

# 837 Health Care Claim: Dental

Functional Group ID=**HC**

## Introduction:

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.

## Notes:

### X12N HIPAA Notes:

The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is as follows: billing provider, subscriber, patient, claim level, and claim service line level. Billing providers who sort claims using this hierarchy use the 837 more efficiently because information that applies to all lower levels in the hierarchy does not have to be repeated within the transaction.

The developers of this implementation guide also recommend this standard for submitting similar data within a prepaid 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 prepaid and request for payment services. This standard allows for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may be used by payers to share data with plan sponsors, employers, regulatory entities, and Community Health Information Networks.

This standard also can be used as a transaction set in support of the Coordination of Benefits (COB) 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.

### ODJFS User Note:

Encounter claims do not need to be sent in 837 format at this point in time.

For each element, in addition to the notes and examples provided by HIPAA, there will be ODJFS User Notes and/or ODJFS Application Notes. These notes will provide information about the rules used for processing claims.

Federally Qualified Health Clinics (FQHCs) and Rural Health Clinics (RHCs) should bill dental procedures on the 837P. Dental groups, individual dentists and fee-for service clinics providing dental services should bill dental procedures on the 837D.

The symbol N/U is used for Not Used elements throughout the document.

## Heading:

Page No.	Pos. No.	Seg. ID	Name	HIPAA Usage	ODJFS Usage	Max.Use	Loop Repeat	Notes and Comments
6	003	ISA	Interchange Control Header	R	R	1		

9	004	GS	Functional Group Header	R	R	1	
11	005	ST	Transaction Set Header	R	R	1	
12	010	BHT	Beginning of Hierarchical Transaction	R	R	1	
14	015	REF	Transmission Type Identification	R	R	1	
						LOOP ID - 1000A	1
15	020	NM1	Submitter Name	R	R	1	n1
17	045	PER	Submitter Contact Information	R	R	2	
						LOOP ID - 1000B	1
19	020	NM1	Receiver Name	R	R	1	

**Detail:**

Page No.	Pos. No.	Seg. ID	Name	HIPAA Usage	ODJFS Usage	Max.Use	Loop Repeat	Notes and Comments
						LOOP ID - 2000A	>1	
21	001	HL	Billing/Pay-to Provider Hierarchical Level	S	R	1		
23	003	PRV	Billing/Pay-to Provider Specialty Information	R	S	1		
	010	CUR	Foreign Currency Information	R	Not Used	1		
						LOOP ID - 2010AA	1	
25	015	NM1	Billing Provider Name	R	R	1		
28	025	N3	Billing Provider Address	S	R	1		
29	030	N4	Billing Provider City/State/ZIP Code	S	R	1		
30	035	REF	Billing Provider Secondary Identification Number	S	S	5	n2	
	035	REF	Claim Submitter Credit/Debit Card Information	R	Not Used	8		
						LOOP ID - 2010AB	1	
32	015	NM1	Pay-to Provider's Name	R	S	1		
35	025	N3	Pay-to Provider's Address	R	R	1		
36	030	N4	Pay-to Provider City/State/Zip	R	R	1		
37	035	REF	Pay-to Provider Secondary Identification Number	Not Used	S	5		
						LOOP ID - 2000B	>1	
39	001	HL	Subscriber Hierarchical Level	R	R	1		
41	005	SBR	Subscriber Information	S	R	1		
						LOOP ID - 2010BA	1	
43	015	NM1	Subscriber Name	S	R	1		
	025	N3	Subscriber Address	S	Not Used	1		
	030	N4	Subscriber City/State/ZIP Code	S	Not Used	1		
45	032	DMG	Subscriber Demographic Information	S	S	1		
	035	REF	Subscriber Secondary Identification	S	Not Used	4		
	035	REF	Property and Casualty Claim Number	R	Not Used	1		
						LOOP ID - 2010BB	1	
46	015	NM1	Payer Name	S	R	1		
	025	N3	Payer Address	S	Not Used	1		
	030	N4	Payer City/State/ZIP Code	S	Not Used	1		
	035	REF	Payer Secondary Identification Number	R	Not Used	3	n3	
						LOOP ID - 2010BC	1	
	015	NM1	Credit/Debit Card Holder Name	R	Not Used	1		
	035	REF	Credit/Debit Card Information	R	Not Used	3		
						LOOP ID - 2300	100	
48	130	CLM	Claim Information	S	R	1		

	135	DTP	Date - Admission	S	Not Used	1
	135	DTP	Date - Discharge	S	Not Used	1
	135	DTP	Date - Referral	S	Not Used	1
53	135	DTP	Date - Accident	S		1
54	135	DTP	Date - Appliance Placement	S	S	5
55	135	DTP	Date - Service	S	S	1
	145	DN1	Orthodontic Total Months of Treatment	S	Not Used	1
	150	DN2	Tooth Status	R	Not Used	35
	155	PWK	Claim Supplemental Information	S	Not Used	10
56	175	AMT	Patient Amount Paid	R	S	1
	175	AMT	Credit/Debit Card - Maximum Amount	S	Not Used	1
	180	REF	Predetermination Identification	R	Not Used	5
	180	REF	Service Authorization Exception Code	Not Used	Not Used	1
57	180	REF	Original Reference Number (ICN/DCN)	Not Used	S	1
58	180	REF	Prior Authorization or Referral Identification	S	S	2
	180	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	R	Not Used	1
59	190	NTE	Claim Note	R	S	20
LOOP ID - 2310A						2
60	250	NM1	Referring Provider Name	R	S	1
	255	PRV	Referring Provider Specialty Information	Not Used	Not Used	1
63	271	REF	Referring Provider Secondary Identification	S	S	5
LOOP ID - 2310B						1
65	250	NM1	Rendering Provider Name	S	S	1
67	255	PRV	Rendering Provider Specialty Information	S	S	1
68	271	REF	Rendering Provider Secondary Identification	S	S	5
LOOP ID - 2310C						1
	250	NM1	Service Facility Location	Not Used	Not Used	1
	271	REF	Service Facility Location Secondary Identification	S	Not Used	5
LOOP ID - 2310D						1
69	280	NM1	Assistant Surgeon Name	S	S	1
	285	PRV	Assistant Surgeon Specialty Information	S	Not Used	1
71	287	REF	Assistant Surgeon Secondary Identification	S	S	1
LOOP ID - 2320						10
72	290	SBR	Other Subscriber Information	Not Used	S	1
75	295	CAS	Claim Adjustment	S	S	5
80	300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	S	1
81	300	AMT	Coordination of Benefits (COB) Approved Amount	Not Used	S	1
82	300	AMT	Coordination of Benefits (COB) Allowed Amount	S	S	1
83	300	AMT	Coordination of Benefits (COB) Patient Responsibility Amount	Not Used	S	1
	300	AMT	Coordination of Benefits (COB) Covered Amount	Not Used	Not Used	1
	300	AMT	Coordination of Benefits (COB) Discount Amount	Not Used	Not Used	1
	300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	Not Used	1
84	305	DMG	Other Insured Demographic Information	S	S	1
85	310	OI	Other Insurance Coverage Information	S	R	1
LOOP ID - 2330A						1

86	325	NM1	Other Subscriber Name	R	R	1
	332	N3	Other Subscriber Address	S	Not Used	1
	340	N4	Other Subscriber City/State/Zip Code	R	Not Used	1
	355	REF	Other Subscriber Secondary Identification	S	Not Used	3
LOOP ID - 2330B						1
88	325	NM1	Other Payer Name	S	R	1
	345	PER	Other Payer Contact Information	S	Not Used	2
90	350	DTP	Claim Paid Date	Not Used	S	1
	355	REF	Other Payer Secondary Identifier	S	Not Used	3
	355	REF	Other Payer Prior Authorization or Referral Number	S	Not Used	2
	355	REF	Other Payer Claim Adjustment Indicator	S	Not Used	1
LOOP ID - 2330C						1
91	325	NM1	Other Payer Patient Information	S	S	1
	355	REF	Other Payer Patient Identification	S	Not Used	3
LOOP ID - 2330D						1
	325	NM1	Other Payer Referring Provider	S	Not Used	1
	355	REF	Other Payer Referring Provider Identification	S	Not Used	3
LOOP ID - 2330E						1
	325	NM1	Other Payer Rendering Provider	S	Not Used	1
	355	REF	Other Payer Rendering Provider Identification	S	Not Used	3
LOOP ID - 2400						50
93	365	LX	Line Counter	S	R	1
94	380	SV3	Dental Service	S	R	1
99	382	TOO	Tooth Information	S	S	32
101	455	DTP	Date - Service	S	S	1
102	455	DTP	Date - Prior Placement	S	S	1
103	455	DTP	Date - Appliance Placement	S	S	1
104	455	DTP	Date - Replacement	S	S	1
	460	QTY	Anesthesia Quantity	S	Not Used	5
	470	REF	Service Predetermination Identification	S	Not Used	1
105	470	REF	Prior Authorization or Referral Number	S	S	2
106	470	REF	Line Item Control Number	S	S	1
	475	AMT	Approved Amount	S	Not Used	1
	475	AMT	Sales Tax Amount	S	Not Used	1
	485	NTE	Line Note	S	Not Used	10
LOOP ID - 2420A						1
107	500	NM1	Rendering Provider Name	S	S	1
	505	PRV	Rendering Provider Specialty Information	S	Not Used	1
109	525	REF	Rendering Provider Secondary Identification	S	S	5
LOOP ID - 2420B						1
	500	NM1	Other Payer Prior Authorization or Referral Number	S	Not Used	1
	525	REF	Other Payer Prior Authorization or Referral Number	S	Not Used	2
LOOP ID - 2420C						1
110	280	NM1	Assistant Surgeon Name	S	S	1
	285	PRV	Assistant Surgeon Specialty Information	S	Not Used	1
112	287	REF	Assistant Surgeon Secondary Identification	S	S	1

LOOP ID - 2430				25		
113	540	SVD	Line Adjudication Information	S	S	1
116	545	CAS	Service Adjustment	S	S	99
121	550	DTP	Line Adjudication Date	S	R	1

**Summary:**

<u>Page No.</u>	<u>Pos. No.</u>	<u>Seg. ID</u>	<u>Name</u>	<u>HIPAA Usage</u>	<u>ODJFS Usage</u>	<u>Max.Use</u>	<u>Loop Repeat</u>	<u>Notes and Comments</u>
122	555	SE	Transaction Set Trailer	R	R	1		
123	565	GE	Functional Group Trailer	R	R	1		
124	575	IEA	Interchange Control Trailer	R	R	1		

**Transaction Set Notes**

1. Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
2. 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.
3. The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

**Segment:** **ISA** Interchange Control Header  
**Position:** 003  
**Loop:**  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To start and identify an interchange of zero or more functional groups and interchange-related control segments

**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

**X12N HIPAA Example**

```
ISA*00*.....*01*SECRET...*ZZ*SUBMITTERS.ID..*ZZ*RECEIVERS.ID...*93060
2*1253*U*00401*000000905*1*T*::~
```

**ODJFS User Note**

```
ISA*00*.....*00*.....*ZZ*7.DIGIT.ID.....*ZZ*MMISODJFS.....*031016*1253*U*
00401*000000001*0*P*::~
```

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
ISA01	I01	<b>Authorization Information Qualifier</b> Code to identify the type of information in the Authorization Information 00 No Authorization Information Present (No Meaningful Information in I02) <b>X12N HIPAA Notes:</b> ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.	M ID 2/2	R
ISA02	I02	<b>Authorization Information</b> 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) <b>ODJFS User Note:</b> This field should contain all spaces.	M AN 10/10	R
ISA03	I03	<b>Security Information Qualifier</b> Code to identify the type of information in the Security Information 00 No Security Information Present (No Meaningful Information in I04) <b>X12N HIPAA Notes:</b> ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.	M ID 2/2	R
ISA04	I04	<b>Security Information</b> 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) <b>ODJFS User Note:</b> This field should contain all spaces.	M AN 10/10	R
ISA05	I05	<b>Interchange ID Qualifier</b> Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified	M ID 2/2	R

**X12N HIPAA Notes:**

This ID qualifies the Sender in ISA06.

		ZZ	Mutually Defined			
<b>ISA06</b>	<b>I06</b>	<b>Interchange Sender ID</b>		<b>M</b>	<b>AN 15/15</b>	<b>R</b>
		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				
		<b>ODJFS User Note:</b>				
		This field should contain the 7-digit Medicaid Trading Partner ID assigned to the sender of this file. Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.				
<b>ISA07</b>	<b>I05</b>	<b>Interchange ID Qualifier</b>		<b>M</b>	<b>ID 2/2</b>	<b>R</b>
		Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified				
		<b>X12N HIPAA Notes:</b>				
		This ID qualifies the Receiver in ISA08.				
		ZZ	Mutually Defined			
<b>ISA08</b>	<b>I07</b>	<b>Interchange Receiver ID</b>		<b>M</b>	<b>AN 15/15</b>	<b>R</b>
		Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them				
		<b>ODJFS User Note:</b>				
		This field should contain the value MMISODJFS assigned to the receiver of this file (Ohio Department of Job and Family Services). Since this is a fixed-length field, it should be filled with spaces to meet the minimum length requirement of 15.				
<b>ISA09</b>	<b>I08</b>	<b>Interchange Date</b>		<b>M</b>	<b>DT 6/6</b>	<b>R</b>
		Date of the interchange				
		<b>X12N HIPAA Notes:</b>				
		The date format is YYMMDD.				
<b>ISA10</b>	<b>I09</b>	<b>Interchange Time</b>		<b>M</b>	<b>TM 4/4</b>	<b>R</b>
		Time of the interchange				
		<b>X12N HIPAA Notes:</b>				
		The time format is HHMM.				
<b>ISA11</b>	<b>I10</b>	<b>Interchange Control Standards Identifier</b>		<b>M</b>	<b>ID 1/1</b>	<b>R</b>
		Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer				
		U	U.S. EDI Community of ASC X12, TDCC, and UCS			
<b>ISA12</b>	<b>I11</b>	<b>Interchange Control Version Number</b>		<b>M</b>	<b>ID 5/5</b>	<b>R</b>
		This version number covers the interchange control segments				
		00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedures Review Board through October 1997			
<b>ISA13</b>	<b>I12</b>	<b>Interchange Control Number</b>		<b>M</b>	<b>N0 9/9</b>	<b>R</b>
		A control number assigned by the interchange sender				
		<b>X12N HIPAA Notes:</b>				
		The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.				
<b>ISA14</b>	<b>I13</b>	<b>Acknowledgment Requested</b>		<b>M</b>	<b>ID 1/1</b>	<b>R</b>
		Code sent by the sender to request an interchange acknowledgment (TA1)				
		<b>X12N HIPAA Notes:</b>				
		See Section A.1.5.1 for interchange acknowledgment information.				
		<b>ODJFS User Note:</b>				
		ODJFS will return an acknowledgment segment (TA1) for the ISA if requested.				
		0	No Acknowledgment Requested			
		1	Interchange Acknowledgment Requested			
<b>ISA15</b>	<b>I14</b>	<b>Usage Indicator</b>		<b>M</b>	<b>ID 1/1</b>	<b>R</b>

Code to indicate whether data enclosed by this interchange envelope is test, production or information

P Production Data

T Test Data

**ISA16**

**I15**

**Component Element Separator**

**M AN 1/1 R**

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

**Segment:** **GS** Functional Group Header  
**Position:** 004  
**Loop:**  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To indicate the beginning of a functional group and to provide control information  
**Syntax Notes:**  
**Semantic Notes:**

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

**Comments:**

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

**Notes:** **X12N HIPAA Example**

GS\*HC\*SENDER CODE\*RECEIVER CODE\*19940331\*0802\*1\*X\*004010X097~

**ODJFS User Note**

GS\*HC\*MEDICAID ID\*MMISODJFS\*20031016\*0802\*1\*X\*004010X097A1~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
GS01	479	<b>Functional Identifier Code</b> Code identifying a group of application related transaction sets HC Health Care Claim (837)	M ID 2/2	R
GS02	142	<b>Application Sender's Code</b> Code identifying party sending transmission; codes agreed to by trading partners <b>Business Rules:</b> 1. ALWAYS use Application Value List '7NUMERIC' <b>X12N HIPAA Notes:</b> Use this code to identify the unit sending the information. <b>ODJFS User Note:</b> This field should contain the 7-digit Medicaid Trading ID assigned to the sender of this file.	M AN 2/15	R
GS03	124	<b>Application Receiver's Code</b> Code identifying party receiving transmission; codes agreed to by trading partners <b>Business Rules:</b> 1. ALWAYS use Application Value List 'ODJFS' <b>X12N HIPAA Notes:</b> Use this code to identify the unit receiving the information. <b>ODJFS User Note:</b> This field should contain the value MMISODJFS assigned to the receiver of this file (Ohio Department of Job and Family Services).	M AN 2/15	R
GS04	373	<b>Date</b> Date expressed as CCYYMMDD <b>X12N HIPAA Notes:</b> Use this date for the functional group creation date.	M DT 8/8	R
GS05	337	<b>Time</b> Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) <b>X12N HIPAA Notes:</b> Use this time for the creation time. The recommended format is HHMM.	M TM 4/8	R

<b>GS06</b>	<b>28</b>	<b>Group Control Number</b>	<b>M</b>	<b>N0 1/9</b>	<b>R</b>
		Assigned number originated and maintained by the sender			
<b>GS07</b>	<b>455</b>	<b>Responsible Agency Code</b>	<b>M</b>	<b>ID 1/2</b>	<b>R</b>
		Code used in conjunction with Data Element 480 to identify the issuer of the standard			
		X	Accredited Standards Committee X12		
<b>GS08</b>	<b>480</b>	<b>Version / Release / Industry Identifier Code</b>	<b>M</b>	<b>AN 1/12</b>	<b>R</b>
		Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments; if code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the 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			
		004010X097A1			

Draft Standards Approved for Publication by ASC X12 Procedures Review Board through October 1997, as published in this implementation guide.

**X12N HIPAA Notes:**

This is a Draft Addenda to the X12N 004010X097 Implementation Guide published in May 2000 and not yet intended for implementation. Since the 004010X097 guide is named for use under HIPAA, this Draft Addenda must go through a Notice of Proposed Rule Making (NPRM) process, just as the original Implementation Guide did, before becoming a final addenda to the guide published by X12N. Only the modifications noted in this Draft Addenda will be considered in the NPRM. Once this Draft addenda is approved for publication by X12N, the value used in GS08 will be "0040X097A1".

