



**For use with ANSI ASC X12N
Payroll Deducted and Other Group
Premium Payment for Insurance Products
Implementation Guide and Addenda**

Payroll Deducted and Other Group Premium Payment for Insurance Products

820

ASC X12N 820 (004010X061A1)

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Washington Healthcare Forum Services (The Forum) is a state-wide consortium of healthcare payer and provider organizations in the Pacific Northwest region. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals, and medical groups.

An electronic version of this and other Companion Guide documents can be found at www.wahealthcareforum.org. From the home page, the path is HIPAA Services, Work Products, Companion Documents for the HIPAA Transactions.

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Objective of This Companion Document

The Forum is publishing this Companion Document to accompany the Implementation Guide and Addenda for the ASC X12N Payroll Deducted and Other Group Premium Payment for Insurance Products (820) Transaction.

This Companion Document is intended for use by employers, government agencies, and other health care coverage premium payers, software systems vendors, health plan destination payers, and others involved in the Electronic Data Interchange (EDI) process.

The primary purpose of the Companion is to authenticate and confirm understandings, assumptions, and conventions, agreed upon by commercial health plans in Washington State, to minimize variability in interpreting and implementing the transaction. Minimizing variability reduces time and cost investments that all healthcare organizations, healthcare premium payers, government agencies, as well as health plans need to make to implement this transaction. Health plans participating in this initiative include: Group Health Cooperative, Premera Blue Cross and Regence BlueShield.

This document does not mandate the format or content of the transaction that is exchanged between trading partners. Under HIPAA, health plans engaging in data exchanges must process any transaction received from an employer, government agency, health plan payer, or a health plan organization or their intermediary, which is compliant with the sanctioned Implementation Guide and Addenda. This Companion Document conveys information that *may* make it easier for health plan vendors, healthcare premium payers, or professional health plan organizations to:

- Implement a compliant transaction.
- Understand responses from health plans about a submitted transaction.

This Companion Document was developed to assist organizations through the implementation process so that the resulting transaction meets the following business objectives:

- *Convey all required business information:* The transaction must convey the comprehensive set of information that is required for health plans to conduct their business.
- *Specify information:* The definition of the transaction must be specific so that trading partners can correctly interpret, from a business perspective, the information that is exchanged.

- *Simplify electronic communication:* The transaction must be standard to simplify electronic communication between trading partners and to comply with HIPAA regulation.

Intended Use as Part of Trading Partner Agreements

This Companion Document is likely to be a part of any trading partner agreement between a health plan and an electronic trading partner such as an intermediary, an employer, a government agency, or a health plan payer group. The term, '*trading partner agreement*', is used to refer to a verbal or documented understanding between organizations. It is not intended to imply any type of contractual commitment. Organizations may refer to this documented understanding by other names.

Trading partners will be encouraged to follow the conventions and codes outlined in this Companion Document. These conventions are suggestions and not mandates. Adherence to these conventions and codes will be assumed unless otherwise stated, and specifically described, in the *trading partner agreement*.

Trading partners should review these conventions and codes before implementing the transaction and should agree on which ones will be followed. These conventions provide a focused starting point for trading partner discussions. Trading partner discussions may lead to modifying, deleting, or adding conventions. Any and all modifications should comply with the trading partner agreement caveats and restrictions stated in the HIPAA Implementation Guide and Addenda.

All conventions should be stated clearly in the *trading partner agreement* so that implementation and operations expectations are defined unambiguously. Conventions that are established in a *trading partner agreement* take precedence over any conventions that are contained in this document.

Caution should be exercised when changing conventions for a single trading partner. Differences in conventions between trading partners may introduce additional complexity into the process of exchanging this transaction with multiple trading partners.

This document assumes that the following data elements, identifying information about the sender and receiver of this transaction, is specifically described in a *trading partner agreement*. This information is contained in a number of fields:

- ISA05 – ISA08 of the ISA segment
- GS02 – GS03 of the GS segment
- N102 – N104 of the Premium Receiver Name Loop (Loop 1000A)
- N102 – N104 of the Premium Payer Name Loop (Loop 1000B).

The *trading partner agreement* may also describe how telecommunication connections are made for the purpose of conducting these transaction exchanges.

Purpose of Assumptions & Conventions

The underlying premises of this Companion Document are that the Payroll Deducted and Other Group Premium Payment for Insurance Products: 820 ANSI ASC X12N Implementation

Guide and Addenda define the superset of business functionality and provide general information about EDI transmission. The Implementation Guide and Addenda address issues such as information flows, delimiters, envelopes, interchange controls, and related topics. The Companion Document does not duplicate these efforts.

In order to establish a simplified implementation environment, this Companion Document describes a set of understandings, assumptions, and conventions to be followed by employers, other healthcare coverage purchasers and health plan trading partners as they implement the 820 transaction and interpret the information contained within it. These conventions provide additional clarity about data structures and the data elements (i.e., "what they mean") and describe how these data elements relate to information contained in the existing information systems belonging to each trading partner (i.e., "how they are used").

This Companion Document does not add, change, or delete the name or value of any data element that is specified in the Implementation Guide and Addenda. However, in order to meet the business objectives outlined above, it does recommend a number of conventions that are intended to clarify and standardize the usage of specific data elements including:

- Some segments and elements that are not used by a health plan in their premium payment process. These unused segments and elements are highlighted in the System Interface Map section of this Companion Document to designate situations for which accommodation is necessary and to guide healthcare professional providers and intermediaries toward specific requirements. These situations are designated on the System Interface Map with one of the following designations:
 - *"Not used for premium processing"* — This designation is used when the data element is situational. While the use of this data element, and the information entered into it, must comply with the Implementation Guide and Addenda, the health plan does not use this information to process premium payments.
 - *"Field must be populated with a valid value. It is not used for premium processing"* — This designation is used when the data element is required. The use of this data element, and the information entered into it, must comply with the Implementation Guide and Addenda. The health plan does not use this information to process premium payments.
- The Implementation Guide and Addenda identify a number of data elements that have a broad range of possible values. Many of these values are not relevant to processing a payment. Often, values that are listed do not clearly relate to relevant business situations. Also, the description of a value may be confusing. In these situations:
 - Values that are not relevant or pertinent to health plans are designated on the System Interface Map of this Companion Document in "outline" font with a strikethrough (e.g., ~~value~~).
 - A clarifying comment may be enclosed in brackets and added after the description (e.g., 01 – Value Description [Clarifying Comment]). The comment is not intended to change the meaning of the value but to add information about the conditions under which it is used.

