

HEALTH CARE CLAIM: INSTITUTIONAL 837 SUPPLEMENTAL GUIDE

For Provider Types 11, 12, 13, & 53

NOTE:
 This document does *NOT* include all elements required to be HIPAA compliant. It displays *only those elements* that benefit from clarification in regards to CBHNP's specific expectations and requirements to adjudicate a claim (showing the complete heirarchical loop outline of the 837 I). This document is to be used in conjunction with the HIPAA ANSI X12N 837 Health Care Claim: Institutional (004010X096) Implementation Guide (IG) and the 837 Health Care Claim: Professional Addenda (00401X096A1).

The information in this document is subject to change without notice.

Disclaimer: The material contained within this document may contain inaccuracies or typographical errors. CBHNP makes no representations as to the accuracy, reliability, completeness, or timeliness of the material within. User acknowledges that reliance on this document will be at the User's own risk.

Red Text = Required to be HIPAA Compliant
 Black Text = Situational Requirement
 Yellow Highlight indicates critical for CBHNP to adjudicate a claim
 Blue Highlight indicates CBHNP uses to adjudicate claims w/ COB payments.

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
Header								
		ISA		R	<i>Interchange Control Header</i>			The ISA is a fixed record length segment and all positions within each of the data elements must be filled.
			ISA01	R	Authorization Information Qualifier	✓	00	No Authorization Information Present
			ISA02	R	Authorization Data Identification		00	No Meaningful Information
			ISA03	R	Security Information Qualifier	✓	00	No Security Information Present
			ISA04	R	Security Information		00	No Meaningful Information
			ISA05	R	Interchange ID Qualifier	✓	ZZ	Indicates Mutually Defined Number
			ISA06	R	Interchange Sender ID		Use the CBHNP assigned submitter ID	This is assigned after a Trading Partner Agreement has been established. A clearinghouse will place their assigned clearinghouse number here.
			ISA07	R	Interchange ID Qualifier	✓	30	Indicates Federal Tax ID Number
			ISA08	R	Interchange Receiver ID		251765391	Use CBHNP EIN Number.
			ISA14	R	Acknowledgement Requested	✓	0	CBHNP will not be generating the 997 Functional Acknowledgement
			ISA15	R	Usage Indicator	✓	P/T	Production or Test
			ISA16	R	Component Element Separator		:	":" = Component Delimiter
		GS		R	<i>Functional Group Header</i>			
			GS02	R	Application Sender's Code		Use the CBHNP assigned submitter ID	This is assigned after a Trading Partner Agreement has been established. A clearinghouse will place their assigned clearinghouse number here.
			GS03	R	Application Receiver's Code		251765391	Use CBHNP EIN Number.
Transaction Set Header								
56		ST		R	<i>Transaction Set Header</i>			
			ST01	R	Transaction Set Identifier Code	✓	837	
			ST02	R	Transaction Set Control Number			
57		BHT		R	<i>Beginning of Heirarchical Transaction</i>			
			BHT01	R	Hierarchical Structure Code	✓	0019	0019 = Information source, Subscriber, Dependent

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
			BHT02	R	Transaction Set Purpose Code	✓	00/18	00=Original Claim Submission 18=Reissue
			BHT03	R	Reference Identification			The inventory file number of the tape or transmission assigned by the submitter's system. This number operates as a batch control numer. It may or may not be identical to the number carried in ST02
			BHT04	R	Transaction Set Creation Date			
			BHT05	R	Transaction Set Creation Time			Use this to identify the time the file was created.
			BHT06	R	Claim or Encounter Identifier		CH	CH=Chargeable, Use when the transmission contains only fee-for-service claims or claims with at least one chargeable line item;
60		REF		R	Transmission Type Identification			
			REF01	R	Reference Identification Qualifier	✓	87	87 = Functional Category
			REF02	R	Transmission Type Code	✓		In Test and Production use "004010X098A1"
Loop ID 1000A - Submitter Name								
61	1000A	NM1		R	Submitter Name			
	1000A		NM103	R	Submitter Last or Organization Name			
	1000A		NM109	R	Submitter Identifier		Use the CBHNP assigned submitter ID	This element contains the Electronic Transmission Identifier Number. Clearinghouses will place the provider's assigned submitter ID here.
	1000A	PER		R	Submitter EDI Contact Information			
Loop ID 1000B - Receiver Name								
	1000B	NM1		R	Receiver Name			
	1000B		NM103	R	Receiver Name		CBHNP	
	1000B		NM109	R	Receiver Primary Identifier		251765391	This is CBHNP's EIN.
Loop ID 2000A - Billing/Pay-to Provider								
	2000A	HL		R	Billing/Pay-to Provider Hierarchical Level			
	2000A	PRV		R	S - Required if the service facility provider is the same as the billing provider and Loop ID 2310E is not used. Billing/Pay-to Provider Specialty Information			
	2000A		PRV01	R	Provider Code	✓	BI	Indicates Billing Provider
	2000A	CUR		S	Foreign Currency Information			
Loop ID 2010AA Billing Provider Name								
	2010AA	NM1		R	Billing Provider Name			
	2010AA		NM101	R	Entity Identifier Code	✓	85	85 Indicates Billing Provider
	2010AA		NM102	R	Entity Type Qualifier	✓	1/2	1 - Person 2 - Non-Person
77	2010AA		NM103	R	Billing Provider Last or Organizational Name			
	2010AA		NM104	R	S - Required if NM102 is a person Billing Provider First Name			
	2010AA		NM105	R	S - Required if NM102 is a person and the middle name/initial is known Billing Provider Middle Name			
	2010AA		NM107	R	S - Required if NM102 is a person and has known suffix Billing Provider Name Suffix			
77	2010AA		NM108	R	Billing Provider Identification Code Qualifier	✓	24/34	24 - Employer's ID Number 34 - Social Security Number During the contingency period, you may continue to submit your Federal Tax ID in this location.