**Segment:** **ST** Transaction Set Header  
**Position:** 005  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the start of a transaction set and to assign a control number  
**Syntax Notes:**  
**Semantic Notes:** 1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).  
**Comments:**  
**Notes:** **X12N HIPAA Example**  
 Example: ST\*837\*987654~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
ST01	143	<b>Transaction Set Identifier Code</b> Code uniquely identifying a Transaction Set <b>X12N HIPAA Notes:</b> INDUSTRY: Transaction Set Identifier Code 837 Health Care Claim <b>X12N HIPAA Notes:</b> REQUIRED	M ID 3/3	R
ST02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>X12N HIPAA Notes:</b> 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. ALIAS: Transaction Set Control Number INDUSTRY: Transaction Set Control Number	M AN 4/9	R

**Segment:** **BHT** Beginning of Hierarchical Transaction  
**Position:** 010  
**Loop:**  
**Level:** Heading  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

**Syntax Notes:**  
**Semantic Notes:**

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

**Comments:**  
**Notes:** **X12N HIPAA Example**  
 Example: BHT\*0019\*00\*0123\*19980108\*0932\*CH~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
BHT01	1005	<b>Hierarchical Structure Code</b> Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set <b>X12N HIPAA Notes:</b> INDUSTRY: Hierarchical Structure Code 0019 Information Source, Subscriber, Dependent	M ID 4/4	R
BHT02	353	<b>Transaction Set Purpose Code</b> Code identifying purpose of transaction set <b>X12N HIPAA Notes:</b> BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. NSF Reference: AA0-23.0 INDUSTRY: Transaction Set Purpose Code 00 Original <b>X12N HIPAA Notes:</b> Original transmission are claims/encounters which have never been sent to the receiver. Generally, nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. 18 Reissue <b>X12N HIPAA Notes:</b> In the case where a transmission was disrupted, the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.	M ID 2/2	R
BHT03	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>X12N HIPAA Notes:</b> The inventory file number of the transmission assigned by the submitter's system. This number operates as a batch control number. It may or may not be identical to the number carried in the ST02. NSF Reference: AA0-05.0	O AN 1/30	R

<b>BHT04</b>	<b>373</b>	<p><b>INDUSTRY:</b> Originator Application Transaction Identifier</p> <p><b>Date</b> <b>O DT 8/8 R</b></p> <p>Date expressed as CCYYMMDD</p> <p><b>X12N HIPAA Notes:</b></p> <p>Use this date to identify the date on which the submitter created the file.</p> <p>NSF Reference: AA0-15.0</p>						
<b>BHT05</b>	<b>337</b>	<p><b>INDUSTRY:</b> Transaction Set Creation Date</p> <p><b>Time</b> <b>O TM 4/8 R</b></p> <p>Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)</p> <p><b>X12N HIPAA Notes:</b></p> <p>Use the time to identify the time of day that the submitter created the file.</p> <p>NSF Reference: AA0-16.0</p>						
<b>BHT06</b>	<b>640</b>	<p><b>INDUSTRY:</b> Transaction Set Creation Time</p> <p><b>Transaction Type Code</b> <b>O ID 2/2 R</b></p> <p>Code specifying the type of transaction</p> <p><b>X12N HIPAA Notes:</b></p> <p>Although this element is required, submitters are not necessarily required to accurately batch claims and encounters at this level. Generally, CH is used for claims and RP is used for encounters. However, use "CH" if an ST-SE envelope contains both claims and encounters. Some trading partner agreements may specify using only one code.</p> <p>ALIAS: Claim or Encounter Indicator</p> <p><b>INDUSTRY:</b> Claim or Encounter Identifier</p> <table border="0"> <tr> <td data-bbox="496 1125 532 1150">CH</td> <td data-bbox="696 1125 818 1150">Chargeable</td> </tr> <tr> <td></td> <td data-bbox="696 1161 1453 1346"> <p><b>X12N HIPAA Notes:</b></p> <p>Use this code when the transmission contains only Fee-for-service claims or claims with at least one chargeable item. If it is not clear whether a transaction is a claim or an encounter, the developers of this implementation guide recommend submitting the transaction as a claim.</p> </td> </tr> <tr> <td data-bbox="496 1356 532 1381">RP</td> <td data-bbox="696 1356 1453 1629"> <p>Reporting</p> <p><b>X12N HIPAA Notes:</b></p> <p>Use RP when the entire ST-SE envelope contains encounter transmissions.</p> <p>Use RP when the transmission is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.</p> </td> </tr> </table>	CH	Chargeable		<p><b>X12N HIPAA Notes:</b></p> <p>Use this code when the transmission contains only Fee-for-service claims or claims with at least one chargeable item. If it is not clear whether a transaction is a claim or an encounter, the developers of this implementation guide recommend submitting the transaction as a claim.</p>	RP	<p>Reporting</p> <p><b>X12N HIPAA Notes:</b></p> <p>Use RP when the entire ST-SE envelope contains encounter transmissions.</p> <p>Use RP when the transmission is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.</p>
CH	Chargeable							
	<p><b>X12N HIPAA Notes:</b></p> <p>Use this code when the transmission contains only Fee-for-service claims or claims with at least one chargeable item. If it is not clear whether a transaction is a claim or an encounter, the developers of this implementation guide recommend submitting the transaction as a claim.</p>							
RP	<p>Reporting</p> <p><b>X12N HIPAA Notes:</b></p> <p>Use RP when the entire ST-SE envelope contains encounter transmissions.</p> <p>Use RP when the transmission is being sent to an entity (usually not a payer or a normal provider-payer transmission intermediary) for purposes other than adjudication of a claim. Such an entity could be a state health data agency which is using the 837 for health data reporting purposes.</p>							

**Segment:** **REF** **Transmission Type Identification**  
**Position:** 015  
**Loop:**  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:** **X12N HIPAA Notes**  
The information carried in this REF is identical to that carried in the GS08. Because the commercial translator community is roughly evenly split on where they look for the implementation guide type, this number is carried in both places.  
**X12N HIPAA Example**  
Example: REF\*87\*004010X097A1~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>		<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>	<u>Name</u>	<u>Attributes</u>	<u>Attributes</u>
REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification <b>X12N HIPAA Notes:</b> INDUSTRY: Reference Identification Qualifier 87 Functional Category An organization or groups of organizations with a common operational orientation such as Quality Control Engineering, etc	M ID 2/3	R
REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>X12N HIPAA Notes:</b> When piloting the transaction set, this value is 004010X097DA1. When sending the transaction set in a production mode, this value is 004010X097A1. INDUSTRY: Transmission Type Code 004010X097A1 Production <b>X12N HIPAA Notes:</b> When sending the transaction set in a production mode, this value is 004010X097A1.	X AN 1/30	R

**Segment:** **NM1** Submitter Name  
**Position:** 020  
**Loop:** 1000A Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

See Section 2.4, Loop ID-1000 for a detailed description about using Loop ID-1000. Ignore the Set Notes below.

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

The example in this NM1 and the subsequent N2 demonstrates how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.

**X12N HIPAA Example**

Example: NM1\*41\*2\*CRAMMER, DOLE, PALMER, AND JOHANSON\*\*\*\*\*46\*W7933THU~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Identifier Code 41 Submitter Entity transmitting transaction set	M ID 2/3	R
NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <b>X12N HIPAA Notes:</b> ALIAS: Submitter Name NSF Reference: AA0-06.0 INDUSTRY: Submitter Last or Organization Name	O AN 1/35	R
NM104	1036	<b>Name First</b> Individual first name <b>X12N HIPAA Notes:</b> Required if NM102 = 1 (person). ALIAS: Submitter Name INDUSTRY: Submitter First Name	O AN 1/25	S
NM105	1037	<b>Name Middle</b> Individual middle name or initial	O AN 1/25	S

**X12N HIPAA Notes:**

Required if NM102 = 1 and the middle name/initial of the person is known.

ALIAS: Submitter Name

INDUSTRY: Submitter Middle Name

<b>NM106</b>	<b>1038</b>	<b>Name Prefix</b>	<b>O</b>	<b>AN 1/10</b>	<b>N/U</b>
<b>NM107</b>	<b>1039</b>	<b>Name Suffix</b>	<b>O</b>	<b>AN 1/10</b>	<b>N/U</b>
<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b>	<b>X</b>	<b>ID 1/2</b>	<b>R</b>

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

**X12N HIPAA Notes:**

INDUSTRY: Identification Code Qualifier

46                      Electronic Transmitter Identification Number (ETIN)  
 A unique number assigned to each transmitter and software developer

**X12N HIPAA Notes:**

Established by trading partner agreement.

<b>NM109</b>	<b>67</b>	<b>Identification Code</b>	<b>X</b>	<b>AN 2/80</b>	<b>R</b>	<b>AN 7/7</b>
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Code identifying a party or other code

**X12N HIPAA Notes:**

ALIAS: Submitter Primary Identification Number

NSF Reference: AA0-02.0, ZA0-02.0

INDUSTRY: Submitter Identifier

**ODJFS User Note:**

This is the seven digit number ODJFS assigned to the Medicaid Trading Partner. Medicaid providers assigned to identify healthcare providers (e.g. Dentists) are not valid.

Medicaid Trading Partners with a test status may only submit test EDI transactions. Medicaid Trading Partners with an active status may submit business transactions to ODJFS. A Medicaid Trading Partner is given an active status when they have passed the testing phase and met all of the criteria specified by ODJFS.

**Segment:** **PER** **Submitter Contact Information**  
**Position:** 045  
**Loop:** 1000A Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 2  
**Purpose:** To identify a person or office to whom administrative communications should be directed  
**Syntax Notes:**

- 1 If either PER03 or PER04 is present, then the other is required.
- 2 If either PER05 or PER06 is present, then the other is required.
- 3 If either PER07 or PER08 is present, then the other is required.

**Semantic Notes:**

**Comments:**

**Notes:**

**X12N HIPAA Notes**

This segment is used to identify the EDI contact person.

Each communication number should always include the area code. The extension, when applicable, should be included in the appropriate PER element immediately after the telephone number (e.g., if the telephone number is included in the PER04, then the extension should be in the PER06).

When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number should always include the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (534)224-2525 would be represented as 5342242525). The extension, when applicable, should be included in the communication number immediately after the telephone number.

By definition of the standard, if PER03 is used, PER04 is required.

**X12N HIPAA Example**

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

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PER01	366	Contact Function Code	M ID 2/2	R
Code identifying the major duty or responsibility of the person or group named				
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Contact Function Code				
		IC Information Contact		
PER02	93	Name	O AN 1/60	R
Free-form name				
<b>X12N HIPAA Notes:</b>				
Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).				
NSF Reference: AA0-13.0				
INDUSTRY: Submitter Contact Name				
PER03	365	Communication Number Qualifier	X ID 2/2	R
Code identifying the type of communication number				
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Communication Number Qualifier				
		ED Electronic Data Interchange Access Number		
		EM Electronic Mail		
		FX Facsimile		

		TE	Telephone			
<b>PER04</b>	<b>364</b>	<b>Communication Number</b>		<b>X</b>	<b>AN 1/80</b>	<b>R</b>
		Complete communications number including country or area code when applicable				
		<b>X12N HIPAA Notes:</b>				
		NSF Reference: AA0-14.0				
		INDUSTRY: Communication Number				
<b>PER05</b>	<b>365</b>	<b>Communication Number Qualifier</b>		<b>X</b>	<b>ID 2/2</b>	<b>S</b>
		Code identifying the type of communication number				
		<b>X12N HIPAA Notes:</b>				
		Used at the discretion of the submitter.				
		INDUSTRY: Communication Number Qualifier				
		ED	Electronic Data Interchange Access Number			
		EM	Electronic Mail			
		EX	Telephone Extension			
		FX	Facsimile			
		TE	Telephone			
<b>PER06</b>	<b>364</b>	<b>Communication Number</b>		<b>X</b>	<b>AN 1/80</b>	<b>S</b>
		Complete communications number including country or area code when applicable				
		<b>X12N HIPAA Notes:</b>				
		Used at the discretion of the submitter.				
		INDUSTRY: Communication Number				
<b>PER07</b>	<b>365</b>	<b>Communication Number Qualifier</b>		<b>X</b>	<b>ID 2/2</b>	<b>S</b>
		Code identifying the type of communication number				
		<b>X12N HIPAA Notes:</b>				
		Used at the discretion of the submitter.				
		INDUSTRY: Communication Number Qualifier				
		ED	Electronic Data Interchange Access Number			
		EM	Electronic Mail			
		EX	Telephone Extension			
		FX	Facsimile			
		TE	Telephone			
<b>PER08</b>	<b>364</b>	<b>Communication Number</b>		<b>X</b>	<b>AN 1/80</b>	<b>S</b>
		Complete communications number including country or area code when applicable				
		<b>X12N HIPAA Notes:</b>				
		Used at the discretion of the submitter.				
		INDUSTRY: Communication Number				

**Segment:** **NM1** Receiver Name  
**Position:** 020  
**Loop:** 1000B Optional (Must Use)  
**Level:** Heading  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

**X12N HIPAA Example**

Example: NM1\*40\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*46\*111222333~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Identifier Code 40 Receiver Entity to accept transmission	M ID 2/3	R
NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier 2 Non-Person Entity	M ID 1/1	R
NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <b>X12N HIPAA Notes:</b> ALIAS: Receiver Name INDUSTRY: Receiver Name	O AN 1/35	R
NM104	1036	<b>Name First</b>	O AN 1/25	N/U
NM105	1037	<b>Name Middle</b>	O AN 1/25	N/U
NM106	1038	<b>Name Prefix</b>	O AN 1/10	N/U
NM107	1039	<b>Name Suffix</b>	O AN 1/10	N/U
NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) <b>X12N HIPAA Notes:</b> INDUSTRY: Identification Code Qualifier 46 Electronic Transmitter Identification Number (ETIN) A unique number assigned to each transmitter and software developer	X ID 1/2	R
NM109	67	<b>Identification Code</b> Code identifying a party or other code <b>X12N HIPAA Notes:</b> ALIAS: Receiver Primary Identification Number NSF Reference: AA0-17.0, ZA0-04.0	X AN 2/80	R



**Segment:** **HL Billing/Pay-to Provider Hierarchical Level**  
**Position:** 001  
**Loop:** 2000A Mandatory  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments

**Syntax Notes:**

**Semantic Notes:**

**Comments:**

- 1 The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.  
The HL segment defines a top-down/left-right ordered structure.
- 2 HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
- 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
- 4 HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
- 5 HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

**Notes:**

**X12N HIPAA Notes**

Use the Billing Provider HL to identify the original entity who submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The Billing Provider entity may be a health care provider, a billing service or some other representative of the provider.

The NSF fields shown in Loop ID-2010AA and Loop ID-2010AB are intended to carry the billing provider information, not billing service information. Refer to your NSF manual for proper use of these fields. If Loop 2010AA contains information on a billing service (rather than a billing provider), do not map the information in that loop to the NSF billing provider fields for Medicare claims.

The Billing/Pay-to Provider HL may contain information about the Pay-to Provider entity. If the Pay-to Provider entity is the same as the Billing Provider entity, then only use Loop ID-2010AA.

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

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Billing/Pay-to Provider Hierarchical Level loops there is an implied maximum of 5000.

If the Billing or Pay-to Provider is also the Rendering Provider and Loop ID-2310A is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.

**X12N HIPAA Example**

Example: HL\*1\*\*20\*1~

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
HL01	628	<b>Hierarchical ID Number</b> A unique number assigned by the sender to identify a particular data segment in a hierarchical structure <b>X12N HIPAA Notes:</b> HL01 must begin with "1" and be incremented by one each time an HL is used in the transaction. Only numeric values are allowed in HL01.	M AN 1/12	R
HL02	734	<b>Hierarchical Parent ID Number</b>	O AN 1/12	N/U
HL03	735	<b>Hierarchical Level Code</b> Code defining the characteristic of a level in a hierarchical structure <b>X12N HIPAA Notes:</b> INDUSTRY: Hierarchical Level Code 20 Information Source Identifies the payor, maintainer, or source of the information	M ID 1/2	R
HL04	736	<b>Hierarchical Child Code</b> Code indicating if there are hierarchical child data segments subordinate to the level being described <b>X12N HIPAA Notes:</b> INDUSTRY: Hierarchical Child Code 1 Additional Subordinate HL Data Segment in This Hierarchical Structure.	O ID 1/1	R

**Segment:** **PRV** Billing/Pay-to Provider Specialty Information  
**Position:** 003  
**Loop:** 2000A Mandatory  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify the identifying characteristics of a provider  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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.

If the Billing or Pay-to Provider is also the Rendering Provider, and Loop 2310B is not used, this PRV segment is required.

This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in Loop ID-2310B. The PRV segment is then coded with the Rendering Provider in Loop ID-2310B.

PRV02 qualifies PRV03.

**X12N HIPAA Example**

Example: PRV\*PT\*ZZ\*1223S0112Y~

**ODJFS User Note**

When the billing or "Pay To" provider is a professional group practice the 2310B loop must be completed. For ODJFS, adjudication is not impacted by the taxonomy number.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
PRV01	1221	<b>Provider Code</b> Code identifying the type of provider <b>X12N HIPAA Notes:</b> INDUSTRY: Provider Code <b>ODJFS User Note:</b> Enter "BI" if loop 2010AB or 2310B are not completed. Enter "PT" or "BI", whichever is applicable if both the 2010AA and 2010AB loops are submitted along with the 2310B. BI Billing PT Pay-To	M ID 1/3	R
PRV02	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification <b>X12N HIPAA Notes:</b> INDUSTRY: Reference Identification Qualifier ZZ Mutually Defined <b>X12N HIPAA Notes:</b> 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: <a href="http://www.wpc-edi.com">http://www.wpc-edi.com</a> . This taxonomy is maintained by the Blue Cross Blue Shield Association and ANSI ASC X12N TG2 WG15.	M ID 2/3	R
PRV03	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	M AN 1/30	R

**X12N HIPAA Notes:**

ALIAS: Provider Specialty Code

NSF Reference: BA0-22.0

INDUSTRY: Provider Taxonomy Code

**Segment:** **NM1 Billing Provider Name**  
**Position:** 015  
**Loop:** 2010AA Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

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

**X12N HIPAA Example**

Example: NM1\*85\*2\*DENTAL ASSOCIATES\*\*\*\*\*34\*123456789~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the billing provider is a dental group practice, the provider information for the rendering provider must be submitted in the 2310B loop.

