



837 Health Care Claim: Professional

HIPAA/V4010X098A1/837 : 837 Health Care Claim: Professional

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Notes

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N 837 Health Care Claim: Professional transaction set addenda Implementation Guide. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guide.

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Modifications:

2011-07-26 - V1.1 - Moved the State Specific Note from ISA09 to ISA08

2011-07-29 - V1.1 - In 2420C-NM108 for 2000B loop, changed State Specific Note from the value "LU" to "XX".

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837 Health Care Claim: Professional

Functional Group=HC

Purpose: This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.

Not Defined:

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

Heading:

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

Detail:

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
LOOP ID - 2000A					<u>>1</u>		
003	PRV	Billing/Pay-to Provider Specialty Information	O	1			Situational
LOOP ID - 2010AA					<u>1</u>	<u>N2/015L</u>	
015	NM1	Billing Provider Name	O	1		N2/015	Required
035	REF	Billing Provider Secondary Identification	O	8			Situational
LOOP ID - 2010AB					<u>1</u>	<u>N2/015L</u>	
015	NM1	Pay-to Provider Name	O	1		N2/015	Situational
035	REF	Pay-to-Provider Secondary Identification	O	5			Situational
LOOP ID - 2000B					<u>>1</u>		
LOOP ID - 2010BA					<u>1</u>	<u>N2/015L</u>	
015	NM1	Subscriber Name	O	1		N2/015	Required
LOOP ID - 2300					<u>100</u>		

<u>Pos</u>	<u>Id</u>	<u>Segment Name</u>	<u>Req</u>	<u>Max Use</u>	<u>Repeat</u>	<u>Notes</u>	<u>Usage</u>
130	CLM	Claim Information	O	1			Required
180	REF	Prior Authorization or Referral Number	O	2			Situational
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational
231	HI	Health Care Diagnosis Code	O	1			Situational
<u>LOOP ID - 2310A</u>					<u>2</u>	<u>N2/250L</u>	
250	NM1	Referring Provider Name	O	1		N2/250	Situational
271	REF	Referring Provider Secondary Identification	O	5			Situational
<u>LOOP ID - 2310B</u>					<u>1</u>	<u>N2/250L</u>	
250	NM1	Rendering Provider Name	O	1		N2/250	Situational
271	REF	Rendering Provider Secondary Identification	O	5			Situational
<u>LOOP ID - 2310D</u>					<u>1</u>	<u>N2/250L</u>	
250	NM1	Service Facility Location	O	1		N2/250	Situational
271	REF	Service Facility Location Secondary Identification	O	5			Situational
<u>LOOP ID - 2320</u>					<u>10</u>	<u>N2/290L</u>	
290	SBR	Other Subscriber Information	O	1		N2/290	Situational
<u>LOOP ID - 2400</u>					<u>50</u>	<u>N2/365L</u>	
455	DTP	Date - Service Date	O	1			Required
470	REF	Prior Authorization or Referral Number	O	2			Situational
<u>LOOP ID - 2410</u>					<u>25</u>	<u>N2/494L</u>	
494	LIN	Drug Identification	O	1		N2/494	Situational
<u>LOOP ID - 2420A</u>					<u>1</u>	<u>N2/500L</u>	
500	NM1	Rendering Provider Name	O	1		N2/500	Situational
525	REF	Rendering Provider Secondary Identification	O	5			Situational
<u>LOOP ID - 2420B</u>					<u>1</u>	<u>N2/500L</u>	
500	NM1	Purchased Service Provider Name	O	1		N2/500	Situational
525	REF	Purchased Service Provider Secondary Identification	O	5			Situational
<u>LOOP ID - 2420C</u>					<u>1</u>	<u>N2/500L</u>	
500	NM1	Service Facility Location	O	1		N2/500	Situational
525	REF	Service Facility Location Secondary Identification	O	5			Situational
<u>LOOP ID - 2420F</u>					<u>2</u>	<u>N2/500L</u>	
500	NM1	Referring Provider Name	O	1		N2/500	Situational
525	REF	Referring Provider Secondary Identification	O	5			Situational

Notes:

- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
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- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
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- 2/250 Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/290L Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.
- 2/290 Loop 2320 contains insurance information about: paying and other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber.
- 2/365L Loop 2400 contains Service Line information.
- 2/494L Loop 2410 contains compound drug components, quantities and prices.
- 2/494 Loop 2410 contains compound drug components, quantities and prices.
- 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.
- 2/500 Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

Guideline Note 1:

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

ISA Interchange Control Header

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

User Option (Usage): Required

Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Element Summary:

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

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

CodeList Summary (Total Codes: 7, Included: 2)

Code Name

00 No Authorization Information Present (No Meaningful Information in I02)

03 Additional Data Identification

ISA02	I02	Authorization Information	M	AN	10/10	Required
-------	-----	----------------------------------	---	----	-------	----------

Description: Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)

ISA03	I03	Security Information Qualifier	M	ID	2/2	Required
-------	-----	---------------------------------------	---	----	-----	----------

Description: Code to identify the type of information in the Security Information

CodeList Summary (Total Codes: 2, Included: 2)

Code Name

00 No Security Information Present (No Meaningful Information in I04)

01 Password

ISA04	I04	Security Information	M	AN	10/10	Required
-------	-----	-----------------------------	---	----	-------	----------

Description: This is used for identifying the security information about the interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

ISA05	I05	Interchange ID Qualifier	M	ID	2/2	Required
-------	-----	---------------------------------	---	----	-----	----------

Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified

Guideline Note 5: This ID qualifies the Sender in ISA06.

State Specific Note 1:

2009-10 - ND - Enter the value "ZZ".

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
CodeList Summary (Total Codes: 38, Included: 9)						
Code Name						
01 Duns (Dun & Bradstreet)						
14 Duns Plus Suffix						
20 Health Industry Number (HIN)						
27 Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)						
28 Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)						
29 Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)						
30 U.S. Federal Tax Identification Number						
33 National Association of Insurance Commissioners Company Code (NAIC)						
ZZ Mutually Defined						
ISA06	I06	Interchange Sender ID	M	AN	15/15	Required
Description: Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element						
State Specific Note 1:						
2009-10 - ND - Enter the 9-digit numeric vendor number assigned by DHS.						
ISA07	I05	Interchange ID Qualifier	M	ID	2/2	Required
Description: Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified						
Guideline Note 5: This ID qualifies the Receiver in ISA08.						
State Specific Note 1:						
2009-10 - ND - Enter the value "ZZ".						
CodeList Summary (Total Codes: 38, Included: 9)						
Code Name						
01 Duns (Dun & Bradstreet)						
14 Duns Plus Suffix						
20 Health Industry Number (HIN)						
27 Carrier Identification Number as assigned by Health Care Financing Administration (HCFA)						
28 Fiscal Intermediary Identification Number as assigned by Health Care Financing Administration (HCFA)						
29 Medicare Provider and Supplier Identification Number as assigned by Health Care Financing Administration (HCFA)						
30 U.S. Federal Tax Identification Number						
33 National Association of Insurance Commissioners Company Code (NAIC)						
ZZ Mutually Defined						
ISA08	I07	Interchange Receiver ID	M	AN	15/15	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p>Description: 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</p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "NDDHSMED".</p>				
ISA09	I08	Interchange Date	M	DT	6/6	Required
		<p>Description: Date of the interchange</p> <p>Guideline Note 5: <i>The date format is YYMMDD.</i></p>				
ISA10	I09	Interchange Time	M	TM	4/4	Required
		<p>Description: Time of the interchange</p> <p>Guideline Note 5: <i>The time format is HHMM.</i></p>				
ISA11	I10	Interchange Control Standards Identifier	M	ID	1/1	Required
		<p>Description: Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer</p> <p>CodeList Summary (Total Codes: 1, Included: 1)</p> <p>Code Name U U.S. EDI Community of ASC X12, TDCC, and UCS</p>				
ISA12	I11	Interchange Control Version Number	M	ID	5/5	Required
		<p>Description: Code specifying the version number of the interchange control segments</p> <p>CodeList Summary (Total Codes: 14, Included: 1)</p> <p>Code Name 00401 Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997</p>				
ISA13	I12	Interchange Control Number	M	NO	9/9	Required
		<p>Description: A control number assigned by the interchange sender</p> <p>Guideline Note 5: <i>The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.</i></p>				
ISA14	I13	Acknowledgment Requested	M	ID	1/1	Required
		<p>Description: Code sent by the sender to request an interchange acknowledgment (TA1)</p>				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
		<p>Guideline Note 5: See Section A.1.5.1 for interchange acknowledgment information.</p> <p>CodeList Summary (Total Codes: 2, Included: 2)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>0</td> <td>No Acknowledgment Requested</td> </tr> <tr> <td>1</td> <td>Interchange Acknowledgment Requested</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	0	No Acknowledgment Requested	1	Interchange Acknowledgment Requested				
<u>Code</u>	<u>Name</u>											
0	No Acknowledgment Requested											
1	Interchange Acknowledgment Requested											
ISA15	I14	Usage Indicator	M	ID	1/1	Required						
		<p>Description: Code to indicate whether data enclosed by this interchange envelope is test, production or information</p> <p>CodeList Summary (Total Codes: 3, Included: 2)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>P</td> <td>Production Data</td> </tr> <tr> <td>T</td> <td>Test Data</td> </tr> </tbody> </table>	<u>Code</u>	<u>Name</u>	P	Production Data	T	Test Data				
<u>Code</u>	<u>Name</u>											
P	Production Data											
T	Test Data											
ISA16	I15	Component Element Separator	M		1/1	Required						
		<p>Description: 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</p> <p>State Specific Note 1: 2009-10 - ND - ND prefers the ":" (colon) sign as the Composite Element Separator, the "*" (star) as the Element Separator, and the "~" (tilde) as the Segment Terminator.</p>										

Guideline Note 1:
 The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by '.' for clarity.

