



HIPAA Transaction Standard Companion Guide

ASC X12N VERSION 005010X223A2 HEALTH CARE CLAIM:
INSTITUTIONAL

Guide Version 1.0

August 14, 2020

Preface

This Companion Document to the ASC X12N Implementation Guides adopted under HIPAA clarifies and specifies the data content when exchanging electronically with MagnaCare. Transmissions based on this companion document, used in tandem with the X12N Implementation Guides, are intended to be compliant with both X12 syntax and those guides. This Companion Guide is intended to convey information that is within the framework of the ASC X12N Implementation Guides adopted for use under HIPAA. The Companion Guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the Implementation Guides.

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1 Introduction

1.1 Scope

This Companion Guide is intended to support the implementation of a batch processing application. MagnaCare will accept inbound submissions that are formatted correctly in X12 terms. The files must comply with the specifications outlined in this companion document as well as the corresponding HIPAA implementation guide. MagnaCare Electronic Data Interchange (EDI) applications will edit for these conditions and reject files that are out of compliance. This companion document will specify everything that is necessary to conduct EDI for this standard transaction.

This includes:

- Communications link specifications
- Submission methods specifications
- Transaction specifications

1.2 Overview

This document is intended to compliment the ASC X12N implementation guide currently adopted from HIPAA. It is compliant with the corresponding HIPAA implementation guides in terms of data element and code standards and requirements. It will be the vehicle that MagnaCare uses with its Clients/ Partners to further qualify the HIPAA-adopted implementation guides.

Data elements that require mutual agreement and understanding will be specified in this companion guide. Types of information that will be clarified within this companion are:

- Qualifiers that will be used from the HIPAA implementation guides to describe certain data elements
- Situational segments and data elements that will be utilized to satisfy business conditions
- Profile information for purpose of establishing who we are trading with for the transmissions exchanged

1.3 References

ASC X12N Implementation Guides

Health Care Claim: Institutional

- 837 (005010X223A2)

Additional Information

Electronic Data Interchange (EDI) is the computer-to-computer exchange of formatted business data between MagnaCare & its Clients and Partners, without human intervention. MagnaCare maintains a dedicated team for the purpose of enabling and processing X12 EDI transmissions with its Clients and partners, and EDI team will engage with the technical resources from clients/ partners before you begin

2 Before you begin

2.1 Important information

Clients/ Partners will be working with two units within MagnaCare to implement EDI transactions:

- MagnaCare Implementation team will serve as the Client's central point of contact. This group will also facilitate the implementation of Clients/ Partners through all steps of external testing. This group will coordinate closely with MagnaCare EDI team who will be responsible for setup of accepting and translating data-file integration.
- MagnaCare EDI team will also implement the communication link and facilitates the notifications for acceptance or rejection of Client's EDI 837 data-file. This group maintains the EDI translator maps. They will also handle all issues relating to files that were accepted from our translator and moved forward for processing, in downstream systems and applications.

2.2 Registration

To register as a Client/ Partner with MagnaCare, you will need to do the following:

1. Initial conversations are held between the Client/Partner & MagnaCare Implementation team.
2. *Agreements are reached as to the transactions that will be conducted.*
3. *A companion guide is provided and reviewed.*
4. *Submitter Id and Receiver Id is established for the purpose of identification.*
5. *Required Client/Partner profiling is built into our EDI translator.*
6. *Test files are exchanged and test runs conducted.*
7. *MagnaCare's security Questionnaire is filled out and approved by security team*
8. *Once the testing phase is completed, the Client/Partner is registered and a client code is issued that would be used in the 837 file.*

2.3 Testing Overview

MagnaCare recommends their Clients/Partners to perform EDI files validations using a commercial third party tool and test at their end prior to sharing the files with MagnaCare. The complexity of X12 files when not tested and certified by a third party tool may cause delays in the ability to enable the X12 submissions in a production environment.

MagnaCare EDI team would spend the majority of the testing period time, working with Client/ Partner on the agreed components of this companion guide, and would not support explaining the X12 or HIPAA implementation guide details

3 Testing Procedures

MagnaCare will establish a set of scenarios intended for testing with the Client/Partner. The scenarios would be a representation of the majority of conditions that will be encountered with production data from these transactions.

3.1 Phases of Testing

3.1.1 Syntactic Testing

MagnaCare uses an industry standard data validator to validate EDI transactions and to translate them for internal processing. In addition to the structural and syntactic integrity of 837 file, the 999 acknowledgement will also be tested during this phase. Any issues identified during this phase of testing need to be addressed in order for subsequent phase to continue.

3.1.2 Compliance Testing

Client/ Partner specific setup, as defined in the companion guide will be verified. Generally, this will be done in conjunction with Syntactic testing.

3.1.3 Scenario Testing

This will normally involve all possible business scenarios to be tested.

3.1.4 Volume Testing

This will involve testing large Claim files. We would like to receive claim files with 200 claims each and corresponding eligibility files.

3.2 Testing Process

The following summarizes the testing process:

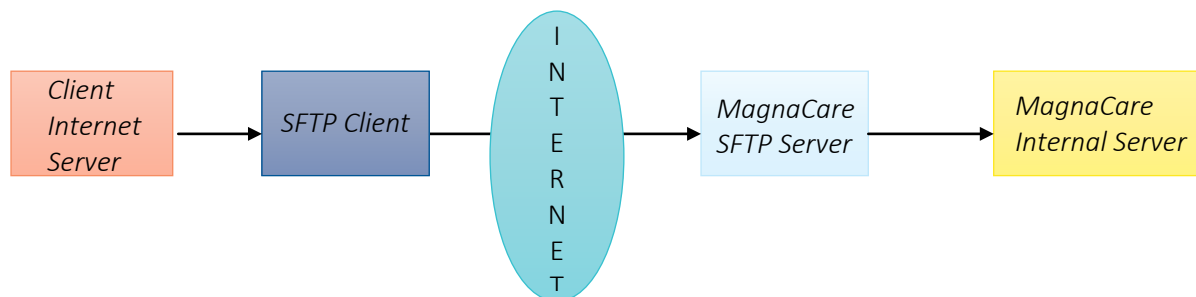
1. Client/ Partner will work with MagnaCare implementation team and post, one or more test files of the X12N formatted sample data, and samples of all relevant business scenarios.
2. Once the files are validated, if any issues are encountered, then Error messages or diagnostics messages will be relayed back to the Client/ Partner.
3. This process will proceed by iteration until requirements are satisfied.
4. Once the scenario based testing is completed, the communication protocols are also tested and verified.
5. As all requirements succeed during testing phase, the results will be documented and the Client/ Partner and MagnaCare implementation team will sign off on testing and move the transaction into production.