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		<b>X12N HIPAA Notes:</b>		
		Use this code to indicate billing provider, billing submitter and encounter reporting entity.		
		INDUSTRY: Entity Identifier Code		
		85 Billing Provider		
		<b>X12N HIPAA Notes:</b>		
		Use this code when the provider is a submitting provider in a capitated environment.		
NM102	1065	Entity Type Qualifier	M ID 1/1	R

Code qualifying the type of entity

**X12N HIPAA Notes:**

INDUSTRY: Entity Type Qualifier

- 1 Person
- 2 Non-Person Entity

**NM103 1035 Name Last or Organization Name O AN 1/35 R**

Individual last name or organizational name

**X12N HIPAA Notes:**

ALIAS: Billing Provider Name

INDUSTRY: Billing Provider Last or Organizational Name

**NM104 1036 Name First O AN 1/25 S**

Individual first name

**X12N HIPAA Notes:**

Required if NM102 = 1 (person).

ALIAS: Billing Provider Name

INDUSTRY: Billing Provider First Name

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

Individual middle name or initial

**X12N HIPAA Notes:**

Required if NM102 = 1 and the middle name/initial of the person is known.

ALIAS: Billing Provider Name

INDUSTRY: Billing Provider Middle Name

**NM106 1038 Name Prefix O AN 1/10 N/U**

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

Suffix to individual name

**X12N HIPAA Notes:**

Required if known.

ALIAS: Billing Provider Name

INDUSTRY: Billing Provider Name Suffix

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

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

**X12N HIPAA Notes:**

If "XX - NPI" is used, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in the REF in this loop.

INDUSTRY: Identification Code Qualifier

- 24 Employer's Identification Number
- 34 Social Security Number
- XX Health Care Financing Administration National Provider Identifier

**NM109 67 Identification Code X AN 2/80 R**

Code identifying a party or other code

**X12N HIPAA Notes:**

ALIAS: Billing Provider's Primary Identification Number

NSF Reference: BA0-02.0, BA0-06.0, BA0-09.0, BA1-02.0, YA0-02.0, YA0-06.0

INDUSTRY: Billing Provider Identifier

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the billing provider is a dental group practice, the provider information for the rendering provider must be submitted in the 2310B loop.

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

**Segment:** N3 Billing Provider Address  
**Position:** 025  
**Loop:** 2010AA Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Example**

Example: N3\*225 MAIN STREET\*BARKLEY BUILDING~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
N301	166	<b>Address Information</b> Address information <b>X12N HIPAA Notes:</b> ALIAS: Billing Provider Address 1 NSF Reference: BA1-07.0, BA1-13.0	M AN 1/55	R
N302	166	<b>Address Information</b> Address information <b>X12N HIPAA Notes:</b> Required if a second address line exists. ALIAS: Billing Provider Address 2 NSF Reference: BA1-08.0, BA1-14.0 INDUSTRY: Billing Provider Address Line	O AN 1/55	S

**Segment:** **N4 Billing Provider City/State/ZIP Code**  
**Position:** 030  
**Loop:** 2010AA Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify the geographic place of the named party  
**Syntax Notes:** 1 If N406 is present, then N405 is required.  
**Semantic Notes:**  
**Comments:** 1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.  
2 N402 is required only if city name (N401) is in the U.S. or Canada.  
**Notes:** **X12N HIPAA Example**  
Example: N4\*CENTERVILLE\*PA\*17111~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N401	19	<b>City Name</b> Free-form text for city name <b>X12N HIPAA Notes:</b> ALIAS: Billing Provider's City NSF Reference: BA1-09.0, BA1-15.0 INDUSTRY: Billing Provider City Name	O AN 2/30	R
N402	156	<b>State or Province Code</b> Code (Standard State/Province) as defined by appropriate government agency <b>X12N HIPAA Notes:</b> ALIAS: Billing Provider's State NSF Reference: BA1-16.0, BA1-10.0 INDUSTRY: Billing Provider State or Province Code	O ID 2/2	R
N403	116	<b>Postal Code</b> Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <b>X12N HIPAA Notes:</b> ALIAS: Billing Provider's ZIP Code NSF Reference: BA1-11.0, BA1-17.0 INDUSTRY: Billing Provider Postal Zone or ZIP Code	O ID 3/15	R
N404	26	<b>Country Code</b> Code identifying the country <b>X12N HIPAA Notes:</b> Required if the address is out of the U.S. ALIAS: Billing Provider Country Code INDUSTRY: Country Code	O ID 2/3	S

**Segment:** **REF** Billing Provider Secondary Identification Number  
**Position:** 035  
**Loop:** 2010AA Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 5  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/NM109 of this loop, then this REF is not used.

If code "XX - NPI" is used in the NM108/NM109 of this loop, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in this REF.

**X12N HIPAA Example**

Example: REF\*SY\*111222333~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the billing provider is a dental group practice, the provider information for the rendering provider must be submitted in the 2310B loop.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R
		Code qualifying the Reference Identification		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Reference Identification Qualifier		
		1D Medicaid Provider Number		
		EI Employer's Identification Number		
		SY Social Security Number		
		<b>X12N HIPAA Notes:</b>		
		The Social Security Number may not be used for Medicare.		
REF02	127	Reference Identification	X AN 1/30	R AN 7/7

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

**X12N HIPAA Notes:**

**ALIAS:** Billing Provider's Secondary Identification Number

NSF Reference: BA0-02.0, BA0-06.0, BA0-08.0, BA0-09.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, CA0-28.0, YA0-06.0

**INDUSTRY:** Billing Provider Additional Identifier

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

**Segment:** **NM1** Pay-to Provider's Name  
**Position:** 015  
**Loop:** 2010AB Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

If the billing provider and the pay-to provider are the same entity, then it is not necessary to put in the pay-to-provider loop.

Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

**X12N HIPAA Example**

Example: NM1\*87\*1\*JONES\*WILLIAM\*\*\*\*XX\*0987654321~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in pay-to provider loop, if used, on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the pay-to loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the billing provider is a dental group practice, the provider information for the rendering provider must be submitted in the 2310B loop.

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
NM101	98	<b>Entity Identifier Code</b>	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Entity Identifier Code		
		87 Pay-to Provider		
NM102	1065	<b>Entity Type Qualifier</b>	M ID 1/1	R
		Code qualifying the type of entity		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Entity Type Qualifier		
		1 Person		

**X12N HIPAA Notes:**

If person is used and if the pay-to provider is the same as the rendering provider, then it is not necessary to use the rendering provider NM1 loop at the claim (2300) loop.

2

Non-Person Entity

**X12N HIPAA Notes:**

If non-person entity is used, then the rendering provider NM1 loop (Loop 2310B) should be used to supply the name of the rendering (warm body) provider.

**NM103 1035 Name Last or Organization Name O AN 1/35 R**

Individual last name or organizational name

**X12N HIPAA Notes:**

Pay-to Provider Last Name or Organization Name

NSF Reference: BA0-18.0, BA0-19.0

INDUSTRY: Pay-to Provider Last or Organizational Name

**NM104 1036 Name First O AN 1/25 S**

Individual first name

**X12N HIPAA Notes:**

Pay-to Provider First Name

Required if NM102 = 1 (person).

NSF Reference: BA0-20.0

INDUSTRY: Pay-to Provider First Name

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

Individual middle name or initial

**X12N HIPAA Notes:**

Pay-to Provider Middle Initial

Required if NM102 = 1 and the middle name/initial of the person is known.

NSF Reference: BA0-21.0

INDUSTRY: Pay-to Provider Middle Name

**NM106 1038 Name Prefix O AN 1/10 N/U**

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

Suffix to individual name

**X12N HIPAA Notes:**

Pay-to Provider Name Suffix

Required if known.

INDUSTRY: Pay-to Provider Name Suffix

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

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

**X12N HIPAA Notes:**

If "XX - NPI" is used, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in the REF in this loop.

INDUSTRY: Identification Code Qualifier

24 Employer's Identification Number

34 Social Security Number

XX Health Care Financing Administration National Provider Identifier

Code identifying a party or other code

**X12N HIPAA Notes:**

Pay-to Provider's Primary Identification Number

NSF Reference: BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, YA0-06.0

INDUSTRY: Pay-to Provider Identifier

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the pay-to provider is a dental group practice, the provider information for the rendering provider must be submitted in the 2310B Loop.

When the 2010AA loop is submitted without the 2010AB loop the information in the 2010AA loop is used. When the 2010AA loop is submitted with the 2010AB loop then the information in the 2010AB loop is used.

**Segment:** N3 Pay-to Provider's Address  
**Position:** 025  
**Loop:** 2010AB Optional  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify the location of the named party  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:** X12N HIPAA Example

Example: N3\*225 MAIN STREET\*BARKLEY BUILDING~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
N301	166	<b>Address Information</b> Address information <b>X12N HIPAA Notes:</b> ALIAS: Pay-to Provider's Address 1 NSF Reference: BA1-07.0, BA1-13.0 INDUSTRY: Pay-to Provider Address Line	M AN 1/55	R
N302	166	<b>Address Information</b> Address information <b>X12N HIPAA Notes:</b> Required if second address line exists. ALIAS: Pay-to Provider's Address 2 NSF Reference: BA1-08.0, BA1-14.0 INDUSTRY: Pay-to Provider Address Line	O AN 1/55	S

**Segment:** N4 Pay-to Provider City/State/Zip  
**Position:** 030  
**Loop:** 2010AB Optional  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify the geographic place of the named party  
**Syntax Notes:** 1 If N406 is present, then N405 is required.  
**Semantic Notes:**  
**Comments:** 1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.  
 2 N402 is required only if city name (N401) is in the U.S. or Canada.  
**Notes:** **X12N HIPAA Example**  
 Example: N4\*CENTERVILLE\*PA\*17111~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
N401	19	City Name Free-form text for city name <b>X12N HIPAA Notes:</b> ALIAS: Pay-to Provider's City NSF Reference: BA1-09.0, BA1-15.0 INDUSTRY: Pay-to Provider City Name	O AN 2/30	R
N402	156	State or Province Code Code (Standard State/Province) as defined by appropriate government agency <b>X12N HIPAA Notes:</b> ALIAS: Pay-to Provider's State NSF Reference: BA1-16.0, BA1-10.0 INDUSTRY: Pay-to Provider State Code	O ID 2/2	R
N403	116	Postal Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States) <b>X12N HIPAA Notes:</b> ALIAS: Pay-to Provider's Zip Code NSF Reference: BA1-17.0 INDUSTRY: Pay-to Provider Postal Zone or ZIP Code	O ID 3/15	R
N404	26	Country Code Code identifying the country <b>X12N HIPAA Notes:</b> Required if the address is out of the U.S. ALIAS: Pay-to Provider country code INDUSTRY: Country Code	O ID 2/3	S

**Segment:** **REF** Pay-to Provider Secondary Identification Number  
**Position:** 035  
**Loop:** 2010AB Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 5  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in the NM108/109 of this loop.

If the reason the number is being used in this REF can be met by the NPI, carried in the NM108/NM109 of this loop, then this REF is not used.

If code " XX - NPI" is used in the NM108/09 of this loop, then either the Employer's Identification Number, Social Security Number or Federal Tax Identification Number of the Provider must be carried in this REF. The number sent is the one which is used in the 1099. If additional numbers are needed in the REF it can be run up to 5 times.

**X12N HIPAA Example**

Example: REF\*SY\*111222333~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the billing loop on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the billing loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

When the billing provider is a dental group practice, the provider information for the rendering provider must be submitted in the 2310B loop.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R

Code qualifying the Reference Identification

**X12N HIPAA Notes:**

**INDUSTRY:** Reference Identification Qualifier

1D	Medicaid Provider Number
EI	Employer's Identification Number
SY	Social Security Number

**X12N HIPAA Notes:**

The Social Security Number may not be used for Medicare.

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

**X12N HIPAA Notes:**

NSF Reference: BA0-02.0, BA0-06.0, BA0-09.0, BA0-10.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, BA0-25.0, BA1-02.0, CA0-28.0, YA0-02.0, YA0-06.0

INDUSTRY: Pay-to Provider Identifier

**ODJFS Application Note:**

Used for Claim Processing

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

The provider information submitted in this loop should be for a Medicaid provider that provides covered Medicaid services. It should not be trading partner information.

**Segment:** **HL** **Subscriber Hierarchical Level**  
**Position:** 001  
**Loop:** 2000B Mandatory  
**Level:** Detail  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To identify dependencies among and the content of hierarchically related groups of data segments

**Syntax Notes:**

**Semantic Notes:**

**Comments:**

- 1 The HL segment is used to identify levels of detail information using a hierarchical structure, such as relating line-item data to shipment data, and packaging data to line-item data.  
The HL segment defines a top-down/left-right ordered structure.
- 2 HL01 shall contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
- 3 HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
- 4 HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. For example, HL03 is used to indicate that subsequent segments in the HL loop form a logical grouping of data referring to shipment, order, or item-level information.
- 5 HL04 indicates whether or not there are subordinate (or child) HL segments related to the current HL segment.

**Notes:**

**X12N HIPAA Notes**

If the subscriber and the patient are the same person, use this HL to identify the subscriber/patient, skip the subsequent (patient) HL and proceed directly to loop ID-2300.

The SUBSCRIBER HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the Subscriber (Loop ID-2010BA) and his or her insurance (loop ID-2010BB). In addition, information about the credit/debit card holder is placed in this HL (loop ID-2010BC). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit card Use, for a description of using the loop ID-2010BC.

Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Subscriber Hierarchical Level loops, there is an implied maximum of 5000.

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

**X12N HIPAA Example**

Example: HL\*2\*1\*22\*1~

**ODJFS User Note**

For Ohio Medicaid, the "insured", "subscriber", and the "patient" are always the same person.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
HL01	628	Hierarchical ID Number	M AN 1/12	R

A unique number assigned by the sender to identify a particular data segment in a

hierarchical structure

**X12N HIPAA Notes:**

INDUSTRY: Hierarchical ID Number

**HL02 734 Hierarchical Parent ID Number O AN 1/12 R**

Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to

**X12N HIPAA Notes:**

INDUSTRY: Hierarchical Parent ID Number

**HL03 735 Hierarchical Level Code M ID 1/2 R**

Code defining the characteristic of a level in a hierarchical structure

**X12N HIPAA Notes:**

INDUSTRY: Hierarchical Level Code

22 Subscriber  
Identifies the employee or group member who is covered for insurance and to whom, or on behalf of whom, the insurer agrees to pay benefits

**HL04 736 Hierarchical Child Code O ID 1/1 R**

Code indicating if there are hierarchical child data segments subordinate to the level being described

**X12N HIPAA Notes:**

The claim loop (Loop ID-2300) can be used both when HL04 has no subordinate levels (HL04 = 0 or is not sent) or when HL04 has subordinate levels indicated (HL04=1). In the first case (HL04 = 0), the subscriber is the patient and there are no dependent claims.

The second case (HL04 = 1) happens when claims/encounters for both the subscriber and a dependent of theirs are being sent under the same billing provider HL (e.g., a father and son are both involved in the same automobile accident and are treated by the same provider). In that case, the subscriber HL04 = 1 because there is a dependent to this subscriber, but the 2300 loop for the subscriber/patient (father) would begin after the subscriber HL. The dependent HL (son) would then be run and the 2300 loop for the dependent/patient would be run after that HL.

HL04 = 1 would also be used when a claim/encounter for a only dependent is being sent.

INDUSTRY: Hierarchical Child Code

0 No Subordinate HL Segment in This Hierarchical Structure.  
1 Additional Subordinate HL Data Segment in This Hierarchical Structure.

**Segment:** **SBR** Subscriber Information  
**Position:** 005  
**Loop:** 2000B Mandatory  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To record information specific to the primary insured and the insurance carrier for that insured

**Syntax Notes:**

- Semantic Notes:**
- 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.

**Comments:**

**Notes:** **X12N HIPAA Example**

Example: SBR\*P\*\*GRP01020102\*\*\*6\*\*\*CI~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
SBR01	1138	<b>Payer Responsibility Sequence Number Code</b> Code identifying the insurance carrier's level of responsibility for a payment of a claim <b>X12N HIPAA Notes:</b> INDUSTRY: Payer Responsibility Sequence Number Code P Primary <b>X12N HIPAA Notes:</b> DA0-02.0-Pri S Secondary <b>X12N HIPAA Notes:</b> DA1-02.0-Sec T Tertiary <b>X12N HIPAA Notes:</b> Use to indicate payer of last resort.	M ID 1/1	R
SBR02	1069	<b>Individual Relationship Code</b> Code indicating the relationship between two individuals or entities <b>X12N HIPAA Notes:</b> Required when the subscriber is the same person as the patient. If the subscriber is not the same person as the patient, do not use this element. NSF Reference: DA0-17.0 INDUSTRY: Individual Relationship Code 18 Self	O ID 2/2	S
SBR03	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>X12N HIPAA Notes:</b> Required if the subscriber's payer identification includes Group or Plan Number. This data element is intended to carry the subscriber's Group Number, not the number that uniquely identifies the subscriber (Subscriber ID, Loop 2010BA-NM109). NSF Reference: DA0-10.0 INDUSTRY: Insured Group or Policy Number	O AN 1/30	S
SBR04	93	<b>Name</b>	O AN 1/60	S

Free-form name

**X12N HIPAA Notes:**

Required if the Subscriber's payer identification includes Plan Name.

ALIAS: Plan Name

NSF Reference: DA0-11.0

INDUSTRY: Insured Group Name

**SBR05 1336 Insurance Type Code O ID 1/3 N/U**  
Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**SBR06 1143 Coordination of Benefits Code O ID 1/1 R**  
Code identifying whether there is a coordination of benefits

**X12N HIPAA Notes:**

INDUSTRY: Coordination of Benefits Code

- 1 Coordination of Benefits  
A method of integrating benefits payable under more than one group health insurance plan so that the insured's benefits from all sources do not exceed 100 percent of the allowable medical expenses
- 6 No Coordination of Benefits

**SBR07 1073 Yes/No Condition or Response Code O ID 1/1 N/U**  
Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**SBR08 584 Employment Status Code O ID 2/2 N/U**  
Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**SBR09 1032 Claim Filing Indicator Code O ID 1/2 S**  
Code identifying type of claim

**X12N HIPAA Notes:**

Required prior to mandated use of PlanID. Not used after PlanID is mandated.

