Excellus BlueCross BlueShield

Companion Guide for the following transactions:

ASC X12N/005010X223 Health Care Claim Institutional (837)

ASC X12N/005010X222 Health Care Claim Professional (837)

ASC X12N/005010X221 Health Care Claim Payment/Advice (835)

ASC X12C/005010X231 Implementation Acknowledgement for Health Care Insurance (999)

ASC X12N/005010X214 Health Care Claim Acknowledgement (277)

Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

Table of Contents

1 Introduction

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard.

On January 16, 2009, HHS published a final rule that replaces the HIPAA Accredited Standards Committee (ASC) X12 Version 4010A1 with the ASC X12 Version 5010.

1.1 Purpose of the Companion Guide

The Excellus BlueCross BlueShield Transaction Companion Guide explains the procedures necessary for Trading Partners of Excellus BCBS to transmit Electronic Data Interchange (EDI) transactions (submission of claims and receipt of electronic remittance advices).

This companion guide to the ASC 005010 HIPAA Implementation Guides clarifies and specifies payer-specific data content being requested when data is transmitted electronically to the clearinghouse. Transmissions based on this payer-specific companion document, used in conjunction with the 005010 HIPAA Implementation Guides, are compliant with both ASC X12 syntax and those guides.

This guide is a revision to the existing Excellus BCBS companion guide which was based on the ASC X12N 4010A1 standard.

As documented in the X12 published Intellectual Property Use guidelines, (http://store.x12.org/x12ip/default_ip.htm), this companion guide is:

- Not intended to replace, duplicate, countermand or contradict any requirement of the associated 005010 HIPAA Implementation Guides.

- Intended to be used solely to clarify the associated ASC 005010 HIPAA Implementation Guide instructions to provide Excellus BCBS payer-specific requirements only. It describes the specific requirements for using the Excellus BCBS Clearinghouse. You will need to refer to the specific 005010 HIPAA Implementation Guides for the guidelines and interpretation of all required/situational fields, loops and segments.

This guide is to be used in conjunction with the following 005010 HIPAA Implementation Guides (with the associated addenda, if any, indicated):

- ASC X12N/005010X223A2 –Health Care Claim: Institutional (837)
- ASC X12N/005010X222A1 – Health Care Claim: Professional (837)
- ASC X12N/005010X221A1 – Health Care Claim Payment/Advice (835)
- ASC X12C/005010X231A1 – Implementation Acknowledgment for Health Care Insurance (999)
- ASC X12N/005010X214 – Health Care Claim Acknowledgement (277)

1.2 Scope

This guide is intended to communicate Excellus BCBS payer-specific requirements.

The effective date of this document is based on and reflects currently published Type 1 Errata for all of the EDI transactions covered by this manual (wherever applicable). The nomenclature used to identify a specific transaction identifies it as having associated errata.

For example:

- ASC X12N/005010X223 – Health Care Claim Institutional (837) with no associated Errata
- ASC X12N/005010X223A2 – Health Care Claim Institutional (837) with Type 1 associated Errata (specifically, A2)

Periodically, the HHS mandated changes to the existing ASC X12 standard and/or Excellus BCBS payer-specific requirements may necessitate a revision to or replacement of this guide. Revisions or replacements will be posted on the Lifetime Healthcare Companies website, www.lifethc.com and the Excellus BCBS website, www.excellus.com/provider (HIPAA Resources).

1.3 References

HIPAA requires that all health insurance payers in the U.S. comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ASC X12N versions have been established as the standard for claim transactions. These implementation guides are available via the Washington Publishing Co. website, www.wpc-edi.com.

2 Getting Started

2.1 Trading Partners

An EDI Trading Partner is defined as any Excellus BCBS customer (provider, billing service, clearinghouse or software vendor, etc.) that transmits or receives electronic data from Excellus BCBS.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is a separate agreement or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

Trading Partner Agreements are available at:
http://www.lifethc.com/vendors/vendor_consent_forms.shtml

Please complete the appropriate forms and mail original documents to:
Excellus Health Plan, Inc
EDI Solutions
PO Box 22999
Rochester New York 14692

2.2 Trading Partner Registration

To register as a testing vendor, provider or clearinghouse, please contact the eCommerce department:

Phone: (585) 238-4618 or toll-free 1 (877) 843-8520
E-mail: Edi.solutions@excellus.com.

