

HEALTH CARE CLAIM: PROFESSIONAL 837 SUPPLEMENTAL GUIDE

NOTE:

This document does *NOT* include all elements required to be HIPAA compliant. It contains *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 P). This document is to be used in conjunction with the HIPAA ANSI ASC X12N 837 Health Care Claim: Professional (004010X098) Implementation Guide (IG) and the 837 Health Care Claim: Professional Addenda (004010X098A1).

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				
		ST		R	<i>Transaction Set Header</i>				
62			ST01	R	Transaction Set Identifier Code	✓	837		
62			ST02	R	Transaction Set Control Number				
		BHT		R	<i>Beginning of Heirarchical Transaction</i>				
63			BHT01	R	Hierarchical Structure Code	✓	0019	0019 = Information source, Subscriber, Dependent	
64			BHT02	R	Transaction Set Purpose Code	✓	00/18	00=Original Claim Submission 18=Reissue Use the reissue code for complete batch resubmission as well as patial batch resubmission. Partial resubmission occurs with claims that were excluded from an original file due to the 5% error rule. Refer to the companion document for additional details.	

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64			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
64			BHT04	R	Transaction Set Creation Date			Identifies the date that the submitter created the file.
65			BHT05	R	Transaction Set Creation Time			Use this to identify the time the file was created.
65			BHT06	R	Transaction Type Code		CH	CH=Chargeable, Use when the transmission contains only fee-for-service claims or claims with at least one chargeable line item; RP=Reporting, Use to send a batch of encounters
		REF		R	Transmission Type Identification			
66			REF01	R	Reference Identification Qualifier	✓	87	87 = Functional Category
66			REF02	R	Transmission Type Code	✓		In Test and Production use "004010X098A1"
				R	Loop ID 1000A - Submitter Name			
	1000A	NM1		R	Submitter Name			
69	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			
	1000B			R	Loop ID 1000B - Receiver Name			
	1000B	NM1		R	Receiver Name			
75	1000B		NM103	R	Receiver Name		CBHNP	
75	1000B		NM109	R	Receiver Primary Identifier		251765391	This is CBHNP's EIN.
	2000A			R	Loop ID 2000A - Billing/Pay-to Provider			
	2000A	HL		R	Billing/Pay-to Provider Hierarchical Level			
	2000A	PRV		S	S - Required if the rendering provider is the same as the billing provider.			
	2000A	CUR		S	Billing/Pay-to Provider Specialty Information			
	2010AA			R	Foreign Currency Information			
	2010AA			R	Loop ID 2010AA Billing Provider Name			
	2010AA	NM1		R	Billing Provider Name			
85	2010AA		NM101	R	Entity Identifier Code	✓	85	85 Indicates Billing Provider
85	2010AA		NM102	R	Entity Type Qualifier	✓	1/2	1 - Person 2 - Non-Person
85	2010AA		NM103	R	Billing Provider Last or Organizational Name			
85	2010AA		NM104	S	S - Required if NM102 is a person			
85	2010AA		NM105	S	S - Required if NM102 is a person and the middle name/initial is known			
85	2010AA		NM107	S	S - Required if NM102 is a person and has known suffix			
86	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 EIN or SSN in this location.
86	2010AA		NM109	R	Billing Provider Identifier			Federal Tax ID Number/Social Security Number XX - National Provider Identifier
86	2010AA		NM108	R	Billing Provider Identification Code Qualifier	✓	XX	If you submit the NPI in this location, you must submit your EIN or SSN in the REF segment with a qualifier of EI or SY.
86	2010AA		NM109	R	Billing Provider Identifier			Billing Provider's NPI
	2010AA	N3		R	Billing Provider Address			
88	2010AA		N301	R	Billing Provider Address Line			
88	2010AA		N302	S	Billing Provider Address Line			
	2010AA	N4		R	Billing Provider City/State/Zip Code			
89	2010AA		N401	R	Billing Provider City Name			
90	2010AA		N402	R	Billing Provider State code			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
90	2010AA		N403	R	Billing Provider Zip code			
	2010AA	REF		S	Billing Provider Secondary Identification			
92	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.
90	2010AA		REF02	R	Billing Provider Additional Identifier			9 digit DPW PROMISE + 4 digit service location code
92	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.
90	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			
	2010AB			S	S - Required if Pay-to Provider is different than billing provider			
	2010AB			S	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 Information			
	2000B			R	Loop ID 2000B - Subscriber Hierarchical Level			
	2000B	HL		R	Subscriber Hierarchical Level			
	2000B	SBR		R	Subscriber Information			
	2000B		SBR01	R	Payer Responsibility Sequence Code	✓		If more than one insurance, CBHNP payer responsibility is always last.