INDUSTRY: Claim Filing Indicator Code

- MC Medicaid

**X12N HIPAA Notes:**

CA0-23.0 (D), DA0-05.0 (D)

**Segment:** **NM1** Subscriber Name  
**Position:** 015  
**Loop:** 2010BA Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.

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

**X12N HIPAA Example**

Example: NM1\*IL\*1\*DOE\*JOHN\*T\*\*JR\*MI\*123456789~

**Data Element Summary**

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Entity Identifier Code		
		IL Insured or Subscriber		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Entity Type Qualifier		
		1 Person		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name	O AN 1/35	R
		Individual last name or organizational name		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Subscriber's Last Name		
		NSF Reference: CA0-04.0, DA0-19.0		
		INDUSTRY: Subscriber Last Name		
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier	X ID 1/2	S
		Code designating the system/method of code structure used for Identification Code (67)		
		<b>X12N HIPAA Notes:</b>		
		Required if NM102 = 1 (person).		
		INDUSTRY: Identification Code Qualifier		
		MI Member Identification Number		
		<b>X12N HIPAA Notes:</b>		
		The code MI is intended to be the subscriber's identification number as assigned by the payer. Payers use different terminology		

to convey the same number. Therefore, the 837 Dental Workgroup recommends using MI - Member Identification Number to convey the following terms: Insured's ID, Subscriber's ID, Health Insurance Claim Number (HIC), etc.  
 MI is also intended to be used in claims submitted to the Indian Health Service/Contract Health Services (IHS/CHS) Fiscal Intermediary for the purpose of reporting the Tribe Residency Code (Tribe County State).  
 In the event that a Social Security Number is also available on an IHS/CHS claim, put the SSN in the REF02.

**NM109**      **67**      **Identification Code**      **X**    **AN 2/80**    **S**      **AN 12/12**

Code identifying a party or other code

**X12N HIPAA Notes:**

Required if NM102 = 1 (person).

NSF Reference: DA0-18.0

**INDUSTRY:** Subscriber Primary Identifier

**ODJFS User Note:**

12-digit Medicaid recipient billing number or the Ohio Disability Assistance billing number.

**Segment:** **DMG** **Subscriber Demographic Information**  
**Position:** 032  
**Loop:** 2010BA Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply demographic information  
**Syntax Notes:** 1 If either DMG01 or DMG02 is present, then the other is required.  
**Semantic Notes:** 1 DMG02 is the date of birth.  
 2 DMG07 is the country of citizenship.  
 3 DMG09 is the age in years.

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required when the patient is the same person as the subscriber. (Required when Loop ID-2000B, SBR02 = 18 (self)).

**X12N HIPAA Example**

Example: DMG\*D8\*19491117\*M~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
DMG01	1250	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>	<b>R</b>
		Code indicating the date format, time format, or date and time format		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Date Time Period Format Qualifier		
		D8 Date Expressed in Format CCYYMMDD		
DMG02	1251	<b>Date Time Period</b>	<b>X AN 1/35</b>	<b>R</b>
		Expression of a date, a time, or range of dates, times or dates and times		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Date of Birth - Patient		
		NSF Reference: CA0-08.0, DA0-24.0		
		INDUSTRY: Subscriber Birth Date		
DMG03	1068	<b>Gender Code</b>	<b>O ID 1/1</b>	<b>R</b>
		Code indicating the sex of the individual		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Gender - Patient		
		NSF Reference: CA0-09.0, DA0-23.0		
		INDUSTRY: Subscriber Gender Code		
		F Female		
		M Male		
		U Unknown		

**Segment:** **NM1** Payer Name  
**Position:** 015  
**Loop:** 2010BB Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

This is the destination payer.

**X12N HIPAA Example**

Example: NM1\*PR\*2\*Union Mutual of Oregon\*\*\*\*\*PI\*123123123~

**Data Element Summary**

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Entity Identifier Code		
		PR Payer		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Entity Type Qualifier		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name	O AN 1/35	R
		Individual last name or organizational name		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Payer Name		
		NSF Reference: DA0-09.0		
		INDUSTRY: Payer Name		
NM104	1036	Name First	O AN 1/25	N/U
NM105	1037	Name Middle	O AN 1/25	N/U
NM106	1038	Name Prefix	O AN 1/10	N/U
NM107	1039	Name Suffix	O AN 1/10	N/U
NM108	66	Identification Code Qualifier	X ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Identification Code Qualifier		
		PI Payor Identification		
		XV Health Care Financing Administration National Payer Identification Number (PAYERID)		
NM109	67	Identification Code	X AN 2/80	R
		Code identifying a party or other code		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Payer Primary Identification Number		

NSF Reference: DA0-07.0

INDUSTRY: Payer Identifier

**ODJFS User Note:**

ODJFS Payer ID = MMISODJFS

**Segment:** **CLM Claim Information**  
**Position:** 130  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify basic data about the claim  
**Syntax Notes:**  
**Semantic Notes:**

- 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.

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

The developers of this implementation guide recommend that trading partners limit the size of the transaction (SE-ST envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BC 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.

**X12N HIPAA Example**

Example: CLM\*013193000001\*500\*\*\*11::1\*Y\*A\*Y\*Y~

**Data Element Summary**

Ref. Des.	Data Element	Name	Base		User	
			Attributes		Attributes	
CLM01	1028	Claim Submitter's Identifier	M	AN 1/38	R	AN 1/20

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

**X12N HIPAA Notes:**

The number that the submitter transmits in this position is echoed back to the submitter 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.

ALIAS: Patient Account Number

NSF Reference: 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, GD0-03.0, GD1-03.0, GE0-03.0, GP0-03.0, GX0-03.0, GX2-03.0, XA0-03.0

INDUSTRY: Patient Account Number

**ODJFS Application Note:**

Stored on claim; returned on 835

**CLM02 782 Monetary Amount O R 1/10 R**

Monetary amount

**X12N HIPAA Notes:**

For encounter transmissions, zero (0) may be a valid amount.

ALIAS: Total Claim Charges

NSF Reference: XA0-12.0

INDUSTRY: Total Claim Charge Amount

**ODJFS User Note:**

Total claim charges must be equal to the sum of all line item charges. For TPL claims, total charges must balance.

**CLM03 1032 Claim Filing Indicator Code O ID 1/2 N/U**

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**CLM04 1343 Non-Institutional Claim Type Code O ID 1/2 N/U**

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**CLM05 C023 Health Care Service Location Information O R**

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

**X12N HIPAA Notes:**

CLM05 applies to all service lines unless it is over written at the line level.

ALIAS: Place of Service Code

NSF Reference: FA0-07.0

**C02301 1331 Facility Code Value M AN 1/2 R**

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

**X12N HIPAA Notes:**

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 guide. 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
- 31 Skilled Nursing Facility
- 35 Adult Living Care Facility

INDUSTRY: Facility Type Code

**ODJFS Application Note:**

		Used for Claim Processing			
<b>C02302</b>	<b>1332</b>	<b>Facility Code Qualifier</b>	<b>O</b>	<b>ID 1/2</b>	<b>N/U</b>
		Refer to 004010X097A1 Data Element Dictionary for acceptable code values.			
<b>C02303</b>	<b>1325</b>	<b>Claim Frequency Type Code</b>	<b>O</b>	<b>ID 1/1</b>	<b>R</b>
		Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type			
		<b>X12N HIPAA Notes:</b>			
		Industry: Claim Submission Reason Code			
		<b>ODJFS Application Note:</b>			
		Used for Claim Processing			
<b>CLM06</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O</b>	<b>ID 1/1</b>	<b>R</b>
		Code indicating a Yes or No condition or response			
		<b>X12N HIPAA Notes:</b>			
		ALIAS: Provider Signature on File Code			
		NSF Reference: EA0-35.0			
		INDUSTRY: Provider or Supplier Signature Indicator			
		N No			
		Y Yes			
<b>CLM07</b>	<b>1359</b>	<b>Provider Accept Assignment Code</b>	<b>O</b>	<b>ID 1/1</b>	<b>S</b>
		Code indicating whether the provider accepts assignment			
		<b>X12N HIPAA Notes:</b>			
		The NSF mapping to FA0-59.0 occurs only in payer-to-payer COB situations.			
		Required for Medicare claims only.			
		NSF Reference: EA0-34.0, FA0-59.0			
		INDUSTRY: Medicare Assignment Code			
		A Assigned			
		C Not Assigned			
		P Patient Refuses to Assign Benefits			
<b>CLM08</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>	<b>O</b>	<b>ID 1/1</b>	<b>R</b>
		Code indicating a Yes or No condition or response			
		<b>X12N HIPAA Notes:</b>			
		ALIAS: Assignment of Benefits Code			
		NSF Reference: DA0-15.0			
		INDUSTRY: Benefits Assignment Certification Indicator			
		N No			
		Y Yes			
<b>CLM09</b>	<b>1363</b>	<b>Release of Information Code</b>	<b>O</b>	<b>ID 1/1</b>	<b>R</b>
		Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations			
		<b>X12N HIPAA Notes:</b>			
		NSF Reference: EA0-13.0			
		INDUSTRY: Release of Information Code			
		N No, Provider is Not Allowed to Release Data			
		Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim			
<b>CLM10</b>	<b>1351</b>	<b>Patient Signature Source Code</b>	<b>O</b>	<b>ID 1/1</b>	<b>N/U</b>
		Refer to 004010X097A1 Data Element Dictionary for acceptable code values.			

<b>CLM11</b>	<b>C024</b>	<b>Related Causes Information</b>	<b>O</b>	<b>S</b>
		To identify one or more related causes and associated state or country information		
		<b>X12N HIPAA Notes:</b>		
		CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related.		
		If DTP - Date of Accident (DTP01 = 439) is used, then CLM11 is required.		
<b>C02401</b>	<b>1362</b>	<b>Related-Causes Code</b>	<b>M ID 2/3</b>	<b>R</b>
		Code identifying an accompanying cause of an illness, injury or an accident		
		<b>Business Rules:</b>		
		Variable Name:2300CLM1101Accident		
		<b>X12N HIPAA Notes:</b>		
		NSF Reference: EA0-05.0, EA0-04.0		
		<b>INDUSTRY: Related Causes Code</b>		
		AA Auto Accident		
		<b>X12N HIPAA Notes:</b>		
		EA0-05.0		
		EM Employment		
		<b>X12N HIPAA Notes:</b>		
		EA0-04.0		
		OA Other Accident		
		<b>X12N HIPAA Notes:</b>		
		EA0-05.0		
<b>C02402</b>	<b>1362</b>	<b>Related-Causes Code</b>	<b>O ID 2/3</b>	<b>S</b>
		Code identifying an accompanying cause of an illness, injury or an accident		
		<b>Business Rules:</b>		
		Variable Name:2300CLM1102Accident		
		<b>X12N HIPAA Notes:</b>		
		Used if more than one code applies.		
		NSF Reference: EA0-05.0, EA0-04.0		
		<b>INDUSTRY: Related Causes Code</b>		
		AA Auto Accident		
		EM Employment		
		OA Other Accident		
<b>C02403</b>	<b>1362</b>	<b>Related-Causes Code</b>	<b>O ID 2/3</b>	<b>S</b>
		Code identifying an accompanying cause of an illness, injury or an accident		
		<b>Business Rules:</b>		
		Variable Name:2300CLM1103Accident		
		<b>X12N HIPAA Notes:</b>		
		Used if more than one code applies.		
		NSF Reference: EA0-05.0, EA0-04.0		
		<b>INDUSTRY: Related Causes Code</b>		
		AA Auto Accident		
		EM Employment		
		OA Other Accident		
<b>C02404</b>	<b>156</b>	<b>State or Province Code</b>	<b>O ID 2/2</b>	<b>S</b>
		Code (Standard State/Province) as defined by appropriate government agency		
		<b>X12N HIPAA Notes:</b>		
		Required if CLM11-1, CLM11-2 or CLM11-3 has a value of "AA".		

ALIAS: Accident State

NSF Reference: EA0-10.0

INDUSTRY: Auto Accident State or Province Code

**C02405**      **26**      **Country Code**      **O**   **ID 2/3**      **S**

Code identifying the country

**X12N HIPAA Notes:**

Required if the automobile accident occurred out of the U.S. to identify the country in which the accident occurred.

INDUSTRY: Country Code

**CLM12**      **1366**      **Special Program Code**      **O**   **ID 2/3**      **S**

Code indicating the Special Program under which the services rendered to the patient were performed

**X12N HIPAA Notes:**

Required if the services were rendered under one of the following circumstances/programs/projects.

NSF Reference: EA0-43.0

INDUSTRY: Special Program Indicator

- 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

**Segment:** **DTP** Date - Accident  
**Position:** 135  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Dependent)  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Business Rules:**

1. If 2300CLM1101Accident EQ 'AA', then set Usage to 'Must Use'
2. If 2300CLM1102Accident EQ 'AA', then set Usage to 'Must Use'
3. If 2300CLM1103Accident EQ 'AA', then set Usage to 'Must Use'

**Notes:** **X12N HIPAA Notes**

Required if CLM11-1, CLM11-2 or CLM11-3 = AA, EM or OA.

**X12N HIPAA Example**

Example: DTP\*439\*D8\*19980108~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 439 Accident Date mishap occurred	M ID 3/3	R
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> NSF Reference: EA0-07.0 INDUSTRY: Accident Date	M AN 1/35	R

**Segment:** **DTP** Date - Appliance Placement  
**Position:** 135  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 5  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.

Required to report the date orthodontic appliances were placed.

**X12N HIPAA Example**

Example: DTP\*452\*D8\*19980108~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 452 Appliance Placement Date orthodontic devices were arranged	<b>M ID 3/3</b>	<b>R</b>
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	<b>M ID 2/3</b>	<b>R</b>
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> NSF Reference: FD0-19.0 INDUSTRY: Orthodontic Banding Date	<b>M AN 1/35</b>	<b>R</b>

**Segment:** **DTP** Date - Service  
**Position:** 135  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

The dates in Loop ID-2300 apply to all service lines within Loop ID-2400 unless a DTP segment occurs in Loop ID-2400 with the same value in DTP01. In that case, the DTP in Loop ID-2400 overrides the DTP in Loop ID-2300 for that service line only.

Required if all of the services on the claim/encounter were performed. This DTP should not be used if the claim is being submitted for Predetermination of Benefits or Pre-Authorization of Benefits..

**ODJFS Application Note**

Used for Claim Processing

**X12N HIPAA Example**

Example: DTP\*472\*D8\*19980108~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 472 Service Begin and end dates of the service being rendered	M ID 3/3	R
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD 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	M ID 2/3	R
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> INDUSTRY: Service Date	M AN 1/35	R

**Segment:** **AMT Patient Amount Paid**  
**Position:** 175  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if the patient has paid any amount toward the claim.

Patient Amount Paid refers to the sum of all amounts paid on the claim by the patient or his/her representative.

The Patient amount Paid indicated in this segment applies to the entire claim. It is recommended that the Patient Amount Paid AMT segment be used at either the line or claim level but not at both.

**ODJFS Application Note**

Used for Claim Processing

**X12N HIPAA Example**

Example: AMT\*F5\*8.5~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Amount Qualifier Code		
		F5 Patient Amount Paid		
		Monetary amount value already paid by one receiving medical care		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		<b>X12N HIPAA Notes:</b>		
		NSF Reference: XA0-19.0		
		INDUSTRY: Patient Amount Paid		
		<b>ODJFS User Note:</b>		
		At this time, Patient Paid Amount should be zero.		

**Segment:** **REF** Original Reference Number (ICN/DCN)  
**Position:** 180  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required when CLM05-3 (Claim Submission Reason code) = "6", "7" or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.

This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number 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.

**ODJFS Application Note**

Used for Claim Adjustment Processing

**X12N HIPAA Example**

Example: REF\*F8\*R555588~

**ODJFS User Note**

This is the unique Transaction Control Number (TCN) assigned by Medicaid to the original claim; use this REF segment when submitting a reversal/correction to the original claim.

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R
		Code qualifying the Reference Identification		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Reference Identification Qualifier		
		F8 Original Reference Number		
REF02	127	Reference Identification	X AN 1/30	R
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		
		<b>X12N HIPAA Notes:</b>		
		NSF Reference: EA0-47.0		
		INDUSTRY: Claim Original Reference Number		
		<b>ODJFS User Note:</b>		
		Use original ODJFS transaction control number (TCN)		

**Segment:** **REF** **Prior Authorization or Referral Identification**  
**Position:** 180  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 2  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.

Required where services on this claim where a referral is involved. Generally, referral numbers are those numbers assigned by the payer to authorize a service prior to its being performed. The referral 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.

This segment should not be used for Predetermination of Benefits.

**X12N HIPAA Example**

REF\*9F\*12345~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3	R
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Reference Identification Qualifier				
G1 Prior Authorization Number An authorization number acquired prior to the submission of a claim				
REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30	R
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Referral Number				
<b>ODJFS User Note:</b>				
This is the Medicaid 6 digit prior authorization number.				

**Segment:** **NTE** Claim Note  
**Position:** 190  
**Loop:** 2300 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 20  
**Purpose:** To transmit information in a free-form format, if necessary, for comment or special instruction

**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**

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

**Notes: X12N HIPAA Notes**

Required when: (1) State regulations mandate information not identified elsewhere within the claim set or (2) to report periodontal charting information.

If this segment is being used to report periodontal charting information, up to 6 measurements per tooth may be reported. The suggested format should be tooth number followed by a measurement for Disto-Lingual, Lingual, Mesio-Lingual, Mesio-Buccal, Buccal or Distal-Buccal. If a tooth has been extracted it should be annotated with "ext" following the tooth number.

Example of Charting for tooth #'s 5, 6 and 7 (extracted tooth): #5 DL3/L4/ML5/MB4/B4/DB4, #6 DL4/L5/ML5/MB4/B4/DB5, #7 ext

The following information should also be reported: description of the amount of recession, indication of teeth having furcation involvement and the extent, and the diagnosis.