4 Transfer of Information

4.1 Data Transfer

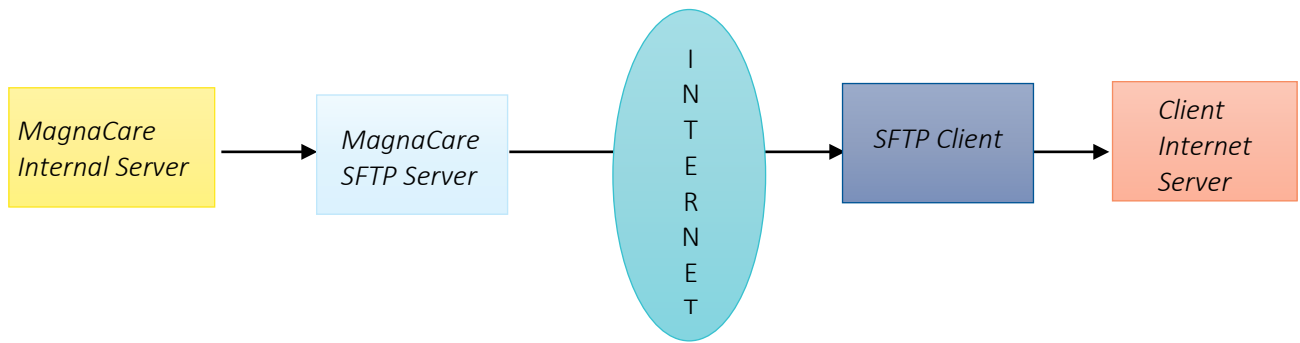
Data can be exchanged with MagnaCare via SFTP over the Internet where the file is encrypted, sent over the Internet and then decrypted. For data inbound to MagnaCare (see Figure 1A), the Client/Partner would encrypt the data on an internal server, transfer it using SFTP Client to MagnaCare's SFTP server. MagnaCare EDI team will then move the encrypted file from SFTP server to an internal server where the file is decrypted and forwarded for processing.

Figure 1A: Encrypted Data sent over the Internet from Client/Partner to MagnaCare SFTP Server



MagnaCare data sent to Client/Partner (see Figure 1B). MagnaCare will generate the X12 data file and encrypt it. Once encrypted, the file will be sent to MagnaCare's SFTP server. At that time, the Client/Partner can retrieve the file, transfer it to their internal system using SFTP client, decrypt it and process it.

Figure 1B: Encrypted Data sent over the Internet from MagnaCare SFTP Server to Client



4.2 Administrative Transmission Procedures

As part of the process establishing the relationship, MagnaCare and the Client/Partner must exchange certain technical information. The requested information will include:

1. Contacts: business, data and communications
2. Dates: testing, production
3. File information; size, naming
4. Transfer; schedule, protocol
5. Server information; host name, user ID, password, file location, file name
6. Notification; failure, success

4.2.1 Re-transmission procedures

When a file needs to be re-transmitted, the Client/Partner will contact their primary Account Management contact at MagnaCare.

4.3 Specification of Communication Protocol

The following items are required from the Client/Partner in order to exchange data with MagnaCare utilizing SFTP server over the Internet.

1. Internet Connectivity; Client/Partner should consider a broadband connection for large files.
2. Computer with SFTP client and connectivity to the Internet.
3. PGP software for encryption/decryption. RSA (or Legacy) keys must be generated and exchanged with MagnaCare via e-mail (public keys only).

4. E-mail capability to exchange configuration and testing information
Initial setup will include confirming SFTP connectivity, exchanging PGP public keys and performing end-to-end communications testing. Before sending data to MagnaCare, the data must be encrypted with PGP and then sent to the MagnaCare SFTP using the SFTP client over the Internet connection. When receiving data from MagnaCare, the SFTP client will be used to get the data from the MagnaCare SFTP server after which PGP will be used to decrypt the data.
 - MagnaCare provides the following connectivity options to establish interface with its servers.
 - SFTP (Secure File Transfer Protocol) with PGP encryption
 - VPN connectivity (for specific clients/ partners with large file volumes)

4.4 Passwords

MagnaCare requires the use of User IDs and Passwords to access its systems and servers and will assign each Client a unique User ID and password when using MagnaCare server. In the event a Client forgets their password, MagnaCare will change the password after verifying the authenticity of the request.

4.5 Encryption

MagnaCare requires the encryption of data that is exchanged via the Internet or any other public network. MagnaCare utilizes Gnu PGP encryption with 2048 bit keys for file encryption.

4.6 SFTP Server

MagnaCare SFTP server can be reached using the DNS name itbbs.magnacare.com . MagnaCare highly recommend using the DNS name rather than the IP address of the server, as we have more than one SFTP server available to meet our Disaster Recovery needs.

5 Additional Requests

If requested, 999 Acknowledgement will be sent so the Client will get confirmation that we received their submission.