- If an employer or intermediary intends to use the message text for any reason, that intent should be discussed with all trading partners and documented in the trading partner agreement.

Intent and Scope of the Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction

The Payroll Deducted and Other Premium Payment transaction will be used to convey information from employers and other health care purchasers to health plans about payment for healthcare coverage services provided.

The Implementation Guide for the Payroll Deducted and Other Premium Payment Transaction talks about using this transaction for Electronic Funds Transfer (EFT) and for Electronic Remittance Information (RI). The EFT and the RI represent two different uses of the 820 transaction – one 820 will be generated for the EFT and a separate 820 will be generated for the RI. HIPAA requires health plans to be able to receive a compliant 820 RI. The 820 EFT is not yet a HIPAA requirement.

Though not yet required by HIPAA, some health plans may be implementing an 820 EFT. Purchasers that are interested in sending this transaction should contact their health plan trading partners.

This Companion Document focuses on the 820 RI. The intent of the 820 RI transaction is to identify health plan members, and corresponding premium amounts, that are included in the premium payment check amount. This information will assist health plans in reconciling enrollment information (previously received on an 834 transaction) with the premium payment information on the 820 transaction.

Transaction Structure & Processing — Batch Mode

By convention, even though the X12N structure allows for either one or multiple transaction types to be transmitted in an ISA–IEA envelope, a separate ISA–IEA set is preferred for each different type of transaction. For example, if an electronic transmission between two trading partners contains enrollments and payments, there must be two ISA–IEA sets; one for the Benefit Enrollment and Maintenance 834 ANSI ASC X12N transaction (834) and one for the payment (820) information.

This Companion Document reflects conventions for **batch** implementation of the Payroll Deducted Group Premium Payment 820 ANSI ASC X12N transaction.

Structure of Transaction: GS–GE & ST–SE

There must be a separate GS–GE set for each purchaser/employer organization that originated a batch of payments. For example, if an electronic transmission from an intermediary, such as Alacrity Clearinghouse, to a health plan contains payments from ClearBell

Telecommunications and from FirstClass Supermarkets, there must be two GS–GE sets — one for ClearBell and one for FirstClass — within the ISA–IEA set for the 820.

Within a GS-GE set, the design of the transaction allows the purchaser/employer to transmit information pertaining to one of more different “coverage groups” (as set up with the health plan receiving the transaction.). The following table indicates each participating health plan’s preference in how the GS-GE is used.

	GHC	Premera	Regence
# of contract groups for each 820 GS-GE set	1	1	Any number

Ideally, there is one and only one ST–SE set for each GS–GE set within an 820 ISA–IEA set.

The Transaction Set Control Numbers in ST02 and SE02 must be identical. Submitters could begin sending transactions using the number 0001 in this element and increment from that starting point. The number must be unique within a specific functional group (GS–GE) and interchange set (ISA–IEA) but can repeat in other groups and interchanges.

Batch Mode Processing

The 820 transaction will be implemented in batch mode. The employer/purchaser will send the 820 transaction to an electronic intermediary or to the health plan through some means of telecommunications and will not remain connected while the receiver processes the transaction.

Health plan will acknowledge receipt of each 820 transaction that they receive, under the following conditions.

- If some or all of the ISA segment is unreadable or does not comply with the Implementation Guide AND if there is sufficient routing information that can be extracted from the ISA, the health plan will respond with an appropriate TA1 transaction or will contact the employer/purchaser via phone/fax. Otherwise, the health plan will be unable to respond. In either case, the batch will not be processed.
- Otherwise, the health plan may/may not respond with a 997 – see table below. The 997 transaction will indicate whether or not the batch can be processed. If the GS segment of the batch does not comply with the Implementation Guide, the health plan may not be able to process the transaction.

Conditions for sending a 997	Group Health	Premera	Regence
Will respond with a 997 to every 820	X	X	

received.			
Will only respond with a 997 if something is wrong with the 820 that was received.			X

Per HIPAA regulations, if the information associated with any of the payments in the 820 ST–SE batch is not correctly formatted from a syntactical perspective, all records within the ST–SE set may be rejected. The health plan notifies the submitting organization of the file rejection *via* a 997 transaction or other method agreed upon in the *trading partner agreement*. Employers and other healthcare coverage purchasers should consider this possible response when determining how many employees and payments they submit in a single 820 ST–SE batch.

Per HIPAA regulations, employers and other healthcare coverage providers must submit, and health plans must be able to process, the employment and payment code sets that are valid at the time that the coverage was initiated. (The validity of the employment and payment data code sets is determined by the employment date not the transaction submission date.) This means that health plans must be able to process versions of the code sets that precede the current version.

Per HIPAA regulations, employers and other healthcare coverage providers must submit, and health plans must be able to process, only the version of the transaction (e.g., 4010, 4050) that is valid at the time that the transaction is received by the health plan. HIPAA regulations do not allow health plans to process earlier or future versions of a transaction in their production systems. Only the current version of the transaction can be supported.

Transaction Processing — Health Plan Production System

A health plan production system processes the 820 transaction in one of three ways:

- *Reject It:* Information is not compliant with the HIPAA standard (e.g., transactions are missing required fields). The transaction is rejected; the payment is not processed.
- *Not Review It:* Information is compliant with the HIPAA standard but a) cannot be processed by the health plan system (e.g., quantity or amount data fields that are outside the range of good business practices), or b) is not relevant to the processing logic (*see* References in System Interface Map). Though the data element is not reviewed, the transaction is processed; the payment is not processed.
- *Process It:* Information is compliant with the HIPAA standard and is consistent with health plan practices. The transaction is processed; the payment is processed.

If a payment is Rejected, the submitting employer or other healthcare coverage provider is notified *via* the 997 transaction. Otherwise, the health plan should process the payment. aware of them.

Privacy and Security Protection

The Implementation Guide, Addenda, and this Companion Document DO NOT specifically address privacy and security protection regarding the use of system or application technology to send and receive this transaction set. For example, registration and management of users, assignment and exchange of passwords, ID, digital certificates, authentication, authorization, and other access restrictions are not addressed in either of these documents. Information about these protections will be contained, typically, in a *Trading Partner Agreement*

or *Business Associate Agreement*. This document presumes that the exchange of this transaction takes place in a processing and communication environment that is secure at both ends — sender and receiver.