When you begin working with an EDI analyst, you will be assigned a submitter identification (ID), log in ID and a password which will allow you to begin testing with the clearinghouse. Once 95 percent of your claims are passing through the edits, contact Excellus BCBS for final approval. Once final approval is received, a production ID will be assigned and you will be a certified vendor.

2.3 Working with Excellus BlueCross BlueShield

Transactions may be sent, 24 hours a day, seven days a week.

Report transmission problems to eCommerce: (585) 238-4618 or toll-free 1 (877) 843-8520

You are responsible for the timely retrieval of all reports delivered to your mailbox.

Important: Reports are only retained for a limited time.

Clearinghouse and payer systems verification must take place prior to approval for production.

For errors received on your TA1 report, please refer to the 005010 HIPAA Implementation Guides:

- ASC X12C/005010X231A1 – Implementation Acknowledgment for Health Care Insurance (999)
- ASC X12N/005010X214 – Health Care Claim Acknowledgement (277)

3 Testing with the Payer

3.1 Test Criteria – Claims

- **Health Care Claim Institutional (837)**
- **Health Care Claim Professional (837)**

Health Care Claim Professional (837)	10 claims each for Managed Care, Indemnity, PPO, Univera, EBS-RMSCO, Secondary claims (if applicable)
Health Care Claim Institutional (837)	10 Inpatient claims each for Managed Care, Indemnity, PPO, Univera, EBS-RMSCO, Secondary claims (if applicable) 10 Outpatient claims each for Managed Care, Indemnity, PPO, Univera, EBS-RMSCO, Secondary claims (if applicable)

Please refer to the appropriate Health Care Claim Institutional (837) TPA outlined in this document to determine if any specific submission requirements are needed.

Secondary Claims: For submission of secondary claims, please refer to the Health Care Claim Institutional (837) TPA for specific coding requirements.

Please note: It is imperative to continue to submit your production claims in the current format while testing. Please do not hold production claims while testing.

4 Connectivity with the Payer / Communications

4.1 Transmission and Retransmission Administrative Procedures

Once your test and submitter IDs are assigned, please follow the procedures below to submit a test file.

NOTE: You may have some or all of the following procedures automatically scripted.

Call the clearinghouse at one of the following numbers:

- 1 (800) 335-0545
- 1 (585) 454-1821
- 1 (315) 477-7485

A Smart Transfer connection will be established and you will be prompted for a login ID. Enter **ansitst** in lower case. You will then be prompted for your submitter login ID. Enter the test login that has been assigned to you in **UPPERCASE.** The system will prompt you for a password. Enter your assigned password in **UPPERCASE**. The menu below will appear on the screen.

```
Date:  01/01/2011     Time: 16:56      Protocol: Zmodem
User ID: user1        Port: /Smart     Transfer: Binary
Trading Partner: 123456789             Compression: None

        1.) Transmit files
        2.) Receive files
        3.) List files
        4.) Set Configuration
       LO) Logoff
```

To **transmit your file**, select option 1. **Type <1> and press <enter>**. When the file transmission is complete, Smart Transfer will return to the main menu.

To **receive reports**, select option 2. **Type <2> and press <enter>**. You will receive all reports that have not been previously downloaded.

When you have finished transmitting your files, or finished downloaded your reports, you must type <**LO**> and press <enter> to sign off from the Smart Transfer system before you close out your communications software.

4.2 Communication Protocol Specifications

The clearinghouse supports modem and SFTP protocols. For further information, please contact the eCommerce Department.