111	2000B		SBR02	S	S - Required when the subscriber is the same as the patient			Claims submitted to CBHNP are always Self because each individual is their own member of Medicaid. Will always be "18"
	2000B		SBR09	R	Individual Relationship Code	✓	18	
	2000B	PAT		S	Claim Filing Indicator Code		MC	CBHNP only accepts Medicaid claims.
	2000B			S	Patient Information			
	2010BA			R	Loop ID 2010BA - Subscriber Name			
	2010BA	NM1		R	Subscriber Name			For claims submitted to CBHNP, subscriber and patient are always the same person.
118	2010BA		NM101	R	Entity Identifier Code	✓	IL	
118	2010BA		NM102	R	Entity Type Qualifier	✓	1	Always a person
118	2010BA		NM103	R	Subscriber Last Name			
118	2010BA		NM104	S	S - Required if NM102 is a person			
118	2010BA		NM105	S	S - Required if NM102 is a person and the middle name/initial is known			
118	2010BA		NM107	S	S - Required if NM102 is a person and has known suffix			
119	2010BA		NM108	R	Subscriber Name Suffix			
119	2010BA		NM109	R	Subscriber Identification Code Qualifier	✓	MI	This element must hold the patient's medicaid ID number.
	2010BA	N3		R	Subscriber Primary Identifier			
121	2010BA		N301	R	Subscriber Address			
121	2010BA		N302	R	Subscriber Address Line			
	2010BA	N4		R	Subscriber Address Line			
122	2010BA		N401	R	Subscriber City/State/ZIP Code			
123	2010BA		N402	R	Subscriber City Name			
123	2010BA		N403	R	Subscriber State Code			
	2010BA	DMG		R	Subscriber Zip Code			
124	2010BA		DMG01	R	Subscriber Demographic Information			
125	2010BA		DMG02	R	Date Time Period Format Qualifier		D8	Date Expressed in Format CCYYMMDD
	2010BA			R	Subscriber Birth Date			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
125	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			R	Loop ID 2010BB - Payer Name			
	2010BB	NM1		R	Payer Name			
131	2010BB		NM101	R	Entity Identifier Code	✓	PR	
131	2010BB		NM102	R	Entity Type Qualifier	✓	2	
131	2010BB		NM103	R	Payer Name		CBHNP	
131	2010BB		NM108	R	Identification Code Qualifier	✓	PI	
131	2010BB		NM109	R	Identification Code		251765391	Use CBHNP EIN Number until the National Plan ID is mandated
	2010BB	N3		S	Payer Address			
	2010BB	N4		S	Payer City/State/ZIP Code			
	2010BB	REF		S	Payer Secondary Identification			
	2010BC			S	Loop ID 2010BC - Responsible Party Name			Loop Never Used To Adjudicate a Claim
	2010BC	NM1		S	Responsible Party Name			
	2010BC	N3		R	Responsible Party Address			
	2010BC	N4		R	Responsible Party City/State/ZIP Code			
	2010BD			S	S - Should never be sent to a payer			
	2010BD			S	Loop ID 2010BD - Credit/Debit Card Holder			Loop Never Used To Adjudicate a Claim
	2010BD	NM1		S	Credit/Debit Card Holder Name			
	2010BD	REF		S	Credit/Debit Card Information			
	2000C			S	S - Required when the patient is a different person than the subscriber.			
	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			
	2010CA	REF		S	Property and Casualty Claim Number			
	2300			R	Loop ID 2300 Claim Information			
	2300	CLM		R	Claim Information			
171	2300		CLM01	R	Patient Account Number			Required for purpose of returning the value in the 835
172	2300		CLM02	R	Total Claim Charge Amount			
	2300		CLM05	R	Place of Service Code			This element consists of sub elements. Applies to all service lines unless it is overwritten at the line level.