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
78	2010AA		NM109	R	Billing Provider Identifier			Federal Tax ID Number/Social Security Number XX -- National Provider Identifier
77	2010AA		NM108	R	Billing Provider Identification Code Qualifier	✓	XX	If submit the NPI in this location, you must submit your EIN or SSN in the REF segment with a qualifier of EI or SY.
78	2010AA		NM109	R	Billing Provider Identifier			Billing Provider's NPI
	2010AA	N3			Billing Provider Address			
79	2010AA		N301	R	Billing Provider Address Line			
	2010AA		N302	S	Billing Provider Address Line			
	2010AA	N4		R	Billing Provider City/State/Zip Code			
80	2010AA		N401	R	Billing Provider City Name			
81	2010AA		N402	R	Billing Provider State Code			
81	2010AA		N403	R	Billing Provider Zip Code			
	2010AA	REF		S	Secondary Identification			
	2010AA		REF01	R	Reference Identification Qualifier	✓	1D	Indicates Medicaid Provider Number During the contingency period, CBHNP will continue to require your 13 digit PROMISE number in this location even if you are submitting the NPI in NM109. If sending the NPI in NM109, HIPAA also requires the EIN in the REF.
83	2010AA		REF02	R	Billing Provider Additional Identifier			9 digit DPW PROMISE + 4 digit service location code
	2010AA		REF01	R	Reference Identification Qualifier	✓	EI/SY	If you are submitting your NPI number in the NM109, you must submit your EIN or SSN in this REF segment.
83	2010AA		REF02	R	Billing Provider Additional Identifier			Federal Tax ID Number/Social Security Number
	2010AA	REF		S	Credit/Debit Card Billing Information			
	2010AA	PER		S	Billing Provider Contact Information			
88	2010AA		PER03	R	Communication Number Qualifier	✓	TE	
89	2010AA		PER04	R	Communication Number			Billing Provider Telephone Number
89	2010AA		PER05	R	Communication Number Qualifier	✓	FX	
89	2010AA		PER06	R	Communication Number			Billing Provider Fax Number
	2010AB				S - Required if Pay-to Provider is different than billing provider Loop ID 2010AB Pay-to Provider Name			
	2010AB	NM1		S	Pay-to Provider Name			
	2010AB	N3		R	Pay-to Provider Address			
	2010AB	N4		R	Pay-to Provider City/State/ZIP Code			
	2010AB	REF		S	Pay-to Provider Secondary Identification			
	2000B			R	Loop ID 2000B - Subscriber Hierarchical Level			
	2000B	HL		R	Subscriber Hierarchical Level			
	2000B	SBR		R	Subscriber Information			
102	2000B		SBR01	R	Payer Responsibility Sequence Code	✓		If more than one insurance, CBHNP payer responsibility is always last.
103	2000B		SBR02	S	Individual Relationship Code	✓	18	Claims submitted to CBHNP are always Self because each individual is their own member of Medicaid. Will always be "18"
103	2000B		SBR03	S	Insured Group or Policy Number			CBHNP members do not have a group number.
103	2000B		SBR04	S	Insured Group Name			CBHNP members do not have a group name.
	2000B		SBR09	R	Claim Filing Indicator Code		MC	CBHNP only accepts Medicaid claims.
	2010BA			R	Loop ID 2010BA - Subscriber Name			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2010BA	NM1		R	Subscriber Name			For claims submitted to CBHNP, subscriber and patient are always the same person.
	2010BA		NM101	R	Entity Identifier Code	✓	IL	
	2010BA		NM102	R	Entity Type Qualifier	✓	1	Always a person
109	2010BA		NM103	R	Subscriber Last Name			This will always be the same as the patient because each individual is their own member of Medicaid.
109	2010BA		NM104	S - Required if NM102 is a person	Subscriber First Name			
109	2010BA		NM105	S - Required if NM102 is a person and the middle name/initial is known	Subscriber Middle Name/Initial			
110	2010BA		NM107	S - Required if NM102 is a person and has known suffix	Subscriber Name Suffix			
110	2010BA		NM108	R	Identification Code Qualifier	✓	MI	
110	2010BA		NM109	S	Subscriber Primary Identifier			This element must hold the patient's medicaid ID number.
	2010BA	N3		R	Subscriber Address			For claims submitted to CBHNP, subscriber and patient are always the same person.
112	2010BA		N301	R	Subscriber Address Line			
112	2010BA		N302	R	Subscriber Address Line			
	2010BA	N4		S	Subscriber City/State/ZIP Code			
113	2010BA		N401	R	Subscriber City Name			
114	2010BA		N402	R	Subscriber State Code			
114	2010BA		N403	R	Subscriber Zip Code			
	2010BA	DMG		R	Subscriber Demographic Information			
115	2010BA		DMG01	R	Date Time Period Format Qualifier		D8	Date Expressed in Format CCYYMMDD
116	2010BA		DMG02	R	Subscriber Birth Date			
116	2010BA		DMG03	R	Subscriber Gender Code			
	2010BA	REF		S	Subscriber Secondary Identification			
	2010BA	REF		S	Property and Casualty Claim Number			Never required by HIPAA.
	2010BB			S - Should never be sent to a payer	Loop ID 2010BB - Credit/Debit Card Account Holder Name			Loop Never Used To Adjudicate a Claim
	2010BB	NM1		S	Credit/Debit Card Account Holder Name			
	2010BB	REF		S	Credit/Debit Card Information			
	2010BC			R	Loop ID 2010BC - Payer Name			
	2010BC	NM1		R	Payer Name			
	2010BC		NM101	R	Entity Identifier Code	✓	PR	
	2010BC		NM102	R	Entity Type Qualifier	✓	2	
127	2010BC		NM103	R	Payer Name		CBHNP	
	2010BC		NM108	R	Identification Code Qualifier	✓	PI	
	2010BC		NM109	R	Identification Code		251765391	Use CBHNP EIN Number until the National Plan ID is mandated
	2010BC	N3		S	Payer Address			
	2010BC	N4		S	Payer City/State/ZIP Code			
	2010BC	REF		S	Payer Secondary Identification			
	2010BD			S	Loop ID 2010BD - Responsible Party Name			Loop Never Used To Adjudicate a Claim
	2010BD	NM1		S	Responsible Party Name			
	2010BD	N3		R	Responsible Party Address			
	2010BD	N4		R	Responsible Party City/State/ZIP Code			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2000C			S	Loop ID 2000C - Patient Hierarchical Level			Loop Never Used because Patient is Always the Same as the Subscriber.
	2000C	HL		S	Patient Hierarchical Level			
	2000C	PAT		R	Patient Information			
	2010CA			S	Loop ID 2010CA - Patient Name			Loop Never Used To Adjudicate a Claim
	2010CA	NM1		R	Patient Name			
	2010CA	N3		S	Patient Address			
	2010CA	N4		S	Patient City/State/ZIP Code			
	2010CA	DMG		S	Patient Demographic Information			
	2010CA	REF		S	Patient Secondary Identification Number			
	2010CA	REF		S	Property and Casualty Claim Number			
	2300			R	Loop ID 2300 Claim Information			
	2300	CLM		R	Claim Information			
158	2300		CLM01	R	Patient Account Number			Required for purpose of returning the value in the 835
159	2300		CLM02	R	Total Claim Charge Amount			This amount is the total of the SV2 segments. A revenue code of 0001 that indicates Total Charges is obsolete and should not be sent.
	2300		CLM05	R	Health Care Service Location Information			This element consists of sub elements. Applies to all service lines unless it is overwritten at the line level.
159	2300		CLM05-1	R	Facility Type Code	✓	11/86	For Inpatient Services, first position is 1 to indicate hospital, second position is 1 to indicate inpatient. For Residential Services, first position is 8 to indicate special facility, second position is 6 to indicate residential facility.
159	2300		CLM05-2	R	Facility Code Qualifier	✓	A	
160	2300		CLM05-3	R	Claim Frequency Code	✓	1/2/3/4/5/7/8	See Detailed Definitions for values from the National Uniform Billing Committee for Type of Bill 1-Original - Expected to be the only bill 2-Interim - First Claim 3-Interim - Continuing Claim 4-Interim - Last Claim Other values that are HIPAA compliant are 5, 7, 8. However, 5 is not pertinent and 7 and 8 are for corrected and voided claims which are processed manually and therefore treated differently. If using a 7 or 8, provide the original claim number in REF02 with a qualifier of 'F8'.
	2300		CLM06	R	Provider or Supplier Signature Indicator	✓	Y/N	Indicate whether provider signature is on file.
	2300		CLM07	R	Medicare Assignment Code	✓		
160	2300		CLM08	R	Benefits Assignment Certification Indicator	✓	Y/N	
161	2300		CLM09	R	Release of Information Code	✓		
	2300		CLM10	S	Patient Signature Source Code	✓		S - Required unless CLM09 is "N"
	2300	DTP		S	Discharge Hour			S - Required on all final inpatient claims.
165	2300		DTP01	R	Date Time Qualifier	✓	096	Discharge Indicator
165	2300		DTP02	R	Date Time Period Format Qualifier	✓	TM	
166	2300		DTP03	S	Discharge Hour			S - Required if patient was discharged. If the patient status is '30', leave this field blank.
	2300	DTP		R	Statement Dates			
167	2300		DTP01	R	Date Time Qualifier	✓	434	