**X12N HIPAA Example**

Example: NTE\*ADD\*#5 DL4/L5/ML6/MB4, #6 L6/ML5/MB4/B5, #7 ext~

**ODJFS User Note**

Use this segment to report Ohio Medicaid Co-payment exclusions.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NTE01	363	Note Reference Code	O ID 3/3	R

Code identifying the functional area or purpose for which the note applies

**X12N HIPAA Notes:**

INDUSTRY: Note Reference Code

ADD Additional Information

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

**X12N HIPAA Notes:**

NSF Reference: HA0-05.0

INDUSTRY: Claim Note Text

**ODJFS User Note:**

When a Medicaid co-payment exclusion applies, the 10 character code (see Application Value List below) must be the first item listed in the NTE02. There must always be a single space between the word COPAY and the four character exclusion code.

ODJFS Example: NTE\*ADD\*COPAY PREG~

Application Value List:

COPAY EMER (Emergency)

COPAY HSPC (Hospice)

COPAY PREG (Pregnancy)

**Segment:** **NM1** Referring Provider Name  
**Position:** 250  
**Loop:** 2310A Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

When there is only one referral on the claim, use "DN - Referring Provider". When more than one referral exists and there is a requirement to report the additional referral, use code "DN" in the first iteration of this loop to indicate the referral received by the rendering provider on this claim. Use code "P3 - Primary Care Provider" in the second iteration of the loop to indicate the initial referral from the primary care provider or whatever provider wrote the initial referral for this patient's episode of care being billed/reported in this transaction.

Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

Required if claim involved a referral.

**X12N HIPAA Example**

Example: NM1\*DN\*1\*SWANSON\*HARRY\*\*\*\*24\*123123123~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
NM101	98	Entity Identifier Code	M ID 2/3	R

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

**Business Rules:**

Variable Name:2310A00NM101

**X12N HIPAA Notes:**

The entity identifier in NM101 applies to all segments in Loop ID-2310.

INDUSTRY: Entity Identifier Code

		DN	Referring Provider				
			<b>X12N HIPAA Notes:</b>				
			Use on first iteration of this loop. Use if loop is used only once.				
		P3	Primary Care Provider				
			Physician that is selected by the insured to provide medical care				
			<b>X12N HIPAA Notes:</b>				
			Use only if loop is used twice. Use only on second iteration of this loop.				
NM102	1065	<b>Entity Type Qualifier</b>		M	ID 1/1	R	
		Code qualifying the type of entity					
		<b>X12N HIPAA Notes:</b>					
		INDUSTRY: Entity Type Qualifier					
		1	Person				
		2	Non-Person Entity				
NM103	1035	<b>Name Last or Organization Name</b>		O	AN 1/35	R	
		Individual last name or organizational name					
		<b>X12N HIPAA Notes:</b>					
		NSF Reference: EA0-22.0					
		INDUSTRY: Referring Provider Last Name					
		<b>ODJFS Application Note:</b>					
		Mandatory for HIPAA; not used for ODJFS processing					
NM104	1036	<b>Name First</b>		O	AN 1/25	S	
		Individual first name					
		<b>X12N HIPAA Notes:</b>					
		Required if NM102 = 1 (person).					
		NSF Reference: EA0-23.0					
		INDUSTRY: Referring Provider First Name					
NM105	1037	<b>Name Middle</b>		O	AN 1/25	S	
		Individual middle name or initial					
		<b>X12N HIPAA Notes:</b>					
		Required if NM102 = 1 and the middle name/initial of the person is known.					
		NSF Reference: EA0-24.0					
		INDUSTRY: Referring Provider Middle Name					
NM106	1038	<b>Name Prefix</b>		O	AN 1/10	N/U	
NM107	1039	<b>Name Suffix</b>		O	AN 1/10	S	
		Suffix to individual name					
		<b>X12N HIPAA Notes:</b>					
		Required if known.					
		INDUSTRY: Referring Provider Name Suffix					
NM108	66	<b>Identification Code Qualifier</b>		X	ID 1/2	S	
		Code designating the system/method of code structure used for Identification Code (67)					
		<b>X12N HIPAA Notes:</b>					
		Required if the Employer's Identification Number, Social Security Number or National Provider Identifier is known.					
		INDUSTRY: Identification Code Qualifier					
		24	Employer's Identification Number				
		34	Social Security Number				
		XX	Health Care Financing Administration National Provider Identifier				

Code identifying a party or other code

**X12N HIPAA Notes:**

Required if the Employer's Identification Number, Social Security Number or National Provider Identifier is known.

Referring Provider Primary Identification Number

NSF Reference: EA0-20.0

**INDUSTRY:** Referring Provider Identifier

**ODJFS User Note:**

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Segment:** **REF** Referring Provider Secondary Identification  
**Position:** 271  
**Loop:** 2310A Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 5  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if NM108/NM109 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.

**X12N HIPAA Example**

Example: REF\*0B\*123123311~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. The referring provider loop is situational, depending on the claim type. If the loop is present in the 837, ODJFS will deny any claims that do not include the NPI in the loop. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the referring provider loop of the electronic claim until further notice.

If the referring entity or provider is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the referring entity or provider. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier Code qualifying the Reference Identification	M ID 2/3	R
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Reference Identification Qualifier				
		1D Medicaid Provider Number		
		EI Employer's Identification Number		
		SY Social Security Number		
<b>X12N HIPAA Notes:</b>				
The Social Security Number may not be used for Medicare.				
REF02	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30	R AN 7/7
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Referring Provider Secondary Identifier				
<b>ODJFS User Note:</b>				

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Segment:** **NM1** Rendering Provider Name  
**Position:** 250  
**Loop:** 2310B Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Information in the 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 the NM101.

Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

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.

**X12N HIPAA Example**

Example: NM1\*82\*1\*SMITH\*BRAD\*\*\*\*\*34\*123456789~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI for the rendering provider on the 837 electronic claim transactions if it is required to adjudicate the claim. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and the legacy ID in the rendering provider loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> The entity identifier in NM101 applies to all segments in Loop ID-2310. INDUSTRY: Entity Identifier Code 82 Rendering Provider	M ID 2/3	R
NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier <b>ODJFS User Note:</b> This must always be a person (1). 1 Person 2 Non-Person Entity	M ID 1/1	R
NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name	O AN 1/35	R

**X12N HIPAA Notes:**

ALIAS: Rendering Provider Last Name

NSF Reference: FB1-14.0

INDUSTRY: Rendering Provider Last or Organization Name

**NM104 1036 Name First O AN 1/25 S**

Individual first name

**X12N HIPAA Notes:**

Required if NM102 = 1 (person).

NSF Reference: FB1-15.0

INDUSTRY: Rendering Provider First Name

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

Individual middle name or initial

**X12N HIPAA Notes:**

Required when middle name/initial of person is known.

NSF Reference: FB1-16.0

INDUSTRY: Rendering Provider Middle Name

**NM106 1038 Name Prefix O AN 1/10 N/U**

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

Suffix to individual name

**X12N HIPAA Notes:**

Required if known.

INDUSTRY: Rendering Provider Name Suffix

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

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

**X12N HIPAA Notes:**

INDUSTRY: Identification Code Qualifier

24 Employer's Identification Number

34 Social Security Number

XX Health Care Financing Administration National Provider Identifier

**NM109 67 Identification Code X AN 2/80 R**

Code identifying a party or other code

**X12N HIPAA Notes:**

NSF Reference: FA0-58.0, FA0-57.0 crosswalk is only used in Medicare COB payer-to-payer claims.

ALIAS: Rendering Provider's Primary Identification Number

NSF Reference: FA0-23.0, FA0-57.0

INDUSTRY: Rendering Provider Identifier

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Segment:** **PRV** Rendering Provider Specialty Information  
**Position:** 255  
**Loop:** 2310B Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify the identifying characteristics of a provider  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of the PRV segment with the same value in PRV01.

PRV02 qualifies PRV03.

Required when adjudication is known to be impacted by provider taxonomy code.

**X12N HIPAA Example**

Example: PRV\*PE\*ZZ\*1223E0200Y~

**ODJFS User Note**

When the billing or "Pay To" provider is a professional group practice the 2310B loop must be completed. For ODJFS, adjudication is not impacted by the taxonomy number.

**Data Element Summary**

Ref. Des.	Data Element	Name	Base Attributes	User Attributes
PRV01	121	Provider Code Code identifying the type of provider <b>X12N HIPAA Notes:</b> INDUSTRY: Provider Code	M ID 1/3	R
		PE Performing		
PRV02	128	Reference Identification Qualifier Code qualifying the Reference Identification <b>X12N HIPAA Notes:</b> INDUSTRY: Reference Identification Qualifier	M ID 2/3	R
		ZZ Mutually Defined <b>X12N HIPAA Notes:</b> 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: <a href="http://www.wpc-edi.com">http://www.wpc-edi.com</a> . This taxonomy is maintained by the Blue Cross Blue Shield Association and ANSI ASC X12N TG2 WG15.		
PRV03	127	Reference Identification Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>X12N HIPAA Notes:</b> ALIAS: Provider Specialty Code NSF Reference: FA0-37.0 INDUSTRY: Provider Taxonomy Code <b>ODJFS Application Note:</b> Used for Claim Processing	M AN 1/30	R

**Segment:** **REF** **Rendering Provider Secondary Identification**  
**Position:** 271  
**Loop:** 2310B Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 5  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

**X12N HIPAA Example**

Example: REF\*0B\*12312321~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI for the rendering provider on the 837 electronic claim transactions if it is required to adjudicate the claim. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and the legacy ID in the rendering provider loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification <b>X12N HIPAA Notes:</b> INDUSTRY: Reference Identification Qualifier ID Medicaid Provider Number EI Employer's Identification Number SY Social Security Number <b>X12N HIPAA Notes:</b> The Social Security Number may not be used for Medicare.	M ID 2/3	R
REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>X12N HIPAA Notes:</b> INDUSTRY: Rendering Provider Secondary Identifier <b>ODJFS User Note:</b> For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop. Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.	X AN 1/30	R

**Segment:** **NM1** Assistant Surgeon Name  
**Position:** 280  
**Loop:** 2310D Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Information in the 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 the NM101.

Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature and X12 syntax rules.

Required when the Assistant Surgeon information is needed to facilitate reimbursement of the claim.

The Assistant Surgeon information must not be used when the Rendering Provider Loop (Loop ID-2310B) is also present for the claim.

**X12N HIPAA Example**

NM1\*DD\*1\*SMITH\*JOHN\*S\*\*\*34\*123456789~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the assistant surgeon loop, if used, on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the assistant surgeon loop of the electronic claim until further notice.

If the assistant surgeon is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the assistant surgeon. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		<b>X12N HIPAA Notes:</b>		
		The entity identifier in NM101 applies to all segments in Loop ID-2310.		
		DD Assistant Surgeon		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		1 Person		
		2 Non-Person Entity		

<b>NM103</b>	<b>1035</b>	<b>Name Last or Organization Name</b> Individual last name or organizational name	<b>O AN 1/35 R</b>
<b>NM104</b>	<b>1036</b>	<b>Name First</b> Individual first name	<b>O AN 1/25 S</b>
		<b>X12N HIPAA Notes:</b> Required if NM102 = 1 (person).	
<b>NM105</b>	<b>1037</b>	<b>Name Middle</b> Individual middle name or initial	<b>O AN 1/25 S</b>
		<b>X12N HIPAA Notes:</b> Required when middle name/initial of person is known.	
<b>NM106</b>	<b>1038</b>	<b>Name Prefix</b>	<b>O AN 1/10 N/U</b>
<b>NM107</b>	<b>1039</b>	<b>Name Suffix</b> Suffix to individual name	<b>O AN 1/10 S</b>
		<b>X12N HIPAA Notes:</b> Required if known.	
<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67)	<b>X ID 1/2 R</b>
		24 Employer's Identification Number	
		34 Social Security Number	
		XX Health Care Financing Administration National Provider Identifier	
		<b>X12N HIPAA Notes:</b> Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.	
<b>NM109</b>	<b>67</b>	<b>Identification Code</b> Code identifying a party or other code	<b>X AN 2/80 S</b>
		<b>ODJFS User Note:</b> If the assistant surgeon is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the assistant surgeon. If the attempt is not successful, the billing provider may use the NPI Registry ( <a href="https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do">https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do</a> ) to obtain the referring entity or provider's NPI to enter it on the claim.  For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.  Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.	

**Segment:** **REF** Assistant Surgeon Secondary Identification  
**Position:** 287  
**Loop:** 2310D Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

**X12N HIPAA Example**

REF\*0B\*12345~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the assistant surgeon loop, if used, on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the assistant surgeon loop of the electronic claim until further notice.

If the assistant surgeon is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the assistant surgeon. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R
		Code qualifying the Reference Identification		
		1D Medicaid Provider Number		
		EI Employer's Identification Number		
		SY Social Security Number		
REF02	127	Reference Identification	X AN 1/30	R AN 7/7

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

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Segment:** **SBR** Other Subscriber Information  
**Position:** 290  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To record information specific to the primary insured and the insurance carrier for that insured

**Syntax Notes:**  
**Semantic Notes:**

- 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.

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if other payers are known to potentially be involved in paying on this claim.

Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

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 its respective 2330 loops.

**X12N HIPAA Example**

Example: SBR\*P\*01\*003450\*GOLDEN PLUS\*\*\*\*\*CI~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SBR01	1138	Payer Responsibility Sequence Number Code	M ID 1/1	R
		Code identifying the insurance carrier's level of responsibility for a payment of a claim		
		<b>X12N HIPAA Notes:</b>		
		NSF Reference: DA0-02.0		
		INDUSTRY: Payer Responsibility Sequence Number Code		
		P Primary		
		S Secondary		
		T Tertiary		
SBR02	1069	Individual Relationship Code	O ID 2/2	R
		Code indicating the relationship between two individuals or entities		
		<b>X12N HIPAA Notes:</b>		
		Use this code to specify the relationship to the person insured.		
		NSF Reference: DA0-17.0		
		INDUSTRY: Individual Relationship Code		
		01 Spouse		
		18 Self		
		19 Child		
		Dependent between the ages of 0 and 19; age qualifications may vary depending on policy		
		20 Employee		
		21 Unknown		
		22 Handicapped Dependent		

		29	Significant Other		
		76	Dependent		
<b>SBR03</b>	<b>127</b>	<b>Reference Identification</b>		<b>O AN 1/30 S</b>	

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

**X12N HIPAA Notes:**

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

NSF Reference: DA0-10.0

INDUSTRY: Insured Group or Policy Number

<b>SBR04</b>	<b>93</b>	<b>Name</b>		<b>O AN 1/60 S</b>	
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Free-form name

**X12N HIPAA Notes:**

Required if the Subscriber's payer identification includes Plan Name.

ALIAS: Plan Name

INDUSTRY: Policy Name

<b>SBR05</b>	<b>1336</b>	<b>Insurance Type Code</b>		<b>O ID 1/3 N/U</b>	
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Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

<b>SBR06</b>	<b>1143</b>	<b>Coordination of Benefits Code</b>		<b>O ID 1/1 N/U</b>	
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Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

<b>SBR07</b>	<b>1073</b>	<b>Yes/No Condition or Response Code</b>		<b>O ID 1/1 N/U</b>	
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Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

<b>SBR08</b>	<b>584</b>	<b>Employment Status Code</b>		<b>O ID 2/2 N/U</b>	
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Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

<b>SBR09</b>	<b>1032</b>	<b>Claim Filing Indicator Code</b>		<b>O ID 1/2 S</b>	
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Code identifying type of claim

**X12N HIPAA Notes:**

Required prior to mandated use of PlanID. Not used after PlanID is mandated.

NSF Reference: DA0-05.0

INDUSTRY: Claim Filing Indicator Code

- |    |   |
|----|---|
| 09 | Self-pay  |
| 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 |
| 17 | Dental Maintenance Organization                     |
| BL | Blue Cross/Blue Shield                              |
| CH | Champus   |
| CI | Commercial Insurance Co.                            |
| DS | Disability  |
| FI | Federal Employees Program                           |
| HM | Health Maintenance Organization                     |
| LM | Liability Medical                                   |
| MB | Medicare Part B                                     |
| MC | Medicaid  |

MH	Managed Care Non-HMO
OF	Other Federal Program
SA	Self-administered Group
VA	Veteran Administration Plan
	<b>X12N HIPAA Notes:</b>
	Refers to Veteran's Affairs Plan.
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined
	<b>X12N HIPAA Notes:</b>
	Unknown

**Segment:** **CAS** Claim Adjustment

**Position:** 295

**Loop:** 2320 Optional

**Level:** Detail

**Usage:** Optional

**Max Use:** 5

**Purpose:** To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

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

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

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

**Notes:** **X12N HIPAA Notes**

Submitters should use the CAS segment to report claim level adjustments from prior payers that cause the amount paid to differ from the amount originally charged.

If it is necessary to send more than one Group Code at the claim level, repeat the CAS segment.

Codes and associated amounts should come from the 835s (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment. See the 835 for definitions of the group codes (CAS01).

Required if the claim has been adjudicated by payer identified in this loop and has claim level adjustment information.

To locate the claim adjustment reason codes that are used in CAS02, 05, 08, 11, 14 and 17 see the Washington Publishing Company website: <http://www.wpc-edi.com>. Follow the buttons to Code Lists - Claim Adjustment Reason Codes.

There are several NSF fields which are not directly crosswalked from the 837 to NSF, particularly with respect to payer-to-payer COB situations. Below is a list of some of these NSF fields and some suggestions regarding how to handle them in the 837.

\*<~>Provider Adjustment Amt (DA3-25.0). This would equal the sum of all the adjustments amounts in CAS03, 06, 09, 12, 15 and 18 at both the claim and the line level. See the 835 for how to balance the CAS adjustments against the total billed amount.  
 \*<~>Beneficiary Liability Amt (FA0-53.0). This amount would equal the sum of all the adjustment amounts in the CAS03, 06, 09, 12, 15 and 18 at both the claim and the line level when CAS01 = PR (patient responsibility).  
 \*<~>Amount Paid to Provider (DA1-33.0). This would be calculated through the use of the CAS codes. Please see the detail on the codes and the discussion of how to use them in the 835 implementation guide.  
 \*<~>Balance Bill Limit Charge (FA0-54.0). This would equal any CAS adjustment where CAS01 = CO and one of the adjustment reason code elements equaled "45".  
 \*<~>Beneficiary Adjustment Amt (DA3-26.0) Amount Paid to Beneficiary (DA1-30.0). The amount paid to the beneficiary is indicated by the use of CAS code "100 - Payment made to patient/insured/responsible party".  
 \*<~>Original Paid Amount (DA3-28.0). The original paid amount can be calculated from the original claim by subtracting all claim adjustments carried in the claim and line level CAS from the original billed amount.

