PR	B5		CONGENITAL:ACCIDENT PRIOR TO EFF DATE AND NOT MD CERTIFIED
619	PR	B5		COSMETIC: SERVICE NOT COVERED.
620	PR	B5		CONGENITAL: SERVICE NOT COVERED.
623	PR	B5		CONGENITAL: SERVICE NOT COVERED.
625	PR	B5		COSMETIC: SERVICE NOT COVERED.
626	PR	B5		CONGENITAL: SURGERY OVER AGE LIMIT. PATIENT IS NOT COVERED.
627	PR	B5		COSMETIC: SERVICE NOT COVERED.
629	PR	B5		COSMETIC: SERVICE NOT COVERED.
630	PR	B5		CONGENITAL: SERVICE NOT COVERED.
631	PR	B5		COSMETIC: SERVICE NOT COVERED.
632	PR	B5		COSMETIC: SERVICE NOT COVERED.
634	PR	B5		CONGENITAL: SERVICE NOT COVERED.
638	PR	B5		COSMETIC: SERVICE NOT COVERED.
643	PR	B5		CONGENITAL: SERVICE NOT COVERED.
661	PR	B5		COSMETIC SURG COV-IF CONG DEFECTS/ACCI INJURY OCCUR DUR COV
667	PR	172		BILLING PROVIDER NOT COMPATIBLE WITH PERFORMING PROVIDER
668	PR	109		CLAIMS FOR VISION CARE SHOULD BE SENT TO. VISION SERVICE PLAN
671	PR	B5		COSMETIC: SERVICE NOT COVERED.
672	PR	B5		COSMETIC: SERVICE NOT COVERED.
673	PR	B5		CONGENITAL: SERVICE NOT COVERED.
674	PR	B5		CONGENITAL: SERVICE NOT COVERED.
681	PR	38		SERVICES PERFORMED/RECEIVED BY A NON-NETWORK PROVIDER ARE NOT COVERED
682	PR	22		CLAIM DENIED DUE TO SUBROGATION RIGHTS
690	CO	197		Services for the condition of chemical dependency and substance abuse are handled by another insurance
691	CO	109		Services for the condition of mental health are handled by another insurance carrier.
700	PR	96	N202	ADJUSTMENT: CREDIT ONLY û CALL PTC UNIT
701	PR	96	N202	ADJUSTMENT: STAT CREDIT û CALL PTC UNIT

702	PR	115		ADJUSTMENT: VOID CLAIM DUE TO RETURNED DOLLARS
711	CO	96	N202	BNFTS NOT PROV FOR EXPNS INSUR HAS NO LGL OBLIG TO PAY AS DETERM BY MED
713	PR	B5		EYE GLS & CONT LNS COV ONLY FOL CATARACT SGY/IF RSLT OF ACC/INJ DUR PLC
714	PR	49		IP ROUTINE PAP SMEARS ARE NOT COVERED
715	PR	49		ROUTINE ULTRASOUNDS/SONOGRAMS PERF DURING PREGNANCY ARE NOT COVERED
716	PR	B5		MEDICAL ADVISOR DID NOT APPROVE MOPS PROCEDURE PERFORMED IP.
717	PR	B5		ACUPUNCTURE SVCS WHEN USED IN LIEU OF ANES COV ONLY IF PERF BY MD
718	PR	197		APP/CERT FRM MNTL HLTH ADVSR NOT OBTND PRIOR TO REC OP TREAT FOR SUB ABS
719	PR	197		APP/CERT NOT OBTND: OP FOCUS PROC PERF IP,ALL RM & BRD NOT COVERED
720	PR	B5		ONLY NORM NEWBORN SVCS ARE COVERED FOR GRANDCHILDREN
721	PR	177		NORM NEWBORN SVCS NOT COV WHEN MOTHER'S OB WAITING PRD NOT MET
722	PR	B5		NORM NEWBORN SVCS FOR GRANDCHILDREN COV ONLY FOR ECTOPIC PREGNANCY
723	PR	96	N130	APPLIANCES/POST SGY ADJ PROV FOR TREAT OF TMJ ARE NOT COVERED
724	PR	23		CHGS PD BY OTHER CARRIER ARE NOT ELIGIBLE FOR BENEFITS
725	CO	39		DENY FOR REBILLING OF NON-APPROVED DAYS
726	PR	45		MAX BEN AVAIL MET:NO APP/CERT FRM MNTL HLTH ADV PRIOR TO TREAT OF MNTL
727	PR	B5		PROSTH APPL REPLCMNT COV FOR DEP CHILD UP TO AGE SPECIFIED IN MEMB CONT
730	PR	1		NON PART MED-SELECT NTWRK HOSP NON ER SVCS:MED A DED NOT WAIVED
731	PR	B5		THIS SVC NOT COV FOR DEP CHILD IF PROVIDER OUT-OF-NETWORK
732	PR	96	N130	TREATMENT FOR TMJ LIMITED TO SURGICAL CARE ONLY
734	CO	24		CHGS BY PCP/MED GRP LAB SVC NOT INCL IN EXMPT LAB TEST LIST NOT COV
739	CO	16		ADDTN'L INFO REQ FROM PROV TO DETERMINE WHY ULTRASOUND PERFORMED
740	PR	197		APP/CERT FROM MENT HLTH ADV NOT OBT PRIOR TO TREAT FOR SUBS ABUSE COND
742	CO	78		ADM REVD-PART PROV:RM CHGS NOT MED NEC NOT ELIG FOR BEN. PROV RESPONSIBL
743	PR	78		ADM REVD-NON PART PROV:RM CHGS NOT MED NEC NOT ELIG FOR BEN. PAT RESPT
744	PR	78		ADM REVD-NON PART PROV:RM CHGS NOT MED NEC NOT ELIG FOR BEN. PAT RESP
746	PR	16	N179	HIPAA COMPLIANT ACCT-PRE-EXISTING CONDITION.QUESTIONNAIRE TO MEMBER
747	PR	16	N179	HIPAA COMPLIANT ACCT-PRE-EXISTING CONDITION.QUESTIONNAIRE TO MEMBER
748	PR	16	N202	HIPAA COMPLIANT-PRE-EXISTING CONDITION.QUESTIONNAIRE TO MEM,PROV OR FAC