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
167	2300		DTP02	R	Date Time Period Format Qualifier	✓	RD8	A range of dates, not a single service date is expected. RD8 indicates the format of CCYYMMDD-CCYYMMDD
168	2300		DTP03	R	Statement From or To Date			If Patient Status Code <= 30, the To Date must be the discharge. If Claim Frequency Code = 1 or 4, the To Date must be the discharge date.
	2300	DTP		S - Required on all inpatient claims	Admission Date/Hour			
169	2300		DTP01	R	Date Time Qualifier	✓	435	Indicates Admission Date
169	2300		DTP02	R	Date Time Period Format Qualifier	✓	DT	CCYYMMDDHHMM
170	2300		DTP03	R	Admission Date and Hour			
	2300	CL1		S - Required when reporting hospital based admission.	Institutional Claim Code			
171	2300		CL101	S - Required when patient is being admitted to the hospital for inpatient services.	Admission Type Code	✓	1/2/3	1 - Emergency 2 - Urgent 3 - Elective
172	2300		CL102	S - Required when patient is being admitted to the hospital for inpatient services.	Admission Source Code	✓		Not Used for Adjudication
172	2300		CL103	S - Required when patient is being admitted to the hospital for inpatient services.	Patient Status Code	✓		Use Patient Status Code Table available from the National Uniform Billing Committee. If Patient Status Code <= 30, then: -Discharge Hour is required -To Date in the Statement From or To Date must be the discharge date If Patient Status Code = 30, then: -Discharge Hour must be blank -To Date in the Statement From or To Date is NOT the discharge date
	2300	PWK		S	Claim Supplemental Information			
	2300	CN1		S	Contract Information			Not Used for Adjudication
	2300	AMT		S - Required if applicable to claim	Payer Estimated Amount Due			
178	2300		AMT01	R	Amount Qualifier Code		C5	Indicates Claim Amount Due, Estimated
179	2300		AMT02	R	Estimated Claim Due Amount			
	2300	AMT		S - Required if applicable to claim	Patient Estimated Amount Due			
180	2300		AMT01	R	Amount Qualifier Code		F3	Indicates Patient Responsibility, Estimated
181	2300		AMT02	R	Estimated Claim Due Amount			
	2300	AMT		S - Required if applicable to claim	Patient Paid Amount			
182	2300		AMT01	R	Amount Qualifier Code		F5	Indicates Patient Paid Amount
183	2300		AMT02	R	Patient Paid Amount			
	2300	AMT		S - Should never be sent to a payer	Credit/Debit Card Maximum Amount			Not Used for Adjudication
	2300	REF		S	Adjusted Repriced Claim Number			Not Used for Adjudication
	2300	REF		S	Repriced Claim Number			Not Used for Adjudication
	2300	REF		S	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries			Not Used for Adjudication
	2300	REF		S	Document Identification Code			Not Used for Adjudication