**X12N HIPAA Example**

Example: CAS\*PR\*1\*793~

CAS\*OA\*93\*15.06~

**ODJFS User Note**

All claim Adjustment Reason Codes and Monetary Amounts and Quantity submitted in this segment will be used for claims processing.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CAS01	1033	<b>Claim Adjustment Group Code</b> Code identifying the general category of payment adjustment <b>X12N HIPAA Notes:</b> INDUSTRY: Claim Adjustment Group Code CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	M ID 1/2	R
CAS02	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made <b>X12N HIPAA Notes:</b> NSF Reference: DA1-16.0, DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0	M ID 1/5	R
CAS03	782	<b>Monetary Amount</b> Monetary amount <b>X12N HIPAA Notes:</b> NSF Reference: DA1-09.0, DA1-10.0, DA1-11.0, DA1-12.0, DA1-13.0, DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0	M R 1/10	R
CAS04	380	<b>Quantity</b> Numeric value of quantity <b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.	O R 1/15	S

CAS05	1034	INDUSTRY: Adjustment Quantity				
		<b>Claim Adjustment Reason Code</b>	<b>X</b>	<b>ID 1/5</b>	<b>S</b>	
		Code identifying the detailed reason the adjustment was made				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-17.0, DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0				
CAS06	782	INDUSTRY: Adjustment Reason Code				
		<b>Monetary Amount</b>	<b>X</b>	<b>R 1/10</b>	<b>S</b>	
		Monetary amount				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0				
CAS07	380	INDUSTRY: Adjustment Amount				
		<b>Quantity</b>	<b>X</b>	<b>R 1/15</b>	<b>S</b>	
		Numeric value of quantity				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.				
CAS08	1034	INDUSTRY: Adjustment Quantity				
		<b>Claim Adjustment Reason Code</b>	<b>X</b>	<b>ID 1/5</b>	<b>S</b>	
		Code identifying the detailed reason the adjustment was made				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-18.0, DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0				
CAS09	782	INDUSTRY: Adjustment Reason Code				
		<b>Monetary Amount</b>	<b>X</b>	<b>R 1/10</b>	<b>S</b>	
		Monetary amount				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0				
CAS10	380	INDUSTRY: Adjustment Amount				
		<b>Quantity</b>	<b>X</b>	<b>R 1/15</b>	<b>S</b>	
		Numeric value of quantity				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.				
CAS11	1034	INDUSTRY: Adjustment Quantity				
		<b>Claim Adjustment Reason Code</b>	<b>X</b>	<b>ID 1/5</b>	<b>S</b>	
		Code identifying the detailed reason the adjustment was made				
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0				

CAS12	782	INDUSTRY: Adjustment Reason Code	X	R 1/10	S
		<b>Monetary Amount</b>			
		Monetary amount			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0			
CAS13	380	INDUSTRY: Adjustment Amount	X	R 1/15	S
		<b>Quantity</b>			
		Numeric value of quantity			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.			
CAS14	1034	INDUSTRY: Adjustment Quantity	X	ID 1/5	S
		<b>Claim Adjustment Reason Code</b>			
		Code identifying the detailed reason the adjustment was made			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0			
CAS15	782	INDUSTRY: Adjustment Reason Code	X	R 1/10	S
		<b>Monetary Amount</b>			
		Monetary amount			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0			
CAS16	380	INDUSTRY: Adjustment Amount	X	R 1/15	S
		<b>Quantity</b>			
		Numeric value of quantity			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.			
CAS17	1034	INDUSTRY: Adjustment Quantity	X	ID 1/5	S
		<b>Claim Adjustment Reason Code</b>			
		Code identifying the detailed reason the adjustment was made			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA3-04.0, DA3-06.0, DA3-08.0, DA3-10.0, DA3-12.0, DA3-14.0, DA3-16.0			
CAS18	782	INDUSTRY: Adjustment Reason Code	X	R 1/10	S
		<b>Monetary Amount</b>			
		Monetary amount			
		<b>X12N HIPAA Notes:</b> Used as needed to show payer adjustments.  NSF Reference: DA1-30.0, DA1-33.0, DA3-05.0, DA3-07.0, DA3-09.0, DA3-11.0, DA3-13.0, DA3-15.0, DA3-17.0, DA3-25.0, DA3-26.0			

<b>CAS19</b>	<b>380</b>	INDUSTRY: Adjustment Amount			
		<b>Quantity</b>	<b>X</b>	<b>R 1/15</b>	<b>S</b>
		Numeric value of quantity			
		<b>X12N HIPAA Notes:</b>			
		Used as needed to show payer adjustments.			
		INDUSTRY: Adjustment Quantity			

**Segment:** **AMT** Coordination of Benefits (COB) Payer Paid Amount  
**Position:** 300  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if claim has been adjudicated by payer identified in this loop. It is acceptable to show "0" amount paid.

**X12N HIPAA Example**

Example: AMT\*D\*411~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		<b>X12N HIPAA Notes:</b> INDUSTRY: Amount Qualifier Code		
		D Payor Amount Paid		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		<b>X12N HIPAA Notes:</b> This amount is a crosswalk from CLP04 in the 835 when doing COB.		
		INDUSTRY: Payer Paid Amount		

**Segment:** **AMT** Coordination of Benefits (COB) Approved Amount  
**Position:** 300  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Used only in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.

The approved amount equals the amount for the total claim that was approved by the payer sending this 837 to another payer.

**X12N HIPAA Example**

Example: AMT\*AAE\*500~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Amount Qualifier Code		
		AAE Approved Amount		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		<b>X12N HIPAA Notes:</b>		
		NSF Reference: DA1-27.0		
		INDUSTRY: Approved Amount		

**Segment:** **AMT** Coordination of Benefits (COB) Allowed Amount  
**Position:** 300  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Used only in payer-to-payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.

The allowed amount equals the amount for the total claim that was allowed by the payer sending this 837 to another payer.

**X12N HIPAA Example**

Example: AMT\*B6\*500~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Amount Qualifier Code				
B6 Allowed - Actual				
Amount considered for payment under the provisions of the contract				
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Allowed Amount				

**Segment:** **AMT** Coordination of Benefits (COB) Patient Responsibility Amount  
**Position:** 300  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To indicate the total monetary amount  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop (2330B NM1).

**X12N HIPAA Example**

Example: AMT\*F2\*15~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
AMT01	522	Amount Qualifier Code Code to qualify amount	M ID 1/3	R
		<b>X12N HIPAA Notes:</b> INDUSTRY: Amount Qualifier Code		
		F2 Patient Responsibility - Actual Calculated value one receiving medical care is obliged to pay		
AMT02	782	Monetary Amount Monetary amount	M R 1/10	R
		<b>X12N HIPAA Notes:</b> This amount is a crosswalk from CLP05 in the 835 when doing COB. INDUSTRY: Patient Responsibility Amount		

**Segment:** **DMG** Other Insured Demographic Information  
**Position:** 305  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply demographic information  
**Syntax Notes:** 1 If either DMG01 or DMG02 is present, then the other is required.  
**Semantic Notes:** 1 DMG02 is the date of birth.  
 2 DMG07 is the country of citizenship.  
 3 DMG09 is the age in years.

**Comments:**

**Notes:**

**X12N HIPAA Notes**

Required when 2330A NM102 = 1 (person).

**X12N HIPAA Example**

Example: DMG\*D8\*19561105\*M~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
DMG01	1250	<b>Date Time Period Format Qualifier</b>	<b>X ID 2/3</b>	<b>R</b>
		Code indicating the date format, time format, or date and time format		
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Date Time Period Format Qualifier		
		D8 Date Expressed in Format CCYYMMDD		
DMG02	1251	<b>Date Time Period</b>	<b>X AN 1/35</b>	<b>R</b>
		Expression of a date, a time, or range of dates, times or dates and times		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Subscriber's Date of Birth		
		INDUSTRY: Other Insured Birth Date		
DMG03	1068	<b>Gender Code</b>	<b>O ID 1/1</b>	<b>R</b>
		Code indicating the sex of the individual		
		<b>X12N HIPAA Notes:</b>		
		ALIAS: Subscriber's Gender		
		INDUSTRY: Other Insured Gender Code		
		F Female		
		M Male		
		U Unknown		

**Segment:** **OI Other Insurance Coverage Information**  
**Position:** 310  
**Loop:** 2320 Optional  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify information associated with other health insurance coverage  
**Syntax Notes:**  
**Semantic Notes:** 1 OI03 is the assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider.

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.

**X12N HIPAA Example**

Example: OI\*\*\*Y\*\*\*Y~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
OI01	1032	<b>Claim Filing Indicator Code</b> Refer to 004010X097A1 Data Element Dictionary for acceptable code values.	O ID 1/2	N/U
OI02	1383	<b>Claim Submission Reason Code</b> Refer to 004010X097A1 Data Element Dictionary for acceptable code values.	O ID 2/2	N/U
OI03	1073	<b>Yes/No Condition or Response Code</b> Code indicating a Yes or No condition or response	O ID 1/1	R
<b>X12N HIPAA Notes:</b>				
This code is a crosswalk from CLM08 when doing COB. NSF Reference: DA0-15.0 INDUSTRY: Benefits Assignment Certification Indicator				
		N No		
		Y Yes		
OI04	1351	<b>Patient Signature Source Code</b> Refer to 004010X097A1 Data Element Dictionary for acceptable code values.	O ID 1/1	N/U
OI05	1360	<b>Provider Agreement Code</b> Refer to 004010X097A1 Data Element Dictionary for acceptable code values.	O ID 1/1	N/U
OI06	1363	<b>Release of Information Code</b> Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations	O ID 1/1	R
<b>X12N HIPAA Notes:</b>				
This code is a crosswalk from CLM09 when doing COB.				
ALIAS: Release of Information				
INDUSTRY: Release of Information Code				
		N No, Provider is Not Allowed to Release Data		
		Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim		

**Segment:** **NM1** Other Subscriber Name  
**Position:** 325  
**Loop:** 2330A Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Submitters are required to send information on all known other subscribers in Loop ID-2330.

The 2330A loop is required when Loop ID-2320 - Other Subscriber Information, is used. Otherwise, the loop is not used.

**X12N HIPAA Example**

Example: NM1\*IL\*1\*DOE\*JOHN\*T\*\*JR\*MI\*333224444~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Identifier Code	M ID 2/3	R
		IL Insured or Subscriber		
NM102	1065	Entity Type Qualifier Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier	M ID 1/1	R
		1 Person		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name Individual last name or organizational name <b>X12N HIPAA Notes:</b> ALIAS: Other Insured's Last Name NSF Reference: DA0-19.0 INDUSTRY: Other Insured Last Name	O AN 1/35	R
NM104	1036	Name First Individual first name <b>X12N HIPAA Notes:</b> ALIAS: Other Insured's First Name NSF Reference: DA0-20.0 INDUSTRY: Other Insured First Name	O AN 1/25	R
NM105	1037	Name Middle Individual middle name or initial <b>X12N HIPAA Notes:</b> Required if NM102 = 1 and the middle name/initial of the person is known. ALIAS: Other Insured's Middle Name	O AN 1/25	S

NSF Reference: DA0-21.0

<b>NM106</b>	<b>1038</b>	<b>INDUSTRY: Other Insured Middle Name</b>			
		<b>Name Prefix</b>	<b>O</b>	<b>AN 1/10</b>	<b>N/U</b>
<b>NM107</b>	<b>1039</b>	<b>Name Suffix</b>	<b>O</b>	<b>AN 1/10</b>	<b>S</b>

Suffix to individual name

**X12N HIPAA Notes:**

Examples: I, II, III, IV, Jr, Sr

Required if known.

ALIAS: Other Insured's Generation

<b>NM108</b>	<b>66</b>	<b>INDUSTRY: Other Insured Name Suffix</b>			
		<b>Identification Code Qualifier</b>	<b>X</b>	<b>ID 1/2</b>	<b>R</b>
		Code designating the system/method of code structure used for Identification Code (67)			

**X12N HIPAA Notes:**

INDUSTRY: Identification Code Qualifier

		<b>MI</b>	<b>Member Identification Number</b>		
<b>NM109</b>	<b>67</b>	<b>Identification Code</b>	<b>X</b>	<b>AN 2/80</b>	<b>R</b>
		Code identifying a party or other code			<b>AN 1/12</b>

**X12N HIPAA Notes:**

ALIAS: Other Insured's Identification Number

INDUSTRY: Other Insured Identifier

**ODJFS User Note:**

Medicaid billing number is required in the NM109 when submitting a claim to Medicare when the claim will be crossed over to Medicaid for payment.

**Segment:** **NM1** Other Payer Name  
**Position:** 325  
**Loop:** 2330B Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Submitters are required to send all known information on other payers in this loop ID-2330.

**X12N HIPAA Example**

Example: NM1\*PR\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*XV\*43~

**ODJFS User Note**

Other Payors include Medicare Part A & B intermediaries, Medicare HMOs (Medicare Part C); other Third Party Payers

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Identifier Code PR Payer	M ID 2/3	R
NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier 2 Non-Person Entity	M ID 1/1	R
NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <b>X12N HIPAA Notes:</b> ALIAS: Other Payer Name NSF Reference: DA0-09.0 INDUSTRY: Other Payer Last or Organization Name	O AN 1/35	R
NM104	1036	<b>Name First</b>	O AN 1/25	N/U
NM105	1037	<b>Name Middle</b>	O AN 1/25	N/U
NM106	1038	<b>Name Prefix</b>	O AN 1/10	N/U
NM107	1039	<b>Name Suffix</b>	O AN 1/10	N/U
NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) <b>X12N HIPAA Notes:</b> INDUSTRY: Identification Code Qualifier PI Payor Identification XV Health Care Financing Administration National Payer Identification Number (PAYERID)	X ID 1/2	R
NM109	67	<b>Identification Code</b> Code identifying a party or other code <b>X12N HIPAA Notes:</b>	X AN 2/80	R

ALIAS: Other Payer Primary Identification Number

NSF Reference: DA0-07.0

INDUSTRY: Other Payer Primary Identifier

**Segment:** **DTP** Claim Paid Date  
**Position:** 350  
**Loop:** 2330B Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

This segment is required when Loop ID-2430 (Service Adjudication Information) is not used.

**X12N HIPAA Example**

Example: DTP\*573\*D8\*19991212~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier	M ID 3/3	R
		573 Date Claim Paid		
DTP02	1250	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Period Format Qualifier	M ID 2/3	R
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> INDUSTRY: Date Claim Paid	M AN 1/35	R

**Segment:** **NM1 Other Payer Patient Information**  
**Position:** 325  
**Loop:** 2330C Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required when it is necessary, in COB situations, to send one or more payer specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330C loop are those patient ID's which belong to non-destination (COB) payers. The patient id(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments.

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.

**X12N HIPAA Example**

Example: NM1\*QC\*1\*\*\*\*\*MI\*6677U801~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Identifier Code QC Patient Individual receiving medical care	M ID 2/3	R
NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier 1 Person	M ID 1/1	R
NM103	1035	<b>Name Last or Organization Name</b>	O AN 1/35	N/U
NM104	1036	<b>Name First</b>	O AN 1/25	N/U
NM105	1037	<b>Name Middle</b>	O AN 1/25	N/U
NM106	1038	<b>Name Prefix</b>	O AN 1/10	N/U
NM107	1039	<b>Name Suffix</b>	O AN 1/10	N/U
NM108	66	<b>Identification Code Qualifier</b> Code designating the system/method of code structure used for Identification Code (67) <b>X12N HIPAA Notes:</b> INDUSTRY: Identification Code Qualifier MI Member Identification Number	X ID 1/2	R
NM109	67	<b>Identification Code</b> Code identifying a party or other code <b>X12N HIPAA Notes:</b> ALIAS: Patient's Other Payer Primary Identification Number INDUSTRY: Other Payer Patient Primary Identifier <b>ODJFS User Note:</b>	X AN 2/80	R

Medicaid billing number is required in the NM109 when submitting a claim to any commercial insurance carrier when the claim will be crossed over to Medicaid for payment.

**Segment:** **LX** Line Counter  
**Position:** 365  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To reference a line number in a transaction set  
**Syntax Notes:**  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.

The data in the LX is not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/unbundling in SVC06.

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

**X12N HIPAA Example**

Example: LX\*1~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
LX01	554	Assigned Number	M N0 1/6	R

Number assigned for differentiation within a transaction set

**X12N HIPAA Notes:**

The service line number is incremented by one for each service line.

ALIAS: Line Counter

NSF Reference: FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0

INDUSTRY: Assigned Number

**Segment:** **SV3 Dental Service**  
**Position:** 380  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify the claim service detail for dental work  
**Syntax Notes:**  
**Semantic Notes:**

- 1 SV302 is a submitted charge amount.
- 2 SV303 is the place of service code representing the location where the dental treatment was rendered.
- 3 SV306 is the number of procedures.
- 4 SV307 is the reason for replacement.
- 5 SV310 is the predetermination of benefits indicator. A "Y" value indicates that this service is being submitted for predetermination of benefits.