173	2300		CLM05-1	R	Facility Type Code			Use the crosswalk of the Place of Service Codes found in the "Pennsylvania Specific Medical Assistance HIPAA Billing Guide, 837 Professional"
173/174	2300		CLM05-3	R	Claim Frequency Type Code	✓	1/7/8	1 =Original Claim; 7=Replacement Claim; 8=Voided Claim
174	2300		CLM06	R	Signature of Physician or Supplier Indicator	✓	Y/N	Resubmission of a denied claim is a 1 (Original)
174	2300		CLM07	R	Provider Accept Assignment Code	✓		
175	2300		CLM08	R	Benefits Assignment Certification Indicator	✓	Y/N	
175	2300		CLM09	R	Release of Information Code	✓		
176	2300		CLM10	S	S - Required unless CLM09 is "N"	✓		
				S	Patient Signature Source Code			
176	2300		CLM11	S	S - Required if condition being reported is accident or employment related	✓		
176	2300		CLM11-1	R	Related Causes Info	✓		
				R	Related Causes Info			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
177	2300		CLM11-2	S - Used if more than one code applies	Related Causes Info	✓		
177	2300		CLM11-3	S - Used if more than one code applies	Related Causes Info	✓		
177	2300		CLM11-4	S - Required if CLM-1, CLM-2 or CLM-3 = "AA" to identify state in which the automobile accident occurred	Auto Accident State or Province Code	✓		
178	2300		CLM12	S - Required if services were rendered under one of the special circumstances/programs/projects	Special Program Indicator	✓	01	Not used for Adjudication
	2300	DTP		S	Date - Initial Treatment			
	2300	DTP		S	Date - Last Seen			
	2300	DTP		S - Required if known and if different than date of service.	Date - Onset of Current Illness/Symptom			
188	2300		DTP01	R	Date/Time Qualifier		431	
189	2300		DTP02	R	Date/Time Period Format Qualifier		D8	
189	2300		DTP03	R	Onset of Current Illness/Injury Date			
	2300	DTP		S	Date - Acute Manifestation			
	2300	DTP		S - Required if claim involves services to patient w/ symptoms similar or identical to previously reported clams.	Date - Similar Illness/Symptom Onset			
192	2300		DTP01	R	Date/Time Qualifier		438	
192	2300		DTP02	R	Date/Time Period Format Qualifier		D8	
193	2300		DTP03	R	Similar Illness or Symptom Date			
	2300	DTP		S	Date - Accident			
	2300	DTP		S	Date - Last Menstrual Period			
	2300	DTP		S	Date - Last X-ray			
	2300	DTP		S	Date - Hearing and Vision Prescription Date			
	2300	DTP		S	Date - Disability Begin			
	2300	DTP		S	Date - Disability End			
205	2300	DTP		S - Required if necessary to adjudicate claim.	Date - Last Worked			
	2300		DTP03	R	Last Worked Date			Not used for Adjudication
	2300	DTP		S - Required if necessary to adjudicate claim.	Date - Authorized Return to Work			
207	2300		DTP03	R	Work Return Date			Not used for Adjudication
	2300	DTP		S - Required on ambulance claims or inpatient medical visits.	Date - Admission			
208	2300		DTP01	R	Date/Time Qualifier		435	
208	2300		DTP02	R	Date/Time Period Format Qualifier		D8	Date Expressed in Format CCYYMMDD
209	2300		DTP03	R	Related Hospital Admission Date			Use to Hold the Date Admitted.
	2300	DTP		S	Date - Discharge			
210	2300		DTP01	R	Date/Time Qualifier		096	
210	2300		DTP02	R	Date/Time Period Format Qualifier		D8	
211	2300		DTP03	R	Related Hospitalization Discharge Date			Use to hold the Date Discharged.
	2300	DTP		S	Date - Assumed and Relinquished Care Dates			
	2300	PWK		S	Claim Supplemental Information			
	2300	CN1		S	Contract Information			
	2300	AMT		S	Credit/Debit Card Maximum Amount			
	2300	AMT		S	Patient Amount Paid			
	2300	AMT		S	Total Purchased Service Amount			
221	2300		AMT02	R	Total Purchased Service Amount			Not used for Adjudication
	2300	REF		S	Service Authorization Exception Code			

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	Mandatory Medicare (Section 4081) Crossover Indicator			
	2300	REF		S	Mammography Certification Number			
	2300	REF		S - Required when services on claim were preauthorized or where a referral is involved	Prior Authorization or Referral Number			
228	2300		REF01	R	Reference Identification Qualifier		G1	
228	2300		REF02	R	Prior Authorization or Referral Number			If authorization number is not sent, claim may be denied or paid at incorrect rate.
	2300	REF		S - Required when CLM05-3 (Claim Submission Reason Code) = "6", "7", or "8" and the payer has assigned a payer number to the claim.	Original Reference Number (ICN/DCN)			Please provide the original CBHNP claim number so that CBHNP can match it in the adjudication system. By matching this number, CBHNP knows this is not a duplicate claim.
230	2300		REF01	R	Reference Identification Qualifier		F8	
230	2300		REF02	R	Claim Original Reference Number			
	2300	REF		S	Clinical Laboratory Improvement Amendment (CLIA) Number			
	2300	REF		S	Repriced Claim Number			
	2300	REF		S	Adjusted Repriced Claim Number			
	2300	REF		S	Investigational Device Exemption Number			
	2300	REF		S	Claim Identification Number for Clearing Houses and Other Transmission Intermediaries			
	2300	REF		S	Ambulatory Patient Group (APG)			
	2300	REF		S	Medical Record Number			
	2300	REF		S	Demonstration Project Identifier			
	2300	K3		S	File Information			
	2300	NTE		S	Claim Note			
	2300	CR1		S	Ambulance Transport Information			
	2300	CR2		S	Spinal Manipulation Service Information			
	2300	CRC		S	Ambulance Certification			
	2300	CRC		S	Patient Condition Information: Vision			
	2300	CRC		S	EPSDT Referral			
	2300	CRC		S	Homebound Indicator			
	2300	HI		S	Health Care Diagnosis Code			Required for CBHNP
265	2300		HI01	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.