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2300	REF			S-Convey control number assigned to the original bill by the payer. <i>Original Reference Number (ICN/DCN)</i>			
191	2300		REF01	R	Reference Identification Qualifier		F8	This is for rebills only.
192	2300		REF02	R	Claim Original Reference Number			Please provide the original CBHNP claim number so that CBHNP can match it in the adjudication system. By matching this number, the CBHNP knows this is not a duplicate claim.
	2300	REF		S	<i>Investigational Device Exemption Number</i>			Not Used for Adjudication
	2300	REF		S	<i>Service Authorization Exception Code</i>			Not Used for Adjudication
	2300	REF		S	<i>Peer Review Organization (PRO) Approval Number</i>			Not Used for Adjudication
198	2300	REF			S - Required if services were preauthorized or where a referral was involved. <i>Prior Authorization or Referral Number</i>			ALL claims submitted to CBHNP require this segment.
198	2300		REF01	R	Reference Identification Qualifier	✓	G1	Indicates Prior Authorization Number
199	2300		REF02	R	Prior Authorization Number			
200	2300	REF			S - Required if provider needs to identify for future inquiries. <i>Medical Record Number</i>			
200	2300		REF01	R	Reference Identification Qualifier	✓	EA	
201	2300		REF02	R	Medical Record Number			Required if provider needs to use for future inquiries and responses.
	2300	REF		S	<i>Demonstration Project Identifier</i>			Not Used for Adjudication
	2300	K3		S	<i>File Information</i>			Not Used for Adjudication
	2300	NTE			S - Used to convey additional information <i>Claim Note</i>			
207	2300		NTE02	R	Claim Note Text			
	2300	NTE			S - Used to convey additional information <i>Billing Note</i>			
209	2300		NTE02	R	Billing Note Text			
	2300	CR6		S	<i>Home Health Care Information</i>			Not Used for Adjudication
	2300	CRC		S	<i>Home Health Functional Limitations</i>			Not Used for Adjudication
	2300	CRC		S	<i>Home Health Activities Permitted</i>			Not Used for Adjudication
	2300	CRC		S	<i>Home Health Mental Status</i>			Not Used for Adjudication
227	2300	HI			S - Required on all claims except for Religious Non-medical claims. <i>Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information</i>			Required for CBHNP
228	2300		H101	R	Health Care Code Information			CBHNP requires a diagnosis code due to reporting requirements to DPW. If you do not have a diagnosis code, call for the appropriate default diagnosis for the service being submitted.
	2300		HI01-1	R	Diagnosis Type Code	✓	BK	BK - Indicates Principal Diagnosis
	2300		HI01-2	R	Diagnosis Code	✓		
	2300		HI02		S - Required to report additional diagnosis and if the preceding H1 data elements have been used to report other diagnosis <i>Health Care Code Information</i>			
	2300		HI02-1	R	Diagnosis Type Code	✓	BJ	BJ - Indicates Admitting Diagnosis
	2300		HI02-2	R	Diagnosis Code	✓		

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
229	2300		HI03	S - Required to report additional diagnosis and if the preceding H1 data elements have been used to report other diagnosis	Health Care Code Information			
	2300		HI03-1	R	Diagnosis Type Code	✓	BN	BN - Indicates E-Code
	2300		HI03-2	R	Diagnosis Code	✓		
	2300	HI		S	<i>Diagnosis Related Group (DRG) Information</i>			
232	2300	HI		S - Required if other conditions coexist w/ principal diagnosis.	<i>Other Diagnosis Information</i>			
	2300		HI01	R	Health Care Code Information			
	2300		HI01-1	R	Code List Qualifier Code	✓	BF	Diagnosis
233	2300		HI01-2	R	Other Diagnosis	✓		<ICD9 code>
	2300		HI02	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
	2300		HI02-1	R	Code List Qualifier Code	✓	BF	Diagnosis
	2300		HI02-2	R	Other Diagnosis	✓		<ICD9 code>
234	2300		HI03	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
	2300		HI03-1	R	Code List Qualifier Code	✓	BF	Diagnosis
	2300		HI03-2	R	Other Diagnosis	✓		<ICD9 code>
	2300		HI04	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
235	2300		HI04-1	R	Code List Qualifier Code	✓	BF	Diagnosis
	2300		HI04-2	R	Other Diagnosis	✓		<ICD9 code>
	2300		HI05	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
	2300		HI05-1	R	Code List Qualifier Code	✓	BF	Diagnosis
	2300		HI05-2	R	Other Diagnosis	✓		<ICD9 code>
236	2300		HI06	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
	2300		HI06-1	R	Code List Qualifier Code	✓	BF	Diagnosis
	2300		HI06-2	R	Other Diagnosis	✓		<ICD9 code>
237	2300		HI07	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
	2300		HI07-1	R	Code List Qualifier Code	✓	BF	Diagnosis
237	2300		HI07-2	R	Other Diagnosis	✓		<ICD9 code>
	2300		HI08	S -Used when necessary to report multiple co-existing conditions	Health Care Code Information			
	2300		HI08-1	R	Code List Qualifier Code	✓	BF	Diagnosis
238	2300		HI08-2	R	Other Diagnosis	✓		<ICD9 code>
	2300	HI		S - Required for inpatients or home IV after inpatient surgery or when a procedure was performed	<i>Principal Procedure Information</i>			
242	2300		HI01	S	Health Care Code Information			Not used for Adjudication