**Comments:**  
**Notes:** **X12N HIPAA Example**  
 Example: SV3\*AD:D2150\*80\*\*\*\*1~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SV301	C003	<b>Composite Medical Procedure Identifier</b> To identify a medical procedure by its standardized codes and applicable modifiers <b>ODJFS Application Note:</b> Used for Claim Processing	M	R
C00301	235	<b>Product/Service ID Qualifier</b> Code identifying the type/source of the descriptive number used in Product/Service ID (234) <b>X12N HIPAA Notes:</b> INDUSTRY: Product or Service ID Qualifier AD American Dental Association Codes This association's membership consists of U.S. dentists. It sets standards for the dental profession <b>X12N HIPAA Notes:</b> CDT = Current Dental Terminology	M ID 2/2	R
C00302	234	<b>Product/Service ID</b> Identifying number for a product or service <b>X12N HIPAA Notes:</b> ALIAS: Procedure Code NSF Reference: FA0-09.0 INDUSTRY: Procedure Code <b>ODJFS User Note:</b> Use the appropriate CDT code.	M AN 1/48	R
C00303	1339	<b>Procedure Modifier</b> This identifies special circumstances related to the performance of the service, as defined by trading partners <b>X12N HIPAA Notes:</b> Use this modifier for the first procedure code modifier.  A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature". If such modifier is available.  ALIAS: Procedure Code Modifier	O AN 2/2	S

		NSF Reference: FA0-10.0		
<b>C00304</b>	<b>1339</b>	INDUSTRY: Procedure Modifier <b>Procedure Modifier</b>	<b>O AN 2/2 S</b>	
		This identifies special circumstances related to the performance of the service, as defined by trading partners <b>X12N HIPAA Notes:</b> Use this modifier for the second procedure code modifier.  A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.  Used at the discretion of the submitter.  ALIAS: Procedure Code Modifier  NSF Reference: FA0-11.0		
<b>C00305</b>	<b>1339</b>	INDUSTRY: Procedure Modifier <b>Procedure Modifier</b>	<b>O AN 2/2 S</b>	
		This identifies special circumstances related to the performance of the service, as defined by trading partners <b>X12N HIPAA Notes:</b> Use this modifier for the third procedure code modifier.  A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.  Used at the discretion of the submitter.  ALIAS: Procedure Code Modifier  NSF Reference: FA0-12.0		
<b>C00306</b>	<b>1339</b>	INDUSTRY: Procedure Modifier <b>Procedure Modifier</b>	<b>O AN 2/2 S</b>	
		This identifies special circumstances related to the performance of the service, as defined by trading partners <b>X12N HIPAA Notes:</b> Use this modifier for the fourth procedure code modifier.  A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.  Used at the discretion of the submitter.  ALIAS: Procedure Code Modifier  NSF Reference: FA0-36.0		
<b>SV302</b>	<b>782</b>	INDUSTRY: Procedure Modifier <b>Monetary Amount</b>	<b>O R 1/10 R</b>	
		Monetary amount <b>X12N HIPAA Notes:</b> Zero "0" is an acceptable value for this element.		

ALIAS: Line Charge Amount  
 NSF Reference: FA0-13.0  
 INDUSTRY: Line Item Charge Amount

**ODJFS Application Note:**  
 Used for Claim Processing

**SV303 1331 Facility Code Value O AN 1/2 S**  
 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  
**X12N HIPAA Notes:**  
 Required if the Place of Service is different than the Place of Service reported in the CLM segment in the 2300 loop.  
 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 guide. 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
- 31 Skilled Nursing Facility
- 35 Adult Living Care Facility

INDUSTRY: Facility Type Code  
**ODJFS Application Note:**  
 Used for Claim Processing

**SV304 C006 Oral Cavity Designation O S**  
 To identify one or more areas of the oral cavity  
**X12N HIPAA Notes:**

Required to report areas of the mouth that are being treated.

**C00601 1361 Oral Cavity Designation Code M ID 1/3 R**  
 Code Identifying the area of the oral cavity in which service is rendered  
**X12N HIPAA Notes:**

NSF Reference: FD0-62.0  
 INDUSTRY: Oral Cavity Designation Code

- 00 Entire Oral Cavity
- 01 Maxillary Area
- 02 Mandibular Area
- 09 Other Area of Oral Cavity  
 An area specified in an annexed document or further explanation available
- 10 Upper Right Quadrant
- 20 Upper Left Quadrant
- 30 Lower Left Quadrant
- 40 Lower Right Quadrant
- L Left  
 Refers to the oral and skeletal structures on the left side
- R Right  
 Refers to the oral and skeletal structures on the right side

**C00602 1361 Oral Cavity Designation Code O ID 1/3 S**

Code Identifying the area of the oral cavity in which service is rendered

**X12N HIPAA Notes:**

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

NSF Reference: FD0-62.0

INDUSTRY: Oral Cavity Designation Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**C00603 1361 Oral Cavity Designation Code O ID 1/3 S**

Code Identifying the area of the oral cavity in which service is rendered

**X12N HIPAA Notes:**

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

NSF Reference: FD0-62.0

INDUSTRY: Oral Cavity Designation Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**C00604 1361 Oral Cavity Designation Code O ID 1/3 S**

Code Identifying the area of the oral cavity in which service is rendered

**X12N HIPAA Notes:**

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

NSF Reference: FD0-62.0

INDUSTRY: Oral Cavity Designation Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**C00605 1361 Oral Cavity Designation Code O ID 1/3 S**

Code Identifying the area of the oral cavity in which service is rendered

**X12N HIPAA Notes:**

Use this code for the additional oral cavity designation codes. The code values in SV304-1 apply to all occurrences of the oral cavity designation code.

NSF Reference: FD0-62.0

INDUSTRY: Oral Cavity Designation Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**SV305 1358 Prosthesis, Crown or Inlay Code O ID 1/1 S**

Code specifying the placement status for the dental work

**X12N HIPAA Notes:**

Required to indicate the placement status of the prosthetic on this line.

NSF Reference: FD0-13.0

INDUSTRY: Prosthesis, Crown, or Inlay Code

I Initial Placement  
R Replacement

**SV306 380 Quantity O R 1/15 R**

Numeric value of quantity

**X12N HIPAA Notes:**

Number of procedures

NSF Reference: FA0-18.0

INDUSTRY: Procedure Count

**ODJFS Application Note:**

Used in Claim Processing

**Segment:** **TOO** **Tooth Information**  
**Position:** 382  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 32  
**Purpose:** To identify a tooth by number and, if applicable, one or more tooth surfaces  
**Syntax Notes:** 1 If either TOO01 or TOO02 is present, then the other is required.  
**Semantic Notes:**  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required to report tooth number and/or tooth surface related to this procedure line.

**X12N HIPAA Example**

Example: TOO\*JP\*12\*L:O~

**ODJFS User Note**

Only one tooth per Procedure Code element is allowed.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
TOO01	1270	<b>Code List Qualifier Code</b> Code identifying a specific industry code list <b>X12N HIPAA Notes:</b> INDUSTRY: Code List Qualifier Code JP National Standard Tooth Numbering System	X ID 1/3	R
TOO02	1271	<b>Industry Code</b> Code indicating a code from a specific industry code list <b>X12N HIPAA Notes:</b> See Appendix C for code source 135: American Dental Association Codes. ALIAS: Tooth Number NSF Reference: FD0-05.0, FD0-07.0, FD0-09.0, FD0-11.0 INDUSTRY: Tooth Code <b>ODJFS Application Note:</b> Used for Claim processing; can only repeat segment one time	X AN 1/30	S
TOO03	C005	<b>Tooth Surface</b> To identify one or more tooth surface codes <b>X12N HIPAA Notes:</b> Required if the procedure code requires tooth surface codes. <b>ODJFS Application Note:</b> Used for Claim Processing	O	S
C00501	1369	<b>Tooth Surface Code</b> Code identifying the area of the tooth that was treated <b>X12N HIPAA Notes:</b> NSF Reference: FD0-06.0, FD0-08.0, FD0-10.0, FD0-12.0 INDUSTRY: Tooth Surface Code B Buccal The surface of the tooth which is closest to the cheek D Distal The surface of the tooth facing away from an invisible line drawn vertically through the center of the face	M ID 1/2	R

F	Facial The surface of a tooth that is directed towards the face
I	Incisal The cutting edges of the anterior teeth
L	Lingual The surface of the tooth that is directed towards the tongue
M	Mesial The surface of a tooth which faces toward an invisible line drawn vertically through the center of the face
O	Occlusal The surfaces of the posterior (back) teeth which provides the chewing function

**C00502 1369 Tooth Surface Code O ID 1/2 S**

Code identifying the area of the tooth that was treated

**X12N HIPAA Notes:**

Additional tooth surface codes can be carried in TOO03-2 through TOO03-5. The code values are the same as in TOO03-1.

Required to report a second tooth surface.

INDUSTRY: Tooth Surface Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**C00503 1369 Tooth Surface Code O ID 1/2 S**

Code identifying the area of the tooth that was treated

**X12N HIPAA Notes:**

Required to report a third tooth surface.

INDUSTRY: Tooth Surface Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**C00504 1369 Tooth Surface Code O ID 1/2 S**

Code identifying the area of the tooth that was treated

**X12N HIPAA Notes:**

Required to report a fourth tooth surface.

INDUSTRY: Tooth Surface Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**C00505 1369 Tooth Surface Code O ID 1/2 S**

Code identifying the area of the tooth that was treated

**X12N HIPAA Notes:**

Required to report a fifth tooth surface.

INDUSTRY: Tooth Surface Code

Refer to 004010X097A1 Data Element Dictionary for acceptable code values.

**Segment:** **DTP** Date - Service  
**Position:** 455  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if the service date is different than the service date reported at the DTP segment in the 2300 loop and the service was performed.

**ODJFS Application Note**

Used for Claim Processing

**X12N HIPAA Example**

Example: DTP\*472\*D8\*19980108~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time	M ID 3/3	R
		<b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 472 Service Begin and end dates of the service being rendered		
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format	M ID 2/3	R
		<b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times	M AN 1/35	R
		<b>X12N HIPAA Notes:</b> NSF Reference: FA0-05.0, FA0-06.0 INDUSTRY: Service Date		

**Segment:** **DTP** Date - Prior Placement  
**Position:** 455  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if the services performed are prosthetic services that were previously placed.

If the SV305 data element = "R - Replacement" the Prior Placement date is required.

**X12N HIPAA Example**

Example: DTP\*441\*D8\*19980108~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 441 Prior Placement Date medical device was last placed or arranged	M ID 3/3	R
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> NSF Reference: FD0-14.0 INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> INDUSTRY: Prior Placement Date	M AN 1/35	R

**Segment:** **DTP** Date - Appliance Placement  
**Position:** 455  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:** **X12N HIPAA Notes**  
 Required if the orthodontic appliance placement date is different than the orthodontic appliance placement date in the DTP segment in the 2300 loop.  
**X12N HIPAA Example**  
 Example: DTP\*452\*D8\*19980108~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 452 Appliance Placement Date orthodontic devices were arranged	M ID 3/3	R
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> NSF Reference: FD0-19.0 INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> INDUSTRY: Orthodontic Banding Date	M AN 1/35	R

**Segment:** **DTP** Date - Replacement  
**Position:** 455  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:** **X12N HIPAA Notes**  
 This DTP segment should be used to report the date an orthodontic appliance was replaced.  
**X12N HIPAA Example**  
 Example: DTP\*446\*D8\*19980108~

**Data Element Summary**

<u>Ref.</u> <u>Des.</u>	<u>Data</u> <u>Element</u>	<u>Name</u>	<u>Base</u> <u>Attributes</u>	<u>User</u> <u>Attributes</u>
DTP01	374	<b>Date/Time Qualifier</b> Code specifying type of date or time, or both date and time <b>X12N HIPAA Notes:</b> INDUSTRY: Date Time Qualifier 446 Replacement Date medical device was reinstalled or rearranged	M ID 3/3	R
DTP02	1250	<b>Date Time Period Format Qualifier</b> Code indicating the date format, time format, or date and time format <b>X12N HIPAA Notes:</b> NSF Reference: FD0-22.0 INDUSTRY: Date Time Period Format Qualifier D8 Date Expressed in Format CCYYMMDD	M ID 2/3	R
DTP03	1251	<b>Date Time Period</b> Expression of a date, a time, or range of dates, times or dates and times <b>X12N HIPAA Notes:</b> INDUSTRY: Replacement Date	M AN 1/35	R

**Segment:** **REF** **Prior Authorization or Referral Number**

**Position:** 470

**Loop:** 2400 Optional (Must Use)

**Level:** Detail

**Usage:** Optional

**Max Use:** 2

**Purpose:** To specify identifying information

**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**

**Notes:**

**X12N HIPAA Notes**

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).

This segment should not be used for Predetermination of Benefits.

**ODJFS Application Note**

Used for Claim Processing

**X12N HIPAA Example**

Example: REF\*9F\*123456567~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3	R
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Reference Identification Qualifier		
		G1 Prior Authorization Number		
		An authorization number acquired prior to the submission of a claim		
REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30	R
		<b>X12N HIPAA Notes:</b>		
		INDUSTRY: Referral Number		
		<b>ODJFS User Note:</b>		
		This is the Medicaid 6 digit prior authorization number.		

**Segment:** **REF** Line Item Control Number  
**Position:** 470  
**Loop:** 2400 Optional (Must Use)  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if it is necessary to send a line control or inventory number. It is strongly suggested that providers send this number, particularly if the provider automatically posts their remittance advice. Payers are required to return this number in the remittance advice transaction (835) if the provider sends it to them in the 837.

**X12N HIPAA Example**

Example: REF\*6R\*543211~

**ODJFS User Note**

Returned on the 835.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	<b>Reference Identification Qualifier</b> Code qualifying the Reference Identification	M ID 2/3	R
		<b>X12N HIPAA Notes:</b> INDUSTRY: Reference Identification Qualifier		
		6R Provider Control Number Number assigned by information provider company for tracking and billing purposes		
REF02	127	<b>Reference Identification</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	X AN 1/30	R
		<b>X12N HIPAA Notes:</b> NSF Reference: FA0-04.4, FB0-04.0, FB1-04.0, FB2-04.0, FD0-04.0, FE0-04.0, HA0-04.0		
		INDUSTRY: Line Item Control Number		

**Segment:** **NM1** Rendering Provider Name  
**Position:** 500  
**Loop:** 2420A Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

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 that what is given in the 2010AA/AB loop.

**X12N HIPAA Example**

Example: NM1\*82\*1\*DICE\*LINDA\*\*\*\*34\*123456789~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI for the rendering provider on the 837 electronic claim transactions if it is required to adjudicate the claim. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and the legacy ID in the rendering provider loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	<b>Entity Identifier Code</b> Code identifying an organizational entity, a physical location, property or an individual <b>X12N HIPAA Notes:</b> The entity identifier in NM101 applies to all segments in Loop ID-2420. INDUSTRY: Entity Identifier Code 82 Rendering Provider	<b>M ID 2/3</b>	<b>R</b>
NM102	1065	<b>Entity Type Qualifier</b> Code qualifying the type of entity <b>X12N HIPAA Notes:</b> INDUSTRY: Entity Type Qualifier 1 Person 2 Non-Person Entity	<b>M ID 1/1</b>	<b>R</b>
NM103	1035	<b>Name Last or Organization Name</b> Individual last name or organizational name <b>X12N HIPAA Notes:</b> NSF Reference: FB1-14.0	<b>O AN 1/35</b>	<b>R</b>

NM104	1036	INDUSTRY: Rendering Provider Last or Organization Name			
		<b>Name First</b>	O	AN 1/25	S
		Individual first name			
		<b>X12N HIPAA Notes:</b>			
		Required if NM102 = 1 (person).			
		ALIAS: Rendering Provider First Name			
		NSF Reference: FB1-15.0			
NM105	1037	INDUSTRY: Rendering Provider First Name			
		<b>Name Middle</b>	O	AN 1/25	S
		Individual middle name or initial			
		<b>X12N HIPAA Notes:</b>			
		Required if NM102 = 1 and the middle name/initial of the person is known.			
		ALIAS: Rendering Provider Middle Name			
		NSF Reference: FB1-16.0			
NM106	1038	INDUSTRY: Rendering Provider Middle Name			
		<b>Name Prefix</b>	O	AN 1/10	N/U
NM107	1039	<b>Name Suffix</b>	O	AN 1/10	
		Suffix to individual name			
		<b>X12N HIPAA Notes:</b>			
		Required if known.			
		ALIAS: Rendering Provider Name Suffix			
NM108	66	INDUSTRY: Rendering Provider Name Suffix			
		<b>Identification Code Qualifier</b>	X	ID 1/2	R
		Code designating the system/method of code structure used for Identification Code (67)			
		<b>X12N HIPAA Notes:</b>			
		INDUSTRY: Identification Code Qualifier			
		24 Employer's Identification Number			
		34 Social Security Number			
		<b>X12N HIPAA Notes:</b>			
		The Social Security Number may not be used for Medicare.			
		XX Health Care Financing Administration National Provider Identifier			
NM109	67	<b>Identification Code</b>	X	AN 2/80	R
		Code identifying a party or other code			
		<b>X12N HIPAA Notes:</b>			
		ALIAS: Rendering Provider Primary Identification Number			
		NSF Reference: FA0-23.0			
		INDUSTRY: Rendering Provider Identifier			
		<b>ODJFS User Note:</b>			
		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.			
		Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.			

**Segment:** **REF** **Rendering Provider Secondary Identification**  
**Position:** 525  
**Loop:** 2420A Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 5  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

**X12N HIPAA Example**

Example: REF\*0B\*A12345~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI for the rendering provider on the 837 electronic claim transactions if it is required to adjudicate the claim. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and the legacy ID in the rendering provider loop of the electronic claim until further notice.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R

Code qualifying the Reference Identification

**X12N HIPAA Notes:**

INDUSTRY: Reference Identification Qualifier

- ID Medicaid Provider Number
- EI Employer's Identification Number
- SY Social Security Number

**X12N HIPAA Notes:**

The Social Security Number may not be used for Medicare.

REF02	127	Reference Identification	X AN 1/30	R
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Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

**X12N HIPAA Notes:**

INDUSTRY: Rendering Provider Secondary Identifier

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Segment:** **NM1** Assistant Surgeon Name  
**Position:** 280  
**Loop:** 2420C Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To supply the full name of an individual or organizational entity  
**Syntax Notes:** 1 If either NM108 or NM109 is present, then the other is required.  
**Semantic Notes:** 1 NM102 qualifies NM103.  
**Comments:**  
**Notes:**

**X12N HIPAA Notes**

Required if the Assistant Surgeon information in this Loop ID-2420C is different from the Assistant Surgeon information supplied in the Loop ID-2310D.

Because the usage of this segment is "situational" this is not a syntactically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature and X12 syntax rules.

Required when the Assistant Surgeon information is needed to facilitate reimbursement.