5 Acknowledgements and Reports – Claim Transactions

- **ASC X12N/005010X223A2 Health Care Claim Institutional (837)**
- **ASC X12N/005010X222A1 Health Care Claim Professional (837)**

You will receive a TRN report advising of the status of your transmission. This report may advise of an unprocessed file if you sent in a Health Care Claim Institutional (837), but have only been approved for Health Care Claim Professional (837) or if your transmission was not complete. The naming convention for this report is **trnNNNNN.txt** (the NNNNN = a 5 byte system generated sequence number).

A TA1 report will be generated if the submitter requests it in the **ISA14** segment of their file. The response will be sent in the ANSI format for **rejected files only.** The naming convention for this report is: **TA1NNNNN_00001.txt** (NNNNN = a 5 byte system generated sequence number).

The Implementation Acknowledgment for Health Care Insurance (999) will report transaction set errors and will be created for all positive and negative cases. If the batch passed through the 005010 HIPAA Implementation Guide edits, it will be an accepted report (IK5 = A). If there were errors, it will be a rejected report (IK5 = R). You must refer to the specific 005010 HIPAA Implementation Guide for any rejected batches and correct the format errors and resubmit the batch. The naming convention for this report is: **ACK.Input File Name_00001.NNNN** (NNNN = a 4 byte system generated sequence number).

Please Note: Excellus BCBS will only be providing the machine readable version of the Implementation Acknowledgment for Health Care Insurance (999) transaction.

The Health Care Claim Acknowledgement (277) report will be generated for each logical file. The naming convention is 277CA.NNNNN.TXT (NNNNN is a 5 byte system generated sequence number). After 2 hours of submitting your claim file you can reconnect, select # 2, and receive your reports. This report will list all claims that have been transmitted. When testing, any claims with edits must be corrected and resubmitted until you have reached a 95 percent acceptance rate.

Please note: Excellus BCBS will only be providing the machine readable version of the Health Care Claim Acknowledgement (277) Transaction.

Within 24 to 48 hours after the original submission, you will need to reconnect select option 2 and receive your Payer Response report file. You may receive multiple payer reports, one from each payer system. These reports will be in the 80 byte printable format. Each rejected claim will have specific edit codes assigned. These claims must be

corrected and resubmitted. The naming convention is **REPJJJ.NNN** (JJJ = the Julian date of the file receipt, and NNN is a 3 byte sequential number).

If you need assistance on correcting any edits that appear on the following reports, please contact the eCommerce Department:

- Implementation Acknowledgment for Health Care Insurance (999)
- Health Care Claim Acknowledgement (277)
- Payer reports

6 Contact information

6.1 eCommerce Department

Hours of Operation: Monday through Thursday 8 a.m. – 4:30 p.m. Friday 9 a.m. – 4 p.m.

- Phone: (585) 238-4618 or toll-free 1 (877) 843-8520
- E-mail: edi.solutions@excellus.com

6.2 Applicable Websites

There are many national and regional organizations which are undertaking various activities in effort to support the success and implementation of HIPAA 5010 including:

Data and Transactions Standards

- National Uniform Billing Committee (NUBC): http://www.nubc.org
- National Uniform Claim Committee (NUCC): http://www.nucc.org
- Washington Publishing Company with implementation guides for the X12N transaction standards: http://www.wpc-edi.com/
- ASC X12 The Accredited Standards Committee: (http://www.x12.org)

Electronic Data Interchange

- National-Workgroup for Electronic Data Interchange Strategic National Implementation Process: http://www.wedi.org/SNIP

Professional and Trade Associations/Workgroups

- The American Hospital Association (AHA): http://www.aha.org
- American Health Information Management Association Compliance: http://www.ahima.org/
- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/NPPES/Welcome.do

7 Common Transaction Properties

7.1 Professional & Institutional Claims

- **ASC X12N/005010X223A2 Health Care Claim Institutional (837)**
- **ASC X12N/005010X222A1 Health Care Claim Professional (837)**

7.1.1 General Rules

1. Only one ISA/IEA will be accepted per transmission. Multiple transmissions may be sent at any time.

2. There should be a maximum of 5,000 claims per transmission.

3. An Implementation Acknowledgement for Health Care Insurance (999) data interchange (the 999 Transaction with the applicable ISA, TA1, GS, GE and IEA segments) will be generated for each ISA through IEA segment set (an ASC X12 data interchange) received from a Trading Partner. The 999 transaction(s) will be routed to the Trading Partner's mailbox.