General Usage

The Implementation Guide, Appendix and Companion Document may not address all of the questions/issues that may arise during the process of developing and implementing the 820 transaction. Employers/purchasers should work collaborative with their health plan trading partners to define the functionality that will work best within the scope of the transaction standard.

Technical

1. Any character used in a data element cannot be used as a delimiter, separator, or terminator. Ideally, the following characters are not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (*, ` , `` , #, :, ~).
2. By convention, preferred field delimiters are: '*' (asterisk) for data element separator, ':' (colon) for sub–element separator, '~' (tilde) for segment terminator.
3. If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM segment, then NM102 should contain a '2' to indicate a non–person entity.
4. The NM107 field in the NM segment (Name Suffix) may contain a suffix (Sr., Jr., or III), degree (M.D., Ph.D.), or a credential.

System Interface Mapping

The following matrix identifies the recommended usage of the data elements when the 820 transaction is interfaced with an information system. Where coded values for data elements are appropriate, codes are provided when the value set is small. Expanded codes for data elements can be found in the *Payroll Deducted and Other Group Premium Payment for Insurance Products 820 ASC X12N 820 Implementation Guide (004010X061) and Addenda (004010X061A1)*.

The columns for the matrix are:

- **Page#:** The page number from the "National Electronic Data Interchange Transaction Set Implementation Guide Payroll Deducted and Other Group Premium Payment for Insurance Products 820 ASC X12N 820 (004010X061)" Rev May 2000.
- **Name:** Industry Name (from the Implementation Guide and Addenda) where available. If no industry name is available, the standard name is used. Any aliases shown in the Implementation Guide and Addenda are not always listed.
- **Seg. Reqmt:** (Segment Requirement): 'R' – Required, 'S' – Situational
- **Pos#:** Position Number (from Implementation Guide and Addenda)
- **Seg. ID:** Segment ID (from Implementation Guide and Addenda)
- **Data Element Usage:** A 'Not Used' in this column means that the Implementation Guide and Addenda dictate this data field is not to be used.
- **Data Element ID:** (from Implementation Guide and Addenda)
- **Qualifier:** A value appearing in this column indicates that the value is the preferred value. (Only single values for a data element appear in this column.)
- **Qualifier Description:** List of possible values. Values that are not relevant or pertinent to health plans are designated in "outline" font with a strikethrough (e.g., ~~value~~). When and as appropriate, comments and conventions about usage appear in this column.

The Implementation Guide and Addenda identify some data segments and elements that are not used by a health plan in their adjudication process. These data segments and elements are highlighted in the System Interface Map section of this Companion Document so that employers or other healthcare coverage providers and intermediaries do not waste time determining health plan specific requirements. These situations are designated on the System Interface Map with one of the following notes:

- *"Not used for premium processing"* — This designation is used when the data element is situational. While the use of this data element, and the information entered into it, must comply with the Implementation Guide and Addenda, the health plan does not use this information to process premium payments.
- *"Field must be populated with a valid value. It is not used for premium processing"* — This designation is used when the data element is required. The use of this data element, and the information entered into it, must comply with the Implementation Guide and Addenda. The health plan does not use this information to process premium payments.

Description of the Layout of the Data

The data in the Implementation Guide and Addenda are grouped in “segments”, “loops”, and “levels”. A “loop” is made up of one or more segments. A “level” is made up of one or more loops.

A non-real example: a name and address would be made up of various segments of data. The name would be broken into first, middle, and last names along with suffix or prefix and some codes pertaining to the name. These fields would be organized into a segment. The address would go through a similar process and be organized into a separate segment. Together, these could be organized into a “loop”. However, there are many names and addresses needed throughout a system and the one just described in the loop is very generic.

Hierarchical Level Data Structure

The hierarchical level (HL) structure identifies and relates the participants involved in the transaction. The participants identified in the 820 transaction are generally Billing/Pay-To Provider, Subscriber, and Patient (when the patient is not the same person as the subscriber). The 0019 value in the BHT hierarchical structure code (BHT01) describes the appearance order of subsequent loops within the transaction set and refers to these participants, respectively, in the following terms:

- Information source (Billing Provider)
- Subscriber (can be the patient when the patient is the subscriber)
- Dependent (patient, when the patient is not the subscriber)
- The term, 'Billing Provider', indicates the information source hierarchical level (HL).
- The term, 'Patient', indicates the dependent HL.

ISA	INTERCHANGE CONTROL HEADER
GS	FUNCTIONAL GROUP HEADER

TABLE 1 — Header

Pos	Seg	Name	Required	Max Use	Loop Repeat
010	ST	Transaction Set Header	R	1	
020	BPR	Financial Information	R	1	
035	TRN	Reassociation Key	R	1	
040	CUR	Non-US Dollars Currency	S	1	
050	REF	Premium Receivers Identification Key	S	>1	
060	DTM	Process Date	S	1	
060	DTM	Delivery Date	S	1	
060	DTM	Coverage Period	S	1	
Loop ID:	1000A	Premium Receiver's Name			1
070	N1	Premium Receiver's Name	R	1	
080	N2	Premium Receiver's Additional Name	S	1	
090	N3	Premium Receiver's Address	S	1	
100	N4	Premium Receiver's City, State, Zip	S	1	
Loop ID:	1000B	Premium Payer's Name			1
070	N1	Premium Payer's Name	R	1	
080	N2	Premium Payer's Additional Name	S	1	
090	N3	Premium Payer's Address	S	1	
100	N4	Premium Payer's City, State, Zip	S	1	
120	PER	Premium Payer's Administrative Contact	S	>1	

TABLE 2 — Detail — Organization Summary Remittance

Pos	Seg	Name	Required	Max Use	Loop Repeat
Loop ID:	2000A	Organization Summary Remittance			1
010	ENT	Organization Summary Remittance	S	1	
Loop ID:	2300A	Organization Summary Remittance Detail			>1
150	RMR	Organization Summary Remittance Detail	R	1	

Loop ID:	2310A	Summary Line Item			1
190	IT1	Summary Line Item	S	1	
Loop ID:	2315A	Member Count			>1
204	SLN	Member Count	S	1	
Loop ID:	2320A	Organization Summary Remittance Level Adjustment			>1
210	ADX	Organization Summary Remittance Level Adjustment	S	1	