749	PR	179		HIPAA COMPLIANT ACCT-PRE-EXISTING CONDITION WAITING PERIOD NOT MET.
750	PR	22		SERV RELATED TO TREAT OF OB AND HANDLED BY ANOTHER INSURER
751	PR	B5		MENTAL HLTH/SUBS ABUSE, BEN DENIED BEHAVORIAL HLTH ADVISOR NOT CONTACT
752	PR	B5		MENTAL HLTH/SUBS ABUSE CARE REQUIRES CERT/APPROVAL.CONTACTED & NOT APPRV
754	PR	B5		CERT/APPROV REQ MENTAL HLTH CARE ADVISOR BE CONTACTED, NOT APPROVED
757	PR	B5		SERV NOT COV, OUT OF NETWRK-SELF REFERRED CARE FOR TREAT INFERTILITY
758	PR	B5		INFERTILITY SERV NOT COV, IN NETWRK INPT/OUTPT FACILITY REQ APPROVAL
759	PR	172		ASSIST SURG CHGS NOT COV WHEN PERFORMED BY THIS TYPE OF HLTH CARE PROV
760	PR	109		UHS RESPONSIBILITY.MAIL HCFA 1500/UB92 TO 1634 W POLK ST.,CHGO,IL 60612
763	PR	9		The diagnosis is inconsistent with the patients age.
767	OA	B11		Charges submitted are the responsibility of the behavioral health vendor, please have the provider bill them
779	OA	50		The medical records do not substantiate or support the medical necessity for the services provided.
780	PR	50	M25	The medical records do not substantiate or support the medical necessity for the services provided.
785	OA	50	M25	Accommodative foot orthotics is considered not medically necessary as they do not address structural or
786	PR	50	M25	Accommodative foot orthotics is considered not medically necessary as they do not address structural or
797	CO	193		Medical records and previous decision reviewed. Maintain denial.
798	PR	193		Medical records and previous decision reviewed. Maintain denial.
801	CO	125	M25	Services requested for reimbursement do not match the services documented in the submitted medical record of
802	PR	125	M25	Services requested for reimbursement do not match the services documented in the submitted medical record of
826	OA	125	M53	HCPS Code is not valid with NDC (National Drug Code)
827	OA	125	M53	NDC (National Drug Code) code is invalid for service date
828	OA	125	M53	NDC (National Drug Code) code is required to price service line
829	OA	125	M53	NDC (National Drug Code) unit exceeds threshold
830	CO	50		Medical necessity cannot be established. (Participating Provider)
831	PR	50		Medical necessity cannot be established. (Non-Participating Provider)
832	PR	50		Services determined not medial necessary
901	CO	277	N366	PROVIDER DID NOT RESPOND TO OUR REQUEST FOR ADDITIONAL INFORMATION
902	CO	277	N366	MEMBER DID NOT RESPOND TO OUR REQUEST FOR ADDITIONAL INFORMATION

914	PR	2		CHGS APPLIED TO PAT COINSURANCE SHARE
919	CO	16	N202	MEDICAL&OFFICE VISIT RECORDS NEEDED TO DETERMINE MED NECESSITY OF SERV
920	PR	50		MEDICAL NECESSITY HAS NOT BEEN ESTABLISHED,THEREFORE,SERVICES NOT COVERD
923	CO	133		THIS CLAIM IS BEING INVESTIGATED FOR 3RD PARTY LIABILITY COVERAGE
925	PR	3		CHARGES APPLIED TOWARD HEALTH CARE PLAN COPAYMENT
926	PR	167		SERVICES ARE NOT COVERED FOR THE DIAGNOSIS CODE SUBMITTED
932	PR	45		BILLED AMT GREATER THAN ALLOWED AMT. NON-CONTRACTING PROV,PT RESPONSIBLE
936	PR	150		SERVICE REVIEWED BY AN OUTSIDE ENTITY, MEDICAL NECESSITY NOT ESTABLISHED
951	CO	45		CHARGE OVER PRICED AMOUNT FOR MULTIPLE SURGERY. PATIENT NOT RESPONSIBLE.
952	PR	38		CHARGE OVER PRICED AMOUNT FOR MULTIPLE SURGERY. PATIENT RESPONSIBLE.
001	PR	16	M77	PLACE OF TREATMENT REQUIRED.
002	PR	16	MA36	PATIENT'S NAME REQUIRED.
003	PR	16	N329	PATIENT'S DATE OF BIRTH REQUIRED.
004	PR	16	MA40	DATE OF ADMISSION REQUIRED FOR AN INPATIENT CLAIM.
005	PR	16	N301	DATE OF SERVICE REQUIRED.
006	PR	31		NO RECORD OF MEMBERSHIP.
007	PR	27		GROUP STOP, COVERAGE NOT IN EFFECT
008	PR	29		TIMELY FILING: END OF THE YEAR IN WHICH THE SERVICES WERE RECEIVED.
009	PR	27		MEMBER STOP INFORCE, COVERAGE NOT IN EFFECT
010	PR	26		SERVICE PRIOR TO EFFECTIVE DATE.
011	PR	27		SERVICE ON OR AFTER TERMINATION DATE.
012	PR	31		DEPENDENT NOT LISTED
013	PR	31		PATIENT NAME DIFFERS FROM NAME ON FILE.
014	PR	31		NO SPOUSE COVERAGE.
015	PR	31		PATIENT NOT ELIGIBLE FOR BENEFITS,PER GROUP.
016	PR	33		NO DEPENDENT COVERAGE.
017	PR	16	N375	STUDENT CERTIFICATION REQUIRED.
018	PR	16	N179	STUDENT CERTIFICATION EXPIRED.
019	PR	16	N50	DATE OF DISCHARGE REQUIRED.
020	PR	16	MA60	NAME AND ADDRESS OF HOSPITAL REQUIRED
021	PR	16	N258	NAME AND ADDRESS OF PHYSICIAN REQUIRED
022	PR	16	N179	MEDICARE A + B EFFECTIVE DATES REQUIRED.
023	PR	16	N46	TIME OF ADMISSION REQUIRED.
024	PR	29		TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
025	PR	29		TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
026	PR	29		TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
027	PR	27		MEMB.ON LAY-OFF DUE TO PREG.PT.MUST CONTACT GRP.FINAL BENEFIT CONSIDERAT
028	PR	31		PATIENT NOT ELIGIBLE FOR BENEFITS.
029	PR	27		RETROACTIVE MEMBERSHIP CHANGE RESULTS IN A DENIAL & REFUND/CREDIT
030	PR	32		MALE SPOUSE NOT ELIGIBLE, MEMBER MALE
031	PR	32		FEMALE SPOUSE NOT ELIGIBLE, MEMBER FEMALE

