

# **837 Health Care Claim: Professional, Short Version**

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

**Version: 1.0 Final**

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# 837 Health Care Claim: Professional

## Functional Group=HC

Note: This guide does not contain all the required and situation data that may be necessary to make up a HIPAA compliant claim. Only segment and elements that have LIPA specific notes or industry notes that LIPA is emphasizing are included. There is a more detailed guide available containing approximately 150 pages.

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

### Not Defined:

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

### Heading:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
005	ST	Transaction Set Header	M	1			Required
010	BHT	Beginning of Hierarchical Transaction	M	1			Required

LOOP ID - 1000A					1	N1/020L	
020	NM1	Submitter Name	O	1		N1/020	Required

LOOP ID - 1000B					1	N1/020L	
020	NM1	Receiver Name	O	1		N1/020	Required

### Detail:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
LOOP ID - 2000A					≥1		
LOOP ID - 2010AA					1	N2/015L	
035	REF	Billing Provider Secondary Identification	O	8			Situational

LOOP ID - 2000B					≥1		
001	HL	Subscriber Hierarchical Level	M	1			Required

LOOP ID - 2010BA					1	N2/015L	
015	NM1	Subscriber Name	O	1		N2/015	Required

LOOP ID - 2010BB					1	N2/015L	
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LOOP ID - 2300					100		
130	CLM	Claim Information	O	1			Required
180	REF	Prior Authorization or Referral Number	O	2			Situational
180	REF	Original Reference Number (ICN/DCN)	O	1			Situational

LOOP ID - 2310B					1	N2/250L	
271	REF	Rendering Provider Secondary Identification	O	5			Situational

LOOP ID - 2400					50	N2/365L	
370	SV1	Professional Service	O	1			Required

LOOP ID - 2420A					1	N2/500L	
525	REF	Rendering Provider Secondary Identification	O	5			Situational
555	SE	Transaction Set Trailer	M	1			Required

### Not Defined:

Pos	Id	Segment Name	Req	Max Use	Repeat	Notes	Usage
	GE	Functional Group Trailer	M	1			Required
	IEA	Interchange Control Trailer	M	1			Required

### Notes:

- 1/020L Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
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- 1/020 Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015 Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/015L Loop 2010 contains information about entities that apply to all claims in loop 2300. For example, these entities may include billing provider, pay-to provider, insurer, primary administrator, contract holder, or claimant.
- 2/250L Loop 2310 contains information about the rendering, referring, or attending provider.
- 2/365L Loop 2400 contains Service Line information.
- 2/500L Loop 2420 contains information about the rendering, referring, or attending provider on a service line level. These segments override the information in the claim - level segments if the entity identifier codes in each NM1 segment are the same.

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

*2. This standard is also recommended for the submission of similar data within a pre-paid managed care context. Referred to as capitated encounters, this data usually does not result in a payment, though it is possible to submit a "mixed" claim that includes both pre-paid and request for payment services. This standard will allow for the submission of data from providers of health care products and services to a Managed Care Organization or other payer. This standard may also be used by payers to share data with plan sponsors, employers, regulatory entities and Community Health Information Networks.*

# ISA Interchange Control Header

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

User Option (Usage): Required

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

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
ISA01	I01	<b>Authorization Information Qualifier</b> <b>Description:</b> Code to identify the type of information in the Authorization Information <i>Use '00' no authorization information</i>	M	ID	2/2	Required
ISA03	I03	<b>Security Information Qualifier</b> <b>Description:</b> Code to identify the type of information in the Security Information <i>Use '00' No password</i>	M	ID	2/2	Required
ISA05	I05	<b>Interchange ID Qualifier</b> <b>Description:</b> Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified <i>'ZZ' Mutually Defined.</i>	M	ID	2/2	Required
ISA06	I06	<b>Interchange Sender ID</b> <b>Description:</b> Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element <i>The sender's identification number as assigned by LIPA when the Electronic Submitter Form is processed.</i>  <i>The sender may not be the organization submitting the file. If a billing service or clearinghouse is used, the number assigned that organization will appear here.</i>	M	AN	15/15	Required
ISA07	I05	<b>Interchange ID Qualifier</b> <b>Description:</b> Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified <i>'ZZ' Mutually defined.</i>	M	ID	2/2	Required
ISA08	I07	<b>Interchange Receiver ID</b> <b>Description:</b> Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them <i>'LIPA' must appear in this field.</i>	M	AN	15/15	Required
ISA14	I13	<b>Acknowledgment Requested</b> <b>Description:</b> Code sent by the sender to request an interchange acknowledgment (TA1) <i>Use '0'. LIPA does not support the TA1 at this time.</i>	M	ID	1/1	Required
ISA16	I15	<b>Component Element Separator</b> <b>Description:</b> Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator <i>LIPA prefers the use of a colon ':' You may choose to use other values but they must be deferent from the Element Separator (usually '*') and the Segment separator (usually '~').</i>	M		1/1	Required