TABLE 2 — Detail — Individual Remittance

Pos	Seg	Name	Required	Max Use	Loop Repeat
Loop ID:	2000B	Individual Remittance			>1
010	ENT	Individual Remittance	S	1	
Loop ID:	2100B	Individual Name			>1
020	NM1	Individual Name	S	1	
Loop ID:	2300B	Individual Premium Remittance Detail			>1
150	RMR	Individual Premium Remittance Detail	S	1	
180	DTM	Individual Coverage Period	S	1	
Loop ID:	2320B	Individual Premium Adjustment			>1
210	ADX	Individual Premium Adjustment	S	1	

TABLE 3 — Summary

Pos	Seg	Name	Required	Max Use	Loop Repeat
010	SE	820 Trailer	R	1	

GE	FUNCTIONAL GROUP TRAILER
IEA	INTERCHANGE CONTROL TRAILER

ENVELOPE — Open

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
B.3	Interchange Control Header			ISA				
B.3	Authorization Information Qualifier				R	ISA01	00	No Authorization Information Present
B.3	Authorization Information				R	ISA02		
B.4	Security Information Qualifier				R	ISA03	00	No Security Information Present
B.4	Security Information				R	ISA04		
B.4	Interchange ID Qualifier				R	ISA05	ZZ	Mutually Defined
B.4	Interchange Sender ID				R	ISA06		ID Code of Sender
B.4	Interchange ID Qualifier				R	ISA07	ZZ	Mutually Defined
B.5	Interchange Receiver ID				R	ISA08		ID Code of Receiver: GHC = contact directly GHO = contact directly Premera = contact Health Plan Regence = contact Health Plan Asuris = contact Health Plan
B.5	Interchange Date				R	ISA09		YYMMDD
B.5	Interchange Time				R	ISA10		HHMM
B.5	Interchange Control Standards Identifier				R	ISA11	U	U.S. EDI Community of ASC x12, TCDD, and UCS
B.5	Interchange Control Version Number				R	ISA12	00401	Draft Standards for Trial Use Approved for Publication by ASCx12 Procedures Board through October 1997
B.5	Interchange Control Number				R	ISA13		A control number assigned by the interchange sender
B.6	Acknowledgment Requested				R	ISA14		0 – No acknowledgment requested 1 – Interchange Acknowledgment Requested
B.6	Usage Indicator				R	ISA15		P = Production Data T = Test Data
B.6	Component Element Separator				R	ISA16	:	This is the delimiter used to separate component data elements within a composite data structure
B.8	Functional Group Header			GS				
B.8	Functional Identifier Code				R	GS01	RA	RA – Payment Order / Remittance Advice (820)
B.8	Application Sender Code				R	GS02		Code identifying party sending transmission. Codes agreed to by trading partners

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
B.8	Application Receiver Code				R	GS03		Code identifying party receiving transmission. Codes agreed to by trading partners ID Code of Receiver: GHC = contact directly GHO = contact directly Premera = contact Health Plan Regence = contact Health Plan Asuris = contact Health Plan
B.8	Date				R	GS04	CCYYMMDD	Creation Date
B.9	Time				R	GS05	HHMM	Creation Time
B.9	Group Control Number				R	GS06		Assigned number originated and maintained by the sender
B.9	Responsible Agency Code				R	GS07	X	Accredited Standards Committee X12
B.9	Version/Release/Industry Identifier Code				R	GS08	004010X061A1 or 004010X061	Addenda Version = 004010X061A1 Standard Version = 004010X061 (004010X061 not valid after October 16, 2003) Standards Approved for Publication by ASC X12 Procedures Review Board through May 2000, as published in the Implementation Guide and Addenda.