6 Transaction Specifications

6.1 Control Segments

6.1.1 ISA - INTERCHANGE CONTROL HEADER

Element	Element Definition	Values	Description
ISA01	AUTHORIZATION INFORMATION QUALIFIER	00	No Authorization Information Present
ISA02	AUTHORIZATION INFORMATION		[space fill]
ISA03	SECURITY INFORMATION QUALIFIER	00	No Security Information Present
ISA04	SECURITY INFORMATION		[space fill]
ISA05	INTERCHANGE ID QUALIFIER	ZZ 30	Mutually Defined U.S. Federal Tax Identification Number
ISA06	INTERCHANGE SENDER ID	Inbound: Mutually Defined or TIN Outbound: 11-3038233	
ISA07	INTERCHANGE ID QUALIFIER	ZZ 30	Mutually Defined U.S. Federal Tax Identification Number
ISA08	INTERCHANGE RECEIVER ID	Inbound: 11-3038233 Outbound: Mutually Defined or TIN	Inbound: "11-3038233" Outbound: Mutually Defined or TIN.
ISA09	INTERCHANGE DATE	YYMMDD	Date of interchange
ISA10	INTERCHANGE TIME	HHMM	Time of interchange
ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	^	Repetition separator
ISA12	INTERCHANGE CONTROL VERSION NUMBER	00501	Draft Standards approved by ASCX12
ISA13	INTERCHANGE CONTROL NUMBER	Assigned by sender	Must be identical to the interchange trailer IEA02
ISA14	ACKNOWLEDGMENT REQUEST	0	No Acknowledgment Requested
ISA15	USAGE INDICATOR	P or T	P = Production, T = Test
ISA16	COMPONENT ELEMENT SEPARATOR	“:”	“:”

6.1.2 IEA - INTERCHANGE

Element	Element Definition	Values	Description
IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		Number of included Functional Groups
IEA02	INTERCHANGE CONTROL NUMBER	Assigned by Sender	Must be identical to the value in ISA13

6.1.3 GS – FUNCTIONAL GROUP HEADER

Element	Element Definition	Values	Description
GS01	FUNCTIONAL IDENTIFIER CODE	HC	Health Care Claim (837)
GS02	APPLICATION SENDER'S CODE	Inbound: Mutually Defined or TIN Outbound: MagnaCare TIN	Sender's code / Tax Identification Number
GS03	APPLICATION RECEIVER'S CODE	Inbound: MagnaCare TIN Outbound: Mutually Defined or TIN	Receiver's code / Tax Identification Number
GS04	DATE	CCYYMMDD	Group creation date
GS05	TIME	HHMM	Creation time
GS06	GROUP CONTROL NUMBER		Assigned and maintained by the sender
GS07	RESPONSIBLE AGENCY CODE	X	Accredited Standards Committee X12
GS08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	005010X223A2	Version/Release/Industry Identifier Code

6.1.4 GE – FUNCTIONAL GROUP TRAILER

Element	Element Definition	Values	Description
GE01	NUMBER OF TRANSACTION SETS INCLUDED		Number of Transaction Sets Included
GE02	GROUP CONTROL NUMBER	Assigned by Sender	Must be identical to the value in GS06

6.1.5 ST – TRANSACTION SET HEADER

Element	Element Definition	Values	Description
ST01	TRANSACTION SET IDENTIFIER CODE	837	Health Care Claim
ST02	TRANSACTION SET CONTROL NUMBER		The transaction set control numbers in ST02 and SE02 must be Identical. This number must be unique within a specific group and interchange
ST03	IMPLEMENTATION CONVENTION REFERENCE	005010X223A2	Implementation Guide Version Name

NOTE: MagnaCare can accept multiple ST-SE segments.

6.1.6 SE – TRANSACTION SET TRAILER

Element	Element Definition	Values	Description
SE01	TRANSACTION SET IDENTIFIER CODE		Total number of segments included in a transaction set including ST and SE segments.
SE02	TRANSACTION SET CONTROL NUMBER	Assigned by Sender	The transaction set control numbers in ST02 and SE02 must be Identical. This number must be unique within a specific group and interchange.

6.1.7 VALID DELIMITERS FOR MAGNACARE EDI

Definition	ASCII	Decimal	Hexadecimal
SEGMENT SEPARATOR	\n (New Line)	13	
ELEMENT SEPARATOR	*	42	2A
COMPOUND ELEMENT SEPARATOR	:	58	3A

6.2 837 Institutional File Layout

This table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides.

Attribute	Element	Element Definition	Values	Description
R	BHT	BEGINNING OF HIERARCHICAL TRANSACTION		
R	01	HIERARCHICAL STRUCTURE CODE	0019	Information Source, Subscriber, Dependent
R	02	TRANSACTION SET PURPOSE CODE	00	00-Original
R	03	REFERENCE IDENTIFICATION		Batch control number and may not be identical to ST02.
R	04	DATE		Transaction set create date in CCYYMMDD format
R	05	TIME		Transaction set create time in HHMM format
R	06	TRANSACTION SET TYPE CODE	CH	Chargeable-fee for service
LOOP 1000A				
R	NM1	SUBMITTER NAME-1000A		
R	01	ENTITY IDENTIFIER CODE	41	Submitter
R	02	ENTITY TYPE QUALIFIER	1, 2	1-Person, 2-Non-person entity
R	03	ORGANIZATION NAME/LAST NAME		Submitter Last Name
S	04	FIRST NAME		Submitter First Name
S	05	MIDDLE NAME		Submitter Middle Name
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	09	IDENTIFICATION CODE		Submitter tax ID
R	PER	SUBMITTER EDI CONTACT INFORMATION1000A		
R	01	CONTACT FUNCTION CODE	IC	Information Contact
R	02	NAME		Submitter Contact Name

Attribute	Element	Element Definition	Values	Description
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Area code number + phone number
S	05	COMMUNICATION QUALIFIER	FX	Fax
S	06	COMMUNICATION NUMBER		Area code number + phone number
S	07	COMMUNICATION QUALIFIER	EM	Email
S	08	COMMUNICATION NUMBER		Email address
LOOP 1000B				
R	NM1	RECEIVER NAME-1000B		
R	01	ENTITY IDENTIFIER CODE	40	Receiver
R	02	ENTITY TYPE QUALIFIER	2	2-Non-person Entity
R	03	ORGANIZATION NAME		Receiver Name
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter ID number
R	09	IDENTIFICATION CODE		Receiver Primary Identifier
LOOP 2000A				
R	HL	BILLING PROVIDER HIERARCHICAL LEVEL		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender, must begin at "1"
R	03	HIERARCHICAL LEVEL CODE	20	Information Source
R	04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segment
S	PRV	BILLING PROVIDER SPECIALTY INFO 2000A		**IDENTIFIES BILLING PROVIDER SPECIALTY
R	01	PROVIDER CODE	BI	BI –Billing
R	02	REFERENCE IDENTIFICATION QUALIFIER	PXC	Health Care Provider Taxonomy Code Qualifier
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code -Required if the provider has more than one specialty.
LOOP 2010AA				