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
243	2300		HI01-4	S	Date Time Period			Not used for Adjudication
	2300	HI		S - Required for inpatients or home IV after inpatient surgery or when additional procedures must be reported.	<i>Other Procedure Information</i>			
244	2300		HI01	R	Health Care Code Information			Not used for Adjudication
	2300	HI		S	<i>Occurrence Span Information</i>			
256	2300		HI01	S -Required when occurrence span information related to the delivery of health care applies.	Health Care Code Information			
256	2300		HI01-1	R	Code List Qualifier Code	✓	BI	Indicates Occurrence Span
257	2300		HI01-2	R	Occurrence Span Code	✓		Use Occurrence Code available from the National Uniform Billing Committee
257	2300		HI01-3	R	Date Time Period Format Qualifier	✓	RD8	
257	2300		HI01-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD-CCYYMMDD
256	2300		HI02	S -Required when occurrence span information related to the delivery of health care applies.	Health Care Code Information			
256	2300		HI02-1	R	Code List Qualifier Code	✓	BI	Indicates Occurrence Span
257	2300		HI02-2	R	Occurrence Span Code	✓		Use Occurrence Code available from the National Uniform Billing Committee
258	2300		HI02-3	R	Date Time Period Format Qualifier	✓	RD8	
258	2300		HI02-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD-CCYYMMDD
267	2300	HI		S -Required when occurrence information related to the delivery of health care applies.	<i>Occurrence Information</i>			
	2300		HI01	S	Health Care Code Information			
	2300		HI01-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
268	2300		HI01-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI01-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI01-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
	2300		HI02	S	Health Care Code Information			
	2300		HI02-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI02-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI02-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI02-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
269	2300		HI03	S	Health Care Code Information			
	2300		HI03-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI03-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI03-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI03-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
270	2300		HI04	S	Health Care Code Information			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2300		HI04-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI04-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI04-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI04-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
271	2300		HI05	S	Health Care Code Information			
	2300		HI05-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI05-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI05-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI05-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
272	2300		HI06	S	Health Care Code Information			
	2300		HI06-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI06-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI06-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI06-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
273	2300		HI07	S	Health Care Code Information			
	2300		HI07-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI07-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI07-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI07-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
274	2300		HI08	S	Health Care Code Information			
	2300		HI08-1	R	Code List Qualifier Code	✓	BH	Indicates Occurrence
	2300		HI08-2	R	Occurrence Code			Use Occurrence Code available from the National Uniform Billing Committee
	2300		HI08-3	R	Date Time Period Format Qualifier	✓	D8	
	2300		HI08-4	R	Occurrence or Occurrence Span Code Associated Date			CCYYMMDD
	2300	HI		S -Required when value information related to the delivery of health care applies.	<i>Value Information</i>			
280	2300		HI01	S	Health Care Code Information			
	2300		HI01-1	R	Code List Qualifier Code	✓	BE	Indicates Value
281	2300		HI01-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI01-5	R	Value Code Associated Amount			
	2300		HI02	S	Health Care Code Information			
	2300		HI02-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI02-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
282	2300		HI02-5	R	Value Code Associated Amount			
	2300		HI03	S	Health Care Code Information			
	2300		HI03-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI03-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI03-5	R	Value Code Associated Amount			
283	2300		HI04	S	Health Care Code Information			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2300		HI04-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI04-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI04-5	R	Value Code Associated Amount			
283	2300		HI05	S	Health Care Code Information			
	2300		HI05-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI05-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI05-5	R	Value Code Associated Amount			
284	2300		HI06	S	Health Care Code Information			
	2300		HI06-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI06-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI06-5	R	Value Code Associated Amount			
285	2300		HI07	S	Health Care Code Information			
	2300		HI07-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI07-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI07-5	R	Value Code Associated Amount			
286	2300		HI08	S	Health Care Code Information			
	2300		HI08-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI08-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI08-5	R	Value Code Associated Amount			
	2300		HI09	S	Health Care Code Information			
	2300		HI09-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI09-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI09-5	R	Value Code Associated Amount			
287	2300		HI10	S	Health Care Code Information			
	2300		HI10-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI10-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI10-5	R	Value Code Associated Amount			
288	2300		HI11	S	Health Care Code Information			
	2300		HI11-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI11-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
	2300		HI11-5	R	Value Code Associated Amount			
288	2300		HI12	S	Health Care Code Information			
	2300		HI12-1	R	Code List Qualifier Code	✓	BE	Indicates Value
	2300		HI12-2	R	Value Code	✓		Use Value Code available from the National Uniform Billing Committee
289	2300		HI12-5	R	Value Code Associated Amount			
290	2300	HI		S	-Required when condition information related to the delivery of health care applies. <i>Condition Information</i>			
290	2300		HI01	R	Health Care Code Information			
	2300		HI01-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
291	2300		HI01-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
291	2300		HI02	S -Required when necessary to report multiple co-existing conditions.	Health Care Code Information			
	2300		HI02-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
	2300		HI02-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.
292	2300		HI03	S -Required when necessary to report multiple co-existing conditions.	Health Care Code Information			
	2300		HI03-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
292	2300		HI03-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.
	2300		HI04	S -Required when necessary to report multiple co-existing conditions.	Health Care Code Information			
	2300		HI04-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
293	2300		HI04-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.
293	2300		HI05	S -Required when necessary to report multiple co-existing conditions.	Health Care Code Information			
	2300		HI05-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
293	2300		HI05-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.
294	2300		HI06	S -Required when necessary to report multiple co-existing conditions.	Health Care Code Information			
	2300		HI06-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
294	2300		HI06-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.
	2300		HI07	S -Required when necessary to report multiple co-existing conditions.	Health Care Code Information			
	2300		HI07-1	R	Code List Qualifier Code	✓	BG	Indicates Condition
295	2300		HI07-2	R	Condition Code	✓		See the Appendix of Condition Codes Accepted by Pennsylvania Medicaid.
299	2300	HI		S -Required when treatment information related to the delivery of health care applies.	Treatment Code Information			Not used for Adjudication
	2300	QTY		R	Claim Quantity			
306	2300		QTY01	R	Quantity Qualifier	✓	CA	
								Supply Number of Covered Days Number of covered days for the time period specified in Loop 2300, Segment DTP03 (Statement From or To Date). The number of covered days should never include the discharge date. - If Patient Status Code = 30 (still a patient), (To Date - From Date + 1) = (Covered Days + Non Covered Days) - If Patient Status Code <> 30, (To Date - From Date) = (Covered Days + Non Covered Days)
307	2300		QTY02	R	Claim Days Count			
	2300		QTY01	R	Quantity Qualifier	✓	NA	