Table 1 — Header

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
62	Transaction Set Header	R	010	ST				<i>To indicate the start of a transaction set and to assign a control number</i>
34	Transaction Set Header	R	010	ST				
34	Transaction Set ID Code				R	ST01	820	Payment Order / Remittance Advice
34	Transaction Set Control #				R	ST02		Assigned by originator [should match SE02]
35	Beginning of Payment Order / Remittance Advice (1 of 1)	R	020	BPR				Financial Information related to transfer of funds from payer to payee.
36	Transaction Handling Code				R	BPR01		Money / information processing code C – Payment accompanies remittance advice – move funds & remittance detail D – Make payment only – move funds only I – Remittance information only – remittance detail & funds moved separately P – Prenotification of future transfers – test EFT transfer U – Split payment & remittance – third party processor splits funds & detail; ends separately X – Handling party option to split payment & remittance – handling of payment & detail at payee option
37	Monetary Amount				R	BPR02		Total premium payment amount Note: limit amount: \$99,999,999.99
37	Credit / Debit Flag Code				R	BPR03	C	C – Credit – credit payee, debit payer D – Debit – debit payee, credit payer (not valid for health premium payment)
37	Payment Method Code				R	BPR04	CHK	Method for movement of payment instructions ACH – Automated Clearing House BOP – Financial Institution Option based on payee instructions or capability CHK – Check FWT – Federal Reserve Funds / Wire Transfer SWT – Society for Worldwide Interbank Financial Telecommunications (S.W.I.F.T.)
38	Payment Format Code <i>Note: Field required when payment is through ACH.</i>				S	BPR05		CCP – Cash Concentration / Disbursement plus Addenda (CCD+) (ACH) CTX – Corporate Trade Exchange (CTX+) (ACH)
39	Number Qualifier <i>Note: Field required when originating financial institution requires DFI to process payment.</i>				S	BPR06		Originating Depository Financial Institution (ODFI) ID Qualifier 01 – ABA transit routing number including check digits (9 digits) 04 – Canadian bank branch & institution, eh? Required if BPR07 present.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
39	(DFI) Identification Number				S	BPR07		ODFI Identifier sending transaction to ACH Required if BPR06 present.
39	Account Number Qualifier Note: Field required when ODFI requires bank account number to process payment.				S	BPR08		ALC – Agency Location Code (federal government only) DA – Demand deposit
40	Account Number				S	BPR09		Sender Bank Account Number Premium payer account number Required if BPR08 present.
40	Transaction Type Code Note: Field required for reassociation. BPR10 must be identical to TRN03 & must be an EIN preceded by a 1.				S	BPR10		Originating Company Identifier Unique identifier designating the company initiating the funds transfer. Instructions — First character is one-digit ANSI identification code designation (ICD) followed by the 9-digit identification number: IRS employer identification number (EIN) Data Universal Numbering System (DUNS) User Assigned Number (UAN) ICDs: EIN = 1, DUNS = 3, UAN = 9
40	Originating Company Supplemental Code Note: Field required for identification of a company subdivision. BPR11 must be identical to TRN04.				S	BPR11		Code defined between the originating company and the originating DFI that uniquely identifies the company initiating the transfer instructions.
40	(DFI) ID Number Qualifier Note: Field required when ODFI needs Receiving DFI to process payment.				S	BPR12		Receiving Depository Financial Institution (RDFI) ID Qualifier 01 – ABA transit routing number including check digits (9 digits) 04 – Canadian bank branch & institution Required if BPR13 present.
41	(DFI) Identification Number				S	BPR13		RDFI Identifier receiving transaction from ACH Required if BPR12 present.
41	Account Number Qualifier Note: Field required when ODFI requires RDFI bank account number to process payment.				S	BPR14		DA – Demand deposit SG – Savings
41	Account Number				S	BPR15		Receiver Bank Account Number Premium receiver account number Required if BPR14 present.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
41	Date				S	BPR16		Check Issue or EFT Effective Date CCYYMMDD Credit Payment — date the originator (premium payer) intends to provide good funds to the receiver (premium receiver). Check Payment — check issuance date. FedWire Payment — the value date. ACH Payment — date the ODFI either corrects this date if it is not a valid effective date or rejects the item based on previous agreement between the originator and their financial institution.
41	Business Function Code				Not Used	BPR17		
41	(DFI) ID Number Qualifier				Not Used	BPR18		
42	(DFI) ID Number				Not Used	BPR19		
42	Account Number Qualifier				Not Used	BPR20		
42	Account Number				Not Used	BPR21		
43	Reassociation Key	R	035	TRN				Trace — uniquely identifies a payment or remittance advice
43	Trace Type Code				R	TRN01		1 – Current Transaction Trace Numbers (Payment & remittance detail intact) 3 – Financial Reassociation Trace Number (Reassociate payment & remittance detail)
44	Reference Identification				R	TRN02		Check or EFT Trace Number Unique to this transaction & reassociates payment with remittance detail
44	Originating Company Identifier Note: See BPR10.				S	TRN03		See BPR10
44	Reference Identification Note: Field required for multiple premium payments for multiple group plans & additional identifier for association is needed. TRN04 must be identical to BPR11.				S	TRN04		Originating Company Supplemental Code
45	Currency	S	040	CUR				Specifies currency used in transaction
46	Entity Identifier Code				R	CUR01		Identifies an organizational entity, physical location, property, or individual 2B – Third Party Administrator PR – Payer
46	Currency Code				R	CUR02		Code (Standard ISO) for charges in currency from specified country MXP – Mexican Pesos CAD – Canadian Dollars USD – United States Dollars
47	Exchange Rate Note: Field required when payment & bill / invoice currencies are not identical.				S	CUR03		Value of multiplier conversion factor to convert monetary value from one currency to another.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
47	Entity Identifier Code				Not Used	CUR04		
47	Currency Code				Not Used	CUR05		
47	Currency Market / Exchange Code				Not Used	CUR06		
47	Date / Time Qualifier				Not Used	CUR07		
47	Date				Not Used	CUR08		
47	Time				Not Used	CUR09		
47	Date / Time Qualifier				Not Used	CUR10		
47	Date				Not Used	CUR11		
47	Time				Not Used	CUR12		
47	Date / Time Qualifier				Not Used	CUR13		
47	Date				Not Used	CUR14		
47	Time				Not Used	CUR15		
47	Date / Time Qualifier				Not Used	CUR16		
47	Date / Time Qualifier				Not Used	CUR16		
47	Date				Not Used	CUR17		
47	Time				Not Used	CUR18		
47	Date / Time Qualifier				Not Used	CUR19		
47	Date				Not Used	CUR20		
47	Time				Not Used	CUR21		
48	Premium Receiver Identification Key <i>Note: Field required to identify master account number when payment is for health premium.</i>	S	050	REF				Premium receiver key associated with premium payment. Provided to payer by receiver.
48	Reference Identification Qualifier				R	REF01		14 – Master Account Number 18 – Plan Number 2F – Consolidated Invoice Number 38 – Master Policy Number 72 – Schedule Reference Number (For U.S. Treasury Department Financial Management Service Disbursed payments, this code indicates a payment schedule number will follow.)
49	Reference Identification				R	REF02		Premium Receiver Reference Identifier Defined for a particular Transaction Set or specified by the Reference Identification Qualifier (For U.S. Treasury Department Financial Management Service Disbursed payments, this is 11-character schedule number submitted by the agency authorizing the payment.) At least 1 instance required.
49	Description				Not Used	REF03		
49	Reference Identifier				Not Used	REF04		
50	Process Date	S	060	DTM				Payment Processed Date (Not used when payment is for health premium).