Guideline Note 2:
 ISA*00*.....*01*SECRET....*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*930602*1253*U*00401*000000905*1*T*~

GS Functional Group Header

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

User Option (Usage): Required

Purpose: To indicate the beginning of a functional group and to provide control information

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS01	479	Functional Identifier Code	M	ID	2/2	Required
<p>Description: Code identifying a group of application related transaction sets</p> <p>CodeList Summary (Total Codes: 240, Included: 1)</p> <p>Code Name HC Health Care Claim (837)</p>						
GS02	142	Application Sender's Code	M	AN	2/15	Required
<p>Description: Code identifying party sending transmission; codes agreed to by trading partners</p> <p>Guideline Note 5: Use this code to identify the unit sending the information.</p> <p>State Specific Note 1: 2009-10 - ND - Enter the 9-digit numeric vendor number assigned by DHS.</p>						
GS03	124	Application Receiver's Code	M	AN	2/15	Required
<p>Description: Code identifying party receiving transmission; codes agreed to by trading partners</p> <p>Guideline Note 5: Use this code to identify the unit receiving the information.</p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "NDDHSMED".</p>						
GS04	373	Date	M	DT	8/8	Required
<p>Description: Date expressed as CCYYMMDD</p> <p>Guideline Note 5: Use this date for the functional group creation date.</p>						
GS05	337	Time	M	TM	4/8	Required
<p>Description: Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD =</p>						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		hundredths (00-99) Guideline Note 5: Use this time for the creation time. The recommended format is HHMM.				
GS06	28	Group Control Number Description: Assigned number originated and maintained by the sender	M	NO	1/9	Required
GS07	455	Responsible Agency Code Description: Code identifying the issuer of the standard; this code is used in conjunction with Data Element 480 CodeList Summary (Total Codes: 2, Included: 1) Code Name X Accredited Standards Committee X12	M	ID	1/2	Required
GS08	480	Version / Release / Industry Identifier Code Description: 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 State Specific Note 1: 2009-10 - ND - Enter the value "004010X098A1". CodeList Summary (Total Codes: 48, Included: 1) Code Name 004010X09 8A1 Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.	M	AN	1/12	Required

Semantics:

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

Comments:

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

Guideline Note 2:
GS*HC*SENDER CODE*RECEIVER CODE*19940331*0802*1*X*004010X097~

ST Transaction Set Header

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

User Option (Usage): Required

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

Element Summary:

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

Description: Code uniquely identifying a Transaction Set

Guideline Note 5: *The only valid value within this transaction set for ST01 is 837.*

State Specific Note 1:

2009-10 - ND - Enter the value "837".

CodeList Summary (Total Codes: 298, Included: 1)

Code Name

837 Health Care Claim

ST02	329	Transaction Set Control Number	M	AN	4/9	Required
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Description: Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

Guideline Note 2: *Transaction Set Control Number*

Guideline Note 5: *The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.*

Semantics:

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

Guideline Note 2:

*ST*837*987654~*

REF Transmission Type Identification

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

User Option (Usage): Required

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

CodeList Summary (Total Codes: 1503, Included: 1)

Code Name

87 Functional Category

Description: An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc

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

Guideline Note 1: *Transmission Type Code*

Guideline Note 5: *When piloting the transaction set, this value is 004010X098DA1. When sending the transaction set in a production mode, this value is 004010X098A1.*

State Specific Note 2:

2009-10 - ND - Enter the value "004010X098A1".

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 2:

REF*87*004010X098A1~

PRV Billing/Pay-to Provider Specialty Information

Pos: 003	Max: 1
Detail - Optional	
Loop: 2000A	Elements: 3

User Option (Usage): Situational

Purpose: To specify the identifying characteristics of a provider

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
PRV01	1221	Provider Code	M	ID	1/3	Required

Description: Code identifying the type of provider

State Specific Note 1:

2009-10 - ND - Enter the value "BI" (Billing) or "PT" (Pay-To).

CodeList Summary (Total Codes: 26, Included: 2)

Code Name

BI Billing
PT Pay-To

PRV02	128	Reference Identification Qualifier	M	ID	2/3	Required
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Description: Code qualifying the Reference Identification

Guideline Note 5: ZZ is used to indicate the "Health Care Provider Taxonomy" code list (provider specialty code) which is available on the Washington Publishing Company web site:

<http://www.wpc-edi.com>. This taxonomy is maintained by the Blue Cross Blue Shield Association and ASC X12N TG2 WG15.

State Specific Note 1:

2009-10 - ND - Enter the value "ZZ" (Mutally Defined) provider taxonomy code list.

CodeList Summary (Total Codes: 1503, Included: 1)

Code Name

ZZ Mutually Defined

PRV03	127	Reference Identification	M	AN	1/30	Required
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Description: Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

Guideline Note 1: Provider Taxonomy Code

Guideline Note 2: Provider Specialty Code

Guideline Note 4: BA0-22.0

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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ExternalCodeList

Name: HCPT

Description: Health Care Provider Taxonomy

Guideline Note 1:

1. Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310B is not used.
2. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The PRV segment is then coded with the Rendering Provider in loop 2310B.
3. PRV02 qualifies PRV03.

Guideline Note 2:

PRV*BI*ZZ*203BA050N~

NM1 Billing Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AA	Elements: 8

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

State Specific Note 1:

2009-10 - ND - Enter the value "85" (Billing Provider).

CodeList Summary (Total Codes: 1312, Included: 1)

Code Name

85 Billing Provider

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

State Specific Note 1:

2009-10 - ND - Enter "1" (Person), "2" (Non-Person Entity).

CodeList Summary (Total Codes: 14, Included: 2)

Code Name

1 Person
2 Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
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Description: Individual last name or organizational name

Guideline Note 1: Billing Provider Last or Organizational Name

Guideline Note 2: Billing Provider Name

Guideline Note 4: BA0-18.0 or BA0-19.0

State Specific Note 1:

2009-10 - ND - Enter the individual's last name or the organization name.

NM104	1036	Name First	O	AN	1/25	Situational
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Description: Individual first name

Guideline Note 1: Billing Provider First Name

Guideline Note 2: Billing Provider Name

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 4: <i>BA0-20.0</i>				
		Guideline Note 5: <i>Required if NM102=1 (person).</i>				
NM105	1037	Name Middle	O	AN	1/25	Situational
		Description: Individual middle name or initial				
		Guideline Note 1: <i>Billing Provider Middle Name</i>				
		Guideline Note 2: <i>Billing Provider Name</i>				
		Guideline Note 4: <i>BA0-21.0</i>				
		Guideline Note 5: <i>Required if NM102=1 and the middle name/initial of the person is known.</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Guideline Note 1: <i>Billing Provider Name Suffix</i>				
		Guideline Note 2: <i>Billing Provider Name</i>				
		Guideline Note 5: <i>Required if known.</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		Guideline Note 5: <i>If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.</i>				
		State Specific Note 1: <i>2009-10 - ND - Enter the value "XX" (National Provider Identifier).</i>				
		CodeList Summary (Total Codes: 215, Included: 3)				
		Code Name				
		24 Employer's Identification Number				
		34 Social Security Number				
		XX Health Care Financing Administration National Provider Identifier				
		Description: <i>Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</i>				
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Guideline Note 1: <i>Billing Provider Identifier</i>				
		Guideline Note 2: <i>Billing Provider Primary Identification Number</i>				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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Guideline Note 4: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0

State Specific Note 1:
2009-10 - ND - Enter the provider's NPI.

ExternalCodeList

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Although the name of this loop/segment is "Billing Provider" the loop/segment really identifies the billing entity. The billing entity does not have to be a health care provider to use this loop. However, some payers do not accept claims from non-provider billing entities.

2. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

Guideline Note 2:

NM1*85*2*CRAMMER, DOLE, PALMER, AND JOHNSON*****24*111223333~

REF Billing Provider Secondary Identification

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "1J" (Facility ID) or "LU" (Location ID) .

CodeList Summary (Total Codes: 1503, Included: 18)

Code Name

- 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
- B3 Preferred Provider Organization Number
- BQ Health Maintenance Organization Code Number
Description: A unique number assigned to each individual Health Maintenance Organization (HMO) health insurance plan (assigned by the HMO)
- EI Employer's Identification Number
- FH Clinic Number
Description: A unique number identifying the clinic location that rendered services
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- G5 Provider Site Number
- LU Location Number
- SY Social Security Number
- U3 Unique Supplier Identification Number (USIN)
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Billing Provider Additional Identifier

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 2: Billing Provider Secondary Identification Number				
		Guideline Note 4: CA0-28.0, BA0-02.0, BA1-02.0, YA0-06.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, BA0-08.0, YA0-02.0				
		State Specific Note 1: 2009-10 - ND - If REF01 - "1J" or "LU", then enter the 9-digit Medicaid Provider ID.				

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

1. Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM108/9 in this loop.
2. If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/09 of this loop, then this REF is not used.
3. If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 8 times.

Guideline Note 2:

REF*1G*98765~

State Specific Note 1:

2009-10 - ND - In the case when a provider's NPI is mapped to multiple Medicaid provider id's, the State requires that the provider send a REF segment with values of "1J" or "LU" as defined in the REF segment.

NM1 Pay-to Provider Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010AB	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
NM101	98	Entity Identifier Code	M	ID	2/3	Required						
<p>Description: Code identifying an organizational entity, a physical location, property or an individual</p> <p>State Specific Note 1: 2009-10 - ND - Enter "87" (Pay-To Provider).</p> <p>CodeList Summary (Total Codes: 1312, Included: 1)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>87</td> <td>Pay-to Provider</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	87	Pay-to Provider		
<u>Code</u>	<u>Name</u>											
87	Pay-to Provider											
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required						
<p>Description: Code qualifying the type of entity</p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "1" (Person), or "2" (Non-Person).</p> <p>CodeList Summary (Total Codes: 14, Included: 2)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Person</td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	1	Person	2	Non-Person Entity
<u>Code</u>	<u>Name</u>											
1	Person											
2	Non-Person Entity											
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required						
<p>Description: Individual last name or organizational name</p> <p>Guideline Note 1: Pay-to Provider Last or Organizational Name</p> <p>Guideline Note 4: BA0-18.0 or BA0-19.0</p>												
NM104	1036	Name First	O	AN	1/25	Situational						
<p>Description: Individual first name</p> <p>Guideline Note 1: Pay-to Provider First Name</p> <p>Guideline Note 4: BA0-20.0</p> <p>Guideline Note 5: Required if NM102=1 (person).</p>												
NM105	1037	Name Middle	O	AN	1/25	Situational						

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>								
		<p>Description: Individual middle name or initial</p> <p>Guideline Note 1: Pay-to Provider Middle Name</p> <p>Guideline Note 4: BA0-21.0</p> <p>Guideline Note 5: Required if NM102=1 and the middle name/initial of the person is known.</p>												
NM107	1039	<p>Name Suffix</p> <p>Description: Suffix to individual name</p> <p>Guideline Note 1: Pay-to Provider Name Suffix</p> <p>Guideline Note 5: Required if known.</p>	O	AN	1/10	Situational								
NM108	66	<p>Identification Code Qualifier</p> <p>Description: Code designating the system/method of code structure used for Identification Code (67)</p> <p>Guideline Note 5: If "XX - NPI" is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop.</p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "XX".</p> <p>CodeList Summary (Total Codes: 215, Included: 3)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>24</td> <td>Employer's Identification Number</td> </tr> <tr> <td>34</td> <td>Social Security Number</td> </tr> <tr> <td>XX</td> <td>Health Care Financing Administration National Provider Identifier</td> </tr> </tbody> </table> <p>Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</p>	<u>Code</u>	<u>Name</u>	24	Employer's Identification Number	34	Social Security Number	XX	Health Care Financing Administration National Provider Identifier	C	ID	1/2	Required
<u>Code</u>	<u>Name</u>													
24	Employer's Identification Number													
34	Social Security Number													
XX	Health Care Financing Administration National Provider Identifier													
NM109	67	<p>Identification Code</p> <p>Description: Code identifying a party or other code</p> <p>Guideline Note 1: Pay-to Provider Identifier</p> <p>Guideline Note 2: Pay-to Provider Primary Identification Number</p> <p>Guideline Note 4: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0</p> <p>State Specific Note 1: 2009-10 - ND - Enter the National Provider Identifier (NPI).</p>	C	AN	2/80	Required								

ExternalCodeList**Name:** 537**Description:** Health Care Financing Administration National Provider Identifier**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Required if the Pay-to Provider is a different entity than the Billing Provider.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.