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2300		QTY02	R	Claim Days Count			Supply Number of Non-Covered Days
307	2300		QTY01	R	Quantity Qualifier	✓	CD	
	2300		QTY02	R	Claim Days Count			Supply Number of Coinsurance Days
307	2300		QTY01	R	Quantity Qualifier	✓	LA	
	2300		QTY02	R	Claim Days Count			Supply Number of Lifetime Reserve Days
	2300	HCP		S	Claim Pricing/Repricing Information			
2305				S - Required on home health claims/encounters that involve billing/reporting home health visits Loop ID 2305 Home Health Care Plan				Loop Never Used To Adjudicate a Claim
	2305	CR7		S	Home Health Care Plan Information			
	2305	HSD		S	Health Care Services Delivery			
2310A				S - Applies to the whole claim unless overridden at the service line. Loop ID 2310A Attending Physician Name				
	2310A	NM1		S	Attending Physician Name			
322	2310A		NM103	R	Attending Physician Last Name			Enter the last name of the attending Physician
322	2310A		NM104	R	Attending Physician First Name			Enter the first name of the attending Physician
	2310A		NM108	R			24/34	24 - Employer's ID Number 34 - Social Security Number During the contingency period, you may continue to submit your EIN or SSN in this location.
323	2310A		NM109	R	Attending Physician Primary Identifier			Federal Tax ID Number/Social Security Number
	2310A		NM108	R			XX	XX -- National Provider Identifier If you have an NPI, please submit it in this location.
323	2310A		NM109	R	Attending Physician Primary Identifier			National Provider Identifier
	2310A	PRV		S	Attending Physician Specialty Information			
	2310A	REF		S	Attending Physician Secondary Identification			
326	2310A		REF01	R	Reference Identification Qualifier		0B	Indicates State License Number
326	2310A		REF02	R	Attending Physician Secondary Identifier			Physician State License Number During the contingency period, please continue to submit the State License Number in this position.
2310B				S - Required when surgical procedure is listed on this claim. Loop ID 2310B Operating Physician Name				
	2310B	NM1		S	Operating Physician Name			
329	2310B		NM103	R	Operating Physician Last Name			Not used for Adjudication
329	2310B		NM104	R	Operating Physician First Name			Not used for Adjudication
	2310B	REF		S	Operating Physician Secondary Identification			
323	2310B		REF01	R	Reference Identification Qualifier			Not used for Adjudication
323	2310B		REF02	R	Operating Physician Secondary Identifier			Not used for Adjudication
2310C				S - Required to indicate physician who rendered service for the principal procedure other than the physician reported in Loop 2310B Loop ID 2310C Other Provider Name				
	2310C	NM1		S	Other Provider Name			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
336	2310B		NM103	R	Other Physician Last Name			Not used for Adjudication
336	2310B		NM104	R	Other Physician First Name			Not used for Adjudication
336	2310B		NM109	R	Other Physician Primary Identifier			Not used for Adjudication
	2310C	REF		S	Other Provider Secondary Identification			
				S - Required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) Loops				
2310E				Loop ID 2310E Service Facility Name				
	2310E	NM1		S	Service Facility Name			
	2310E	N3		R	Service Facility Address			
	2310E	N4		R	Service Facility City/State/Zip Code			
	2310E	REF		S	Service Facility Secondary Identification			
2320				S - Required if other payers are known to be involved with this claim				
2320				Loop ID 2320 Other Subscriber Information				
				Create a 2320 Loop for every payer known to be involved.				
359	2320	SBR		S	Other Subscriber Information			Claims submitted with other payer information without adjudication and remittance advice information from those payers will be denied because Medicaid is always the payer of last resort.
360	2320		SBR01	R	Payer Responsibility Sequence Code			If more than one insurance, CBHNP payer responsibility is always last. For each payer indicate if P - Primary, S - Secondary, T - Tertiary
361	2320		SBR02	R	Individual Relationship Code	✓		Use the relationship code that applies to the Insurance Group Number in SBR03
363	2320		SBR03	S - Required if exists	Insured Group or Policy Number			Use to carry the group number, not the number that uniquely identifies the subscriber.
363	2320		SBR04	S - Required if exists	Other Insured Group Name			
	2320	CAS		S - Required if claim has been adjudicated by payer identified in this loop.	Claim Level Adjustment			
	2320		CAS01	R	Claim Adjustment Group Code	✓		
	2320		CAS02	R	Adjustment Reason Code	✓		
	2320		CAS03	R	Adjustment Amount	✓		This is the UNPAID amount.
	2320	AMT		S - Required if claim has been adjudicated by payer identified in this loop.	Payer Prior Payment			
371	2320		AMT01	R	Amount Qualifier Code	✓	C4	Indicates Prior Payment - Actual
	2320		AMT02	R	Other Payer Patient Paid Amount			Amount paid by Payer indicated in this loop. This is the amount in CLP04 in the 835. This is a claim level paid, not service line level paid.
	2320	AMT		S	Coordination of Benefits (COB) Total Allowed Amount			
	2320	AMT		S	Coordination of Benefits (COB) Total Submitted Charges			
	2320	AMT		S	Diagnostic Related Group (DRG) Outlier Amount			
	2320	AMT		S	Coordination of Benefits (COB) Total Medicare Paid Amount			
	2320	AMT		S	Medicare Paid Amount - 100%			
	2320	AMT		S	Medicare Paid Amount - 80%			
	2320	AMT		S	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount			
	2320	AMT		S	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount			
	2320	AMT		S	Coordination of Benefits (COB) Total Non-Covered Amount			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2320	AMT		S	Coordination of Benefits (COB) Total Denied Amount			
	2320	DMG		S	Other Subscriber Demographic Information			
390	2320	OI		R	Other Insurance Coverage Information			All Information in the OI segment applies only to the payer identified in the 2330B loop of this iteration of the 2320 loop.
	2320		OI 03	R	Benefits Assignment Certification Indicator	✓	Y/N	
	2320		OI 06	R	Release of Information Code	✓		
392	2320	MIA		S - Use to convey the Medicare Inpatient Adjudication information transmitted in the 835	Medicare Inpatient Adjudication Information			
	2320	MOA		S - Use to convey the Medicare Outpatient Adjudication information transmitted in the 835	Medicare Outpatient Adjudication Information			
2330A				S - Required to send information on all known subscribers in Loop ID 2320	Loop ID 2330A Other Subscriber Name			Record subscriber information of payer's identified in Loop ID 2320
400	2330A	NM1		R	Other Subscriber Name			
401	2330A		NM101	R	Entity Identifier Code	✓	IL	
	2330A		NM102	R	Entity Type Qualifier	✓	1	Always a person
401	2330A		NM103	R	Other Insured Last Name			
401	2330A		NM104	S - Required if NM102 is a person	Other Insured First Name			
402	2330A		NM105	S - Required if is a person and the middle name/initial is known	Other Insured Middle Name/Initial			
402	2330A		NM107	S - Required if known	Other Insured Name Suffix			
403	2330A		NM109	R	Other Insured Identifier			
	2330A	N3		S - Required when the provider has the other subscriber address on file.	Other Subscriber Address			
404	2330A		N301	R	Other Insured Address Line			
	2330A		N302	S - Required if second address line exists	Other Insured Address Line			
	2330A	N4		S - Required when N3 is present	Other Subscriber City/State/ZIP Code			
406	2330A		N401	R	Other Insured City Name			
407	2330A		N402	R	Other Insured State Code			
407	2330A		N403	R	Other Insured Zip Code			
	2330A	REF		S - Required if additional identification numbers are necessary to adjudicate the claim	Other Subscriber Secondary Information			
409	2330A		REF02	R	Other Insured Additional Identifier			
2330B				S - Required if Loop 2320 (Other Subscriber Information) is used .	Loop ID 2330B Other Payer Name			Create a 2330B Loop for all payers other than CBHNP.
	2330B	NM1		R	Other Payer Name			
410	2330B		NM101	R	Entity Identifier Code	✓	PR	PR Indicates Insured
411	2330B		NM102	R	Entity Type Qualifier	✓	2	1 - Person; 2 - Non-person entity
411	2330B		NM103	R	Other Payer Last or Organization Name			Supply name of other payer(s)
411	2330B		NM108	R	Identification Code Qualifier	✓	PI	
	2330B		NM109	R	Other Payer Primary Identifier			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2330B	N3		S	Other Payer Address			
	2330B	N4		S	Other Payer City/State/Zip Code			
	2330B	DTP		S	S - Required if claim has been adjudicated by payer identified in this loop. Claim Adjudication Date			Because CBHNP is the payer of last resort, if other payers are involved, this should always have a value.
	2320B		DTP01	R	Date/Time Qualifier	✓	573	Date Claim Paid Indicator
	2320B		DTP02	R	Date/Time Period Format Qualifier	✓	D8	Date Expressed in Format CCYYMMDD
	2320B		DTP03	R	Adjudication or Payment Date			Claims submitted to CBHNP require adjudication date from all known payers.
	2330B	REF		S	S-Used when necessary to identify the 'other' payer's claim number. Other Payer Secondary Identification and Reference Number			
417	2330B		REF01	R	Reference Identification Qualifier		F8	
417	2330B		REF02	R	Other Payer Secondary Identifier			Please give back the CBHNP claim number so that CBHNP can match it in the adjudication system. By matching this number, the CBHNP knows this is not a duplicate claim.
	2330B	REF		S	Other Payer Prior Authorization or Referral Number			
	2330C			S	Loop ID 2330C Other Payer Patient Information			
	2330C	NM1		S	Other Payer Patient Information			
	2330C	REF		S	Other Payer Patient Identification Number			
	2330D			S	Loop ID 2330D Other Payer Attending Provider			
	2330D	NM1		S	Other Payer Attending Provider			
	2330D	REF		R	Other Payer Attending Provider Identification			
	2330E			S	Loop ID 2330E Other Payer Operating Provider			
	2330E	NM1		S	Other Payer Operating Provider			
	2330E	REF		R	Other Payer Operating Provider Identification			
	2330F			S	Loop ID 2330F Other Payer Other Provider			
	2330F	NM1		S	Other Payer Other Provider			
	2330F	REF		R	Other Payer Other Provider Identification			
	2330H			S	Loop ID 2330H Other Payer Service Facility Provider			
	2330H	NM1		S	Other Payer Service Facility Provider			
	2330H	REF		R	Other Payer Service Facility Provider Identification			
	2400			R	Loop ID 2400 Service Line Number			
444	2400	LX		R	Service Line Number			
	2400	SV2		R	Institutional Service Line			
446	2400		SV201	R	Service Line Revenue Code	✓		Enter the Revenue Code available from the National Uniform Billing Committee with a total of 4 characters. CBHNP pays a flat all-inclusive rate per day . All charges for the date range supplied should be bundled together and submitted under one appropriate Room & Board revenue code.
446	2400		SV202	S	S - Required for outpatient claims Service Line Procedure Code			
446	2400		SV202-1	S	Product or Service ID Qualifier	✓		