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
50	Date / Time Qualifier		Not Used for Premium Processing		R	DTM01	009	Processed
50	Date				R	DTM02		CCYYMMDD <i>At least 1 instance required.</i>
51	Time				Not Used	DTM03		
51	Time Code				Not Used	DTM04		
51	Date / Time Period Format Qualifier				Not Used	DTM05		
51	Date / Time Period				Not Used	DTM06		
52	Delivery Date	S						Premium Delivery Date (Not used when payment is for health premium).
52	Date / Time Qualifier				R	DTM01	035	Delivered
53	Date				R	DTM02		CCYYMMDD <i>At least 1 instance required.</i>
53	Time				Not Used	DTM03		
53	Time Code				Not Used	DTM04		
53	Date / Time Period Format Qualifier				Not Used	DTM05		
53	Date / Time Period				Not Used	DTM06		
54	Coverage Period	S			060	DTM		
54	Date / Time Qualifier				R	DTM01	582	Report Period
54	Date				Not Used	DTM02		
54	Time				Not Used	DTM03		
55	Time Code				Not Used	DTM04		
55	Date / Time Period Format Qualifier				R	DTM05	RD8	Code indicating date, time, or date & time format CCYYMMDD CCYYMMDD
55	Date / Time Period				R	DTM06		Coverage Perid
56	Loop ID: 1000A Premium Receiver's Name	R	070	N1				Name and identifier of premium receiver. Required for HIPAA health premium payments.
56	Entity Identifier Code				R	N101	PE	Identifies an organizational entity, physical location, property, or individual PE – Payee
57	Name				S	N102		Information Receiver Last or Organization Name At least 1 instance of N102 or N103 required.
57	Identification Code Qualifier				S	N103		1 – DUNS Number (Dun & Bradstreet) 9 – DUNS + 4 DUNS Number with 4-character suffix EQ – Insurance Company Assigned Identification Number FI – Federal Taxpayer ID Number XV – HCFA National Plan ID (XV required when National Plan ID is mandated; use FI as alternate HIPAA compliant identifier) At least 1 instance of N102 or N103 required. Required if N104 present.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
57	Identification Code				S	N104		Receiver Identifier Required if N103 present.
57	Entity Relationship Code		Not Used for Premium Processing		Not Used	N105		
57	Entity Identifier Code				Not Used	N106		
58	Premium Receiver Additional Name	S						
58	Name				R	N201		Receiver Additional Name Information for N102
58	Name				Not Used	N202		
59	Premium Receiver's Address	S						
59	Address Information				R	N301		Receiver Address Line
59	Address Information <i>Note: Field required when 2nd address line is needed.</i>				S	N302		Receiver Address Line 2
60	Premium Receiver's City, State, Zip	S						Geographic Location
60	City Name				R	N401		Information Receiver City Name
60	State of Province Code				R	N402		Information Receiver State Code
61	Postal Code				R	N403		Information Receiver Postal Zone or Zip Code
61	Country Code <i>Note: Field required when address is outside United States.</i>				S	N404		
61	Location Qualifier			Not Used	N405			
61	Location Identifier			Not Used	N406			
74	Loop ID: 1000B Premium Payer's Name	R	070	NM1				Name and identifier of premium payer. Required for HIPAA health premium payments.
62	Entity Identifier Code		Not Used for Premium Processing		R	N101	PR	Identifies an organizational entity, physical location, property, or individual PR – Payer
63	Name				S	N102		Premium Payer Name At least 1 instance of N102 or N103 required.
63	Identification Code Qualifier				S	N103	65	65 – National Employee Identification (EIN is Mandated National Employer ID Number) 1 – DUNS Number (Dun & Bradstreet) 9 – DUNS + 4 DUNS Number with 4-character suffix 24 – Employer's Identification Number 75 – State or Province Assigned Number (In US, Medicare premium payments) EQ – Insurance Company Assigned Identification Number FI – Federal Taxpayer ID Number PI – Payer Identification (Federal Agency Payroll Office Number) At least 1 instance of N102 or N103 required. Required if N104 present.
63	Identification Code.				S	N104		Premium Payer Identifier Required if N103 present.
63	Entity Relationship Code				Not Used	N105		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description			
64	Entity Identifier Code				Not Used	N106					
65	Premium Payer Additional Name	S									
65	Name				R	N201			Premium Payer Additional Name Information for N102		
65	Name				Not Used	N202			Not Used		
66	Premium Payer's Address	S									
66	Address Information				R	N301			Premium Payer Address Line		
66	Address Information <i>Note: Field required when 2nd address line is needed.</i>				S	N302			Premium Payer Address Line 2		
67	Premium Payer's City, State, Zip	S							Geographic Location		
67	City Name				R	N401			Information Receiver City Name		
67	State of Province Code				R	N402			Information Receiver State Code		
68	Postal Code				R	N403			Information Receiver Postal Zone or Zip Code		
68	Country Code <i>Note: Field required when address is outside United States.</i>				S	N404					
68	Location Qualifier				Not Used	N405					
68	Location Identifier				Not Used	N406					
69	Premium Payer's Administrative Contact	S							Administrative Communications Contact		
70	Contact Function Code				Not Used for Premium Processing		R	PER01	IC	Information Contact	
70	Name						R	PER02			Include if different name from NM1 or N1
70	Communication Number Qualifier <i>Note: Field required when sender needs to relay communication information.</i>						S	PER03			EM – Electronic Mail FX – Facsimile TE – Telephone Required if PER04 present.
70	Communication Number		S	PER04					AAABBBCCCC Required if PER03 present.		
70	Communication Number Qualifier <i>Note: See PER03</i>		S	PER05					EM – Electronic Mail EX – Telephone Extension (Extension for PER04) FX – Facsimile TE – Telephone Required if PER06 present.		
71	Communication Number		S	PER06					AAABBBCCCC Required if PER05 present.		
71	Communication Number Qualifier <i>Note: See PER03</i>		S	PER07					EM – Electronic Mail EX – Telephone Extension (Extension for PER04) FX – Facsimile TE – Telephone Required if PER08 present.		
71	Communication Number		S	PER08					AAABBBCCCC Required if PER07 present.		
71	Contact Inquiry Reference		Not Used	PER09							