032	PR	32		PATIENT SEX DIFFER FROM MEMBER RECORD
034	PR	B11		BANK SYSTEM PROCESSED CLAIM
035	PR	31		MEMBER HAS NO BLUE CROSS AND/OR BLUE SHIELD COVERAGE.
036	PR	27		TERMINAL OB - GROUP DID NOT APPROVE BENEFITS.
037	PR	27		TERMINAL OB DATE HAS EXPIRED.
041	PR	29		TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
043	PR	29		TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
044	PR	29		TIME LIMIT FOR FILING CLAIMS HAS EXPIRED.
047	PR	16	N202	CONTACTING PAR PLAN FOR CONTRACTUAL INFORMATION
051	PR	29		TIMELY FILE LIMIT 2 YRS.
058	PR	B11		RETURN CLAIMS TO THE OUT-OF-STATE PROVIDER
059	PR	B11		BLUE CARD BORDER ST.PROV HAS DUAL PARTICIPATION AGRMNT WITH IL&HOMEPLAN
060	PR	141		BLUECARD CLAIM SPANS THE IL PROV PARTICIPATION AGREMENT EFFECTIVE DATE
C03	OA	22		This service cannot be processed until charges are filed with other insurance carrier
C33	OA	22		Subscriber has not responded to request for other coverage Information.
C35	CO	A1		Provider has indicated there is other coverage. Our records do not indicate there is other coverage. This service
F01	CO	22		DENIED BY LABOR FUND PAYMENT INFO FROM OTHER CARRIER NOT RECEIVED.
F02	PR	35		DENIED BY LABOR FUND LIFETIME MAX ALLOWANCE HAS BEEN MET.
F03	PR	22		DENIED BY LABOR FUND SUB HAS NOT COMPLIED WITH REQUIREMENTS OF OTH CARR
F04	CO	A1	N61	REBILL HOSPITAL COVERED AND NON-COVERED DAYS SEPERATELY.
F05	CO	133		PRIOR CLM SENT LESS THAN 30 DAYS. ORIGINAL CLM WITH FUNDS DEPT.
F06	PR	A1	N4	DENIED.LABOR FUND REQUIRES EOB TO CONSIDER PAYMENT.
F07	PR	A1	N179	DENIED.LABOR FUND NEEDS ACCIDENT/INJURY QUESTIONAIRE TO CONSIDER PAYMENT
F08	PR	A1	N179	DENIED.LABOR FUND NEEDS WORKMEN'S COMP QUESTIONAIRE TO CONSIDER PAYMENT
F09	PR	A1	N179	DENIED.LABOR FUND REQUESTED CLAIM FORM.UPON RECEIPT WILL CONSIDER PAYMNT
F10	PR	A1	N29	DENIED.LABOR FUND REQUESTS PHYSICAL THERAPY NOTES TO CONSIDER PAYMENT.
F11	PR	A1	N179	DENIED. LABOR FUND REQUESTS ELIGIBILITY INFORMATION TO CONSIDER PAYMENT.
F12	PR	A1	N179	DENIED. LABOR FUND REQUESTS MARRIAGE CERTIFICATE TO CONSIDER PAYMENT.
F13	PR	A1	N179	DENIED. LABOR FUND REQUESTS STUDENT CERTIFICATION TO CONSIDER PAYMENT.
F14	PR	A1	N179	DENIED. LABOR FUND REQUESTS BIRTH CERTIFICATE TO CONSIDER PAYMENT.
F15	PR	A1	N179	DENIED.LABOR FUND REQUESTS INFO FROM MEMBER RE: EMPLOYER CONTRIBUTIONS.
F16	PR	A1	N29	DENIED. LABOR FUND REQUESTS MEDICAL RECORDS TO CONSIDER FOR PAYMENT.