The Assistant Surgeon information must not be used when the Rendering Provider loop (Loop ID-2310B) is also present for the claim.

**X12N HIPAA Example**

NM1\*DD\*1\*SMITH\*JOHN\*S\*\*\*34\*123456789~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the assistant surgeon loop, if used, on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the assistant surgeon loop of the electronic claim until further notice.

If the assistant surgeon is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the assistant surgeon. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
NM101	98	Entity Identifier Code	M ID 2/3	R
		Code identifying an organizational entity, a physical location, property or an individual		
		<b>X12N HIPAA Notes:</b>		
		The entity identifier in NM101 applies to all segments in Loop ID-2310.		
		DD Assistant Surgeon		
NM102	1065	Entity Type Qualifier	M ID 1/1	R
		Code qualifying the type of entity		
		1 Person		
		2 Non-Person Entity		
NM103	1035	Name Last or Organization Name	O AN 1/35	R

		Individual last name or organizational name			
<b>NM104</b>	<b>1036</b>	<b>Name First</b>	<b>O</b>	<b>AN 1/25</b>	<b>S</b>
		Individual first name			
		<b>X12N HIPAA Notes:</b>			
		Required if NM102 = 1 (person)			
<b>NM105</b>	<b>1037</b>	<b>Name Middle</b>	<b>O</b>	<b>AN 1/25</b>	<b>S</b>
		Individual middle name or initial			
		<b>X12N HIPAA Notes:</b>			
		Required when middle name/initial of person is known.			
<b>NM106</b>	<b>1038</b>	<b>Name Prefix</b>	<b>O</b>	<b>AN 1/10</b>	<b>N/U</b>
<b>NM107</b>	<b>1039</b>	<b>Name Suffix</b>	<b>O</b>	<b>AN 1/10</b>	<b>S</b>
		Suffix to individual name			
		<b>X12N HIPAA Notes:</b>			
		Required if known.			
<b>NM108</b>	<b>66</b>	<b>Identification Code Qualifier</b>	<b>X</b>	<b>ID 1/2</b>	<b>R</b>
		Code designating the system/method of code structure used for Identification Code (67)			
		24 Employer's Identification Number			
		34 Social Security Number			
		XX Health Care Financing Administration National Provider Identifier			
		<b>X12N HIPAA Notes:</b>			
		Required value if the National Provider ID is mandated for use.			
		Otherwise, one of the other listed codes may be used.			
<b>NM109</b>	<b>67</b>	<b>Identification Code</b>	<b>X</b>	<b>AN 2/80</b>	<b>S</b>
		Code identifying a party or other code			
		<b>ODJFS User Note:</b>			
		If the assistant surgeon is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the assistant surgeon. If the attempt is not successful, the billing provider may use the NPI Registry ( <a href="https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do">https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do</a> ) to obtain the referring entity or provider's NPI to enter it on the claim.			
		For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.			
		Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.			

**Segment:** **REF** Assistant Surgeon Secondary Identification  
**Position:** 287  
**Loop:** 2420C Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To specify identifying information  
**Syntax Notes:**

- 1 At least one of REF02 or REF03 is required.
- 2 If either C04003 or C04004 is present, then the other is required.
- 3 If either C04005 or C04006 is present, then the other is required.

**Semantic Notes:**

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

**Comments:**  
**Notes:**

**X12N HIPAA Notes**

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

**X12N HIPAA Example**

REF\*OB\*12345~

**ODJFS User Note**

The National Provider Identifier is mandated to be used on electronic claims on and after May 23, 2008. ODJFS will deny electronic claims that are missing an NPI in the assistant surgeon loop, if used, on the 837 electronic claim transactions. Although the legacy ID is not required, ODJFS will continue to accept claims that contain both the NPI and legacy ID in the assistant surgeon loop of the electronic claim until further notice.

If the assistant surgeon is required to be identified and does not furnish an NPI, the billing provider must first attempt to obtain that NPI by directly contacting the assistant surgeon. If the attempt is not successful, the billing provider may use the NPI Registry (<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>) to obtain the referring entity or provider's NPI to enter it on the claim.

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
REF01	128	Reference Identification Qualifier	M ID 2/3	R
		Code qualifying the Reference Identification		
		1D Medicaid Provider Number		
		EI Employer's Identification Number		
		SY Social Security Number		

REF02	127	Reference Identification	X AN 1/30	S
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier		

**ODJFS User Note:**

For Typical providers, ODJFS expects the NPI to be sent with the XX qualifier in the NM108 and the NPI in the NM109. Typical providers can send their EIN or SSN in the REF segment of this loop.

Atypical providers should send their EIN or SSN in the NM1 segment and their Medicaid 7-digit legacy ID in the REF segment with an REF01 qualifier of 1D.

**Segment:** **SVD** Line Adjudication Information  
**Position:** 540  
**Loop:** 2430 Optional  
**Level:** Detail  
**Usage:** Optional  
**Max Use:** 1  
**Purpose:** To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

**Syntax Notes:**

**Semantic Notes:**

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

**Comments:**

- 1 SVD03 represents the medical procedure code upon which adjudication of this service line was based. This may be different than the submitted medical procedure code.
- 2 SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.

**Notes:**

**X12N HIPAA Notes**

To show unbundled lines: If, in the original claim, line 3 is unbundled into (for examples) 2 additional lines, then the SVD for line 3 is used 3 times: once for the original adjustment to line 3 and then two more times for the additional unbundled lines. If a line item control number (REF01 = 6R) exists for the line, that number may be used in SVD06 instead of the LX number when a line is unbundled.

Because the usage of this segment is "situational" this is not a syntatically required loop. If the loop is used, then it is a "required" segment. See Appendix A for further details on ASC X12 nomenclature X12 syntax rules.

Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.

**X12N HIPAA Example**

Example: SVD\*43\*55\*AD:D0330\*\*1~

**Data Element Summary**

<u>Ref.</u>	<u>Data</u>	<u>Name</u>	<u>Base</u>	<u>User</u>
<u>Des.</u>	<u>Element</u>		<u>Attributes</u>	<u>Attributes</u>
SVD01	67	<b>Identification Code</b> Code identifying a party or other code <b>X12N HIPAA Notes:</b> This number shown matches NM109 in the Loop ID-2330B Identifying other payer. Crosswalked from 004010 835 Loop 1000A N104 (if PlanID is used) or REF02. ALIAS: Payer Identification Code	M AN 2/80	R
SVD02	782	INDUSTRY: Other Payer Primary Identifier <b>Monetary Amount</b> Monetary amount <b>X12N HIPAA Notes:</b> Zero "0" is an acceptable value for this element. The FA0-52.0 NSF crosswalk is only used in payer-to-payer COB situations. Crosswalked from 004010 835 SVC03. ALIAS: Amount Paid for This Service Line	M R 1/10	R

NSF Reference: FA0-52.0

INDUSTRY: Service Line Paid Amount

**ODJFS Application Note:**

Used for Claim Processing.

**SVD03 C003 Composite Medical Procedure Identifier O R**  
To identify a medical procedure by its standardized codes and applicable modifiers

**X12N HIPAA Notes:**

This element contains the procedure code that was used to pay this service line. It crosswalks from SVC01 in the 835 transaction.

Crosswalked from 004010 835 SVC01.

**C00301 235 Product/Service ID Qualifier M ID 2/2 R**  
Code identifying the type/source of the descriptive number used in Product/Service ID (234)

**X12N HIPAA Notes:**

INDUSTRY: Product or Service ID Qualifier

AD American Dental Association Codes  
This association's membership consists of U.S. dentists. It sets standards for the dental profession

ZZ Mutually Defined

**X12N HIPAA Notes:**

Jurisdictionally Defined Procedure and Supply Codes (used for Worker's Compensation claims).

**C00302 234 Product/Service ID M AN 1/48 R**  
Identifying number for a product or service

**X12N HIPAA Notes:**

INDUSTRY: Procedure Code

**C00303 1339 Procedure Modifier O AN 2/2 S**  
This identifies special circumstances related to the performance of the service, as defined by trading partners

**X12N HIPAA Notes:**

Use this modifier for the first procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.

INDUSTRY: Procedure Modifier

**C00304 1339 Procedure Modifier O AN 2/2 S**  
This identifies special circumstances related to the performance of the service, as defined by trading partners

**X12N HIPAA Notes:**

Use this modifier for the second procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.

INDUSTRY: Procedure Modifier

**C00305 1339 Procedure Modifier O AN 2/2 S**  
This identifies special circumstances related to the performance of the service, as defined

by trading partners

**X12N HIPAA Notes:**

Use this modifier for the third procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.

INDUSTRY: Procedure Modifier

**C00306 1339 Procedure Modifier O AN 2/2 S**

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

**X12N HIPAA Notes:**

Use this modifier for the fourth procedure code modifier.

Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.

A modifier must be from code source 135 (American Dental Association) found in the "Code on Dental Procedures and Nomenclature", if such modifier is available.

INDUSTRY: Procedure Modifier

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

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

**X12N HIPAA Notes:**

Required if SVC01-7 was returned in the 835 transaction.

INDUSTRY: Procedure Code Description

**SVD04 234 Product/Service ID O AN 1/48 N/U**

**SVD05 380 Quantity O R 1/15 R**

Numeric value of quantity

**X12N HIPAA Notes:**

Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units. Crosswalked from 004010 835 SVC05.

INDUSTRY: Paid Service Unit Count

**Segment:** **CAS** Service Adjustment

**Position:** 545

**Loop:** 2430 Optional

**Level:** Detail

**Usage:** Optional

**Max Use:** 99

**Purpose:** To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

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

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

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

**Notes:** **X12N HIPAA Notes**

Required if the payer identified in loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.

Mapping CAS information into a flat file format may involve reading specific Claim Adjustment Reason Codes and then mapping the subsequent Monetary Amount and/or Quantity elements to specified fields in the flat file.

There are some NSF COB elements which are covered through the use of the CAS segment. Please see the claim level CAS segment for a note on handling those crosswalks at the claim level. Some of that information may apply at the line level. Further information is given below which is more specific to line level issues.

Balance bill limiting charge (FA0-54.0). The adjustment for this information would be conveyed in a CAS amount element if the provider billed for more than they were allowed under contract.

The Claim Adjustment Reason codes are located on the Washington Publishing Company web site: <http://www.wpc-edi.com>.

**X12N HIPAA Example**

Example: CAS\*PR\*1\*793~

**ODJFS User Note**

All claim Adjustment Reason Codes and Monetary Amounts and Quantity submitted in this segment will be used for claims processing.

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
CAS01	1033	<b>Claim Adjustment Group Code</b> Code identifying the general category of payment adjustment <b>X12N HIPAA Notes:</b> ALIAS: Adjustment Group Code INDUSTRY: Claim Adjustment Group Code CO Contractual Obligations CR Correction and Reversals OA Other adjustments PI Payor Initiated Reductions PR Patient Responsibility	M ID 1/2	R
CAS02	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made <b>X12N HIPAA Notes:</b> Use the Claim Adjustment Reason code list (see Appendix C). ALIAS: Adjustment Reason Code - Line Level NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0 INDUSTRY: Adjustment Reason Code	M ID 1/5	R
CAS03	782	<b>Monetary Amount</b> Monetary amount <b>X12N HIPAA Notes:</b> Use this amount for the adjustment amount. ALIAS: Adjusted Amount - Line Level NSF Reference: FA0-027.0, FA0-28.0, FA0-35.0, FA0-48.0, FB0-06.0, FB0-07.0, FB0-08.0, FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0 INDUSTRY: Adjustment Amount <b>ODJFS Application Note:</b> Used for Claims Processing	M R 1/10	R
CAS04	380	<b>Quantity</b> Numeric value of quantity <b>X12N HIPAA Notes:</b> Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments. ALIAS: Adjusted Units - Line Level INDUSTRY: Adjustment Quantity	O R 1/15	S
CAS05	1034	<b>Claim Adjustment Reason Code</b> Code identifying the detailed reason the adjustment was made <b>X12N HIPAA Notes:</b> Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.	X ID 1/5	S

		ALIAS: Adjustment Reason Code - Line Level			
		NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0			
		INDUSTRY: Adjustment Reason Code			
CAS06	782	<b>Monetary Amount</b>	X	R 1/10	S
		Monetary amount			
		<b>X12N HIPAA Notes:</b>			
		Use this amount for the adjustment amounts. Use as needed to show payer adjustments.			
		ALIAS: Adjusted Amount - Line Level			
		NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0			
		INDUSTRY: Adjustment Amount			
CAS07	380	<b>Quantity</b>	X	R 1/15	S
		Numeric value of quantity			
		<b>X12N HIPAA Notes:</b>			
		Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.			
		ALIAS: Adjusted Units - Line Level			
		INDUSTRY: Adjustment Quantity			
CAS08	1034	<b>Claim Adjustment Reason Code</b>	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		<b>X12N HIPAA Notes:</b>			
		Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.			
		ALIAS: Adjustment Reason Code - Line Level			
		NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0			
		INDUSTRY: Adjustment Reason Code			
CAS09	782	<b>Monetary Amount</b>	X	R 1/10	S
		Monetary amount			
		<b>X12N HIPAA Notes:</b>			
		Use this amount for the adjustment amounts. Use as needed to show payer adjustments.			
		ALIAS: Adjusted Amount - Line Level			
		NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0			
		INDUSTRY: Adjustment Amount			
CAS10	380	<b>Quantity</b>	X	R 1/15	S
		Numeric value of quantity			
		<b>X12N HIPAA Notes:</b>			
		Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.			
		ALIAS: Adjusted Units - Line Level			
		INDUSTRY: Adjustment Quantity			
CAS11	1034	<b>Claim Adjustment Reason Code</b>	X	ID 1/5	S
		Code identifying the detailed reason the adjustment was made			
		<b>X12N HIPAA Notes:</b>			

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

ALIAS: Adjustment Reason Code - Line Level

NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

INDUSTRY: Adjustment Reason Code

**CAS12 782 Monetary Amount X R 1/10 S**

Monetary amount

**X12N HIPAA Notes:**

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

ALIAS: Adjusted Amount - Line Level

NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

INDUSTRY: Adjustment Amount

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

Numeric value of quantity

**X12N HIPAA Notes:**

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

ALIAS: Adjusted Units - Line Level

INDUSTRY: Adjustment Quantity

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

Code identifying the detailed reason the adjustment was made

**X12N HIPAA Notes:**

Use the Claim Adjustment Reason Code list (see Appendix C). Use as needed to show payer adjustments.

ALIAS: Adjustment Reason Code - Line Level

NSF Reference: FB3-05.0, FB3-07.0, FB3-09.0, FB3-11.0, FB3-13.0, FB3-15.0, FB3-17.0

INDUSTRY: Adjustment Reason Code

**CAS15 782 Monetary Amount X R 1/10 S**

Monetary amount

**X12N HIPAA Notes:**

Use this amount for the adjustment amounts. Use as needed to show payer adjustments.

ALIAS: Adjusted Amount - Line Level

NSF Reference: FB3-06.0, FB3-08.0, FB3-10.0, FB3-12.0, FB3-14.0, FB3-16.0, FB3-18.0

INDUSTRY: Adjustment Amount

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

Numeric value of quantity

**X12N HIPAA Notes:**

Use this quantity for the units of service being adjusted. Use as needed to show payer adjustments.

ALIAS: Adjusted Units - Line Level

INDUSTRY: Adjustment Quantity

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



**Segment:** **DTP** Line Adjudication Date  
**Position:** 550  
**Loop:** 2430 Optional  
**Level:** Detail  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To specify any or all of a date, a time, or a time period  
**Syntax Notes:**  
**Semantic Notes:** 1 DTP02 is the date or time or period format that will appear in DTP03.  
**Comments:**  
**Notes:** **X12N HIPAA Example**

Example: DTP\*573\*D8\*19961131~

**Data Element Summary**

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
DTP01	374	Date/Time Qualifier	M ID 3/3	R
Code specifying type of date or time, or both date and time				
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Date Time Qualifier				
		573 Date Claim Paid		
DTP02	1250	Date Time Period Format Qualifier	M ID 2/3	R
Code indicating the date format, time format, or date and time format				
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Date Time Period Format Qualifier				
		D8 Date Expressed in Format CCYYMMDD		
DTP03	1251	Date Time Period	M AN 1/35	R
Expression of a date, a time, or range of dates, times or dates and times				
<b>X12N HIPAA Notes:</b>				
INDUSTRY: Adjudication or Payment Date				

**Segment:** **SE** Transaction Set Trailer  
**Position:** 555  
**Loop:**  
**Level:** Summary  
**Usage:** Mandatory  
**Max Use:** 1  
**Purpose:** To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

**Syntax Notes:**

**Semantic Notes:**

**Comments:** 1 SE is the last segment of each transaction set.

**Notes:** **X12N HIPAA Example**

Example: SE\*211\*987654~

#### Data Element Summary

<u>Ref. Des.</u>	<u>Data Element</u>	<u>Name</u>	<u>Base Attributes</u>	<u>User Attributes</u>
SE01	96	<b>Number of Included Segments</b> Total number of segments included in a transaction set including ST and SE segments <b>X12N HIPAA Notes:</b> INDUSTRY: Transaction Segment Count	M N0 1/10	R
SE02	329	<b>Transaction Set Control Number</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>X12N HIPAA Notes:</b> The Transaction Set Control Numbers in ST02 and SE02 must be identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.  ALIAS: Transaction Set Control Number  INDUSTRY: Transaction Set Control Number	M AN 4/9	R

**Segment:** **GE** Functional Group Trailer  
**Position:** 565  
**Loop:**  
**Level:** Summary  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To indicate the end of a functional group and to provide control information  
**Syntax Notes:**  
**Semantic Notes:** 1 The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.  
**Comments:** 1 The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.  
**Notes:** **X12N HIPAA Example**

GE\*1\*1~

**Data Element Summary**

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

**Segment:** **IEA** Interchange Control Trailer  
**Position:** 575  
**Loop:**  
**Level:** Summary  
**Usage:** Optional (Must Use)  
**Max Use:** 1  
**Purpose:** To define the end of an interchange of zero or more functional groups and interchange-related control segments

**Syntax Notes:**

**Semantic Notes:**

**Comments:**

**Notes:** X12N HIPAA Example

IEA\*1\*000000905~

#### Data Element Summary

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