4. Each ASC X12 data interchange received from a Trading Partner must meet the ASC X12 syntax rules presented in the 005010 HIPAA Implementation Guide. Note: If an X12 syntax rule is violated, the Implementation Acknowledgement for Health Care Insurance (999) data interchange must indicate that the ASC X12 interchange is being rejected. The Trading Partner must correct and resubmit.

5. The syntactical requirements presented in the ASC X12N/005010X223A2 Health Care Claim Institutional (837) Implementation Guide will be used to determine whether the Trading Partner submitted a 5010 transaction in accordance with the aforementioned implementation guideline. Note: If a listing of code values is shown in the implementation guide for a Data Element and a code value, not in the listing, is submitted, an error will be issued on the Health Care Claim Acknowledgement (277) indicating that an invalid code value was detected.

6. The ISA, GS, GE and IEA segments are presented in Appendix B of the ASC X12N/005010X223A2 Health Care Claim Institutional (837). These segments must be submitted to meet the ASC X12 enveloping syntax requirements for the interchange of an ASC X12 transaction and the data presented in the Data Elements will be edited.

Values for the edits are as follows:

A) For Syntax and Symantec Errors, violations will always result in the rejection of the ISA – IEA, ST-SE, data interchange via the 999 data interchange. If there is a data interchange (ISA or GS) error, all of the ST - SE transactions in the data interchange will be rejected, with a net result of the data interchange being rejected.

B) A Business Validation edit will result in either an Implementation Acknowledgment for Health Care Insurance (999) or a Health Care Claim Acknowledgement (277) error.

Therefore, rejection may occur at the ISA (Interchange), the ST (File), the BATCH (Billing Provider HL), the SUB (Subscriber HL), the PAT (Patient HL) or the CLM (Claim) level.

7.2 Health Care Claim Professional (837) TPA

This section delineates Excellus BCBS payer-specific instructions for the ASC X12 transactions. The segment name, loop and element name used are those in the 005010 HIPAA Implementation Guide.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
File size			Max 5000 CLM segments within a ISA-IEA	
Recommended File Delimiters			*= Data Element Separator : = Sub Element Separator ~ = (Tilde) Segment Terminator { = Repetition Separator	
			All ALPHA characters should be in uppercase.	
Interchange Control Header				
Interchange ID Qualifier		ISA05	ZZ	Mutually Defined.
Interchange ID Qualifier		ISA07	ZZ	Mutually Defined.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Interchange Receiver ID		ISA08	00804 – BCBSRA 00805 – BCBSCNY 00806 – BCBSUW	Receiver Plan ID.
Acknowledgment Requested		ISA14	1	This will insure that a TA1 report will be generated if the file rejects.
Functional Group Header				
Application Receiver's Code		GS03	00804 – BCBSRA 00805 – BCBSCNY 00806 – BCBSUW	Receiver Plan ID.
Beginning of Hierarchical Transaction				
Transaction Type Code		BHT06	CH	Used for claims.
Submitter Name				
Identification Code	1000A	NM109	Current Submitter ID	This number is identified in the administrative set up for your mailbox. If it is not correct, the file will not process.
Receiver Name				
Identification Code	1000B	NM109	00804 – BCBSRA 00805 – BCBSCNY 00806 – BCBSUW	Receiver Plan ID.
Billing Provider Specialty Information	2000A	PRV		Required if the rendering provider is the same entity as the billing provider.
Billing Provider Tax Identification				
Reference Identification Qualifier	2010AA	REF01	EI = Employer's ID SY = Social Security #	This is the Tax ID of the entity to be paid for the submitted services. REF segment in this loop is required with either Employee ID or Social Security (see note in TR3).
Subscriber Information				
Claim Filing Indicator Code	2000B	SBR09	BL = Blue Shield CI = Univera	Use appropriate qualifier.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Payer Information				
Identification Code	2010BB	NM109	Please see the member's ID card for the correct Payer ID/Plan Code to use. The following are a few, but not all possible examples: 00802 – EXCELLUS 00804 – BCBSRA 00805 – BCBSCNY 00806 – BCBSUW	
Claim Information				
Delay Reason Code	2300	CLM20		Will be accepted, however, you must follow current procedures for late filing.
Referring Provider Name	2310A			Required for all managed care claims.
Rendering Provider Specialty	2310B	PRV		Required if the billing provider is a group and rendering provider is in 2310B.
Supervising Provider Name	2310D	NM1		Required for NP/PA claims.