F17	PR	A1	N179	DENIED. LABOR FUND REQUEST TPL INFORMATION TO CONSIDER FOR PAYMENT.
G01	CO	B13		GMIS-CHGE EXACT DUPLICAT OF CHGE ALREADY PROCESSED-PT CANNOT BE BILLED
G02	PR	B13		GMIS-CHGE EXACT DUP OF ALREADY PROCESSED CHGE,-PT NOTIFIED
G03	CO	97		GMIS-PMT INCLUDED IN ALLOWANCE FOR PRIM SERV,-PT NOT RESPONSIBLE
G04	PR	97		GMIS-PMT INCLUDED IN ALLOWACE FOR PRIM SERV,-PT NOTIFIED
G05	CO	97		GMIS-SEPARATELY BILLED SERV HAVE BEEN REBUNDLED-PT CANNOT BE BILLED
G06	PR	97		GMIS-SEPARATELY BILLED SERV HAVE BEEN REBUNDLED-PT NOTIFIED
G07	CO	97		GMIS-SERV ARE MUTUALLY EXCLUSIVE-PT CANNOT BE BILLED
G08	PR	45		GMIS-SERV ARE MUTUALLY EXCLUSIVE-PT NOTIFIED
G09	CO	97		SEPARATE CHARGE NOT ALLOWED, INCLUDED IN ANOTHER SRVC. PT CANNOT BE BILL
G10	PR	96	N130	NON-PARTICIPATING POST OPERATIVE
G11	CO	96	N130	PARTICIPATING PRE-OPERATIVE
G12	PR	96	N130	NON-PARTICIPATING PRE-OPERATIVE
G13	CO	97		GMIS-A SEPARATE CHGE IS NOT ALLOWED, IS INCLUDED IN ANOTHER SERVICE
G14	PR	97		GMIS-A SEPARATE CHGE IS NOT ALLOWED, IS INCLUDED IN ANOTHER SERVICE
G15	CO	4	N519	This procedure code is not recommended for reimbursement
G16	PR	4	N519	This procedure code/modifer combination is invalid
G17	CO	7		This code submitted is inappropriate for the patient's gender (PPO Provider)
G18	PR	7		This code submitted is inappropriate for the patient's gender (Non PPO Provider)
G19	CO	6		This code submitted is inappropriate for the patient's age (PPO Provider)
G20	PR	6		This code submitted is inappropriate for the patient's age (Non PPO Provider)
LCH	OA	B13		LATE CHARGE BILLED ON THE UB92 CLAIM FORM
LCI	PR	129		INPATIENT LATE CHAREG BILL, NO ORIGINAL CLAIM ON FILE
SAJ	CO	B13		LABOR FUND-POSSIBLE ADJUSTMENT OF PREVIOUSLY FINALIZED CLAIM
SDU	CO	18		LABOR FUND-SUSPECTED DUPLICATE CHARGE.
T43	PR	38		CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE
T58	PR	45		CHARGE EXCEEDS MULTIPLE IMAGING PRICED AMOUNT. NON PAR. PT. RESPONSIBLE
T59	CO	45		CHARGE EXCEED MULTIPLE IMAGING PRICED AMOUNT. PT NOT RESPONSIBLE.
T61	CO	B5		Service is not billable with multiple units. Provider is Participating. Patient is not responsible for charges over the allowed amount. EFFECTIVE 7/16/2012
T62	PR	B5		Service is not billable with multiple units. Provider is Non- Participating. Patient is responsible for charges over the allowed amount. EFFECTIVE 7/16/2012

B. 835 Institutional – Sample Claims

Sample (1)

Institutional w/1 line of service. Coinsurance applied

```
Total charge $244.50
BCBSIL Discount $ 98.29
Coinsurance amt $29.24
Total Eligible/Payable Amount $244.50
----------------------------------------------------------

BPR*I*116.97*C*CHK************20120213~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120213~
N1*PR*UNKNOWN UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*LOYOLA UNIVERSITY MEDICAL CENTER*XX*1376521575~
N3*P O BOX 95009~
N4*CHICAGO*IL*606940000~
REF*1A*0000000500~
REF*TJ*364015560~
LX*1~
CLP*0000000500*1*244.5*116.97**15*02012001234594P0X00*13*1~
NM1*QC*1*UNKNOWN*UNKNOWN*R***MI*123456789~
NM1*IL*1*UNKNOWN*UNKNOWN*R***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:73610:RT*244.5*116.97*00320*1~
DTM*150*20111226~
DTM*151*20111226~
CAS*CO*45*98.29~ BCBSIL Discount Amount
CAS*PR*2*29.24~ Coinsurance Amount applied
AMT*B6*244.5~Total Eligible/Payable Amount
```

Sample (2)

Institutional w/Mult lines of services. Deduct. & Copay applied

```
Total charge $640.00
BCBSIL Discount $487.03
Deductible Amt $15.06
Copay Amt $15.54
Total Eligible/Payable Amount $640.00
----------------------------------------------------------

BPR*I*122.37*C*CHK************20120213~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120213~
N1*PR*UNKNOWN UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*EDWARD HOSPITAL*XX*1427069632~
N3*801 S WASHINGTON~
N4*NAPERVILLE*IL*605400000~
REF*1A*0000000312~
REF*TJ*363297173~
LX*1~
CLP*0000000312*1*640*122.37**15*020121234562E330X00*13*1~
NM1*QC*1*UNKNOWN*UNKNOWN*M***MI*123456789~
NM1*IL*1*UNKNOWN*UNKNOWN*W***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:73140*315*60.23*00320*1~
DTM*150*20111230~
DTM*151*20111230~
CAS*CO*45*239.71~ BCBSIL Discount Amount
CAS*PR*1*15.06~ Deductible Amount applied
AMT*B6*315~ Total Eligible/Payable Amount
SVC*HC:99203:25*325*62.14*00526*1~
DTM*150*20111230~
DTM*151*20111230~
CAS*CO*45*247.32~ BCBSIL Discount Amount
CAS*PR*3*15.54~ CoPay Amount applied
AMT*B6*325~ Total Eligible/Payable Amount
```