## Notes:

The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element

separator defines the element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange. Spaces in the example are represented by '.' for clarity.

**Example:**

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

**User Note 5:**

The ISA is a fixed length record. All fields must be padded with spaces to the correct length and separated by '\*'.

# GS Functional Group Header

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

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

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GS02	142	<b>Application Sender's Code</b> <b>Description:</b> Code identifying party sending transmission; codes agreed to by trading partners <i>This identifies the organization submitting the claims in the file. This may be the same as the value found in ISA 06 Interchange Sender ID. It should not be the identifier assigned a billing service or clearinghouse, but the actual originator of the claim. This value must also appear in the NM 109 (Submitter Identifier) in loop 1000A.</i>	M	AN	2/15	Required
GS03	124	<b>Application Receiver's Code</b> <b>Description:</b> Code identifying party receiving transmission; codes agreed to by trading partners <i>Use 'LIPA'</i>	M	AN	2/15	Required

## Semantics:

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

## Comments:

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

## Example:

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

## User Note 5:

Only one GS/GE loop per file when submitting to LIPA.

# ST Transaction Set Header

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

**User Option (Usage):** Required

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

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
ST01	143	<b>Transaction Set Identifier Code</b> <b>Description:</b> Code uniquely identifying a Transaction Set <i>The only valid value within this transaction set for ST01 is 837.</i>	M	ID	3/3	Required
ST02	329	<b>Transaction Set Control Number</b> <b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>Alias:</b> <i>Transaction Set Control Number</i> <i>The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Submitters could begin sending transactions using the number 0001 in this element and increment from there. The number must be unique within a specific functional group (GS-GE) and interchange (ISA-IEA), but can repeat in other groups and interchanges.</i>	M	AN	4/9	Required

## Semantics:

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

## Example:

ST\*837\*987654~

# BHT Beginning of Hierarchical Transaction

Pos: 010	Max: 1
Heading - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, and time

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
BHT02	353	<b>Transaction Set Purpose Code</b> <b>Description:</b> Code identifying purpose of transaction set <b>Alias:</b> <i>Transaction Set Purpose Code</i> <b>NSF Reference:</b> AA0-23.0 <i>BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.</i>	M	ID	2/2	Required
BHT06	640	<i>The REISSUE value will seldom be used.</i> <b>Transaction Type Code</b> <b>Description:</b> Code specifying the type of transaction <b>Industry:</b> <i>Claim or Encounter Identifier</i> <b>Alias:</b> <i>Claim or Encounter Indicator</i> <i>Use 'CH' for all transactions</i>	O	ID	2/2	Required

## Semantics:

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

## Notes:

1. The second example denotes the case where the entire transaction set contains ENCOUNTERS.

## Example:

```
BHT*0019*00*0123*19970618*0932*CH~
BHT*0019*00*44445*19970213*0345*RP~
```

**NM1 Submitter Name**

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000A	Elements: 2

**User Option (Usage):** Required

To supply the full name of an individual or organizational entity

**Element Summary:**

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <i>Use '46'</i>	C	ID	1/2	Required
NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> <i>Submitter Identifier</i> <b>Alias:</b> <i>Submitter Primary Identification Number</i> <b>NSF Reference:</b> <i>AA0-02.0, ZA0-02.0</i> <i>Value should be the same as in GS02 Application Sender's Code.</i>	C	AN	2/80	Required

**Syntax:**

1. P0809 - If either NM108,NM109 is present, then all are required
2. C1110 - If NM111 is present, then all of NM110 are required

**Semantics:**

1. NM102 qualifies NM103.

**Comments:**

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

**Notes:**

1. The example in this NM1 and the subsequent N2 demonstrate how a name that is more than 35 characters long could be handled between the NM1 and N2 segments.
2. See Section 2.4, Loop ID-1000, Data Overview, for a detailed description about using Loop ID-1000. Ignore the Set Notes below.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.