7.21 Health Care Claim Professional (837) COB Requirements

In order to bill any secondary claims electronically, the following segments/elements will be required. If these are not submitted, the claim will either error from the payer system, or will be returned for the missing information, requesting an EOB from the primary carrier.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
COB Requirements				
Claim Level				

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Subscriber Information	2000B	SBR		Segment information with all required elements from the IG.
Patient Amount Paid				
Amount Qualifier Code	2300	AMT01	F5	Amount Qualifier Code.
Monetary Amount	2300	AMT02	Monetary amount	Patient Amount Paid.
Other Subscriber Information	2320	SBR		Segment information with all required elements from the IG.
Claim Level Adjustments	2320	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/ coinsurance amounts, denied and allowed charges.
Coordination of Benefits (COB) Payer Paid Amount				
Amount Qualifier Code	2320	AMT01	D	Amount Qualifier Code.
Monetary Amount		AMT02	Monetary amount	Payer paid amount.
Remaining Patient Liability				
Amount Qualifier Code	2320	AMT01	EAF	Amount Qualifier Code.
Monetary Amount		AMT02	Monetary amount	Remaining patient liability
Other Insurance Coverage Information	2320	OI		All pertinent elements are needed.
Other Subscriber Name	2330A	NM1, N3, N4		All pertinent elements are needed.
Other Payer Name	2330B	NM1		All pertinent elements are needed.
Line Level				
Line Adjudication Information	2430	SVD		All pertinent elements are needed.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Line Adjustment	2430	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/ coinsurance amounts, denied and allowed charges.
Line Check or Remittance Date	2430	DTP		All pertinent elements are needed.

7.3 Health Care Claim Institutional (837) TPA

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
File size			Max 5000 CLM segments within a ISA-IEA	
Recommended File Delimiters			*= Data Element Separator : = Sub Element Separator ~ = (Tilde) Segment Terminator { = Repetition Separator	
			All ALPHA characters should be in upper case.	
`				
Interchange Control Header				
Interchange ID Qualifier		ISA05	ZZ	Mutually defined.
Interchange ID Qualifier		ISA07	ZZ	Mutually defined.
Interchange Receiver ID		ISA08	00304 – BCBSRA 00305 – BCBSCNY 00306 – BCBSUW	Receiver Plan ID.
Acknowledgment Requested		ISA14	1	This will insure that a TA1 report will be generated if the file rejects.
Functional Group Header				
Application Receiver's Code		GS03	00304 – BCBSRA 00305 – BCBSCNY 00306 – BCBSUW	Receiver plan ID.
Beginning of Hierarchical Transaction				
Transaction Type Code		BHT06	CH	Used for claims.
Submitter Name				
Identification Code	1000A	NM109	Current submitter id	This number is identified in the administrative set up for your mailbox. If it is not correct, the file will not process.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Receiver Name				
Identification Code	1000B	NM109	00304 – BCBSRA 00305 – BCBSCNY 00306 – BCBSUW	Receiver plan ID.
Billing Provider Specialty Information	2000A	PRV		Required if the service facility provider is the same entity as the billing provider.
Subscriber Information				
Claim Filing Indicator Code		SBR09	BL = Blue CI = Univera	
Payer Information				
Identification Code	2010BB	NM109	Please see the member's id card for the correct value to use. The following are a few, but not all possible examples: 00302 – EXCELLUS 00304 – BCBSRA 00305 – BCBSCNY 00306 – BCBSUW	Payer identifier.
Claim Information				
Delay Reason Code	2300	CLM20		Will be accepted, however you must follow current procedures for late filing.
Value Information				
Code List Qualifier Code	2300	HI01-1	BE	Value Information (for submitting newborn weight). This HI is required to report newborn birth weight. This is mandatory for all newborn claims. Submit birth weight in grams with associated amount.
Industry Code		HI01-2	54	Value code to report newborn birth weight.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Monetary Amount		HI01-5	NNNN	Birth weight in grams. It would look like: HI*BE:54:::1234~
Attending Provider Name	2310A	NM1		Required on all inpatient claims.