Guideline Note 2:

NM1*87*1*CRAMMER*JOSEPH****XX*09876543~

REF Pay-to-Provider Secondary Identification

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "1J" (Facility ID) or "LU" (Location ID) .

CodeList Summary (Total Codes: 1503, Included: 18)

Code Name

- 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
- B3 Preferred Provider Organization Number
- BQ Health Maintenance Organization Code Number
Description: A unique number assigned to each individual Health Maintenance Organization (HMO) health insurance plan (assigned by the HMO)
- EI Employer's Identification Number
- FH Clinic Number
Description: A unique number identifying the clinic location that rendered services
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- G5 Provider Site Number
- LU Location Number
- SY Social Security Number
- U3 Unique Supplier Identification Number (USIN)
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Pay-to Provider Identifier

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 2: <i>Pay-to Provider Additional Identifier</i>				
		Guideline Note 4: <i>BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0</i>				
		State Specific Note 1: <i>2009-10 - ND - If REF01 - "1J" or "LU", then enter the 9-digit Medicaid Provider ID.</i>				

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

1. *Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.*
2. *If "code XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in this REF. The number sent is the one which is used on the 1099. If additional numbers are needed the REF can be run up to 5 times.*

Guideline Note 2:

*REF*1G*98765~*

State Specific Note 1:

2009-10 - ND - In the case when a provider's NPI is mapped to multiple Medicaid provider id's, the State requires that the provider send a REF segment with values of "1J" or "LU" as defined in the REF segment.

NM1 Subscriber Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 8

User Option (Usage): Required

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>						
NM101	98	Entity Identifier Code	M	ID	2/3	Required						
<p>Description: Code identifying an organizational entity, a physical location, property or an individual</p> <p>CodeList Summary (Total Codes: 1312, Included: 1)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>IL</td> <td>Insured or Subscriber</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	IL	Insured or Subscriber		
<u>Code</u>	<u>Name</u>											
IL	Insured or Subscriber											
NM102	1065	Entity Type Qualifier	M	ID	1/1	Required						
<p>Description: Code qualifying the type of entity</p> <p>CodeList Summary (Total Codes: 14, Included: 2)</p> <table border="1"> <thead> <tr> <th><u>Code</u></th> <th><u>Name</u></th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Person</td> </tr> <tr> <td>2</td> <td>Non-Person Entity</td> </tr> </tbody> </table>							<u>Code</u>	<u>Name</u>	1	Person	2	Non-Person Entity
<u>Code</u>	<u>Name</u>											
1	Person											
2	Non-Person Entity											
NM103	1035	Name Last or Organization Name	O	AN	1/35	Required						
<p>Description: Individual last name or organizational name</p> <p>Guideline Note 1: <i>Subscriber Last Name</i></p> <p>Guideline Note 4: <i>CA0-04.0, DA0-19.0</i></p> <p>State Specific Note 1: <i>2009-10 - ND - Medicaid recipient last name.</i></p>												
NM104	1036	Name First	O	AN	1/25	Situational						
<p>Description: Individual first name</p> <p>Guideline Note 1: <i>Subscriber First Name</i></p> <p>Guideline Note 4: <i>CA0-05.0, DA0-20.0</i></p> <p>Guideline Note 5: <i>Required if NM102=1 (person).</i></p> <p>State Specific Note 1: <i>2009-10 - ND - Medicaid recipient first name.</i></p>												
NM105	1037	Name Middle	O	AN	1/25	Situational						
<p>Description: Individual middle name or initial</p>												

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p>Guideline Note 1: <i>Subscriber Middle Name</i></p> <p>Guideline Note 4: <i>CA0-06.0, DA0-21.0</i></p> <p>Guideline Note 5: <i>Required if NM102=1 and the middle name/initial of the person is known.</i></p> <p>State Specific Note 1: <i>2009-10 - ND - Medicaid recipient middle name/initial.</i></p>				
NM107	1039	<p>Name Suffix</p> <p>Description: Suffix to individual name</p> <p>Guideline Note 1: <i>Subscriber Name Suffix</i></p> <p>Guideline Note 2: <i>Subscriber Generation</i></p> <p>Guideline Note 4: <i>CA0-07.0, DA0-22.0</i></p> <p>Guideline Note 5: <i>Required if known.</i></p> <p><i>Examples: I, II, III, IV, Jr, Sr</i></p>	O	AN	1/10	Situational
NM108	66	<p>Identification Code Qualifier</p> <p>Description: Code designating the system/method of code structure used for Identification Code (67)</p> <p>Guideline Note 5: <i>Required if NM102 = 1 (person)</i></p> <p>CodeList Summary (Total Codes: 215, Included: 2)</p> <p>Code Name</p> <p>MI Member Identification Number</p> <p>ZZ Mutually Defined</p>	C	ID	1/2	Situational
NM109	67	<p>Identification Code</p> <p>Description: Code identifying a party or other code</p> <p>Guideline Note 1: <i>Subscriber Primary Identifier</i></p> <p>Guideline Note 4: <i>DA0-18.0, CA1-05.0, CA1-06.0</i></p> <p>Guideline Note 5: <i>Required if the Subscriber is the patient. If the subscriber is not the patient, use if known. An identifier must be present in either the subscriber or the patient loop.</i></p> <p>State Specific Note 1: <i>2009-10 - ND - Medicaid recipient identificaiton number.</i></p>	C	AN	2/80	Situational

Syntax Rules:

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

2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. *In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.*
2. *Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.*

Guideline Note 2:

*NM1*IL*1*DOE*JOHN*T**JR*MI*123456~*

CLM Claim Information

Pos: 130	Max: 1
Detail - Optional	
Loop: 2300	Elements: 12

User Option (Usage): Required

Purpose: To specify basic data about the claim

Element Summary:

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

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

Guideline Note 1: *Patient Account Number*

Guideline Note 4: *CA0-03.0, CB0-03.0, DA0-03.0, DA1-03.0, DA2-03.0, EA0-03.0, EA1- 03.0, EA2-03.0, FA0-03.0, FB0-03.0, FB1-03.0, FB2-03.0, FD0-03.0, FE0-03.0, GA0-03.0, GC0-03.0, GX0-03.0, GX2-03.0, XA0-03.0, CA1-03. 0, GU0-03.0, HA0-03.0*

Guideline Note 5: *The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. This permits the submitter to use the value in this field as a key in the submitter's system to match the claim to the payment information returned in the 835 transaction. The two recommended identifiers are either the Patient Account Number or the Claim Number in the billing submitter's patient management system. The developers of this implementation guide strongly recommend that submitters use completely unique numbers for this field for each individual claim.*

The maximum number of characters to be supported for this field is '20'. A provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored nor returned by any 837-receiving system.

CLM02	782	Monetary Amount	O	R	1/18	Required
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Description: Monetary amount

Guideline Note 1: *Total Claim Charge Amount*

Guideline Note 2: *Total Submitted Charges*

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 4: XA0-12.0				
		Guideline Note 5: For encounter transmissions, zero (0) may be a valid amount.				
CLM05	C023	Health Care Service Location Information	O	Comp		Required
		Description: To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered				
		Guideline Note 2: Place of Service Code				
		Guideline Note 4: FA0-07.0				
		Guideline Note 5: CLM05 applies to all service lines unless it is over written at the line level.				
CLM05-01	1331	Facility Code Value	M	AN	1/2	Required
		Description: Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format				
		Guideline Note 1: Facility Type Code				
		Guideline Note 5: Use this element for codes identifying a place of service from code source 237. As a courtesy, the codes are listed below, however, the code list is thought to be complete at the time of publication of this implementation guideline. Since this list is subject to change, only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here.				
		11 Office				
		12 Home				
		21 Inpatient Hospital				
		22 Outpatient Hospital				
		23 Emergency Room - Hospital				
		24 Ambulatory Surgical Center				
		25 Birthing Center				
		26 Military Treatment Facility				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		31 Skilled Nursing Facility				
		32 Nursing Facility				
		33 Custodial Care Facility				
		34 Hospice				
		41 Ambulance - Land				
		42 Ambulance - Air or Water				
		51 Inpatient Psychiatric Facility				
		52 Psychiatric Facility Partial Hospitalization				
		53 Community Mental Health Center				
		54 Intermediate Care Facility/Mentally Retarded				
		55 Residential Substance Abuse Treatment Facility				
		56 Psychiatric Residential Treatment Center				
		50 Federally Qualified Health Center				
		60 Mass Immunization Center				
		61 Comprehensive Inpatient Rehabilitation Facility				
		62 Comprehensive Outpatient Rehabilitation Facility				
		65 End Stage Renal Disease Treatment Facility				
		71 State or Local Public Health Clinic				
		72 Rural Health Clinic				
		81 Independent Laboratory				
		99 Other Unlisted Facility				

ExternalCodeList

Name: 237

Description: Place of Service from Health Care Financing Administration Claim Form