Attribute	Element	Element Definition	Values	Description
R	NM1	BILLING PROVIDER NAME 2010AA		
R	01	ENTITY IDENTIFIER CODE	85	Billing provider
R	2	ENTITY TYPE QUALIFIER	2	2-Non-person entity
R	03	NAME LAST		Billing Provider Organizational Name
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
R	N3	BILLING PROVIDER ADDRESS 2010AA		
R	01	STREET		Billing Provider Street (Physical address)
S	02	STREET 2		Billing Provider Street 2
R	N4	BILLING PROVIDER CITY/STATE/ZIP CODE 2010AA		
R	01	CITY		Billing Provider City
R	02	STATE		Billing Provider State
R	03	POSTAL CODE		Billing Provider Zip code
R	REF	BILLING PROVIDER TAX IDENTIFICATION 2010AA		
R	01	REFERENCE IDENTIFICATION QUALIFIER	EI	Employer's Identification Number
R	02	REFERENCE IDENTIFICATION		Billing Provider Tax Identification Number
S	PER	BILLING PROVIDER CONTACT INFORMATION		
R	01	CONTACT FUNCTION CODE	IC	Information contact
I	02	NAME		Billing provider contact name
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Physician phone number
LOOP 2010AB				

Attribute	Element	Element Definition	Values	Description
S	NM1	PAY TO ADDRESS NAME 2010AB		
R	01	ENTITY IDENTIFIER CODE	87	Pay to provider
R	2	ENTITY TYPE QUALIFIER	2	non-person entity
R	N3	PAY-TO ADDRESS 2010AB		
R	01	ADDRESS INFORMATION		Pay to provider address
S	02	ADDRESS INFORMATION		Pay to provider address 2
R	N4	PAY TO ADDRESS CITY/STATE/ZIP CODE 2010AB		
R	01	CITY NAME		Pay to provider city
R	02	STATE		Pay to provider state
R	03	ZIP CODE		Pay to provider zip code
LOOP 2000B				
R	HL	SUBSCRIBER HIERARCHICAL LEVEL 2000B		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
R	02	HIERARCHICAL PARENT ID NUMBER		ID number of the next higher hierarchical segment
R	03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	04	HIERARCHICAL CHILD CODE	0 or 1	No subordinates or has subordinates
R	SBR	SUBSCRIBER INFORMATION 2000B		
R	01	PAYER RESPONSIBILITY SEQUENCE CODE NUMBER	P, S	Primary Payer, Secondary Payer. If claim is for primary payer then "P" else if claim is for secondary payer then "S".
S	02	INDIVIDUAL RELATIONSHIP CODE	18	18-Self (required when subscriber is patient)
S	03	REFERENCE IDENTIFICATION		Subscriber Group or Policy number
S	04	NAME		Group name
S	09	CLAIM FILING INDICATOR	HM, ZZ	HM- Health Maintenance Organization ZZ - Mutually Defined

Attribute	Element	Element Definition	Values	Description
LOOP 2010BA				
R	NM1	SUBSCRIBER NAME 2010BA		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1, 2	1= Person , 2 = non Person
R	03	NAME LAST		Subscriber last name
S	04	NAME FIRST		Subscriber first name
S	05	NAME MIDDLE		Subscriber middle name
S	07	NAME SUFFIX		Subscriber suffix
R	08	IDENTIFICATION CODE QUALIFIER	MI	Member Identification number
R	09	IDENTIFICATION CODE		MagnaCare Subscriber member number (Alternate ID/SSN)
S	N3	SUBSCRIBER ADDRESS 2010BA		
R	01	ADDRESS INFORMATION		Subscriber address
S	02	ADDRESS INFORMATION		Subscriber address 2
S	N4	SUBSCRIBER CITY/STATE/ZIP CODE 2010BA		
R	01	CITY NAME		Subscriber City
R	02	STATE		Subscriber State
R	03	POSTAL CODE		Subscriber Zip code
S	DMG	SUBSCRIBER DEMOGRAPHIC INFORMATION 2010BA		
R	01	DATE FORMAT QUALIFIER	D8	CCYYMMDD
R	02	DATE TIME PERIOD		Subscriber date of birth
R	03	GENDER CODE	F, M, U	Female, male, unknown
S	REF	SUBSCRIBER SECONDARY INFORMATION 2010BA		

Attribute	Element	Element Definition	Values	Description
R	01	REFERENCE IDENTIFICARION QUALIFIER	SY	Social Security Number
R	02	REFERENCE IDENTIFICATION		Subscriber SSN
LOOP 2010BB				
R	NM1	PAYER NAME		
R	01	ENTITY IDENTIFIER CODE	PR	Payer
R	02	ENTITY TYPE DESCRIPTION	2	Non-Person Entity
R	03	NAME LAST OR ORGANIZATION		Payer Name
R	08	IDENTIFICATION CODE QUALIFER	XV, PI	Payer Identification PI Prior to mandated Plan ID
R	09	IDENTIFICATION CODE NUMBER		Payer Identifier
S	N3	PAYER ADDRESS 2010BB		
R	01	ADDRESS INFORMATION		PAYER ADDRESS LINE
S	02	ADDRESS INFORMATION		PAYER ADDRESS LINE
R	N4	PAYER CITY/STATE/ZIP CODE 2010BB		
R	01	CITY NAME		PAYER CITY NAME
S	02	STATE OR PROVINCE CODE		PAYER STATE OR PROVINCE CODE
S	03	POSTAL CODE		PAYER POSTAL ZONE OR ZIP CODE
S	04	COUNTRY CODE		
LOOP 2000C				
R	HL	PATIENT HIERARCHICAL LEVEL 2000C		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
R	02	HIERARCHICAL PARENT ID NUMBER		ID number of the next higher hierarchical segment
R	03	HIERARCHICAL LEVEL CODE	23	Dependent
R	04	HIERARCHICAL CHILD CODE	0	No subordinates or has subordinates