Sample (3)

Institutional w/Multiple lines of service. Full Denial

```
Total charge $875.25
BCBSIL Discount $0
Total Eligible/Payable Amount $0
----------------------------------------------------------

BPR*I*0*C*CHK************20120213~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120213~
N1*PR*UNKNOWN UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*CENTEGRA HOSPITAL MCHENRY*XX*1982611281~
N3*P O BOX 1570~
N4*MCHENRY*IL*600510000~
REF*1A*0000000319~
REF*TJ*362338884~
LX*1~
CLP*0000000319*1*875.25*0**15*020120012345D560X00*13*1~
NM1*QC*1*UNKNOWN*UNKNOWN*R***MI*123456789~
NM1*IL*1*UNKNOWN*UNKNOWN*R***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:72040*448.5*0*00320*1~
DTM*150*20111226~
DTM*151*20111226~
CAS*PR*119*448.50~ Total Ineligible Amount (see 835 companion guide for
      correct denial reason)
CAS*CO*45*0~ BCBSIL Discount Amount
AMT*B6*0~ Total Eligible/Payable Amount
REF*RB*400~ Ineligible Reason Code
SVC*HC:72072*426.75*0*00320*1~
DTM*150*20111226~
DTM*151*20111226~
CAS*PR*119*426.75~ Total Ineligible Amount (see 835 companion guide for
      correct denial reason)
CAS*CO*45*0~ BCBSIL Discount Amount
AMT*B6*0~ Total Eligible/Payable Amount
REF*RB*400~ Ineligible Reason Code
```

Sample (4)

Institutional w/Mult. lines of service. All elig. dollars Paid

```
Total charge $289.50
BCBSIL Discount $0
Total Eligible/Payable Amount $289.50
----------------------------------------------------------

BPR*I*145.91*C*CHK************20120213~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120213~
N1*PR*UNKNOWN UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*CENTRAL DUPAGE HOSPITAL*XX*1003864810~
N3*DEPT 4698~
N4*CAROL STREAM*IL*601220000~
REF*1A*0000000363~
REF*TJ*362513909~
LX*1~
CLP*0000000363*1*289.5*145.91**15*0201200123657Y80X00*13*1~
NM1*QC*1*UNKNOWN*UNKNOWN*M***MI*123456789~
NM1*IL*1*UNKNOWN*UNKNOWN*M***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*NU:00272*18*9.07**1~
DTM*150*20111221~
DTM*151*20111221~
CAS*CO*45*8.93~BCBSIL Discount Amount
AMT*B6*18~ Total Eligible/Payable Amount
SVC*HC:99214:25*271.5*136.84*00516*1~
DTM*150*20111221~
DTM*151*20111221~
CAS*CO*45*134.66~ BCBSIL Discount Amount
AMT*B6*271.5~ Total Eligible/Payable Amount
```

Sample (5)

Institutional w/Mult. lines of service. Deduct., Coins. & Copay applied

Total charge $3460.00
BCBSIL Discount $642.27
Coinsurance Amount $119.66
Deductible Amount $563.37
Copay Amount $27.56
Total Eligible/Payable Amount $3460.00

```
BPR*I*642.27*C*CHK************20120213~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120213~
N1*PR*UNKNOWN UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*ADVOCATE CONDELL MEDICAL CENTER*XX*1124272547~
N3*801 S MILWAUKEE AVE~
N4*LIBERTYVILLE*IL*600480000~
REF*1A*0000051046~
REF*TJ*262525968~
LX*1~
CLP*0000051046*1*3460*642.27**15*0201201050V09240X00*13*1~
NM1*QC*1*UNKNOWN*UNKNOWN*T***MI*123456859~
NM1*IL*1*UNKNOWN*UNKNOWN*T***MI*123456859~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*NU:00250*96*30.03**1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*58.46~ BCBSIL Discount Amount
CAS*PR*3*7.51~ CoPay Amount applied
AMT*B6*96~ Total Eligible/Payable Amount
SVC*HC:96361*171*53.49*00260*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*104.14~ BCBSIL Discount Amount
CAS*PR*1*13.37~ Deductible Amount applied
AMT*B6*171~ Total Eligible/Payable Amount
SVC*HC:99285:25*1663*80.18*00450*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*1012.77~ BCBSIL Discount Amount
CAS*PR*1*550~ Deductible Amount applied
CAS*PR*3*20.05~ CoPay Amount applied
AMT*B6*1663~ Total Eligible/Payable Amount
SVC*HC:96375*624*195.18*00450*3~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*380.02~ BCBSIL Discount Amount
```

```
CAS*PR*2*48.8~ CoPay Amount applied
AMT*B6*624~ Total Eligible/Payable Amount
SVC*HC:96374*243*76.01*00450*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*147.99~ BCBSIL Discount Amount
CAS*PR*2*19~ Coinsurance Amount applied
AMT*B6*243~ Total Eligible/Payable Amount
SVC*HC:96372*147*45.98*00450*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*89.52~ BCBSIL Discount Amount
CAS*PR*2*11.5~ Coinsurance Amount applied
AMT*B6*147~ Total Eligible/Payable Amount
SVC*HC:J2930*118*36.91*00636*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*71.86~ BCBSIL Discount Amount
CAS*PR*2*9.23~ Coinsurance Amount applied
AMT*B6*118~ Total Eligible/Payable Amount
SVC*HC:J1200*104*32.53*00636*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*63.34~ BCBSIL Discount Amount
CAS*PR*2*8.13~ Coinsurance Amount applied
AMT*B6*104~ Total Eligible/Payable Amount
SVC*HC:J2405*101*31.59*00636*4~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*61.51~ BCBSIL Discount Amount
CAS*PR*2*7.9~ Coinsurance Amount applied
AMT*B6*101~ Total Eligible/Payable Amount
SVC*HC:J0171*97*30.34*00636*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*59.07~ BCBSIL Discount Amount
CAS*PR*2*7.59~ Coinsurance Amount applied
AMT*B6*97~ Total Eligible/Payable Amount
SVC*HC:J7030*96*30.03*00636*1~
DTM*150*20120101~
DTM*151*20120101~
CAS*CO*45*58.46~ BCBSIL Discount Amount
CAS*PR*2*7.51~ Coinsurance Amount applied
AMT*B6*96~ Total Eligible/Payable Amount
```