7.31 Health Care Claim Institutional (837) COB Requirements

In order to bill any secondary claims electronically, the following segments/elements will be required. If these are not submitted, the claim will either error from the payer system, or will be returned for the missing information, requesting an EOB from the primary carrier.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
COB REQUIREMENTS				
Claim Level				
Subscriber Information	2000B	SBR		Segment information with all required elements from the IG.
Other Subscriber Information	2320	SBR		Segment information with all required elements from the IG.
Claim Level Adjustments	2320	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/coinsurance amounts, denied and allowed charges.
Coordination of Benefits (COB) Payer Paid Amount				
Amount Qualifier Code	2320	AMT01	D	
Monetary Amount		AMT02	Monetary amount	Payer paid amount.
Remaining Patient Liability				

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Amount Qualifier Code	2320	AMT01	EAF	
Monetary Amount		AMT02	Monetary amount	Remaining patient liability.
Coordination of Benefits (COB) Total Non-covered Amount				
Amount Qualifier Code	2320	AMT01	A8	
Monetary Amount		AMT02	Monetary amount	Non-covered charges-actual.
Other Insurance Coverage Information	2320	OI		All pertinent elements are needed.
Other Subscriber Information	2330A	NM1, N3, N4		All pertinent elements are needed.
Other Payer Name	2330B	NM1		All pertinent elements are needed.
Line Level				
Line Adjudication Information	2430	SVD		All pertinent elements are needed.
Line Adjustment	2430	CAS		Segment with the appropriate reason codes and associated amounts. These should include deductible, copayment/coinsurance amounts, denied and allowed charges
Line Check or Remittance Date	2430	DTP		All pertinent elements are needed.

7.4 Health Care Claim Payment/Advice (835) TPA

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
INTERCHANGE CONTROL HEADER	**--**	**ISA**	**-**	
Authorization Information Qualifier		ISA01	00	
Authorization Information		ISA02	blanks	
Security Information Qualifier		ISA03	00	
Security Information		ISA04	blanks	
Interchange ID Qualifier		ISA05	ZZ	
Interchange Sender ID		ISA06		Originator Tax ID.
Interchange ID Qualifier		ISA07	ZZ	
Repetition Separator		ISA11	{	
Interchange Control Number		ISA13		Control Number - First Two Positions = Payer System ID.
Acknowledgment Requested		ISA14	1	
Component Element Separator		ISA16	:	
FUNCTIONAL GROUP HEADER	**--**	**GS**		
Application Sender's Code		GS02		Originator Tax ID.
Application Receiver's Code		GS03		Receiver ID.
Version/Release/Industry Identifier Code		GS08	005010X221A1	
FINANCIAL INFORMATION	**--**	**BPR**		
Transaction Handling Code		BPR01	H or I	H - Notification Only I - Remittance Information Only
Credit / Debit Flag Code		BPR03	C	
Payment Method Code		BPR04	ACH or CHK or NON	If ACH is used, BPR05 through BPR10 and BPR12 through BPR15 will have valid values.