266	2300		HI01-1	R	Diagnosis Type Code		BK	BK - Indicates Principal Diagnosis
266	2300		HI01-2	R	Diagnosis Code	✓		
266	2300		HI02	S - Required to report additional diagnosis and if the preceding H1 data elements have been used to report other diagnosis	Health Care Code Information			
266	2300		HI02-1	R	Diagnosis Type Code	✓	BF	BF - Indicates Diagnosis
266	2300		HI02-2	R	Diagnosis Code	✓		
267	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			
267	2300		HI03-1	R	Diagnosis Type Code		BF	BF - Indicates Diagnosis
267	2300		HI03-2	R	Diagnosis Code	✓		
267	2300		HI04	S - Required to report additional diagnosis and if the preceding H1 data elements have been used to report other diagnosis	Health Care Code Information			
268	2300		HI04-1	R	Diagnosis Type Code		BF	BF - Indicates Diagnosis

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268	2300		HI04-2	R	Diagnosis Code	✓		
	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 - Required if claim involved a referral	Loop ID 2310A Referring Provider Name			Loop Never Used To Adjudicate a Claim
	2310A	NM1		S	Referring Provider Name			
283	2310A		NM103	R	Referring Provider Last Name			
283	2310A		NM104	R	Referring Provider First Name			
	2310A	PRV		S	Referring Provider Specialty Information			
	2310A	REF		S	Referring Provider Secondary Identification			
288	2310A		REF01	R	Reference Identification Qualifier	✓		
289	2310A		REF02	R	Referring Provider Secondary Identifier			Not used for Adjudication
	2310B			S - required when the Rendering Provider NM information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.	Loop ID 2310B Rendering Provider Name			
290	2310B	NM1		S	Rendering Provider Name			
291	2310B		NM101	R	Entity Identifier Code	✓	82	82 Indicates Rendering Provider. This is only required if it differs from the Billing Provider.
291	2310B		NM102	R	Entity Type Qualifier	✓	1/2	1 - Person 2 - Non-Person
291	2310B		NM103	R	Rendering Provider Last or Organizational Name			
291	2310B		NM104	S - Required if NM102 is a person	Rendering Provider First Name			
292	2310B		NM105	S - Required if NM102 is a person and the middle name/initial is known	Rendering Provider Middle Name			
292	2310B		NM107	S - Required if NM102 is a person and has known suffix	Rendering Provider Name Suffix			
292	2310B		NM108	R	Rendering 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 EIN or SSN in this location.
292	2310B		NM109	R	Rendering Provider Identifier			Federal Tax ID Number/Social Security Number XX - National Provider Identifier You can submit the NPI in this location during the contingency period.
292	2310B		NM108	R	Rendering Provider Identification Code Qualifier	✓	XX	Rendering Provider's NPI
292	2310B		NM109	R	Rendering Provider Identifier			
	2310B	PRV		S	Rendering Provider Specialty Information			
	2310B	REF		S	Rendering Provider Secondary Identification			
296	2310B		REF01	R	Reference Identification Qualifier	✓	1D	Indicates Medicaid Provider Number Rendering Provider is only to be submitted if different than billing provider. If Rendering is submitted, CBHNP requires your 13 digit PROMISE number in this location during the contingency period even if you are submitting the NPI in NM109. If sending the NPI in NM109, HIPAA also requires the EIN in the REF.
297	2310B		REF02	R	Rendering Provider Additional Identifier			9 digit DPW PROMISE + 4 digit service location code
296	2310B		REF01	R	Reference Identification Qualifier	✓	0B	Indicates State License Number

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
297	2310B		REF02	R	Rendering Provider Additional Identifier			During the contingency period, continue to submit the State License # in this location.
	2310C				Loop ID 2310C Purchased Service Provider Name			
	2310C	NM1		S	Purchased Service Provider Name			
	2310C	REF		S	Purchased Service Provider Secondary Identification			
	2310D				S - Required when the location of health care service is different than that carried in the Billing/Pay-to Provider Loops. Loop ID 2310D Service Facility Location			In the case where service was rendered in the patient's home do not use this loop. In that case, the place of service code in CLM05-1 should indicate that the service occurred in the patient's home.