Attribute	Element	Element Definition	Values	Description
R	PAT	PATIENT INFORMATION		
R	R	INDIVIDUAL RELATIONSHIP CODE	01, 19, 20, 21 39, 40, 53, G8	Specifies patient relationship to the person insured
LOOP 2010CA				
R	NM1	PATIENT NAME 2010CA		
R	01	ENTITY IDENTIFIER CODE	QC	Patient
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Patient last name
S	04	NAME FIRST		Patient first name
S	05	NAME MIDDLE		Patient middle name
S	07	NAME SUFFIX		Patient suffix
S	N3	PATIENT ADDRESS 2010BA		
R	01	ADDRESS INFORMATION		Patient address
S	02	ADDRESS INFORMATION		Patient address 2
S	N4	PATIENT CITY/STATE/ZIPCODE 2010CA		
R	01	CITY NAME		Patient City
R	02	STATE		Patient State
R	03	POSTAL CODE		Patient Zip code
S	DMG	PATIENT DEMOGRAPHIC INFORMATION 2010CA		
R	01	DATE FORMAT QUALIFIER	D8	CCYYMMDD
R	02	DATE TIME PERIOD		Patient date of birth
R	03	GENDER CODE	F, M, U	Female, male, unknown
LOOP 2300				
R	CLM	CLAIM INFORMATION 2300		
R	01	CLAIM SUBMITTER'S IDENTIFIER		Patient account number

Attribute	Element	Element Definition	Values	Description
R	02	MONETARY AMOUNT		Total charges (must equal sum of the SV202's)
R	05	HEALTH CARE SERVICE LOCATION		Place of service
R	05-1	FACILITY CODE VALUE		Facility Type code
R	05-2	FACILITY CODE QUALIFIER	A	Uniform Billing Claim Form Bill Type
R	05-3	CLAIM FREQUENCY TYPE CODE		Claim frequency code
R	07	PROVIDER ACCEPT ASSIGN	A, B, C	Assignment or Plan Participation Code
R	08	RESPONSE CODE	Y, N, W	Assign of benefits by Insurer indicator. W- NOT APPLICABLE
R	09	RELEASE OF INFORMATION	I, Y	Release of information
S	20	DELAY REASON CODE		Delay reason code
S	DTP	DISCHARGE HOUR 2300		Required on all inpatient claims
R	01	DATE/TIME QUALIFIER	096	
R	02	DATE/TIME PERIOD FORMAT QUALIFIER	TM	Time
R	03	DATE/TIME PERIOD	HHMM	
S	DTP	STATEMENT DATES 2300		
R	01	DATE/TIME QUALIFIER	434	
R	02	DATE/TIME PERIOD FORMAT QUALIFIER	RD8	
R	03	DATE TIME PERIOD	CCYYMMDD- CCYYMMDD	Statement From and To Date
S	DTP	ADMISSION DATE/HOUR 2300		
R	01	DATE/TIME QUALIFIER	435	
R	02	DATE TIME PERIOD FORMAT QUALIFIER	D8, DT	D8 - Date Expressed in Format CCYYMMDD DT - Date and Time Expressed in Format CCYYMMDDHHMM

Attribute	Element	Element Definition	Values	Description
R	03	DATE TIME PERIOD		CCYYMMDD, CCYYMMDDHHMM
R	CL1	INSTITUTIONAL CLAIM CODE 2300		
R	01	ADMISSION TYPE CODE		Priority of admission or visit
S	02	ADMISSION SOURCE CODE		Point of origin for admission or visit
R	03	PATIENT STATUS CODE		Patient status code
S	PWK	CLAIM SUPPLEMENTAL INFORMATION 2300		
	01	REPORT TYPE CODE		Report type code listed in TR3
R	02	REPORT TRANSMISSION CODE		Code defining timing, transmission method or format
S	05	IDENTIFICATION CODE QUALIFIER	AC	Required when PWK02=BM, EL, EM, FX, OR FT
S	06	IDENTIFICATION CODE		
S	REF	REFERRAL OR PRIOR AUTHORIZATION NUMBER 2300		
R	01	REFERENCE IDENTIFICATION QUALIFIER	9F, G1	9F – Referral G1 = Prior Authorization Number
R	02	REFERENCE IDENTIFICATION		Referral or Prior Authorization Number
S	REF	PAYER CLAIM CONTROL NUMBER 2300		(Required when CLM05-03 indicates replacement or void
R	01	REFERENCE IDENTIFICATION QUALIFIER	F8	to a previously adjudicated claim)
R	02	REFERENCE IDENTIFICATION		Original claim number
S	REF	REPRICED CLAIM NUMBER CLAIM IDENTIFER FOR TRANSMISSION INTERMDIARIES		
R	01	REFERENCE IDENTIFICATION QUALIFIER	9A/D9	D9 – Client claim number 9A – Repricer Claim number
R	02	REFERENCE IDENTIFICATION		
S	REF	AUTO ACCIDENT STATE 2300		Required if services reported on this claim are related to an auto accident.

Attribute	Element	Element Definition	Values	Description
R	01	REFERENCE IDENTIFICATION QUALIFIER	LU	Reference Identification Qualifier
R	02	Reference Identification		Auto Accident State or Province Code
S	REF	MEDICAL RECORD NUMBER 2300		ACTUAL MEDICAL RECORD OF THE PATIENT
R	01	REFERENCE IDENTIFICATION QUALIFIER	EA	Medical record qualifier
R	02	MEDICAL RECORD NUMBER		Medical record number
S	K3	FILE NOTE		
S	01	FIXED FORMAT INFORMATION		Free Format Data – Additional Information
S	NTE	BILLING NOTE 2300		
R	01	REFERENCE CODE	ADD	Note reference code
R	02	MESSAGE		Free form data-Additional information
R	HI	PRINCIPAL DIAGNOSIS CODE 2300		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	ABK BK	Principal diagnosis ICD-10 codes Principal diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
S	01-09	YES/NO CONDITION OR RESPONSE CODE	N, U, W, Y	Present on Admission indicator
S	HI	ADMITTING DIAGNOSIS		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	ABJ BJ	Admitting diagnosis ICD-10 codes Admitting diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
S	HI	PATIENT'S REASON FOR VISIT		Required when claim involves outpatient visits
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	APR PR	diagnosis ICD-10 codes diagnosis ICD-9 codes