CLM05-03	1325	Claim Frequency Type Code	O	ID	1/1	Required
		Description: Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p>Guideline Note 1: <i>Claim Frequency Code</i></p> <p>Guideline Note 2: <i>Claim Submission Reason Code</i></p> <p>Guideline Note 3: <i>235: Claim Frequency Type Code</i></p> <p>ExternalCodeList Name: 235 Description: Claim Frequency Type Code</p>				
CLM06	1073	<p>Yes/No Condition or Response Code</p> <p>Description: Code indicating a Yes or No condition or response</p> <p>Guideline Note 1: <i>Provider or Supplier Signature Indicator</i></p> <p>Guideline Note 2: <i>Provider Signature on File</i></p> <p>Guideline Note 4: <i>EA0-37.0</i></p> <p>CodeList Summary (Total Codes: 4, Included: 2)</p> <p>Code Name</p> <p>N No Y Yes</p>	O	ID	1/1	Required
CLM07	1359	<p>Provider Accept Assignment Code</p> <p>Description: Code indicating whether the provider accepts assignment</p> <p>Guideline Note 1: <i>Medicare Assignment Code</i></p> <p>Guideline Note 5: <i>CLM07 indicates whether the provider accepts Medicare assignment.</i></p> <p><i>The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.</i></p> <p>CodeList Summary (Total Codes: 4, Included: 4)</p> <p>Code Name</p> <p>A Assigned B Assignment Accepted on Clinical Lab Services Only C Not Assigned P Patient Refuses to Assign Benefits</p>	O	ID	1/1	Required
CLM08	1073	<p>Yes/No Condition or Response Code</p> <p>Description: Code indicating a Yes or No condition or response</p> <p>Guideline Note 1: <i>Benefits Assignment Certification Indicator</i></p> <p>Guideline Note 2: <i>Assignment of Benefits Indicator</i></p> <p>Guideline Note 4: <i>DA0-15.0</i></p>	O	ID	1/1	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p>CodeList Summary (Total Codes: 4, Included: 2)</p> <p>Code Name</p> <p>N No</p> <p>Y Yes</p>				
CLM09	1363	<p>Release of Information Code</p> <p>Description: Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations</p> <p>Guideline Note 2: <i>Release of Information Code</i></p> <p>Guideline Note 4: <i>EA0-13.0</i></p> <p>CodeList Summary (Total Codes: 6, Included: 6)</p> <p>Code Name</p> <p>A Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization</p> <p>I Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes</p> <p>M The Provider has Limited or Restricted Ability to Release Data Related to a Claim</p> <p>N No, Provider is Not Allowed to Release Data</p> <p>O On file at Payor or at Plan Sponsor</p> <p>Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim</p>	O	ID	1/1	Required
CLM10	1351	<p>Patient Signature Source Code</p> <p>Description: Code indicating how the patient or subscriber authorization signatures were obtained and how they are being retained by the provider</p> <p>Guideline Note 2: <i>Patient Signature Source Code</i></p> <p>Guideline Note 4: <i>DA0-16.0</i></p> <p>Guideline Note 5: <i>CLM10 is required except in cases where code "N" is used in CLM09.</i></p> <p>CodeList Summary (Total Codes: 5, Included: 5)</p> <p>Code Name</p> <p>B Signed signature authorization form or forms for both HCFA-1500 Claim Form block 12 and block 13 are on file</p> <p>C Signed HCFA-1500 Claim Form on file</p> <p>M Signed signature authorization form for HCFA-1500 Claim Form block 13 on file</p> <p>P Signature generated by provider because the patient was not physically present for services</p> <p>S Signed signature authorization form for HCFA-1500 Claim Form block 12 on file</p>	O	ID	1/1	Situational
CLM11	C024	<p>Related Causes Information</p> <p>Description: To identify one or more related causes and associated state or</p>	O	Comp		Situational

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		country information				
		Guideline Note 2: <i>Accident/Employment/Related Causes</i>				
		Guideline Note 5: <i>CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related. If CLM11-1, CLM11-2, or CLM11-3 equals AP, then map Yes to EA0-09.0. 2440 If DTP - Date of Accident (DTP01=439) is used, then CLM11 is required.</i>				
CLM11-01	1362	Related-Causes Code	M	ID	2/3	Required
		Description: Code identifying an accompanying cause of an illness, injury or an accident				
		Guideline Note 1: <i>Related Causes Code</i>				
		Guideline Note 4: <i>EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 -Employment, EA0-09.0 - Responsibility Indicator</i>				
		CodeList Summary (Total Codes: 6, Included: 4)				
		Code Name				
		AA Auto Accident				
		AP Another Party Responsible				
		EM Employment				
		OA Other Accident				
CLM11-02	1362	Related-Causes Code	O	ID	2/3	Situational
		Description: Code identifying an accompanying cause of an illness, injury or an accident				
		Guideline Note 1: <i>Related Causes Code</i>				
		Guideline Note 4: <i>EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 -Employment, EA0-09.0 - Responsibility Indicator</i>				
		Guideline Note 5: <i>Used if more than one code applies.</i>				
		CodeList Summary (Total Codes: 6, Included: 4)				
		Code Name				
		AA Auto Accident				
		AP Another Party Responsible				
		EM Employment				
		OA Other Accident				
CLM11-03	1362	Related-Causes Code	O	ID	2/3	Situational
		Description: Code identifying an accompanying cause of an illness, injury or an accident				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p>Guideline Note 1: <i>Related Causes Code</i></p> <p>Guideline Note 4: <i>EA0-05.0 - Auto Accident or Other Accident, EA0-04.0 -Employment, EA0-09.0 - Responsibility Indicator</i></p> <p>Guideline Note 5: <i>Used if more than one code applies.</i></p> <p>CodeList Summary (Total Codes: 6, Included: 4)</p> <p>Code Name</p> <p>AA Auto Accident</p> <p>AP Another Party Responsible</p> <p>EM Employment</p> <p>OA Other Accident</p>				
CLM11-04	156	<p>State or Province Code</p> <p>Description: Code (Standard State/Province) as defined by appropriate government agency</p> <p>Guideline Note 1: <i>Auto Accident State or Province Code</i></p> <p>Guideline Note 3: <i>22: States and Outlying Areas of the U.S.</i></p> <p>Guideline Note 4: <i>EA0-10.0</i></p> <p>Guideline Note 5: <i>Required if CLM11-1, -2, or -3 = AA to identify the state in which the automobile accident occurred. Use state postal code (CA = California, UT = Utah, etc).</i></p> <p>ExternalCodeList</p> <p>Name: 22</p> <p>Description: States and Outlying Areas of the U.S.</p>	O	ID	2/2	Situational
CLM11-05	26	<p>Country Code</p> <p>Description: Code identifying the country</p> <p>Guideline Note 3: <i>5: Countries, Currencies and Funds</i></p> <p>Guideline Note 5: <i>Required if the automobile accident occurred out of the United States to identify the country in which the accident occurred.</i></p> <p>ExternalCodeList</p> <p>Name: 5</p> <p>Description: Countries, Currencies and Funds</p>	O	ID	2/3	Situational
CLM12	1366	<p>Special Program Code</p> <p>Description: Code indicating the Special Program under which the services rendered to the patient were performed</p>	O	ID	2/3	Situational

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 1: <i>Special Program Indicator</i>				
		Guideline Note 2: <i>Special Program Code</i>				
		Guideline Note 4: <i>EA0-43.0</i>				
		Guideline Note 5: <i>Required if the services were rendered under one of the following circumstances/programs/projects.</i>				
		State Specific Note 1: <i>2009-10 - ND - Enter the value "01" (EPSDT).</i>				
		CodeList Summary (Total Codes: 10, Included: 7)				
		Code Name				
		01 Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP)				
		02 Physically Handicapped Children's Program				
		03 Special Federal Funding				
		05 Disability				
		07 Induced Abortion - Danger to Life				
		08 Induced Abortion - Rape or Incest				
		09 Second Opinion or Surgery				
CLM16	1360	Provider Agreement Code	O	ID	1/1	Situational
		Description: Code indicating the type of agreement under which the provider is submitting this claim				
		Guideline Note 1: <i>Participation Agreement</i>				
		Guideline Note 5: <i>Required if a non-participating (non-par) provider is submitting a participating (par) claim/encounter. Sending the "P" code indicates that a non-par provider is sending a par claim as allowed under certain plans.</i>				
		CodeList Summary (Total Codes: 7, Included: 1)				
		Code Name				
		P Participation Agreement				
		Description: <i>Any agreement between the provider of service and the plan administrator</i>				
CLM20	1514	Delay Reason Code	O	ID	1/2	Situational
		Description: Code indicating the reason why a request was delayed				
		Guideline Note 2: <i>Delay Reason Code</i>				
		Guideline Note 5: <i>This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the</i>				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<i>response has been delayed.</i>				
		<i>Required when claim is submitted late (past contracted date of filing limitations) and any of the codes below apply.</i>				
CodeList Summary (Total Codes: 14, Included: 11)						
		<u>Code</u> <u>Name</u>				
	1	Proof of Eligibility Unknown or Unavailable				
	2	Litigation				
	3	Authorization Delays				
	4	Delay in Certifying Provider				
	5	Delay in Supplying Billing Forms				
	6	Delay in Delivery of Custom-made Appliances				
	7	Third Party Processing Delay				
	8	Delay in Eligibility Determination				
	9	Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules				
	10	Administration Delay in the Prior Approval Process				
	11	Other				

Semantics:

1. CLM02 is the total amount of all submitted charges of service segments for this claim.
2. CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file; an "N" value indicates the provider signature is not on file.
3. CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.
4. CLM13 is CHAMPUS nonavailability indicator. A "Y" value indicates a statement of non-availability is on file; an "N" value indicates statement of nonavailability is not on file or not necessary.
5. CLM15 is charges itemized by service indicator. A "Y" value indicates charges are itemized by service; an "N" value indicates charges are summarized by service.
6. CLM18 is explanation of benefit (EOB) indicator. A "Y" value indicates that a paper EOB is requested; an "N" value indicates that no paper EOB is requested.

Guideline Note 1:

1. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
2. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
3. For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

Guideline Note 2:

CLM*A37YH556*500***11::1*Y*A*Y*Y*C~

REF Prior Authorization or Referral Number

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "9F" (Referral Number) or "G1" (Prior Authorization Number).