	2310D	NM1		S	Service Facility Location			
304	2310D		NM101	R	Entity Identifier Code	✓	77/FA	
304	2310D		NM102	R	Entity Type Qualifier	✓	2	
304	2310D		NM103	S	Laboratory or Facility Name			
305	2310D		NM108	S	Identification Code Qualifier	✓	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.
305	2310D		NM109	S	Identification Code			Federal Tax ID Number/Social Security Number
305	2310D		NM108	S	Identification Code Qualifier	✓	XX	XX - National Provider Identifier If you have an NPI number, submit it in this location.
305	2310D		NM109	S	Identification Code			National Provider Identifier
	2310D	N3		R	Service Facility Location Address			
307	2310D		N301	R	Laboratory or Facility Address Line			
307	2310D		N302	S	Laboratory or Facility Address Line			
	2310D	N4		R	Service Facility Location City/State/ZIP			
308	2310D		N401	R	Laboratory or Facility City Name			
309	2310D		N402	R	Laboratory or Facility State Code			
309	2310D		N403	R	Laboratory or Facility Zip Code			
	2310D	REF		S	Service Facility Location Secondary Identification			
310	2310D		REF01	R	Reference Identification Qualifier	✓	1D	Required if outpatient service is performed in an inpatient facility. Indicates Medicaid Provider Number During the contingency period, continue to submit the facility's 13 digit PROMISE number in this location.
311	2310D		REF02	R	Laboratory or Facility Secondary Identifier			
	2310E				S - Required when the rendering provider is supervised by a physician Loop ID 2310E Supervising Provider Name			
	2310E	NM1		S	Supervising Provider Name			
	2310E	REF		S	Supervising Provider Secondary Identification			
	2320				S - Required if other payers are known to be involved with this claim Loop ID 2320 Other Subscriber Information			Information in this loop should come from from 835s(Remittance Advice) received on the claim. Repeat Loop if more than one additional insurance. For example, loop occurs twice if HCFA 1500 form shows additional insurance in Box 11 and Box 9
	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.
319	2320		SBR01	R	Payer Responsibility Sequence Number Code	✓	P	First Occurrence of Loop is always Primary. If two additional insurances, second occurrence of loop is Secondary, and as a result Loop 2000B, SBR01 would be Tertiary.
319	2320		SBR02	R	Individual Relationship Code	✓		
320	2320		SBR03	S - Required if exists	Insured Group or Policy Number			
320	2320		SBR04	S - Required if exists	Other Insured Group Name			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
321	2320		SBR05	R	Insurance Type Code	✓		Value not on HCFA 1500 form and would need to be inferred
321	2320		SBR09	R	Claim Filing Indicator Code	✓	MC	Indicates the type of claim. Value not on HCFA 1500 form and would need to be inferred
	2320	CAS			<i>Claim Level Adjustments</i>			
326	2320		CAS01	R	Claim Adjustment Group Code	✓		
326	2320		CAS02	R	Claim Adjustment Reason Code	✓		
327	2320		CAS03	R	Adjustment Amount	✓		This is the UNPAID amount.
					S - Required if claim has been adjudicated by payer identified in this loop.			
327	2320	AMT			<i>Coordination of Benefits (COB) Payer Paid Amount</i>			
332	2320		AMT01	R	Amount Qualifier Code	✓	D	D - Indicates Payer Paid Amount
332	2320		AMT02	R	Payer 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 - Used Primarily in Payer-Payer COB situations.			
	2320	AMT			S - Used Primarily in Payer-Payer COB situations.			
					S - Required if Patient is responsible for payment according to another payer's adjudication.			
335	2320	AMT			<i>Coordination of Benefits (COB) Patient Responsibility Amount</i>			
335	2320		AMT01	R	Amount Qualifier Code	✓	F2	F2 - Indicates Patient Responsibility -Actual Amount Value not on HCFA 1500 form but required for COB claims.
335	2320		AMT02	R	Other Payer Patient Responsibility Amount			Amount that is the patient's responsibility according to the Payer indicated in this loop. This is the amount in CLP05 in the 835.
	2320	AMT			S - Used Primarily in Payer-Payer COB situations.			
					S - Required if Payer identified in this loop included this information in the remittance advice.			
337	2320	AMT			<i>Coordination of Benefits (COB) Discount Amount</i>			See AMT in 835 (Loop CLP, position 062) when AMT01 = D8.
					S - Required if Payer identified in this loop included this information in the remittance advice.			
338	2320	AMT			<i>Coordination of Benefits (COB) Per Day Limit Amount</i>			See AMT in 835 (Loop CLP, position 062) when AMT01 = DY.
					S - Required if Payer identified in this loop included this information in the remittance advice.			
339	2320	AMT			<i>Coordination of Benefits (COB) Patient Paid Amount</i>			See AMT in 835 (Loop CLP, position 062) when AMT01 = F5.