**Example:**

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

# NM1 Receiver Name

Pos: 020	Max: 1
Heading - Optional	
Loop: 1000B	Elements: 3

**User Option (Usage):** Required

To supply the full name of an individual or organizational entity

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM103	1035	<b>Name Last or Organization Name</b> <b>Description:</b> Individual last name or organizational name <b>Industry:</b> <i>Receiver Name</i> <i>Use 'LIPA'</i>	O	AN	1/35	Required
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67)	C	ID	1/2	Situational
NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> <i>Receiver Primary Identifier</i> <b>Alias:</b> <i>Receiver Primary Identification Number</i> <b>NSF Reference:</b> <i>AA0-17.0, ZA0-04.0</i> <i>Use value supplied by LIPA.</i>	C	AN	2/80	Situational

## Syntax:

1. P0809 - If either NM108,NM109 is present, then all are required
2. C1110 - If NM111 is present, then all of NM110 are required

## Semantics:

1. NM102 qualifies NM103.

## Comments:

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

## Notes:

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

## Example:

NM1\*40\*2\*UNION MUTUAL OF OREGON\*\*\*\*\*46\*11122333~

# REF Billing Provider Secondary Identification

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

**User Option (Usage):** Situational

To specify identifying information

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
REF01	128	<b>Reference Identification Qualifier</b> <b>Description:</b> Code qualifying the Reference Identification	M	ID	2/3	Required
REF02	127	<b>Reference Identification</b> <b>Description:</b> Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier <b>Industry:</b> <i>Billing Provider Additional Identifier</i> <b>Alias:</b> <i>Billing Provider Secondary Identification Number</i> <b>NSF Reference:</b> <i>CA0-28.0, BA0-02.0, BA1-02.0, YA0-06.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, BA0-08.0, YA0-02.0</i>	C	AN	1/30	Required

## Syntax:

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

## Semantics:

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

## Notes:

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

## Example:

REF\*1G\*98765~

## User Note 5:

LIPA requires at least 1 secondary REF containing the provider's LIPA assigned billing ID #. This requirement will be removed when the NPI is issued to all providers.

If a billing organization does not have the ability to submit with the LIPA Id arrangements can be made on a case by case basis to use the State Medicaid ID or the UPIN.

# HL Subscriber Hierarchical Level

Pos: 001	Max: 1
Detail - Mandatory	
Loop: 2000B	Elements: 1

User Option (Usage): Required

To identify dependencies among and the content of hierarchically related groups of data segments

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
HL04	736	<b>Hierarchical Child Code</b> <b>Description:</b> Code indicating if there are hierarchical child data segments subordinate to the level being described <i>Use '0'. Claims billed to LIPA use the subscriber as the patient. No Patient loop will be present.</i>	O	ID	1/1	Required

## Comments:

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

## Notes:

1. If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.
2. The Subscriber HL contains information about the person who is listed as the subscriber/insured for the destination payer entity (Loop ID-2010BA). The Subscriber HL contains information identifying the subscriber (Loop ID-2010BA), his or her insurance (Loop ID-2010BB), and responsible party (Loop ID-2010BC). In addition, information about the credit/debit card holder is placed in this HL (Loop ID-2010BD). The credit/debit card holder may or may not be the subscriber. See Appendix G, Credit/Debit Card Use, for a description of using Loop ID-2010BD.
3. Because this is a required segment, this is a required loop. See Appendix A for further details on ASC X12 syntax rules.
4. Receiving trading partners may have system limitations regarding the size of the transmission they can receive. The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. While the implementation guide sets no specific limit to the number of Subscriber Hierarchical Level loops, there is an implied maximum of 5000.