Sample (6)

Institutional w/1 Line of service. Pended claim

Total charge $1327.00
BCBSIL Discount $0
Total Eligible/Payable Amount $0

```
BPR*I*0*C*CHK************20120213~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120213~
N1*PR*UNKNOWN UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*RESURRECTION HOSPITAL*XX*1205923539~
N3*P O BOX 220281~
N4*CHICAGO*IL*606220000~
REF*1A*0000000269~
REF*TJ*363330926~
LX*1~
CLP*0000000269*1*1327*0**15*020122131024H123X00*13*1~
NM1*QC*1*UNKNOWN UNKNOWN*UNKNOWN*H***MI*123456789~
NM1*IL*1*UNKNOWN UNKNOWN*UNKNOWN*H***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*252   338~
SVC*HC:93880*1327*0*00921*1~
DTM*150*20120104~
DTM*151*20120104~
AMT*B6*1327~
```

Sample (7)

Institutional denial for Coverage Expiration date

```
Coverage Date required:  DTM w/036
Ineligible Reason:       CAS W/PR
Ineligible Reason Code:  011

-----------------------------------------------------

BPR*I*0*C*CHK************20111117~
TRN*1*N000001176*1362141703~
REF*EV*BCBSI 5010~
DTM*405*20111118~
N1*PR*UNKNOWN UNKNOWN*XV*460483581~
N3*LOCAL 597*45 N. OGDEN AVENUE~
N4*CHICAGO*IL*606071885~
PER*BL*UNKNOWN UNKNOWN*UNKNOWN@125.ORG~
N1*PE*CENTRAL DUPAGE HOSPITAL*XV*362513909~
N3*25 NORTH WINFIELD RD~
N4*WINFIELD*IL*601901234~
REF*TJ*362513909~
LX*3~
CLP*SCPINPATMATNTYMTHER*1*5381.50*0*185.00*12*0201123650P32110X00~
NM1*QC*1*UNKNOWN UNKNOWN*M****MI*123456789~
NM1*IL*1*UNKNOWN UNKNOWN*M****MI*123456789~
REF*1A*0000000363~
REF*1L*000PXXXXX~
REF*CE*1~
DTM*036*20110907~ Coverage Date
SVC*NU:0170*2490.00*0**1~
DTM*472*20110908~
CAS*PR*27*2490~ Ineligible Reason
AMT*B6*0~
REF*RB*011~ Ineligible Reason Code
```

Sample (8)

Institutional w/Mult.lines of service. Over Semi Room Rate applied

Total charge $1590.00
BCBSIL Discount $169.74.27
Over Semi Room Rate/Ineligible Amt $900.00

```
------------------------------------------------------
BPR*I*520.26*C*CHK************20111117~
TRN*1*1*1362951116~
REF*EV*LABOR~
N1*PR*UNKNOWN UNKNOWN~
N3*28600 Bella Vista Pkwy. Ste. 1110~
N4*Warrenville*IL*605551600~
PER*BL*UNKNOWN UNKNOWN*TE*4107721522~
N1*PE*PROVENA HOSPICE URBANA*XX*1407893282~
N3*9223 W ST FRANCIS RD~
N4*FRANKFORT*IL*604238330~
REF*TJ*460483581~
REF*1A*0000050607~
LX*1~
CLP*1*1*1590.00*520.26**12*0201027123457560C00*99*1~
NM1*QC*1*UNKNOWN*UNKNOWN*M***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
DTM*232*20111028~
SVC*NU:110*1200.00*226.20~
DTM*150*20110106~
CAS*PR*45*900~ Ineligible Amount for Over Semi Room Rate
CAS*CO*45*73.80~  Discount Amt
REF*RB*406~ Over Semi Room Rate
AMT*B6*300~ Total Eligible/Payable amount
SVC*NU:656*195.00*147.03~
DTM*150*20110106~
CAS*CO*45*47.97~Discount Amt
AMT*B6*195~Total Eligible/Payable amount
SVC*NU:656*195.00*147.03~
DTM*150*20110106~
CAS*CO*45*47.97~Discount Amt
AMT*B6*195~Total Eligible/Payable amount
```

C. 835 Professional – Sample Claims

Sample (1)