					S - Required if Payer identified in this loop included this information in the remittance advice.			
340	2320	AMT			<i>Coordination of Benefits (COB) Tax Amount</i>			See AMT in 835 (Loop CLP, position 062) when AMT01 = T.
	2320	AMT			<i>Coordination of Benefits (COB) Total Claim Before Taxes Amount</i>			See AMT in 835 (Loop CLP, position 062) when AMT01 = T2.
	2320	DMG			S			
	2320	OI			<i>Subscriber Demographic Information</i>			
					<i>Other Insurance Coverage Information</i>			
345	2330		OI103	R	Benefits Assignment Certification Indicator	✓	Y	This is a crosswalk from CLM08 when doing COB
345	2330		OI104	S	Patient Signature Source Code	✓	B	This is a crosswalk from CLM10 when doing COB
345	2330		OI106	R	Release of Information Code	✓	A	This is a crosswalk from CLM09 when doing COB
					S - Required if returned in the electronic remittance advice.			
347	2320	MOA			<i>Medicare Outpatient Adjudication Information</i>			
	2330A				S - Required if Loop 2320 (Other Subscriber Information) is used .			
	2330A	NM1		R	Loop ID 2330A Other Subscriber Name			
					<i>Other Subscriber Name</i>			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
351	2330A		NM101	R	Entity Identifier Code	✓	IL	IL Indicates Insured
351	2330A		NM102	R	Entity Type Qualifier	✓	1/2	1 - Person; 2 - Non-Person Entity
351	2330A		NM103	R	Other Insured Last Name			
351	2330A		NM104	S - Required when the other subscriber is a person (NM102 = "1")	Other Insured First Name			
351	2330A		NM105	S - Required if is a person and the middle name/initial is known	Other Insured Middle Name/Initial			
352	2330A		NM107	S - Required if known	Other Insured Name Suffix			
	2330A	N3		S	Other Subscriber Address			
354	2330A		N301	R	Other Insured Address Line			
354	2330A		N302	S - Required if second address line exists	Other Insured Address Line			
	2330A	N4		S	Other Subscriber City/State/ZIP Code			
355	2330A		N401	S - Required when information available	Other Insured City Name			
356	2330A		N402	R	Other Insured State Code			
356	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			
	2330B			S - Required if Loop 2320 (Other Subscriber Information) is used .	Loop ID 2330B Other Payer Name			
	2330B	NM1		R	Other Payer Name			
360	2330B		NM101	R	Entity Identifier Code	✓	PR	PR Indicates Insured
360	2330B		NM102	R	Entity Type Qualifier	✓	2	1 - Person; 2 - Non-person entity
360	2330B		NM103	R	Other Payer Last or Organization Name			
361	2330B		NM109	R	Other Payer Primary Identifier			
	2330B	PER		S	Other Payer Contact Information			
366	2330B	DTP		S - Required if claim has been adjudicated by payer identified in this loop.	Claim Adjudication Date			
366	2320		DTP01	R	Date/Time Qualifier	✓	573	Date Claim Paid Indicator
366	2320		DTP02	R	Date/Time Period Format Qualifier	✓	D8	Date Expressed in Format CCYYMMDD
367	2320		DTP03	R	Adjudication or Payment Date			Claims submitted to CBHNP require adjudication date from all known payers.
	2330B	REF		S	Other Payer Secondary Identifier			
	2330B	REF		S	Other Payer Prior Authorization or Referral Number			
	2330B	REF		S	Other Payer Claim Adjustment Indicator			
	2330C				Loop ID 2330C Other Payer Patient Information			
	2330C	NM1		S	Other Payer Patient Information			
	2330C	REF		S	Other Payer Patient Identification			
	2330D				Loop ID 2330D Other Payer Referring Provider			
	2330D	NM1		S	Other Payer Referring Provider			
	2330D	REF		R	Other Payer Referring Provider Secondary Identification			
	2330E				Loop ID 2330E Other Payer Rendering Provider			
	2330E	NM1		S	Other Payer Rendering Provider			
	2330E	REF		R	Other Payer Rendering Provider Secondary Identification			
	2330F				Loop ID 2330F Other Payer Purchased Service Provider			
	2330F	NM1		S	Other Payer Purchased Service Provider			
	2330F	REF		R	Other Payer Purchased Service Provider Identification			
	2330G				Loop ID 2330G Other Payer Service Facility Provider			
	2330G	NM1		S	Other Payer Service Facility Provider			
	2330G	REF		R	Other Payer Service Facility Provider Identification			

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
	2330H				Loop ID 2330H Other Payer Supervising Provider			
	2330H	NM1		S	Other Payer Supervising Provider			
	2330H	REF		R	Other Payer Supervising Provider Identification			
	2400			R	Loop ID 2400 Service Line			
	2400	LX		R	Service Line			
	2400	SV1		R	Professional Service			
400	2400		SV101	R	Composite Medical Procedure Identifier			Element consists of sub elements
401	2400		SV101-1	R	Product or Service ID Qualifier	✓	HC	Indicates HCPCS codes used.