CodeList Summary (Total Codes: 1503, Included: 2)

Code Name

- 9F Referral Number
- G1 Prior Authorization Number

Description: An authorization number acquired prior to the submission of a claim

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

Guideline Note 1: Prior Authorization or Referral Number

Guideline Note 4: DA0-14.0

State Specific Note 1:

2009-10 - ND - If REF01 = "9F", then enter the Referral Number. If REF01 = "G1", then enter the Prior Authorization Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

1. Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.
2. Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The UMO (Utilization Management Organization) is generally the entity empowered to make

a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.

Guideline Note 2:

*REF*G1*13579~*

REF Original Reference Number (ICN/DCN)

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - For adjustments/voids, enter the value "F8".

CodeList Summary (Total Codes: 1503, Included: 1)

Code Name

F8 Original Reference Number

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

Guideline Note 1: Claim Original Reference Number

Guideline Note 2: Claim Original Reference Number (ICN/DCN)

Guideline Note 4: EA0-47.0

State Specific Note 1:

2009-10 - ND - For adjustments/voids, enter the original 13-digit Medicaid internal control number (ICN).

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

1. Required when CLM05-3 (Claim Submission Reason Code) = "6", "7", or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.
2. This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and, for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number. In this case the payer is expecting the provider to give them back their (the payer's) claim number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows

this is not a duplicate claim. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.

Guideline Note 2:

*REF*F8*R555588~*

HI Health Care Diagnosis Code

Pos: 231	Max: 1
Detail - Optional	
Loop: 2300	Elements: 8

User Option (Usage): Situational

Purpose: To supply information related to the delivery of health care

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI01	C022	Health Care Code Information	M	Comp		Required

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

Guideline Note 2: *Principal Diagnosis*

Guideline Note 5: *With a few exceptions, it is not recommended to put E codes in HI01. E codes may be put in any other HI element using BF as the qualifier.*

The diagnosis listed in this element is assumed to be the principal diagnosis.

HI01-01	1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Guideline Note 1: *Diagnosis Type Code*

State Specific Note 1:

2009-10 - ND - Enter the value "BK" (Diagnosis).

CodeList Summary (Total Codes: 558, Included: 1)

Code Name

BK Principal Diagnosis

HI01-02	1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Guideline Note 1: *Diagnosis Code*

Guideline Note 4: *EA0-32.0, GX0-31.0, GU0-12.0*

ExternalCodeList

Name: 131D

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

HI02	C022	Health Care Code Information	O	Comp		Situational
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Description: To send health care codes and their associated dates, amounts and quantities

Guideline Note 2: *Diagnosis*

Guideline Note 5: *Refer to*

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p><i>HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.</i></p> <p><i>Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.</i></p>				
HI02-01	1270	<p>Code List Qualifier Code</p> <p>Description: Code identifying a specific industry code list</p> <p>Guideline Note 1: <i>Diagnosis Type Code</i></p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "BF" (Diagnosis).</p> <p>CodeList Summary (Total Codes: 558, Included: 1)</p> <p>Code Name BF Diagnosis</p>	M	ID	1/3	Required
HI02-02	1271	<p>Industry Code</p> <p>Description: Code indicating a code from a specific industry code list</p> <p>Guideline Note 1: <i>Diagnosis Code</i></p> <p>Guideline Note 4: <i>EA0-33.0, GX0-32.0, GU0-13.0</i></p> <p>ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis</p>	M	AN	1/30	Required
HI03	C022	<p>Health Care Code Information</p> <p>Description: To send health care codes and their associated dates, amounts and quantities</p> <p>Guideline Note 2: <i>Diagnosis</i></p> <p>Guideline Note 5: <i>Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.</i></p> <p><i>Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.</i></p>	O	Comp		Situational
HI03-01	1270	<p>Code List Qualifier Code</p> <p>Description: Code identifying a specific industry code list</p> <p>Guideline Note 1: <i>Diagnosis Type Code</i></p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "BF" (Diagnosis).</p>	M	ID	1/3	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		CodeList Summary (Total Codes: 558, Included: 1) <u>Code Name</u> BF Diagnosis				
HI03-02	1271	Industry Code Description: Code indicating a code from a specific industry code list Guideline Note 1: <i>Diagnosis Code</i> Guideline Note 4: <i>EA0-34.0, GX0-33.0, GU0-14.0</i> ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis	M	AN	1/30	Required
HI04	C022	Health Care Code Information Description: To send health care codes and their associated dates, amounts and quantities Guideline Note 2: <i>Diagnosis</i> Guideline Note 5: <i>Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.</i> <i>Required if needed to report an additional diagnoses and if the preceeding HI data elements have been used to report other diagnoses.</i>	O	Comp		Situational
HI04-01	1270	Code List Qualifier Code Description: Code identifying a specific industry code list Guideline Note 1: <i>Diagnosis Type Code</i> State Specific Note 1: <i>2009-10 - ND - Enter the value "BF" (Diagnosis).</i>	M	ID	1/3	Required
		CodeList Summary (Total Codes: 558, Included: 1) <u>Code Name</u> BF Diagnosis				
HI04-02	1271	Industry Code Description: Code indicating a code from a specific industry code list Guideline Note 1: <i>Diagnosis Code</i> Guideline Note 4: <i>EA0-35.0, GX0-34.0, GU0-15.0</i> ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis	M	AN	1/30	Required

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

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

Guideline Note 2: *Diagnosis*

Guideline Note 5: *Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.*

Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI05-01 1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Guideline Note 1: *Diagnosis Type Code*

State Specific Note 1:

2009-10 - ND - Enter the value "BF" (Diagnosis).

CodeList Summary (Total Codes: 558, Included: 1)

Code Name

BF Diagnosis

HI05-02 1271 **Industry Code** M AN 1/30 Required

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

Guideline Note 1: *Diagnosis Code*

ExternalCodeList

Name: 131D

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

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

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

Guideline Note 2: *Diagnosis*

Guideline Note 5: *Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.*

Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI06-01 1270 **Code List Qualifier Code** M ID 1/3 Required

Description: Code identifying a specific industry code list

Guideline Note 1: *Diagnosis Type Code*

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<p>State Specific Note 1: 2009-10 - ND - Enter the value "BF" (Diagnosis).</p> <p>CodeList Summary (Total Codes: 558, Included: 1)</p> <p>Code Name BF Diagnosis</p>				
HI06-02	1271	<p>Industry Code</p> <p>Description: Code indicating a code from a specific industry code list</p> <p>Guideline Note 1: <i>Diagnosis Code</i></p> <p>ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis</p>	M	AN	1/30	Required
HI07	C022	<p>Health Care Code Information</p> <p>Description: To send health care codes and their associated dates, amounts and quantities</p> <p>Guideline Note 2: <i>Diagnosis</i></p> <p>Guideline Note 5: <i>Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.</i></p> <p><i>Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.</i></p>	O	Comp		Situational
HI07-01	1270	<p>Code List Qualifier Code</p> <p>Description: Code identifying a specific industry code list</p> <p>Guideline Note 1: <i>Diagnosis Type Code</i></p> <p>State Specific Note 1: 2009-10 - ND - Enter the value "BF" (Diagnosis).</p> <p>CodeList Summary (Total Codes: 558, Included: 1)</p> <p>Code Name BF Diagnosis</p>	M	ID	1/3	Required
HI07-02	1271	<p>Industry Code</p> <p>Description: Code indicating a code from a specific industry code list</p> <p>Guideline Note 1: <i>Diagnosis Code</i></p> <p>ExternalCodeList Name: 131D Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis</p>	M	AN	1/30	Required

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HI08	C022	Health Care Code Information	O	Comp		Situational

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

Guideline Note 2: *Diagnosis*

Guideline Note 5: *Refer to HI01-1(C022-01) and HI01-3(C022-03) for C022-01 and C022-03.*

Required if needed to report an additional diagnoses and if the preceding HI data elements have been used to report other diagnoses.

HI08-01	1270	Code List Qualifier Code	M	ID	1/3	Required
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Description: Code identifying a specific industry code list

Guideline Note 1: *Diagnosis Type Code*

State Specific Note 1:

2009-10 - ND - Enter the value "BF" (Diagnosis).

CodeList Summary (Total Codes: 558, Included: 1)

Code Name

BF Diagnosis

HI08-02	1271	Industry Code	M	AN	1/30	Required
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Description: Code indicating a code from a specific industry code list

Guideline Note 1: *Diagnosis Code*

ExternalCodeList

Name: 131D

Description: International Classification of Diseases Clinical Mod (ICD-9-CM) Diagnosis

Guideline Note 1:

1. *Required on all claims/encounters except claims for which there are no diagnoses (e.g., taxi claims).*
2. *Do not transmit the decimal points in the diagnosis codes. The decimal point is assumed.*

Guideline Note 2:

*HI*BK:8901*BF:87200*BF:5559~*

NM1 Referring Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310A	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Guideline Note 5: *The entity identifier in NM101 applies to all segments in this Loop ID-2310.*

CodeList Summary (Total Codes: 1312, Included: 2)

Code Name

- DN Referring Provider
- P3 Primary Care Provider

Description: *Physician that is selected by the insured to provide medical care*

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 2)

Code Name

- 1 Person
- 2 Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
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Description: Individual last name or organizational name

Guideline Note 1: *Referring Provider Last Name*

Guideline Note 4: *EA0-24.0*

NM104	1036	Name First	O	AN	1/25	Situational
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Description: Individual first name

Guideline Note 1: *Referring Provider First Name*

Guideline Note 4: *EA0-25.0*

Guideline Note 5: *Required if NM102=1 (person).*

NM105	1037	Name Middle	O	AN	1/25	Situational
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Description: Individual middle name or initial

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 1: Referring Provider Middle Name				
		Guideline Note 4: EA0-26.0				
		Guideline Note 5: Required if NM102=1 and the middle name/initial of the person is known.				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Guideline Note 1: Referring Provider Name Suffix				
		Guideline Note 2: Referring Provider Generation				
		Guideline Note 5: Required if known.				
NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		Guideline Note 5: Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.				
		State Specific Note 1: 2009-10 - ND - ND requires the qualifier "XX".				
		CodeList Summary (Total Codes: 215, Included: 3)				
		Code Name				
		24 Employer's Identification Number				
		34 Social Security Number				
		XX Health Care Financing Administration National Provider Identifier				
		Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.				
NM109	67	Identification Code	C	AN	2/80	Situational
		Description: Code identifying a party or other code				
		Guideline Note 1: Referring Provider Identifier				
		Guideline Note 2: Referring Provider Primary Identifier				
		Guideline Note 4: EA0-20.0				
		Guideline Note 5: Required if Employer's Identification/Social Security number (Tax ID) or National Provider Identifier is known.				
		State Specific Note 1: 2009-10 - ND - ND requires the referring provider's NPI.				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
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ExternalCodeList**Name:** 537**Description:** Health Care Financing Administration National Provider Identifier**Syntax Rules:**

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. When there is only one referral on the claim, use code "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.
3. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
4. Required if claim involved a referral.
5. When reporting the provider who ordered services such as diagnostic and lab utilize the 2310A loop at the claim level. For ordered services such as DMERC utilize the 2420E Loop at the line level.