Professional w/1 line of service. Paid w/Over PPO Allowance sent on 837 record (reference HCP03 & PWK)

```
Total Charge $390.00
Over PPO Allowance $245.00
Deductible applied $132.30
Coinsurance applied $2.54
Total Eligible/Payable Amount $145.00
-------------------------------------------------

BPR*I*10.16*C*CHK************20120209~
TRN*1*1*1000000001~
REF*EV*BCBSIL 5010~
DTM*405*20120209~
N1*PR*UNKNOWN SAMPLE*XV*000000001~
N3*300 W. Plainfield~
N4*Country Side*IL*60525~
PER*BL*UNKNOWN SAMPLE*TE*8123109190*EM*UNKNOWN@datagrove.com~
N1*PE*DMG HEALTH PARTNERS*XX*1801833983~
N3*1860 PAYSPHERE CIRCLE~
N4*CHICAGO*IL*606740018~
REF*1B*0002215161~
REF*TJ*362657618~
LX*1~
CLP*0002215161*1*390*10.16**15*0201201850V12340X00*99*1~
NM1*QC*1*UNKNOWN*SAMPLE****MI*123456789~
NM1*IL*1*UNKNOWN*SAMPLE****MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:77080*390*10.16**1~
DTM*150*20120116~
DTM*151*20120116~
CAS*CO*45*245~ Over PPO Allowance
CAS*PR*1*132.3~ Deductible amt
CAS*PR*2*2.54~ Coinsurance amt
REF*RB*503~ (837 PWK ineligible reason code: Over PPO Allowance
      indicator)
AMT*B6*145~ Total eligible/Payable Amount
```

Sample (2)

Professional w/1 line of service. Full Denial

```
Total Charge $50.00
Total Ineligible Amount $50.00 (must returned CAS segment: reference
      835 companion guide)
Total Eligible/Payable Amount $0 Due to denial
---------------------------------------------------

BPR*H*0*C*NON************20120209~
TRN*1*1*1000000001~
REF*EV*BCBSIL 5010~
DTM*405*20120209~
N1*PR*UNKNOWN*XV*000000001~
N3*500 W. Plainfield~
N4*Country Side*IL*60525~
PER*BL*UNKNOWN Sample*TE*8234109190*EM*UNKNOWN@datagrove.com~
N1*PE*CHEELY CHIROPRACTIC CLINIC LTD*XX*1801929716~
N3*131 N  BELLWOOD DR   STE  D~
N4*EAST  ALTON*IL*620242088~
REF*1B*0006082035~
REF*TJ*364132836~
LX*1~
CLP*0006082035*4*50*0**15*02012015123S4490X00*99*1~
NM1*QC*1*UNKNOWN*SAMPLE****MI*123456789~
NM1*IL*1*UNKNOWN*SAMPLE****MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:98941:52*50*0**1~
DTM*150*20120106~
DTM*151*20120106~
CAS*PR*31*50~ All dollars considered Ineligible must reference 835
      companion guide for correction code
REF*RB*015~ Ineligible Reason Code
AMT*B6*0~ Total eligible/Payable Amount
```

Sample (3)

Professional w/1 line of service. Reduced 837 Eligible/Payable Amt

```
Total Charge $190.00
Over PPO Allowance $40.00
Total Ineligible Amount $10.00 (must returned CAS segment: reference
      835 companion guide)
Reduced due to over max amount for services
Total Eligible/Payable Amount $140.00

-----------------------------------------------------
BPR*H*140*C*NON***********20120209~
TRN*1*1*1000000001~
REF*EV*BCBSIL 5010~
DTM*405*20120209~
N1*PR*UNKNOWN Sample*XV*000000001~
N3*600 W. Plainfield~
N4*Country Side*IL*60525~
PER*BL*UNKNOWN Sample*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*MERCY HEALTH SYSTEM CORPORATION*XX*1234718603~
N3*1000 MINERAL POINT AVENUE~
N4*JANESVILLE*WI*535482940~
REF*1B*0005621473~
REF*TJ*390816848~
LX*1~
CLP*0005621473*1*190*140**15*02012011234561J0X00*99*1~
NM1*QC*1*UNKNOWN*SAMPLE****MI*123456789~
NM1*IL*1*UNKNOWN*SAMPLE****MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:99213*190*140**1~
DTM*150*20120109~
DTM*151*20120109~
CAS*CO*45*40~ Over PPO Allowance
CAS*PR*119*10~ Ineligible Amount additional dollars reduced by Fund
REF*RB*503~ (837 PWK ineligible reason code: Over PPO Allowance
      indicator)
REF*RB*400~ Ineligible reason code for additional dollars (see
      CAS*PR*119)
AMT*B6*140~ Total eligible/Payable Amount.  Original amount $150.00 but
      reduced by Maximum amount $10.00 new amount $140.00
```

Sample (4)

Professional w/2 line of service. Paid at 100%

Total Charge $350.00
Total Eligible/Payable Amount $350.00

```
---------------------------------------------------------
BPR*I*350*C*CHK************20120203~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120203~
N1*PR*UNKNOWN Sample*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*NORTHWEST COMMUNITY HEALTH SVCS*XX*1134433154~
N3*25233 NETWORK PLACE~
N4*CHICAGO*IL*606730000~
REF*1B*0001601644~
REF*TJ*363312906~
LX*1~
CLP*0001601644*1*350*350**15*02012045696236L0X00*99~
NM1*QC*1*UNKNOWN*SAMPLE*M***MI*123456789~
NM1*IL*1*UNKNOWN*SAMPLE*M***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
AMT*AU*350~
SVC*HC:99396:25*270*270**1~
DTM*150*20120110~
DTM*151*20120110~
AMT*B6*270~ Total Eligible/Payable Amount $270.00
SVC*HC:93000*80*80**1~
DTM*150*20120110~
DTM*151*20120110~
AMT*B6*80~ Total Eligible/Payable Amount $80.00
```

Sample (5)