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Originating Company Supplemental Code		BPR11		If managed care, will contain the IPA program code.
REASSOCIATION TRACE NUMBER	**--**	**TRN**		
Reference Identification		TRN02		Check Number, EFT Trace Number or NONE if no payment.
PAYEE IDENTIFICATION	**1000B**	**N1**		
Identification Code		N104		NPI number or payee tax ID number.
PAYEE ADDITIONAL IDENTIFICATION	**1000B**	**REF**		
Reference Identification Qualifier		REF01	PQ and/or TJ	PQ - Payee ID TJ - Payee Tax Id
HEADER NUMBER	**2000**	**LX**		
Assigned Number		LX01		There can be multiples. Will have sequential numbering.
PROVIDER SUMMARY INFORMATION	**2000**	**TS3**		
Facility Code Value		TS302	99	Facility Type Code.
CLAIM PAYMENT INFORMATION	**2100**	**CLP**		
Claim Status Code		CLP02	1, 2, 4, 22	1 - Processed as Primary 2 - Processed as Secondary 4 - Denied 22 - Reversal of a Previous Payment
Claim Filing Indicator Code		CLP06	12 or 13 or HM	12 - Indemnity 13 - Drugs HM – HMO
PATIENT NAME	**2100**	**NM1**		
Identification Code Qualifier		NM108	MI	MI' until individual identifier is effective, then II

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
CORRECTED PRIORITY PAYER NAME	**2100**	**NM1**		**This segment may or may not be present.**
Name Last or Organization Name		NM103		Payer name or message.
Identification Code Qualifier		NM108	PI	
Identification Code		NM109		Payer name or message.
OTHER CLAIM RELATED IDENTIFICATION	**2100**	**REF**		
Reference Identification Qualifier		REF01	BB	BB for managed care claims only.
STATEMENT FROM OR TO DATE	**2100**	**DTM**		**This loop will be returned when reimbursement is made at the claim level.**
CLAIM CONTACT INFORMATION	**2100**	**PER**		**Segment may or may not be present.**
Communication Number Qualifier		PER03	TE	Telephone
CLAIM SUPPLEMENTAL INFORMATION	**2100**	**AMT**		**This segment is for NYHCRA Amounts.**
Amount Qualifier Code		AMT01	I or T	I - Interest T - Tax
CLAIM SUPPLEMENTAL INFORMATION QUANTITY	**2100**	**QTY**		**Outlier Days will be reported in this segment.**
Quantity Qualifier		QTY01	OU or CA	OU - Outlier CA - Covered Actual
SERVICE PAYMENT INFORMATION	**2110**	**SVC**		
Product / Service ID Qualifier		SVC01-1	HC or NU or N4	HC - CPT / HCPCS Codes NU - NUBC Codes N4 - NDC Codes

SEGMENT NAME	LOOP	ELEMENT NAME	VALID VALUE	REQUIREMENTS
Product / Service ID		SVC04		Will only be returned if revenue and procedure codes used for claim adjudication - NUBC revenue code.
Composite Medical Procedure Identifier		SVC06		Procedure code. Will only be returned if data was changed to adjudicate the claim. You would receive the submitted data in this field.
Quantity		SVC07		Original units of service count. Will only be returned if data was changed to adjudicate the claim. You would receive the submitted data in this field..
SERVICE DATE	**2110**	**DTM**		**Will only be returned when reimbursement is made at the line item level.**
SERVICE SUPPLEMENTAL AMOUNT	**2110**	**AMT**		
Amount Qualifier Code		AMT01	B6	Allowed - Actual
PROVIDER ADJUSTMENT	**--**	**PLB**		**This segment is used to report Provider level adjustments such as a loan repayment or a capitation payment.**
Adjustment Identifier		PLB03		
Adjustment Reason Code		PLB03-1	FB or PI or WU	FB - Forward Balancing PI - Periodic Interim Payment WU -Unspecified Recovery

This page is intentionally blank.