Attribute	Element	Element Definition	Values	Description
R	01-2	INDUSTRY CODE		Diagnosis code
R	02-1	CODE LIST QUALIFIER	APR PR	diagnosis ICD-10 codes diagnosis ICD-9 codes
R	02-2	INDUSTRY CODE		Diagnosis code
R	03-1	CODE LIST QUALIFIER	APR PR	diagnosis ICD-10 codes diagnosis ICD-9 codes
R	03-2	INDUSTRY CODE		Diagnosis code
S	HI	EXTERNAL CAUSE OF INJURY		Required when external cause of injury is needed to describe an injury, poisoning or adverse effect
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	ABN BN	diagnosis ICD-10 codes diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
S	HI	DIAGNOSIS RELATED GROUP (DRG) INFO.		Required when an inpatient hospital is under DRG contract with a payer and contract requires provider to identify the DRG to the payer.
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	DR	
R	01-2	INDUSTRY CODE		DRG code
S	HI	OTHER DIAGNOSIS CODE		Required when other condition(s) coexist or develop(s) subsequently during the patient's treatment.
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	ABF BF	diagnosis ICD-10 codes

Attribute	Element	Element Definition	Values	Description
				diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
		TO BE REPEATED 12 TIMES		
S	HI	PRINCIPAL PROCEDURE INFO.		Required on inpatient claims when a procedure was performed.
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BBR BR, CAH	diagnosis ICD-10 codes diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
R	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
R	01-4	DATE TIME PERIOD	CCYYM MDD	Principal procedure code date
S	HI	OTHER PROCEDURE INFO.		Required on inpatient claims when a procedure must be reported.
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BBQ BQ	diagnosis ICD-10 codes diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
R	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
R	01-4	DATE TIME PERIOD	CCYYMMDD	Principal procedure code date
		TO BE REPEATED 12 TIMES		
S	HI	OCCURRENCE SPAN INFO.		Required when there is occurrence span code that applies to this claim
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BI	Occurrence span
R	01-2	INDUSTRY CODE		Diagnosis code

Attribute	Element	Element Definition	Values	Description
R	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
R	01-4	DATE TIME PERIOD TO BE REPEATED 12 TIMES	CCYYMMDD	Principal procedure code date
S	HI	OCCURRENCE INFO.		Required when there is occurrence code that applies to this claim
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BH	Occurrence Code
R	01-2	INDUSTRY CODE		Diagnosis code
R	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
R	01-4	DATE TIME PERIOD	CCYYMMDD	Principal procedure code date
		TO BE REPEATED 12 TIMES		
S	HI	VALUE INFO.		Required when there is value code that applies to this claim
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BE	Value Code
R	01-2	INDUSTRY CODE		Diagnosis code
		TO BE REPEATED 12 TIMES		
S	HI	CONDITION INFO.		Required when there is condition code that applies to this claim
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BG	Condition Code
R	01-2	INDUSTRY CODE		Diagnosis code
		TO BE REPEATED 12 TIMES		
S	HI	TREATMENT CODE INFORMATION		Required when Home Health Agencies need to report Plan of Treatment information under various payer contracts
R	01	HEALTH CARE CODE INFORMATION		

Attribute	Element	Element Definition	Values	Description
R	01-1	CODE LIST QUALIFIER	TC	Value Code
R	01-2	INDUSTRY CODE		Diagnosis code
		TO BE REPEATED 12 TIMES		
S	HCP	CLAIM PRICING/REPRICING INFORMATION 2300		
R	01	PRICING METHODOLOGY		Specific code use is determined by Trading Partner Agreement due to the variances in contracting policies in the industry.
R	02	MONETARY AMOUNT		Repriced Allowed Amount
R	03	MONETARY AMOUNT		Repriced Savings Amount
S	04	Reference Identification		Repricing Organization Identifier (Remark Codes)
LOOP 2310A				
S	NM1	ATTENDING PROVIDER NAME 2310A		Required when claim contains any service other than nonscheduled transportation claims.
R	01	ENTITY IDENTIFIER CODE	71	Attending Physician
R	02	ENTITY TYPE	1	1 Person
R	03	LAST NAME		Attending physician last name
S	04	FIRST NAME		Attending physician first name
S	05	NAME MIDDLE		Attending physician middle initial
S	07	NAME SUFFIX		Attending physician suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
S	PRV	ATTENDING PROVIDER SPECIALTY INFO		

Attribute	Element	Element Definition	Values	Description
R	01	PROVIDER CODE	AT	Provider Code
R	02	REFERENCE IDENTIFICATION QUALIFIER	PXC	Health care Provider Taxonomy Code
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code
LOOP 2310B				
S	NM1	OPERATING PROVIDER NAME 2310B		Required when surgical procedure is listed on the claim
R	01	ENTITY IDENTIFIER CODE	72	Operating Physician
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
LOOP 2310C				
S	NM1	OTHER OPERATING PHYSICIAN NAME 2310C (New in 5010)		Other provider name identifier "73" has been replaced by this loop
R	01	ENTITY IDENTIFIER CODE	ZZ	Mutually defined
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial

Attribute	Element	Element Definition	Values	Description
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
LOOP 2310D				
S	NM1	RENDERING PROVIDER NAME 2310D		Required when rendering provider is different than the attending provider reported in loop 2310A
R	01	ENTITY IDENTIFIER CODE	82	Mutually defined
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
LOOP 2310E				
S	NM1	SERVICE FACILITY LOCATION NAME 2310E		Required when the location of health care service is different than that carried in loop-2010AA (billing provider)
R	01	ENTITY IDENTIFIER CODE	77	Service Location
R	02	ENTITY TYPE QUALIFIER	2	Non-person entity
S	03	NAME LAST OR ORGANIZATION NAME		Laboratory/facility name
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID

Attribute	Element	Element Definition	Values	Description
S	09	IDENTIFICATION CODE		NPI Number
S	N3	SERVICE FACILITY LOCATION 2310E		
R	01	ADDRESS INFORMATION		Laboratory or Facility Address Line
S	02	ADDRESS INFORMATION		Laboratory or Facility Address Line 2
S	N4	SERVICE FACILITY LOCATION CITY/STATE/ZIPCODE 2310E		
R	01	CITY NAME		Laboratory or Facility City Name
R	02	STATE		Laboratory or Facility State Name
R	03	POSTAL CODE		Laboratory or Facility Postal Zone or Zip code
LOOP 2310F				
S	NM1	REFERRING PROVIDER NAME 2310F		Required on outpatient claim when referring provider is different than the Attending Provider.
R	01	ENTITY IDENTIFIER CODE	DN	Mutually defined
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number

Attribute	Element	Element Definition	Values	Description
LOOP 2320				
S	SBR	OTHER SUBSCRIBER INFORMATION 2320		
R	01	PAYER RESPONSIBILITY SEQUENCE NUMBER	P, S	If claim is for secondary payer then this should equal "P" for Primary Payer else "S" for Secondary Payer
R	02	INDIVIDUAL RELATIONSHIP CODE		Individual Relationship Code
S	03	REFERENCE IDENTIFICATION		Group number
S	04	NAME		Group or plan name
S	09	CLAIM FILING INDICATOR CODE	WC, MB, MA, HM, ZZ	Workers' Compensation Health Claim, Medicare Part B, Medicare Part A, Health maintenance organization
S	CAS	LINE ADJUDICATION INFORMATION 2320		
R	01	CLAIM ADJUSTMENT GROUP CODE	PR, CO, CR, OA, PI	If multiple adjustment group codes available the "PR" adjustment group code is required to be the first CAS segment sent.
R	02	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	04	QUANTITY		Adjusted Units -Claim Level
S	05	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	07	QUANTITY		Adjusted Units -Claim Level
S	08	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	10	QUANTITY		Adjusted Units -Claim Level
S	11	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code

Attribute	Element	Element Definition	Values	Description
S	12	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	13	QUANTITY		Adjusted Units -Claim Level
S	14	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	16	QUANTITY		Adjusted Units -Claim Level
S	17	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount -Claim Level
S	19	QUANTITY		Adjusted Units -Claim Level
S	AMT	COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT 2320		
R	01	AMOUNT QUALIFIER	D	Payer amount paid
R	02	MONETARY AMOUNT		Amount Paid
S	AMT	REMAINING PATIENT LIABILITY 2320		
R	01	AMOUNT QUALIFIER CODE	EAF	Amount Owed
R	02	MONETARY AMOUNT		Remaining Patient Liability
S	AMT	COB TOTAL NON-COVERED AMOUNT 2320		
R	01	AMOUNT QUALIFIER CODE	A8	Non Covered Charges - Actual
R	02	MONETARY AMOUNT		Non Covered Charge Amount
R	OI	OTHER INSURANCE COVERAGE INFO		
R	03	YES/NO CONDITION REPOSE	Y, N, W	Assignment of Benefits Indicator
R	06	RELEASE OF INFORMATION CODE	I, Y	Release of Information Code.
LOOP 2330A				
S	NM1	OTHER SUBSCRIBER NAME 2330A		

Attribute	Element	Element Definition	Values	Description
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1 , 2	Person Non –person
R	03	NAME LAST		SUBSCRIBER LAST NAME
S	04	NAME FIRST		SUBSCRIBER FIRST NAME
S	05	NAME MIDDLE		SUBSCRIBER MIDDLE NAME
S	07	NAME SUFFIX		SUBSCRIBER SUFFIX
R	08	IDENTIFICATION CODE QUALIFIER	MI	MEMBER IDENTIFICATION
R	09	IDENTIFICATION CODE		SUBSCRIBER IDENTIFICATION NUMBER
LOOP 2330B				
S	NM1	OTHER PAYER NAME 2330B		
R	01	ENTITY IDENTIFIER CODE	PR	PAYER
R	02	ENTITY TYPE QUALIFIER	2	NON-PERSON
R	03	ORGANIZATION NAME		OTHER PAYER ORGANIZATION NAME
R	08	IDENTIFICATION CODE QUALIFIER	PI	PAYER IDENTIFICATION
R	09	IDENTIFICATION CODE		PAYER IDENTIFICATION NUMBER
LOOP 2400				
R	LX	SERVICE LINE NUMBER 2400		
R	01	ASSIGNED NUMBER		Line counter
R	SV2	INSTITUTIONAL SERVICE LINE 2400		
R	01	PRODUCT/SERVICE ID		Service Line Revenue Code

Attribute	Element	Element Definition	Values	Description
S	02-1	COMPOSITE MEDICAL PROCEDURE IDENTIFIER	ER, HC, HP,IV, WK	Use HC-HCPCS codes,
R	02-2	PRODUCT/SERVICE ID		Procedure Code
S	02-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	02-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	02-5	PROCEDURE MODIFIER		Procedure Modifier 3
S	02-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	02-7	DESCRIPTION		DEFINITIVE DESCRIPTION OF PROCEDURE CODE
R	03	MONETARY AMOUNT		Service Line charge amount
R	04	UNIT OR BASIS FOR MEASUREMNT CODE	DA,UN	DA – Days, UN - Units
R	05	QUANTITY		Service line units
S	07	MONETARY AMOUNT		Line item denied charge or non-covered charge amount
S	PWK	PWK -LINE SUPPLEMENTAL INFORMATION 2400		
R	01	REPORT TYPE CODE		Attachment report Type Code
R	02	REPORT TRANSMISSION CODE	AA, BM, EL, EM, FT, FX	METHOD OR FORMAT OF TRANSMSSION
S	05	IDENTIFICATION CODE QUALIFIER	AC	
S	06	IDENTIFICATION CODE		ATTACHMENT CONTROL NUMBER
S	DTP	DATE-SERVICE DATE 2400		
R	01	DATE/TIME QUALIFIER	472	Service Date
R	02	DATE/TIME FORMAT	D8, RD8	Date Time Period Format Qualifier