401	2400		SV101-2	R	Procedure Code			Use the new HCPCS codes and not the obsolete local codes.
401	2400		SV101-3	R	Procedure Modifier - 1			Use to send the second modifier. Please note: local codes may have cross-walked to a HCPCS code plus up to two modifiers.
402	2400		SV101-4	R	Procedure Modifier - 2			Use to send the second modifier. Please note: local codes may have cross-walked to a HCPCS code plus up to two modifiers.
402	2400		SV102	R	Line Item Charge Amount			Usual charge identifies the dollars and cents of the amount originally submitted by the service provider for the line item. Negative values are not permitted.
403	2400		SV103	R	Unit or Basis for Measurement Code	✓	UN	UN - for days or units; cross reference table of Procedure Codes to Unit Qualifier
403	2400		SV104	R	Quantity/Service Unit Count			
404	2400		SV105		Place of Service Code	✓		Only use this if the place of service is different from the place of service in the claim information section
405	2400		SV107		Composite Diagnosis Code Pointer	✓		Use these pointers to designate the primary diagnosis code for this service line in declining level of importance to service line. Acceptable values are 1 through 8, inclusive
405	2400		SV107-1	R	Diagnosis Code Pointer	✓		Use this pointer for the primary diagnosis for this service line that substantiates the treatment supplied.
405	2400		SV107-2		Diagnosis Code Pointer	✓		
405	2400		SV107-3		Diagnosis Code Pointer	✓		
406	2400		SV109		Emergency Indicator	✓		Not used for Adjudication. A "Y" is indicated if service relates to an emergency. If not, leave value blank.
	2400	SV5		S	Durable Medical Equipment Service			
	2400	PWK		S	DMERC CMN Indicator			
	2400	CR1		S	Ambulance Transport Information			
	2400	CR2		S	Spinal Manipulation Service Information			
	2400	CR3		S	Durable Medical Equipment Certification			
	2400	CR5		S	Home Oxygen Therapy Information			
	2400	CRC		S	Ambulance Certification			
	2400	CRC		S	Hospice Employee Indicator			
	2400	CRC		S	DMERC Condition Indicator			
	2400	DTP		R	Date - Service Date			
435	2400		DTP01	R	Date/Time Qualifier		472	

IG Page #	Loop ID	SEG ID	Data Element	REQUIREMENT DESIGNATOR	Name	Check IG for Specific ID or Code Set Required	Expected Value	Notes:
								D8 - Single date in CCYYMMDD Please Note: Do not send a date range. A date range is only for a drug duration and is not applicable to claims sent to CBHNP. If a date range is used, it is impossible to know the number of units for each individual date. Adjudication must be done on a single day basis.
436	2400		DTP02	R	Date/Time Period Format Qualifier	✓	D8	
436	2400		DTP03	R	Service Date			
	2400	DTP		S	Date - Certification Revision Date			
	2400	DTP		S	Date - Begin Therapy Date			
	2400	DTP		S	Date - Last Certification Date			
	2400	DTP		S	Date - Last Seen			
	2400	DTP		S	Date - Test			
	2400	DTP		S	Date - Oxygen Saturation/Arterial Blood Gas Test			
	2400	DTP		S	Date - Shipped			
	2400	DTP		S	Date - Onset of Current Symptom/Illness			
	2400	DTP		S	Date - Last X-ray			
	2400	DTP		S	Date - Acute Manifestation			
	2400	DTP		S	Date - Initial Treatment			
	2400	DTP		S	Date - Similar Illness/Symptom Onset			
	2400	MEA		S	Test Result			
	2400	CN1		S	Contract Information			
	2400	REF		S	Repriced Line Item Reference Number			
	2400	REF		S	Adjusted Repriced Line Item Reference Number			
	2400	REF		S	Prior Authorization or Referral Number			
	2400	REF		S	Line Item Control Number			As noted in the IG, it is STRONGLY recommended that a unique control number is always sent. If a control number is not sent, it may be difficult to match the 835 returned by CBHNP to your original claim.