## Example:

HL \*2\*1\*22\*1~

# NM1 Subscriber Name

Pos: 015	Max: 1
Detail - Optional	
Loop: 2010BA	Elements: 2

**User Option (Usage):** Required

To supply the full name of an individual or organizational entity

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
NM108	66	<b>Identification Code Qualifier</b> <b>Description:</b> Code designating the system/method of code structure used for Identification Code (67) <i>Required if NM102 = 1 (person)</i> <i>Use 'MI' Member Identification number.</i>	C	ID	1/2	Situational
NM109	67	<b>Identification Code</b> <b>Description:</b> Code identifying a party or other code <b>Industry:</b> <i>Subscriber Primary Identifier</i> <b>NSF Reference:</b> <i>DA0-18.0, CA1-05.0, CA1-06.0</i> <i>Use the patient's Member ID. If this is a Medicaid member the OMAP Prime number should be used (not the SSN). For commercial plans the Member Id from their card should be used.</i>	C	AN	2/80	Situational

## Syntax:

1. P0809 - If either NM108, NM109 is present, then all are required
2. C1110 - If NM111 is present, then all of NM110 are required

## Semantics:

1. NM102 qualifies NM103.

## Comments:

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

## Notes:

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

## Example:

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

# CLM Claim Information

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

User Option (Usage): Required

To specify basic data about the claim

## Element Summary:

Ref	Id	Element Name	Req	Type	Min/Max	Usage
CLM05	C023	<b>Health Care Service Location Information</b> <b>Description:</b> To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered <b>Alias:</b> <i>Place of Service Code</i> <b>NSF Reference:</b> <i>FA0-07.0</i> <i>CLM05 applies to all service lines unless it is over written at the line level.</i>	O	Comp		Required
	1325	<b>Claim Frequency Type Code</b> <b>Description:</b> Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type <b>Industry:</b> <i>Claim Frequency Code</i> <b>Alias:</b> <i>Claim Submission Reason Code</i> <i>LIPA only recognizes the following codes:</i>  <i>'1' - new claim</i> <i>'7' - corrected claim</i> <i>'8' - deleted claim.</i>  <i>The reason for the correction or deletion should be stated in loop 2320 CAS 02.</i>	O	ID	1/1	Required

## Semantics:

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

## Notes:

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

## Example:

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

# REF Prior Authorization or Referral Number

Pos: 180	Max: 2
Detail - Optional	
Loop: 2300	Elements: 0

**User Option (Usage):** Situational

To specify identifying information

## Syntax:

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

## Semantics:

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

## Notes:

1. Numbers at this position apply to the entire claim unless they are overridden in the REF segment in Loop ID-2400. A reference identification is considered to be overridden if the value in REF01 is the same in both the Loop ID-2300 REF segment and the Loop ID-2400 REF segment. In that case, the Loop ID-2400 REF applies only to that specific line.
2. Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed. The UMO (Utilization Management Organization) is generally the entity empowered to make a decision regarding the outcome of a health services review or the owner of information. The referral or prior authorization number carried in this REF is specific to the destination payer reported in the 2010BB loop. If other payers have similar numbers for this claim, report that information in the 2330 loop REF which holds that payer's information.

## Example:

REF\*G1\*13579~

## User Note 5:

The entire 15 digit LIPA Auth number MUST be used.

# REF Original Reference Number (ICN/DCN)

Pos: 180	Max: 1
Detail - Optional	
Loop: 2300	Elements: 0

**User Option (Usage):** Situational

To specify identifying information

## Syntax:

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

## Semantics:

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

## Notes:

1. Required when CLM05-3 (Claim Submission Reason Code) = "7", or "8" and the payer has assigned a payer number to the claim. The resubmission number is assigned to a previously submitted claim/encounter by the destination payer or receiver.
2. This segment can be used for the payer assigned Original Document Control Number/Internal Control Number (DCN/ICN) assigned to this claim by the payer identified in the 2010BB loop of this claim. This number would be received from a payer in a case where the payer had received the original claim and, for whatever reason, had (1) asked the provider to resubmit the claim and (2) had given the provider the payer's claim identification number. In this case the payer is expecting the provider to give them back their (the payer's) claim number so that the payer can match it in their adjudication system. By matching this number in the adjudication system, the payer knows this is not a duplicate claim. This information is specific to the destination payer reported in the 2010BB loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.

## Example:

REF\*F8\*R555588~

## User Note 5:

This is the LIPA assigned 15 digit 'claim number'.