Table 2 — Detail — Organization Summary Remittance

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
72	Loop ID: 2000A Organization Summary Remittance	S	010	ENT				Provide company remittance line items that pertain to group level premium or contribution payments.
73	Assigned Number				R	ENT01		Unique number assigned to differentiate transaction sets. ENT01 must be a sequential number within the transaction set, starting with 1, and incrementing by 1.
73	Entity Identifier Code				R	ENT02		Identifies an organizational entity, physical location, property, or individual 2L – Corporation Required if ENT03 or ENT04 present.
73	Identification Code Qualifier				S	ENT03		65 – National Employee Identification (EIN is Mandated National Employer ID Number 1 – DUNS Number (Dun & Bradstreet) 9 – DUNS + 4 DUNS Number with 4-character suffix FI – Federal Taxpayer ID Number Required if ENT02 or ENT04 present.
73	Identification Code <i>Note: Field required when payment is for health premium.</i>				S	ENT04		Organization Identification Code Required if ENT02 or ENT03 present.
73	Entity Identifier Code				Not Used	ENT05		
73	Identification Code Qualifier				Not Used	ENT06		
73	Identity Code				Not Used	ENT07		
73	Reference Identification Qualifier				Not Used	ENT08		
73	Reference Identification				Not Used	ENT09		
74	Loop ID: 2300A Organization Summary Remittance Detail	R	150	RMR				Provides detailed remittance information related to summary bill payment.
75	Reference Identification Qualifier				R	RMR01	IL	11 – Account Number 1L – Group or Policy Number (Required when payment is for health premium and no invoice received. Can be used to identify FEHB "Enrollment Code" being paid.) CT – Contract Number IK – Invoice Number Required if RMR02 present.
75	Reference Identification				R	RMR02		Contract, Invoice, Account, Group or Policy Number Required if RMR01 present.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
75	Payment Action Code				S	RMR03		PA – Payment in Advance PI – Pay Item PO – Payment on Account PP – Partial Payment
76	Monetary Amount				R	RMR04		Detail Premium Payment Amount
76	Monetary Amount <i>Note: Field required when Insurer sent invoice & paid & invoice amounts differ.</i>			Not Used for Premium Processing	S	RMR05		Billed Premium Amount
76	Monetary Amount				Not Used	RMR06		
76	Adjustment Reason Code				Not Used	RMR07		
76	Monetary Amount				Not Used	RMR08		
77	Loop ID: 2310A Summary Line Item	S	190	IT1				Required for HIPAA health premium payments.
78	Assigned Identification				R	IT101		Unique Line Item Control Number
78	Quantity Invoiced				Not Used	IT102		
78	Unit or Basis for Measurement Code				Not Used	IT103		
78	Unit Price				Not Used	IT104		
78	Basis of Unit Price Code				Not Used	IT105		
78	Product / Service ID Qualifier				Not Used	IT106		
78	Product / Service ID				Not Used	IT107		
78	Product / Service ID Qualifier				Not Used	IT108		
78	Product / Service ID				Not Used	IT109		
78	Product / Service ID Qualifier				Not Used	IT110		
78	Product / Service ID				Not Used	IT111		
78	Product / Service ID Qualifier				Not Used	IT112		
79	Product / Service ID				Not Used	IT113		
79	Product / Service ID Qualifier				Not Used	IT114		
79	Product / Service ID				Not Used	IT115		
79	Product / Service ID Qualifier				Not Used	IT116		
79	Product / Service ID				Not Used	IT117		
79	Product / Service ID Qualifier				Not Used	IT118		
79	Product / Service ID				Not Used	IT119		
79	Product / Service ID Qualifier				Not Used	IT120		
79	Product / Service ID				Not Used	IT121		
79	Product / Service ID Qualifier				Not Used	IT122		
79	Product / Service ID				Not Used	IT123		
79	Product / Service ID Qualifier				Not Used	IT124		
79	Product / Service ID				Not Used	IT125		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
80	Loop ID: 2315A Member Count	S	204	SLN				One occurrence required for HIPAA health premium payments. Provides optional member counts under a summary RMR / IT1 item. Used multiple times within each RMR loop to identify contract types and number of contract holders — the employee or individual whose signature is on the enrollment documentation.
81	Assigned Identification				R	SLN01		Unique Line Item Control Number
81	Assigned Identification				Not Used	SLN02		Not Used
82	Relationship Code				R	SLN03		Pay-To Provider Last or Organizational Name
82	Quantity				R	SLN04		Number of contract holders with type of coverage in SLN05-1 Required if SLN05 present.
82	Composite Unit of Measure				R	SLN05		Required if SLN04 present.
82	Unit or Basis for Measurement Code				R	SLN05-1		SNL04 value indicating number of contract holders 10 – Group: Family coverage IE – Person: Individual coverage PR – Pair: Self & Spouse only coverage
82	Exponent				Not Used	SLN05-2		
82	Multiplier				Not Used	SLN05-3		
82	Unit or Basis for Measurement Code				Not Used	SLN05-4		
82	Exponent				Not Used	SLN05-5		
82	Multiplier				Not Used	SLN05-6		
82	Unit or Basis for Measurement Code				Not Used	SLN05-7		
82	Exponent				Not Used	SLN05-8		
82	Multiplier				Not Used	SLN05-9		
82	Unit or Basis for Measurement Code				Not Used	SLN05-10		
82	Exponent				Not Used	SLN05-11		
82	Multiplier				Not Used	SLN05-12		
82	Unit or Basis for Measurement Code				Not Used	SLN05-13		
83	Exponent				Not Used	SLN05-14		
83	Multiplier				Not Used	SLN05-15		
83	Unit Price				Not Used	SLN06		
83	Basis of Unit Price Code				Not Used	SLN07		
83	Relationship Code				Not Used	SLN08		
83	Product / Service ID Qualifier				Not Used	SLN09		
83	Product / Service ID				Not Used	SLN10		
83	Product / Service ID Qualifier				Not Used	SLN11		
83	Product / Service ID				Not Used	SLN12		
83	Product / Service ID Qualifier				Not Used	SLN13		
83	Product / Service ID				Not Used	SLN14		
83	Product / Service ID Qualifier				Not Used	SLN15		
83	Product / Service ID				Not Used	SLN16		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
83	Product / Service ID Qualifier				Not Used	SLN17		
83	Product / Service ID				Not Used	SLN18		
83	Product / Service ID Qualifier				Not Used	SLN19		
83	Product / Service ID				Not Used	SLN20		
83	Product / Service ID Qualifier				Not Used	SLN21		
83	Product / Service ID				Not Used	SLN22		
83	Product / Service ID Qualifier				Not Used	SLN23		
83	Product / Service ID				Not Used	SLN24		
83	Product / Service ID Qualifier				Not Used	SLN25		
83	Product / Service ID				Not Used	SLN26		
83	Product / Service ID Qualifier				Not Used	SLN27		
83	Product / Service ID				Not Used	SLN28		
84	Loop ID: 2320A Organization Summary Remittance Level Adjustment	S	210	ADX				Provides adjustments made at the summary level of payment. Must be used as necessary to fulfill balancing requirements. Required when paid amount is different from any invoiced amount.
85	Monetary Amount				R	ADX01		Adjustment Amount
85	Adjustment Reason Code				R	ADX02		20 – Balance Due Declined (Used when entire balance due is disputed) 52 – Credit for Previous Overpayment 53 – Remittance for Previous Underpayment AA – Prepaid Benefit or Advances H1 – Information Forthcoming (Detail provided through separate mechanism) H6 – Partial Payment Remitted (Payer does not have sufficient funds to remit full balance due) IA – Invoice Amount Does Not Match Account Analysis Statement (Invoice does not match expected number / type of members & charges) J3 – Promised Adjustment Not Received (Adjustment promised for previous invoice not reflected in current invoice)
85	Reference Identification Qualifier				Not Used	ADX03		
85	Reference Identification				Not Used	ADX04		