Guideline Note 2:

```
NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~
```

REF Referring Provider Secondary Identification

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - ND requires the value "LU".

CodeList Summary (Total Codes: 1503, Included: 12)

Code Name

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- SY Social Security Number
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Referring Provider Secondary Identifier

Guideline Note 4: EA0-20.0

State Specific Note 1:

2009-10 - ND - ND requires the Medicaid Provider Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

1. Required if NM108/09 in this loop is not used or if a secondary number is necessary to identify the provider. Until the NPI is mandated for use, this REF may be required if necessary to adjudicate the claim.

Guideline Note 2:

*REF*1D*A12345~*

NM1 Rendering Provider Name

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310B	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Guideline Note 5: *The entity identifier in NM101 applies to all segments in this Loop ID-2310.*

CodeList Summary (Total Codes: 1312, Included: 1)

<u>Code</u>	<u>Name</u>
82	Rendering Provider

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 2)

<u>Code</u>	<u>Name</u>
1	Person
2	Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
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Description: Individual last name or organizational name

Guideline Note 1: *Rendering Provider Last or Organization Name*

Guideline Note 2: *Rendering Provider Last Name*

Guideline Note 4: *FB1-14.0*

NM104	1036	Name First	O	AN	1/25	Situational
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Description: Individual first name

Guideline Note 1: *Rendering Provider First Name*

Guideline Note 4: *FB1-15.0*

Guideline Note 5: *Required if NM102=1 (person).*

NM105	1037	Name Middle	O	AN	1/25	Situational
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Description: Individual middle name or initial

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 1: <i>Rendering Provider Middle Name</i>				
		Guideline Note 4: <i>FB1-16.0</i>				
		Guideline Note 5: <i>Required if NM102=1 and the middle name/initial of the person is known.</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Guideline Note 1: <i>Rendering Provider Name Suffix</i>				
		Guideline Note 2: <i>Rendering Provider Generation</i>				
		Guideline Note 5: <i>Required if known.</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		Guideline Note 4: <i>FA0-57.0</i>				
		Guideline Note 5: <i>FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.</i>				
		State Specific Note 1: <i>2009-10 - ND - State requires the value "XX".</i>				
		CodeList Summary (Total Codes: 215, Included: 3)				
		Code Name				
		24 Employer's Identification Number				
		34 Social Security Number				
		XX Health Care Financing Administration National Provider Identifier				
		Description: <i>Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</i>				
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Guideline Note 1: <i>Rendering Provider Identifier</i>				
		Guideline Note 2: <i>Rendering Provider Primary Identifier</i>				
		Guideline Note 4: <i>FA0-23.0, FA0-58.0</i>				
		Guideline Note 5: <i>FA0-58.0 crosswalk is only used in Medicare COB payer-to-payer claims.</i>				
		State Specific Note 1: <i>2009-10 - ND - State requires NPI.</i>				
		ExternalCodeList				

Name: 537

Description: Health Care Financing Administration National Provider Identifier

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
3. Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.
4. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.

Guideline Note 2:

NM1*82*1*BEATTY*GARY*C**SR*XX*12345678~

REF Rendering Provider Secondary Identification

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

Guideline Note 4: FA0-57.0

State Specific Note 1:

2009-10 - ND - State requires the qualifier "LU".

CodeList Summary (Total Codes: 1503, Included: 12)

Code Name

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- SY Social Security Number
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Rendering Provider Secondary Identifier

Guideline Note 4: FA0-58.0

State Specific Note 1:

2009-10 - ND - State requires the Medicaid Provider Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

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

Guideline Note 2:

*REF*1D*A12345~*

NM1 Service Facility Location

Pos: 250	Max: 1
Detail - Optional	
Loop: 2310D	Elements: 5

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

State Specific Note 1:
2009-10 - ND - Enter the value "FA".

CodeList Summary (Total Codes: 1312, Included: 4)

<u>Code</u>	<u>Name</u>
77	Service Location
FA	Facility
LI	Independent Lab
	Description: Outside laboratory which provides test results for entity providing medical services
TL	Testing Laboratory

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 1)

<u>Code</u>	<u>Name</u>
2	Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Situational
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Description: Individual last name or organizational name

Guideline Note 1: Laboratory or Facility Name

Guideline Note 2: Laboratory/Facility Name

Guideline Note 4: EA0-39.0

Guideline Note 5: Required except when service was rendered in the patient's home.

NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
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Description: Code designating the system/method of code structure used for Identification Code (67)

Guideline Note 5: Required if either

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Employer's Identification/Social Security Number or National Provider Identifier is known.				
		State Specific Note 1: 2009-10 - ND - Enter the value "XX".				
		CodeList Summary (Total Codes: 215, Included: 3)				
		Code Name				
		24 Employer's Identification Number				
		34 Social Security Number				
		XX Health Care Financing Administration National Provider Identifier				
		Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.				
NM109	67	Identification Code	C	AN	2/80	Situational
		Description: Code identifying a party or other code				
		Guideline Note 1: Laboratory or Facility Primary Identifier				
		Guideline Note 2: Laboratory/Facility Primary Identifier				
		Guideline Note 4: EA1-04.0, EA0-53.0				
		Guideline Note 5: Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.				
		State Specific Note 1: 2009-10 - ND - Enter the facility's NPI.				
		ExternalCodeList				
		Name: 537				
		Description: Health Care Financing Administration National Provider Identifier				

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Information in Loop ID-2310 applies to the entire claim unless overridden on a service line by the presence of Loop ID-2420 with the same value in NM101.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
3. This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops.
4. Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the

place of service is different than the HPSA billing address.

5. The purpose of this loop is to identify specifically where the service was rendered. In cases where it was rendered at the patient's home, do not use this loop. In that case, the place of service code in CLM05- 1 should indicate that the service occurred in the patient's home.

Guideline Note 2:

NM1*TL*2*A-OK MOBILE CLINIC*****24*11122333~

REF Service Facility Location Secondary Identification

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

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "LU".

CodeList Summary (Total Codes: 1503, Included: 13)

Code Name

- 0B State License Number
- 1A Blue Cross Provider Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- TJ Federal Taxpayer's Identification Number
- X4 Clinical Laboratory Improvement Amendment Number
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Laboratory or Facility Secondary Identifier

Guideline Note 2: Laboratory/Facility Secondary Identification Number

Guideline Note 4: EA1-04.0, EA0-53.0

State Specific Note 1:

2009-10 - ND - Enter the facility Medicaid Provider Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

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

Guideline Note 2:

*REF*1D*A12345~*

SBR Other Subscriber Information

Pos: 290	Max: 1
Detail - Optional	
Loop: 2320	Elements: 6

User Option (Usage): Situational

Purpose: To record information specific to the primary insured and the insurance carrier for that insured

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SBR01	1138	Payer Responsibility Sequence Number Code	M	ID	1/1	Required

Description: Code identifying the insurance carrier's level of responsibility for a payment of a claim

Guideline Note 2: *Payer responsibility sequence number code*

Guideline Note 4: *DA0-02.0, DA1-02.0, DA2-02.0*

CodeList Summary (Total Codes: 6, Included: 3)

Code Name

- P Primary
- S Secondary
- T Tertiary

SBR02	1069	Individual Relationship Code	O	ID	2/2	Required
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Description: Code indicating the relationship between two individuals or entities

Guideline Note 2: *Individual relationship code*

Guideline Note 4: *DA0-17.0*

CodeList Summary (Total Codes: 153, Included: 24)

Code Name

- 01 Spouse
- 04 Grandfather or Grandmother
- 05 Grandson or Granddaughter
- 07 Nephew or Niece
- 10 Foster Child
- 15 Ward
- 17 Stepson or Stepdaughter
- 18 Self
- 19 Child
- 20 Employee
- 21 Unknown
- 22 Handicapped Dependent

Description: *Dependent between the ages of 0 and 19; age qualifications may vary depending on policy*

- Code Name**
- 23 Sponsored Dependent
Description: Dependents between the ages of 19 and 25 not attending school; age qualifications may vary depending on policy
 - 24 Dependent of a Minor Dependent
Description: A child not legally of age who has been granted adult status
 - 29 Significant Other
 - 32 Mother
 - 33 Father
 - 36 Emancipated Minor
Description: A person who has been judged by a court of competent jurisdiction to be allowed to act in his or her own interest; no adult is legally responsible for this minor; this may be declared as a result of marriage
 - 39 Organ Donor
Description: Individual receiving medical service in order to donate organs for a transplant
 - 40 Cadaver Donor
Description: Deceased individual donating body to be used for research or transplants
 - 41 Injured Plaintiff
 - 43 Child Where Insured Has No Financial Responsibility
Description: Child is covered by the insured but the insured is not the legal guardian
 - 53 Life Partner
 - G8 Other Relationship

SBR03 127 **Reference Identification** O AN 1/30 Situational

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

Guideline Note 1: Insured Group or Policy Number

Guideline Note 2: Group or Policy Number

Guideline Note 4: DA0-10.0

Guideline Note 5: Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109).