Attribute	Element	Element Definition	Values	Description
R	03	DATE/TIME PERIOD		SERVICE DATE CCYYMMDD format.
S	NTE	THIRD PARTY ORGANIZATION NOTES 2400		
	01	NOTE REFERENCE CODE	TPO	Third Party Organization Notes
	02	DESCRIPTION		Line note text
S	HCP	LINE PRICING/REPRICING INFORMATION	2400	
R	01	PRICING METHODOLOGY		Specific code use is determined by Trading Partner Agreement due to the variances in contracting policies in the industry.
R	02	MONETARY AMOUNT		Repriced Allowed Amount
S	03	MONETARY AMOUNT		Repriced Savings Amount
S	04	Reference Identification		Repricing Organization Identifier (Remark Codes)
LOOP 2410				
S	LIN	DRUG IDENTIFICATION 2410		
	02	PRODUCT/SERVICE ID QUALIFIER	N4	National Drug Code Qualifier
	03	PRODUCT/SERVICE ID		National Drug Code
R	CTP	DRUG QUALITY 2410		Required if loop 2410 is present
R	04	QUANTITY		National Drug Unit Count
R	05 -01	UNIT OR BASIS MEASUREMENT CODE	F2, GR, ME, ML, UN	F2 International Unit, GR Gram ME Milligram ML Milliliter UN Unit
LOOP 2420A				
S	NM1	OPERATING PROVIDER NAME 2420A		Required when surgical procedure is listed on the claim
R	01	ENTITY IDENTIFIER CODE	72	Operating Physician

Attribute	Element	Element Definition	Values	Description
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
LOOP 2420B				
S	NM1	OTHER OPERATING PHYSICIAN NAME 2420B		Other provider name identifier "73" has been replaced by this loop
R	01	ENTITY IDENTIFIER CODE	ZZ	Mutually defined
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
LOOP 2420C				
S	NM1	RENDERING PROVIDER NAME 2420C		Required when rendering provider is different than the attending provider reported in loop 2310A
R	01	ENTITY IDENTIFIER CODE	82	
R	02	ENTITY TYPE QUALIFIER	1	Person

Attribute	Element	Element Definition	Values	Description
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
LOOP 2420D				
S	NM1	REFERRING PROVIDER NAME 2420D		Required on outpatient claim when referring provider is different than the Attending Provider.
R	01	ENTITY IDENTIFIER CODE	DN	Mutually defined
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST OR ORGANIZATION NAME		Operating provider last name
S	04	NAME FIRST		Operating provider first name
S	05	NAME MIDDLE		Operating provider middle initial
S	07	NAME SUFFIX		Rendering provider suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI Number
LOOP 2430				
S	SVD	LINE ADJUDICATION INFORMATION 2430		
R	01	IDENTIFICATION CODE		Other Payer Primary Identifier. This number should match NM109 in Loop ID-2330B identifying Other Payer.
R	02	MONETARY AMOUNT		Service Line Paid Amount.
R	03	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		

Attribute	Element	Element Definition	Values	Description
R	03-1	PRODUCT/SERVICE ID QUALIFIER	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
R	03-2	PRODUCT/SERVICE ID		Procedure Code
S	03-3	PROCEDURE MODIFIER		Procedure Modifier 1
S	03-4	PROCEDURE MODIFIER		Procedure Modifier 2
S	03-5	PROCEDURE MODIFIER		Procedure Modifier 3
S	03-6	PROCEDURE MODIFIER		Procedure Modifier 4
S	03-7	DESCRIPTION		Procedure Code Description
R	04	PRODUCT/SERVICE ID		Service line revenue code
R	05	QUANTITY		Paid Service Unit Count
S	06	ASSIGNED NUMBER		Bundled or Unbundled Line Number
S	CAS	LINE ADJUDICATION INFORMATION 2430		
R	01	CLAIM ADJUSTMENT GROUP CODE	CO,CR,OA,PI,PR	If multiple adjustment group codes available the "PR" adjustment group code is required to be the first CAS segment sent.
R	02	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount -Line Level
S	04	QUANTITY		Adjusted Units -Line Level
S	05	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount -Line Level
S	07	QUANTITY		Adjusted Units -Line Level
S	08	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount -Line Level
S	10	QUANTITY		Adjusted Units -Line Level

Attribute	Element	Element Definition	Values	Description
S	11	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	12	MONETARY AMOUNT		Adjusted Amount -Line Level
S	13	QUANTITY		Adjusted Units -Line Level
S	14	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount -Line Level
S	16	QUANTITY		Adjusted Units -Line Level
S	17	CLAIM ADJUSTMENT REASON CODE		Adjustment Reason Code. CODE SOURCE 139: Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount -Line Level
S	19	QUANTITY		Adjusted Units -Line Level
R	DTP	LINE CHECK OR REMITTANCE DATE		
R	01	DATE/TIME QUALIFIER	573	Date Claim Paid
R	02	DATE/TIME FORMAT	D8	Date Time Period Format Qualifier
R	03	DATE/TIME PERIOD	CCYYMMDD	Adjudication or Payment Date

7 Appendix

A. Implementation Checklist

The following task list should be completed to facilitate a smooth implementation of the EDI process.

TASK	Responsibility	Date
<input type="checkbox"/> ESTABLISH STANDARD ISA AND GS INFORMATION	Client & MagnaCare	
<input type="checkbox"/> CONFIRM BUSINESS RULES	Client & MagnaCare	
<input type="checkbox"/> DETERMINE COMMUNICATION METHOD	Client & MagnaCare	
<input type="checkbox"/> SET UP THE ENCRYPTION PROCESS	Client & MagnaCare	
<input type="checkbox"/> ESTABLISH A SCHEDULE FOR TESTING	Client & MagnaCare	
<input type="checkbox"/> COMPLETE TESTING	Client & MagnaCare	
<input type="checkbox"/> SIGN OFF ON COMPANION GUIDE	Client & MagnaCare	
<input type="checkbox"/> PRODUCTION CUT-OVER	Client & MagnaCare	