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
447	2400		SV202-2	S	Procedure Code			Use HCPCS Procedure Code
447	2400		SV202-3	S	Procedure Modifier			Use to send the first modifier.
447	2400		SV202-4	S	Procedure Modifier			Use to send the second modifier.
448	2400		SV203	R	Line Item Charge Amount			Submitted Charge Amount. The summary line revenue code of '0001' is now obsolete.
448	2400		SV204	R	Unit or Basis for Measurement Code	✓		
449	2400		SV205	R	Service Unit Count			
449	2400		SV206	S - Required when associated revenue code is 100-219	Service Line Rate			
449	2400		SV207	S - Use if needed to report line specific non-covered charge amount.	Line Item Denied Charge or Non-Covered Charge Amount			Not used for Adjudication
	2400	PWK		S	Line Supplemental Information			
456	2400	DTP		S - Required for outpatient claims when revenue, procedure, HIEC or drug codes are reported in the SV2 segment.	Service Line Date			
457	2400		DTP03	R	Service Date			Not used for Adjudication
	2400	DTP		S	Assessment Date			
	2400	AMT		S	Service Tax Amount			
	2400	AMT		S	Facility Tax Amount			
	2400	HCP		S	Line Pricing/Repricing Information			
	2410			S	Loop ID 2410 Drug Identification			
		LIN		S	Drug Identification			
		CTP		S	Drug Pricing			
		REF		S	Prescription Number			
	2420A			S - Required if different than that carried in 2310A claim level loop	Loop ID 2420A Attending Physician Name			
	2420A	NM1		S	Attending Physician Name			
	2420A	REF		S	Attending Physician Secondary Identification			
	2420B			S - Required if different than that carried in 2310B claim level loop	Loop ID 2420B Operating Physician Provider Name			
	2420B	NM1		S	Operating Physician Provider Name			
	2420B	REF		S	Operating Physician Provider Secondary Identification			
	2420C			S - Required if different than that carried in 2310C claim level loop	Loop ID 2420C Other Provider Name			
	2420C	NM1		S	Other Provider Name			
	2420C	REF		S	Other Provider Secondary Identification			
	2430			S - Required if payer identified in loop 2330B adjudicated the claim and made adjustments at the service line level.	Service Line Adjudication Information			
	2430	SVD		S	Service Line Adjudication Information			
491	2430		SVD01	R	Payer Identifier			
	2430		SVD02	R	Service Line Paid Amount			Payer Paid Amounts