Table 2 — Detail — Individual Remittance

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
86	Loop ID: 2000B Individual Remittance	S	010	ENT				Provide remittance line items that pertain to an individual enrolled in a group plan.
87	Assigned Number				R	ENT01		Unique number assigned to differentiate transactions within transaction sets
87	Entity Identifier Code				R	ENT02		Identifies an organizational entity, physical location, property, or individual 2J – Individual Required if ENT03 or ENT04 present.
87	Identification Code Qualifier				R	ENT03	22	Code designating structure used for Identification Code 34 – Social Security Number EI – Employee Identification Number ZZ – HIPAA Individual Identifier (Not yet mandated) Required if ENT02 or ENT04 present.
87	Identification Code				R	ENT04		Receiver's Individual Identifier Required if ENT02 or ENT03 present.
87	Hierarchical Child Code				Not Used	ENT05		
87	Hierarchical Child Code				Not Used	ENT06		
87	Hierarchical Child Code				Not Used	ENT07		
87	Hierarchical Child Code				Not Used	ENT08		
87	Hierarchical Child Code				Not Used	ENT09		
88	Loop ID: 2100B Individual Name	S	020	NM1				Relay name and identifier of the individual for whom the premium payment is being submitted.
88	Entity Identifier Code				R	NM101		EY – Employee Name QE – Policyholder
89	Entity Type Qualifier				R	NM102		1 – Person
89	Name Last or Organization Name				S	NM103		Individual Last Name
89	Name First				S	NM104		Subscriber First Name The first name is required when NM102 = "1".
89	Name Middle				S	NM105		Individual Middle Name
89	Name Prefix				S	NM106		Individual Name Prefix
89	Name Suffix				S	NM107		Individual Name Suffix
89	Identification Code Qualifier				S	NM108		Code designating structure used for Identification Code 34 – Social Security Number EI – Employee Identification Number ZZ – Insured's Unique Identification Number Required if NM109 present.
90	Identification Code				S	NM109		Individual Identifier Required if NM108 present.
90	Entity Relationship Code				Not Used	NM110		
90	Entity Identification Code				Not Used	NM111		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
91	Loop ID: 2300B Individual Premium Remittance Detail	S	150	RMR				Detailed remittance information related to an employee or member of a group plan including start and end coverage period date associated with premium payment. Required for HIPAA health premium payments.
92	Reference Identification Qualifier				R	RMR01		11 – Account Number 9J – Pension Contract AZ – Health Insurance Policy Number B7 – Life Insurance Policy Number CT – Contract Number ID – Insurance Certificate Number IG – Insurance Policy Number IK – Invoice Number KW – Certification Required for HIPAA health premium payments: Health Plan Invoice Required ID Not received AZ Received IK Required if RMR02 present.
92	Reference Identification Qualifier				R	RMR02		Insurance Remittance Reference Number Required if RMR01 present.
92	Payment Action Code Note: Field is not used for HIPAA health premium payments.		Not Used for Premium Processing		S	RMR03		PI – Pay Item PP – Partial Payment
93	Monetary Amount				R	RMR04		Amount being paid on this remittance item
93	Monetary Amount Note: Field is required when paid amount is different than amount billed.				S	RMR05		Billed premium amount
93	Monetary Amount				Not Used	RMR06		
93	Adjustment Reason Code				Not Used	RMR07		
93	Monetary Amount				Not Used	RMR08		
94	Individual Coverage Period	S	180	DTM				Coverage period start and end date Required when premium payer is not paying from an invoice but paying on account for a coverage period.
94	Date/ Time Qualifier				R	DTM01	582	Report Period
94	Date				Not Used	DTM02		
95	Time				Not Used	DTM03		
95	Time Code				Not Used	DTM04		
95	Date / Time Period Format Qualifier				R	DTM05	RD8	Code indicating date, time, or date & time format CCYYMMDD_CCYYMMDD At least 1 instance of DTM05 required. Required if DTM06 present.
95	Date / Time Period				R	DTM06		Coverage Period Required if DTM05 present.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
96	Loop ID: 2320B Individual Premium Adjustment	S	210	ADX				Make adjustments to individual premium remittance detail. Required when amount paid is different from any invoiced amount.
96	Monetary Amount				R	ADX01		Adjustment Amount
97	Adjustment Reason Code				R	ADX02		20 – Balance Due Declined (Used when entire balance due is disputed) 52 – Credit for Previous Overpayment 53 – Remittance for Previous Underpayment AA – Prepaid Benefit or Advances AX – Person no longer employed (Never use as substitute for 834 termination transaction) H1 – Information Forthcoming (Detail provided through separate mechanism) H6 – Partial Payment Remitted (Payer does not have sufficient funds to remit full balance due) IA – Invoice Amount Does Not Match Account Analysis Statement (Invoice does not match expected number / type of members & charges) J3 – Promised Adjustment Not Received (Adjustment promised for previous invoice not reflected in current invoice)
97	Reference Identification Qualifier				Not Used	ADX03		
97	Identification Code				Not Used	ADX04		

Table 3 — Summary

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
98	820 Trailer	R	010	SE				
	Functional Group Trailer			SE				
	Number of Included Segments				R	SE01		Transaction segment count. Total number of segments included in transaction set including ST & SE
	Transaction Set Control Number				R	SE02		[Should match ST02]

ENVELOPE — Close

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
B.10	Functional Group Trailer			GE				
B.10	Functional Group Trailer			GE				
B.10	Number of Transaction Sets Included				R	GE01		Total number of transaction sets included in the functional group or interchange group terminated by the trailer containing this data element
B.10	Group Control Number				R	GE02		Assigned number originated and maintained by the sender
B.7	Interchange Control Trailer			IEA				
B.7	Number of Included Functional Groups				R	IEA01		A count of the number of functional groups included in an interchange
B.7	Interchange Control Number				R	IEA02		Assigned number originated and maintained by the sender

APPENDICES

820 Transaction Record Relationships