Professional w/Multiple lines. Reduced 837 Eligible/Payable Amt W/Coin

```
Total Charge $120.00
Over PPO Allowance $76.00
Total Ineligible Amount $12.50 (must returned CAS segment: reference
      835 companion guide)
Reduced due to over max amount for services
Total Eligible/Payable Amount $140.00

--------------------------------------------------------
ST*835*0394~
BPR*I*15.2*C*CHK************20120203~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120203~
N1*PR*UNKNOWN SAMPLE*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN SAMPLE*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*MCHENRY COUNTY ORTHOPAEDICS S C*XX*1922292663~
N3*420 N ROUTE 31~
N4*CRYSTAL LAKE*IL*600120000~
REF*1B*0005619608~
REF*TJ*363892041~
LX*1~
CLP*0005619608*1*120*15.2**15*0201201741824200C00*99*1~
NM1*QC*1*UNKNOWN*SAMPLE*J***MI*123456789~
NM1*IL*1*UNKNOWN*SAMPLE*K***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:97140:GP*65*4**1~
DTM*150*20111228~
DTM*151*20111228~
CAS*CO*45*35~Over PPO Allowance
CAS*PR*119*20~Ineligible Amount additional dollars reduced by Fund
CAS*PR*2*6~ Applied Coinsurance amount
REF*RB*503~(837 PWK ineligible reason code: Over PPO Allowance
      indicator)
REF*RB*400~ Ineligible reason code for additional dollars (see
      CAS*PR*119)
AMT*B6*10~ Total eligible/Payable Amount.  Original amount $30.00 but
           reduced by Maximum amount $20.00 new amount $10.00
SVC*HC:97035:GP*55*11.2**1~
DTM*150*20111228~
DTM*151*20111228~
CAS*CO*45*41~Over PPO Allowance
CAS*PR*2*2.8~ Applied Coinsurance Amount
REF*RB*503~(837 PWK ineligible reason code: Over PPO Allowance
      indicator)
AMT*B6*14~Total eligible/Payable Amount.
```

Sample (6)

Professional w/Multiple lines. Service Line payment and denials

```
Total Charge $289.00
Total Ineligible Amount $182.00 (must returned CAS segment: reference
      835 companion guide)
Lines 1 thru 4 payable
Lines 5 thru 6 denied due to service duplication previously submitted

---------------------------------------------------

PR*I*85.6*C*CHK***********20120203~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120203~
N1*PR*UNKNOWN*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN SAMPLE*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*TEAM DOCTORS P C*XX*1336364140~
N3*6432 S PULASKI ROAD~
N4*CHICAGO*IL*606290000~
REF*1B*0001632028~
REF*TJ*364482189~
LX*1~
CLP*0001632028*1*289*85.6**15*0201201456985670C00*99*1~
NM1*QC*1*UNKNOWN*SAMPLE*A***MI*123456789~
NM1*IL*1*UNKNOWN*SAMPLE*A***MI*123456789~
REF*1L*000PXXXXX~
REF*CE*1~
SVC*HC:98942*77*41.6**1~
DTM*150*20110924~
DTM*151*20110924~
CAS*CO*45*25~Over PPO Allowance
CAS*PR*2*10.4~Applied Coinsurance Amount
REF*RB*503~(837 PWK ineligible reason code: Over PPO Allowance
      indicator)
AMT*B6*52~Total eligible/Payable Amount.
SVC*HC:98943*48*22.4**1~
DTM*150*20110924~
DTM*151*20110924~
CAS*CO*45*20~Over PPO Allowance
CAS*PR*2*5.6~Applied Coinsurance Amount
REF*RB*503~(837 PWK ineligible reason code: Over PPO Allowance
      indicator)
AMT*B6*28~Total eligible/Payable Amount.
SVC*HC:97012*41*13.6**1~
DTM*150*20110924~
DTM*151*20110924~
CAS*CO*45*24~Over PPO Allowance
CAS*PR*2*3.4~Applied Coinsurance Amount
REF*RB*503~(837 PWK ineligible reason code: Over PPO Allowance
      indicator)
AMT*B6*17~Total eligible/Payable Amount.
SVC*HC:97014*41*8**1~
DTM*150*20110924~
```

```
DTM*151*20110924~
CAS*CO*45*31~Over PPO Allowance
CAS*PR*2*2~Applied Coinsurance Amount
REF*RB*503~(837 PWK ineligible reason code: Over PPO Allowance
      indicator)
AMT*B6*10~Total eligible/Payable Amount.
SVC*HC:97012*41*0**1~
DTM*150*20110926~
DTM*151*20110926~
CAS*OA*18*41~All dollars considered Ineligible must reference 835
      companion guide for correction code
REF*RB*129~ Ineligible Reason code
SVC*HC:97014*41*0**1~
DTM*150*20110926~
DTM*151*20110926~
CAS*OA*18*41~All dollars considered Ineligible must reference 835
      companion guide for correction code
REF*RB*129~Ineligible Reason code
```

Sample (7)

Professional Pended claim by Fund: Pended claim. Fund must use internal pend codes

```
BPR*H*0*C*NON************20120203~
TRN*1*1*1000000001~
REF*EV*BCBSI 5010~
DTM*405*20120203~
N1*PR*UNKNOWN SAMPLE*XV*000000001~
N3*12 East Erie Street~
N4*Chicago*IL*60611~
PER*BL*UNKNOWN SAMPLE*TE*8569109190*EM*UNKNOWN@datagrove.com~
N1*PE*SPECIAL CARE ORTHOPEDICS AND*XX*1972629376~
N3*675 W NORTH AVE*STE 607~
N4*MELROSE PARK*IL*601600000~
REF*1B*0001629113~
REF*TJ*364340337~
LX*1~
CLP*0001629113*1*95*0**15*020125698000W330X00*99~
NM1*QC*1*UNKNOWN*SAMPLE*M***MI*987654321~
NM1*IL*1*UNKNOWN*SAMPLE*M***MI*987654321~
REF*1L*000PXXXXX~
REF*CE*2471  345~
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LQ*HE*     N130~
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