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2430		SVD03	R	Composite Medical Procedure	✓		This element includes sub-elements. Crosswalks from SVC01 in the 835 transmission.
492	2430		SVD05	R	Paid Units of Service			Crosswalk from SVC05 in 835
	2430	CAS		S	Service Line Adjustment			
495	2430		CAS01	R	Claim Adjustment Group Code	✓		
496	2430		CAS02	R	Claim Adjustment Reason Code	✓		
496	2430		CAS03	R	Adjustment Amount	✓		This is the UNPAID amount.
	2430	DTP		S	Service Line Adjudication Date			
502	2430		DTP01	R	Date Time Qualifier	✓	573	Date Claim Paid Indicator
502	2430		DTP02	R	DateTime Period Format Qualifier	✓	D8	
502	2430		DTP03	R	Service Adjudication or Payment Date			Claims submitted to CBHNP require adjudication date from all known payers.
Transaction Set Trailer								
		SE		R	Transaction Set Trailer			
Trailer								
		GE		R	Functional Group Footer			
		IEA		R	Interchange Control Footer			
			IEA01	R	Number of Included Functional Groups			
	2440	LQ		S	Form Identification Code			
	2440	FRM		R	Supporting Documentation			
Transaction Set Trailer								
		SE		R	Transaction Set Trailer			
Trailer								
		GE		R	Functional Group Footer			
		IEA		R	Interchange Control Footer			
			IEA01	R	Number of Included Functional Groups			

APPENDIX I - CONDITION CODES

The following condition codes are accepted by Pennsylvania

- 02 Condition is Employment Related
- 03 Patient Covered By Insurance Not Reflected Here
- X2 Medicare EOMB on File
- X4 Medicare Denial on File
- X5 Third Party Statement on File
- Y4 Medicare Benefits Exhausted
- Y5 Third Party Benefits Exhausted
- Y6 Third Party Denial on File