472	2400		REF01	S	Reference Identification Qualifier	✓	6R	Indicates Provider Control Number
473	2400		REF02	S	Line Item Control Number			
	2400	REF		S	Mammography Certification Number			
	2400	REF		S	Clinical Laboratory Improvement Amendment (CLIA) Identification			
	2400	REF		S	Referring Clinical Laboratory Improvement Amendment (CLIA) Facility Identification			
	2400	REF		S	Immunization Batch Number			
	2400	REF		S	Ambulatory Patient Group (APG)			
	2400	REF		S	Oxygen Flow Rate			
	2400	REF		S	Universal Product Number (UPN)			
	2400	AMT		S	Sales Tax Amount			
	2400	AMT		S	Approved Amount			
	2400	AMT		S	Postage Claimed Amount			
	2400	K3		S	File Information			
	2400	NTE		S	Line Note			
	2400	PS1		S	Purchased Service Information			
	2400	HSD		S	Health Care Services Delivery			
	2400	HCP		S	Line Pricing/Repricing Information			
	2410				Loop ID 2410 Drug Identification			
		LIN		S	Drug Identification			
		CTP		S	Drug Pricing			
		REF		S	Prescription Number			
	2420A				Loop ID 2420A Rendering Provider Name			
	2420A	NM1		S	Rendering Provider Name			
	2420A	PRV		S	Rendering Provider Specialty Information			
	2420A	REF		S	Rendering Provider Secondary Information			
	2420B				Loop ID 2420B Purchased Service Provider Name			
	2420B	NM1		S	Purchased Service 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:
	2420B	REF		S	<i>Purchased Service Provider Secondary Identification</i>			
	2420C				Loop ID 2420C Service Facility Location			
	2420C	NM1		S	<i>Service Facility Location</i>			
	2420C	N3		R	<i>Service Facility Location Address</i>			
	2420C	N4		R	<i>Service Facility Location City/State/ZIP</i>			
	2420C	REF		S	<i>Service Facility Location Secondary Identification</i>			
	2420D				Loop ID 2420D Supervising Service Provider Name			
	2420D	NM1		S	<i>Supervising Provider Name</i>			
	2420D	REF		S	<i>Supervising Provider Name Secondary Identification</i>			
	2420E				Loop ID 2420E Ordering Provider Name			
	2420E	NM1		S	<i>Ordering Provider Name</i>			
	2420E	N3		S	<i>Ordering Provider Address</i>			
	2420E	N4		S	<i>Ordering Provider City/State/ZIP</i>			
	2420E	REF		S	<i>Ordering Provider Secondary Identification</i>			
	2420E	PER		S	<i>Ordering Provider Contact Information</i>			
	2420F				Loop ID 2420F Referring Provider Name			
	2420F	NM1		S	<i>Referring Provider Name</i>			
	2420F	PRV		S	<i>Referring Provider Specialty Information</i>			
	2420F	REF		S	<i>Referring Provider Secondary Information</i>			
	2420G				Loop ID 2420G Other Payer Prior Authorization or Referral Number			
	2420G	NM1		S	<i>Other Payer Prior Authorization or Referral Number</i>			
	2420G	REF		R	<i>Other Payer Prior Authorization or Referral Number</i>			
	2430				Loop ID 2430 Line Adjudication Information			
	2430				S - Required if payer identified in loop 2330B adjudicated the claim and made adjustments at the service line level.			
	2430	SVD		S	<i>Line Adjudication Information</i>			
554	2430		SVD01	R	<i>Other Payer Primary Identifier</i>			
554	2430		SVD02	R	<i>Service Line Paid Amount</i>			Payer Paid Amounts
554	2430		SVD03	R	<i>Composite Medical Procedure</i>	✓		This element includes sub-elements. Crosswalks from SVC01 in the 835 transmission.
554	2430		SVD05	R	<i>Paid Service Unit Count</i>			Crosswalk from SVC05 in 835
	2430	CAS		S	<i>Line Adjustment</i>			
560	2430		CAS01	R	<i>Claim Adjustment Group Code</i>	✓		
560	2430		CAS02	R	<i>Claim Adjustment Reason Code</i>	✓		
560	2430		CAS03	R	<i>Adjustment Amount</i>	✓		This is the UNPAID amount.
	2430	DTP		S	<i>Line Adjudication Date</i>			
566	2430		DTP01	R	<i>Date Time Qualifier</i>	✓	573	Date Claim Paid Indicator
566	2430		DTP02	R	<i>Date Time Period Format Qualifier</i>	✓	D8	
566	2430		DTP03	R	<i>Adjudication or Payment Date</i>			Claims submitted to CBHNP require adjudication date from all known payers.
	2440				Loop ID 2440 Form Identification Code			
	2440	LQ		S	<i>Form Identification Code</i>			
	2440	FRM		R	<i>Supporting Documentation</i>			
					Transaction Set Trailer			
		SE		R	<i>Transaction Set Trailer</i>			
					Trailer			
		GE		R	<i>Functional Group Footer</i>			
		IEA		R	<i>Interchange Control Footer</i>			
			IEA01	R	<i>Number of Included Functional Groups</i>			