# REF Rendering Provider Secondary Identification

Pos: 271	Max: 5
Detail - Optional	
Loop: 2310B	Elements: 0

**User Option (Usage):** Situational

To specify identifying information

## Syntax:

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

## Semantics:

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

## Notes:

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

## Example:

REF\*1D\*A12345~

## User Note 5:

LIPA requires the submission of one REF segment containing the LIPA provider ID #. This requirement will be removed when the NPIN is implemented.

# SV1 Professional Service

Pos: 370	Max: 1
Detail - Optional	
Loop: 2400	Elements: 0

**User Option (Usage):** Required

To specify the claim service detail for a Health Care professional

## Syntax:

1. P0304 - If either SV103,SV104 is present, then all are required

## Semantics:

1. SV102 is the submitted charge amount.
2. SV105 is the place of service.
3. SV108 is the independent lab charges.
4. SV109 is the emergency-related indicator; a "Y" value indicates service provided was emergency related; an "N" value indicates service provided was not emergency related.
5. SV111 is early and periodic screen for diagnosis and treatment of children (EPSDT) involvement; a "Y" value indicates EPSDT involvement; an "N" value indicates no EPSDT involvement.
6. SV112 is the family planning involvement indicator. A "Y" value indicates family planning services involvement; an "N" value indicates no family planning services involvement.
7. SV117 is the health care manpower shortage area (HMSA) facility identification.
8. SV118 is the health care manpower shortage area (HMSA) zip code.
9. SV119 is a noncovered charge amount.

## Comments:

1. If SV113 is equal to "L" or "N", then SV114 is required.

## Example:

SV1\*HC:99211:25\*12.25\*UN\*1\*11\*\*1:2:3\*\*N~

## User Note 5:

*LIPA can only accept one Procedure Code and the first 2 modifiers. Additional information will not be used for claims payment.*

# REF Rendering Provider Secondary Identification

Pos: 525	Max: 5
Detail - Optional	
Loop: 2420A	Elements: 0

**User Option (Usage):** Situational

To specify identifying information

## Syntax:

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

## Semantics:

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

## Notes:

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

## Example:

REF\*1D\*A12345~

## User Note 5:

LIPA requires the submission of one REF segment containing the LIPA provider ID #. This requirement will be removed when the NPIN is implemented.

# SE Transaction Set Trailer

Pos: 555	Max: 1
Detail - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
SE01	96	<b>Number of Included Segments</b> <b>Description:</b> Total number of segments included in a transaction set including ST and SE segments <b>Industry:</b> <i>Transaction Segment Count</i> <b>Alias:</b> <i>Segment Count</i>	M	N0	1/10	Required
SE02	329	<b>Transaction Set Control Number</b> <b>Description:</b> Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set <b>Alias:</b> <i>Transaction Set Control Number</i> <i>The Transaction Set Control Numbers in ST02 and SE02 must be identical. The Transaction Set Control Number is assigned by the originator and must be unique within a functional group (GS-GE) and interchange (ISA-IEA). This unique number also aids in error resolution research.</i>	M	AN	4/9	Required

## Comments:

- SE is the last segment of each transaction set.

## Example:

SE\*211\*987654~

# GE Functional Group Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

To indicate the end of a functional group and to provide control information

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
GE01	97	<b>Number of Transaction Sets Included</b> <b>Description:</b> Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element	M	N0	1/6	Required
GE02	28	<b>Group Control Number</b> <b>Description:</b> Assigned number originated and maintained by the sender	M	N0	1/9	Required

## Semantics:

1. The data interchange control number GE02 in this trailer must be identical to the same data element in the associated functional group header, GS06.

## Comments:

1. The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

# IEA Interchange Control Trailer

Pos:	Max: 1
Not Defined - Mandatory	
Loop: N/A	Elements: 2

**User Option (Usage):** Required

To define the end of an interchange of zero or more functional groups and interchange-related control segments

## Element Summary:

<u>Ref</u>	<u>Id</u>	<u>Element Name</u>	<u>Req</u>	<u>Type</u>	<u>Min/Max</u>	<u>Usage</u>
IEA01	I16	<b>Number of Included Functional Groups</b> <b>Description:</b> A count of the number of functional groups included in an interchange	M	N0	1/5	Required
IEA02	I12	<b>Interchange Control Number</b> <b>Description:</b> A control number assigned by the interchange sender	M	N0	9/9	Required

## Example:

IEA\*1\*000000905~

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