SBR04 93 **Name** O AN 1/60 Situational

Description: Free-form name

Guideline Note 1: Other Insured Group Name

Guideline Note 2: Group or Plan Name

Guideline Note 4: DA0-11.0

Guideline Note 5: Required if the

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		<i>subscriber's payer identification includes a Group or Plan Name.</i>				
SBR05	1336	Insurance Type Code	O	ID	1/3	Required
		Description: Code identifying the type of insurance policy within a specific insurance program				
		Guideline Note 2: <i>Insurance type code</i>				
		Guideline Note 4: <i>DA0-06.0</i>				
		CodeList Summary (Total Codes: 45, Included: 15)				
		Code	Name			
		AP	Auto Insurance Policy			
		C1	Commercial			
		CP	Medicare Conditionally Primary			
		GP	Group Policy			
			Description: <i>Two or more people who are part of complete unit who enter into an insurance contract with an insurance company</i>			
		HM	Health Maintenance Organization (HMO)			
		IP	Individual Policy			
		LD	Long Term Policy			
		LT	Litigation			
		MB	Medicare Part B			
		MC	Medicaid			
			Description: <i>Program of health care services made available to medically indigent and other needy persons, regardless of age, under terms of a 1965 amendment to the U.S. Social Security Act</i>			
		MI	Medigap Part B			
			Description: <i>Health insurance policy intended to cover the non-covered portion of expenses eligible for Medicare Part B reimbursement which must be paid by a Medicare beneficiary for health care services and/or supplies received</i>			
		MP	Medicare Primary			
			Description: <i>Medicare has the primary responsibility to pay for health care services and/or supplies received by a covered beneficiary (a person entitled to medicare benefits)</i>			
		OT	Other			
		PP	Personal Payment (Cash - No Insurance)			
		SP	Supplemental Policy			
			Description: <i>An insurance policy intended to cover non-covered charges of another insurance policy</i>			
SBR09	1032	Claim Filing Indicator Code	O	ID	1/2	Situational
		Description: Code identifying type of claim				
		Guideline Note 2: <i>Claim filing indicator code</i>				
		Guideline Note 4: <i>DA0-05.0</i>				
		Guideline Note 5: <i>Required prior to mandated used of PlanID. Not used after PlanID is mandated.</i>				

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
State Specific Note 1:						
2009-10 - ND - If subscriber has Medicare Part B, enter the value "MB".						
CodeList Summary (Total Codes: 45, Included: 23)						
	<u>Code</u>	<u>Name</u>				
	09	Self-pay				
	10	Central Certification				
	11	Other Non-Federal Programs				
	12	Preferred Provider Organization (PPO)				
	13	Point of Service (POS)				
	14	Exclusive Provider Organization (EPO)				
	15	Indemnity Insurance				
	16	Health Maintenance Organization (HMO) Medicare Risk				
	AM	Automobile Medical				
	BL	Blue Cross/Blue Shield				
	CH	Champus				
	CI	Commercial Insurance Co.				
	DS	Disability				
	HM	Health Maintenance Organization				
	LI	Liability				
	LM	Liability Medical				
	MB	Medicare Part B				
	MC	Medicaid				
	OF	Other Federal Program				
	TV	Title V				
	VA	Veteran Administration Plan				
	WC	Workers' Compensation Health Claim				
	ZZ	Mutually Defined				

Semantics:

1. SBR02 specifies the relationship to the person insured.
2. SBR03 is policy or group number.
3. SBR04 is plan name.
4. SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer; an "N" value indicates the payer is not the destination payer.

Guideline Note 1:

1. Required if other payers are known to potentially be involved in paying on this claim.
2. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
3. All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is needed to be carried, run the 2320 Loop again with it's respective 2330 Loops.
- See Section 1.4.4 for more information on handling COB.
4. See Section 1.4.5 Crosswalking COB Data Elements for more information on handling COB in the 837.

Guideline Note 2:

SBR*S*01*GR00786**MC****OF~

DTP Date - Service Date

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

User Option (Usage): Required

Purpose: To specify any or all of a date, a time, or a time period

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
DTP01	374	Date/Time Qualifier	M	ID	3/3	Required

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

Guideline Note 1: Date Time Qualifier

CodeList Summary (Total Codes: 1112, Included: 1)

Code Name

472 Service

DTP02	1250	Date Time Period Format Qualifier	M	ID	2/3	Required
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Description: Code indicating the date format, time format, or date and time format

CodeList Summary (Total Codes: 39, Included: 2)

Code Name

D8 Date Expressed in Format CCYYMMDD

RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

Description: A range of dates expressed in the format CCYYMMDD-CCYYMMDD where CCYY is the numerical expression of the century CC and year YY, MM is the numerical expression of the month within the year, and DD is the numerical expression of the day within the year; the first occurrence of CCYYMMDD is the beginning date and the second occurrence is the ending date

DTP03	1251	Date Time Period	M	AN	1/35	Required
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Description: Expression of a date, a time, or range of dates, times or dates and times

Guideline Note 1: Service Date

Guideline Note 4: FA0-05.0, FA0-06.0

State Specific Note 1:

2009-10 - ND - If DTP02="D8", then enter the From Date Of Service(DOS) in the format CCYYMMDD. If DTP03="RD8", then enter the DOS range in the format CCYYMMDD-CCYYMMDD.

Semantics:

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

Guideline Note 1:

1. The total number of DTP segments in the 2400 loop cannot exceed 15.

2. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug will be used by the patient. Use RD8 for this purpose.

3. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written).

Guideline Note 2:

*DTP*472*RD8*19970607-19970608~*

REF Prior Authorization or Referral Number

Pos: 470	Max: 2
Detail - Optional	
Loop: 2400	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "G1".

CodeList Summary (Total Codes: 1503, Included: 2)

Code Name

- 9F Referral Number
- G1 Prior Authorization Number

Description: An authorization number acquired prior to the submission of a claim

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

Guideline Note 1: Prior Authorization or Referral Number

State Specific Note 1:

2009-10 - ND - Enter the Prior Authorization Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

Required if service line involved a prior authorization number or referral number that is different than the number reported at the claim level (Loop-ID 2300).

Guideline Note 2:

REF*9F*12345678~

LIN Drug Identification

Pos: 494	Max: 1
Detail - Optional	
Loop: 2410	Elements: 2

User Option (Usage): Situational

Purpose: To specify basic item identification data

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
LIN02	235	Product/Service ID Qualifier	M	ID	2/2	Required

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

Guideline Note 1: *Product or Service ID Qualifier*

State Specific Note 1:

2009-10 - ND - Enter the N4 National Drug Code (NDC) in 5-4-2 format.

CodeList Summary (Total Codes: 477, Included: 1)

Code Name

N4 National Drug Code in 5-4-2 Format

Description: *5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size*

LIN03	234	Product/Service ID	M	AN	1/48	Required
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Description: Identifying number for a product or service

Guideline Note 1: *National Drug Code*

Guideline Note 2: *National Drug Code*

ExternalCodeList

Name: 240

Description: National Drug Code by Format

Syntax Rules:

1. P0405 - If either LIN04 or LIN05 is present, then the other is required.
2. P0607 - If either LIN06 or LIN07 is present, then the other is required.
3. P0809 - If either LIN08 or LIN09 is present, then the other is required.
4. P1011 - If either LIN10 or LIN11 is present, then the other is required.
5. P1213 - If either LIN12 or LIN13 is present, then the other is required.
6. P1415 - If either LIN14 or LIN15 is present, then the other is required.
7. P1617 - If either LIN16 or LIN17 is present, then the other is required.
8. P1819 - If either LIN18 or LIN19 is present, then the other is required.
9. P2021 - If either LIN20 or LIN21 is present, then the other is required.
10. P2223 - If either LIN22 or LIN23 is present, then the other is required.
11. P2425 - If either LIN24 or LIN25 is present, then the other is required.
12. P2627 - If either LIN26 or LIN27 is present, then the other is required.
13. P2829 - If either LIN28 or LIN29 is present, then the other is required.
14. P3031 - If either LIN30 or LIN31 is present, then the other is required.

Semantics:

1. LIN01 is the line item identification

Comments:

1. See the Data Dictionary for a complete list of IDs.
2. LIN02 through LIN31 provide for fifteen different product/service IDs for each item. For example: Case, Color, Drawing No., U.P.C. No., ISBN No., Model No., or SKU.

Guideline Note 1:

1. *The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410.*
2. *Use Loop ID 2410 to specify billing/reporting for drugs provided that may be part of the service(s) described in SV1.*

Guideline Note 2:

LIN**N4*01234567891~

NM1 Rendering Provider Name

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420A	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Guideline Note 5: *The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.*

CodeList Summary (Total Codes: 1312, Included: 1)

Code Name

82 Rendering Provider

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 2)

Code Name

1 Person

2 Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
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Description: Individual last name or organizational name

Guideline Note 1: *Rendering Provider Last or Organization Name*

Guideline Note 2: *Rendering Provider Last Name*

Guideline Note 4: *FB1-14.0*

NM104	1036	Name First	O	AN	1/25	Situational
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Description: Individual first name

Guideline Note 1: *Rendering Provider First Name*

Guideline Note 4: *FB1-15.0*

Guideline Note 5: *Required if NM102=1 (person).*

NM105	1037	Name Middle	O	AN	1/25	Situational
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Description: Individual middle name or initial

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 1: <i>Rendering Provider Middle Name</i>				
		Guideline Note 4: <i>FB1-16.0</i>				
		Guideline Note 5: <i>Required if NM102=1 and the middle name/initial of the person is known.</i>				
NM107	1039	Name Suffix	O	AN	1/10	Situational
		Description: Suffix to individual name				
		Guideline Note 1: <i>Rendering Provider Name Suffix</i>				
		Guideline Note 2: <i>Rendering Provider Generation</i>				
		Guideline Note 5: <i>Required if known.</i>				
NM108	66	Identification Code Qualifier	C	ID	1/2	Required
		Description: Code designating the system/method of code structure used for Identification Code (67)				
		Guideline Note 4: <i>FA0-57.0</i>				
		State Specific Note 1: <i>2009-10 - ND - Enter the value "XX".</i>				
		CodeList Summary (Total Codes: 215, Included: 3)				
		Code Name				
		24 Employer's Identification Number				
		34 Social Security Number				
		XX Health Care Financing Administration National Provider Identifier				
		Description: <i>Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</i>				
NM109	67	Identification Code	C	AN	2/80	Required
		Description: Code identifying a party or other code				
		Guideline Note 1: <i>Rendering Provider Identifier</i>				
		Guideline Note 2: <i>Rendering Provider Primary Identifier</i>				
		Guideline Note 4: <i>FA0-23.0, FA0-58.0</i>				
		State Specific Note 1: <i>2009-10 - ND - Enter the Rendering Provider NPI.</i>				
		ExternalCodeList				
		Name: 537				
		Description: Health Care Financing Administration National Provider Identifier				

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
2. Required if the Rendering Provider NM1 information is different than that carried in the 2310B (claim) loop, or if the Rendering provider information is carried at the Billing/Pay-to Provider loop level (2010AA/AB) and this particular service line has a different Rendering Provider than what is given in the 2010AA/AB loop. The identifying payer-specific numbers are those that belong to the destination payer identified in loop 2010BB.
3. Used for all types of rendering providers including laboratories. The Rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute provider (locum tenens) was used, that person should be entered here.

Guideline Note 2:

NM1*82*1*SMITH*JUNE*L***XX*87654321~

REF Rendering Provider Secondary Identification

Pos: 525	Max: 5
Detail - Optional	
Loop: 2420A	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "LU".

CodeList Summary (Total Codes: 1503, Included: 12)

Code Name

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- SY Social Security Number
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Rendering Provider Secondary Identifier

State Specific Note 1:

2009-10 - ND - Enter the Rendering Provider's Medicaid Provider Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

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

Guideline Note 2:

*REF*1D*A12345~*

NM1 Purchased Service Provider Name

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420B	Elements: 4

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Guideline Note 5: *The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.*

CodeList Summary (Total Codes: 1312, Included: 1)

Code Name

QB Purchase Service Provider

Description: *Entity from which medical supplies may be bought*

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 2)

Code Name

1 Person

2 Non-Person Entity

NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
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Description: Code designating the system/method of code structure used for Identification Code (67)

Guideline Note 5: *Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.*

CodeList Summary (Total Codes: 215, Included: 3)

Code Name

24 Employer's Identification Number

34 Social Security Number

XX Health Care Financing Administration National Provider Identifier

Description: *Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.*

NM109	67	Identification Code	C	AN	2/80	Situational
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Description: Code identifying a party or other code

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 1: <i>Purchased Service Provider Identifier</i>				
		Guideline Note 2: <i>Purchased Service Provider's Primary Identification Number</i>				
		Guideline Note 4: <i>FB0-11.0</i>				
		Guideline Note 5: <i>Required if either Employer's Identification/Social Security Number or National Provider Identifier is known.</i>				
		ExternalCodeList				
		Name: 537				
		Description: Health Care Financing Administration National Provider Identifier				

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.
 2. Required if purchased services are being billed/reported on this claim. Purchased services are situations where (for example) a physician purchases a diagnostic exam from an outside entity. Purchased services do not include substitute (locum tenens) provider situations. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.

Guideline Note 2:

NM1*QB*2*XYZ HOLTER MONITOR INC*****34*444556666~

REF Purchased Service Provider Secondary Identification

Pos: 525	Max: 5
Detail - Optional	
Loop: 2420B	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

CodeList Summary (Total Codes: 1503, Included: 14)

Code Name

- 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
- EI Employer's Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- SY Social Security Number
- U3 Unique Supplier Identification Number (USIN)
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Purchased Service Provider Secondary Identifier

Guideline Note 4: FBO-11.0

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

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

Guideline Note 2:

*REF*1D*A12345~*

NM1 Service Facility Location

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420C	Elements: 5

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

Guideline Note 5: *The entity identifier in NM101 applies to all segments in this iteration of Loop ID-2420.*

State Specific Note 1:
2009-10 - ND - Enter the value "FA".

CodeList Summary (Total Codes: 1312, Included: 4)

Code Name

77 Service Location

FA Facility

LI Independent Lab

Description: *Outside laboratory which provides test results for entity providing medical services*

TL Testing Laboratory

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 1)

Code Name

2 Non-Person Entity

NM103	1035	Name Last or Organization Name	O	AN	1/35	Situational
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Description: Individual last name or organizational name

Guideline Note 1: *Laboratory or Facility Name*

Guideline Note 2: *Service Facility Location Name*

Guideline Note 4: *GX0-25.0*

Guideline Note 5: *Required except when service was rendered in the patient's home.*

NM108	66	Identification Code Qualifier	C	ID	1/2	Situational
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Description: Code designating the

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		system/method of code structure used for Identification Code (67)				
		Guideline Note 5: <i>Required if either Employer's Identification/Social Security Number (tax ID of service location) or National Provider Identifier is known.</i>				
		State Specific Note 1: 2009-10 - ND - Enter the value "XX".				
		CodeList Summary (Total Codes: 215, Included: 3)				
		Code Name				
		24 Employer's Identification Number				
		34 Social Security Number				
		XX Health Care Financing Administration National Provider Identifier				
		Description: <i>Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.</i>				

NM109	67	Identification Code	C	AN	2/80	Situational
		Description: Code identifying a party or other code				
		Guideline Note 1: <i>Laboratory or Facility Primary Identifier</i>				
		Guideline Note 2: <i>Service Facility Location Identification Number</i>				
		Guideline Note 5: <i>Required if either Employer's Identification/Social Security Number (tax ID of service location) or National Provider Identifier is known.</i>				
		State Specific Note 1: 2009-10 - ND - Enter the Facility's Medicaid Provider Number.				
		ExternalCodeList				
		Name: 537				
		Description: Health Care Financing Administration National Provider Identifier				

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:
1. Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.

2. Required when the location of health care service for this service line is different than that carried in the 2010AA (Billing Provider), 2010AB (Pay-to Provider), or 2310D Service Facility Location loops. All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.

Guideline Note 2:

NM1*TL*2*A-OK MOBILE CLINIC*****24*11122333~

REF Service Facility Location Secondary Identification

Pos: 525	Max: 5
Detail - Optional	
Loop: 2420C	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "LU".

CodeList Summary (Total Codes: 1503, Included: 13)

Code Name

- 0B State License Number
- 1A Blue Cross Provider Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- TJ Federal Taxpayer's Identification Number
- X4 Clinical Laboratory Improvement Amendment Number
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Service Facility Location Secondary Identifier

Guideline Note 2: Service Facility Location Secondary Identification Number

State Specific Note 1:

2009-10 - ND - Enter the Facility's Medicaid Provider Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

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

Guideline Note 2:

*REF*1D*A12345~*

NM1 Referring Provider Name

Pos: 500	Max: 1
Detail - Optional	
Loop: 2420F	Elements: 8

User Option (Usage): Situational

Purpose: To supply the full name of an individual or organizational entity

Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM101	98	Entity Identifier Code	M	ID	2/3	Required

Description: Code identifying an organizational entity, a physical location, property or an individual

State Specific Note 1:

2009-10 - ND - Enter the value "DN".

CodeList Summary (Total Codes: 1312, Included: 2)

Code Name

DN Referring Provider
P3 Primary Care Provider

Description: Physician that is selected by the insured to provide medical care

NM102	1065	Entity Type Qualifier	M	ID	1/1	Required
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Description: Code qualifying the type of entity

CodeList Summary (Total Codes: 14, Included: 1)

Code Name

1 Person

NM103	1035	Name Last or Organization Name	O	AN	1/35	Required
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Description: Individual last name or organizational name

Guideline Note 1: Referring Provider Last Name

Guideline Note 4: FB1-10.0

NM104	1036	Name First	O	AN	1/25	Required
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Description: Individual first name

Guideline Note 1: Referring Provider First Name

Guideline Note 4: FB1-11.0

NM105	1037	Name Middle	O	AN	1/25	Situational
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Description: Individual middle name or initial

Guideline Note 1: Referring Provider Middle Name

Guideline Note 4: FB1-12.0

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
		Guideline Note 5: Required if NM102=1 and the middle name/initial of the person is known.				
NM107	1039	Name Suffix Description: Suffix to individual name Guideline Note 1: Referring Provider Name Suffix Guideline Note 2: Referring Provider Generation Guideline Note 5: Required if known.	O	AN	1/10	Situational
NM108	66	Identification Code Qualifier Description: Code designating the system/method of code structure used for Identification Code (67) Guideline Note 5: Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known. State Specific Note 1: 2009-10 - ND - Enter the value "XX". CodeList Summary (Total Codes: 215, Included: 3) Code Name 24 Employer's Identification Number 34 Social Security Number XX Health Care Financing Administration National Provider Identifier Description: Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	C	ID	1/2	Situational
NM109	67	Identification Code Description: Code identifying a party or other code Guideline Note 1: Referring Provider Identifier Guideline Note 2: Referring Provider's Identification Number Guideline Note 4: FB1-13.0, FA0-24.0 Guideline Note 5: Required if either Employer's Identification/Social Security Number (Referring Provider tax ID) or National Provider Identifier is known. State Specific Note 1: 2009-10 - ND - Enter the Referring Provider's NPI. ExternalCodeList Name: 537 Description: Health Care Financing Administration National Provider Identifier	C	AN	2/80	Situational

Syntax Rules:

1. P0809 - If either NM108 or NM109 is present, then the other is required.
2. C1110 - If NM111 is present, then NM110 is required.

Semantics:

1. NM102 qualifies NM103.

Comments:

1. NM110 and NM111 further define the type of entity in NM101.

Guideline Note 1:

1. *Because the usage of this segment is "Situational" this is not a syntactically required loop. If this loop is used, then this segment is a "Required" segment. See Appendix A for further details on ASC X12 syntax rules.*
2. *Required if this service line involves a referral and the referring provider is different than the rendering provider and if the referring provider differs from that reported at the claim level (loop 2310A). All payer-specific identifying numbers belong to the destination payer identified in the 2010BB loop.*
3. *When there is only one referral on the service line use code "DN -Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code DN in the first iteration of this loop to indicate the referral received by the rendering provider on this service line. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.*

Guideline Note 2:

*NM1*DN*1*WELBY*MARCUS*W**JR*34*444332222~*

REF Referring Provider Secondary Identification

Pos: 525	Max: 5
Detail - Optional	
Loop: 2420F	Elements: 2

User Option (Usage): Situational

Purpose: To specify identifying information

Element Summary:

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

Description: Code qualifying the Reference Identification

State Specific Note 1:

2009-10 - ND - Enter the value "LU".

CodeList Summary (Total Codes: 1503, Included: 12)

Code Name

- 0B State License Number
- 1B Blue Shield Provider Number
- 1C Medicare Provider Number
- 1D Medicaid Provider Number
- 1G Provider UPIN Number
- 1H CHAMPUS Identification Number
- EI Employer's Identification Number
- G2 Provider Commercial Number
Description: A unique number assigned to a provider by a commercial insurer
- LU Location Number
- N5 Provider Plan Network Identification Number
Description: A number assigned to identify a specific provider in a health care plan network
- SY Social Security Number
- X5 State Industrial Accident Provider Number

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

Guideline Note 1: Referring Provider Secondary Identifier

State Specific Note 1:

2009-10 - ND - Enter the Referring Provider's Medicaid Provider Number.

Syntax Rules:

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

Semantics:

1. REF04 contains data relating to the value cited in REF02.

Guideline Note 1:

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

Guideline Note 2:

*REF*1D*A12345~*