



Forum Companion Document

For use with ANSI ASC X12N
Health Care Claim: Payment/Advice
Implementation Guide and Addenda

Health Care Claim: Payment/Advice 835

ASC X12N 835 (004010X091A1)

“Expanded Data Requirements”

*Version:
November 28, 2005*

System Interface Mapping

The following matrix identifies the recommended usage of the data elements when the 835 Health Care Claim Payment/Advice transaction is being 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 *ASC X12N Health Care Claim Payment/Advice Implementation Guide*.

The columns for the matrix are:

- Page#: The page number from the Implementation Guide ASC X12N 837 Professional (004010X098) Rev Nov 1999.
- Name: Industry Name (from Implementation Guide) where available. If there is no industry name available, the standard name is used. Any aliases shown in the Implementation Guide are not always listed.
- Seg. Reqmt: (Segment Requirement): 'R' - Required, 'S' – Situational
- Pos#: Position Number (from Implementation Guide)
- Seg. ID: Segment ID (from Implementation Guide)
- Data Element Usage: A 'Not Used' in this column means that the Implementation Guide dictates this data field is not to be used.
- Data Element ID: (from Implementation Guide)
- Qualifier: A value appearing in this column will indicate that the value is the preferred value. (Only single values for a data element will appear in this column.)
- Qualifier Description: List of possible values. Values that are not meaningful to health plans will be designated with a strikethrough (e.g. ~~value~~). When and as appropriate, comments and conventions about usage will appear in this column.

The Implementation Guide identifies some data segments and data elements that do not apply to typical and likely business scenarios. These data segments and data elements are highlighted in the System Interface Map section of this Companion Document so that providers and intermediaries will not waste time determining how to process them. These situations will be designated on the System Interface Map with the following note:

- *Not Populated by Health Plan* – This note will be used when the data element is 'Situational'.

These data segments and data elements will be populated if those rare business scenarios occur.

Description of the layout of the data

The data in the Implementation Guide is grouped in what it calls “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.

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	
040	TRN	Reassociation Trace Number	R	1	
050	CUR	Foreign Currency Information	S	1	
060	REF	Receiver Identification	S	1	
060	REF	Version Identification	S	1	
070	DTM	Production Date	S	1	
Loop	ID:	1000A Payer Identification			1
080	N1	Payer Identification	R	1	
100	N3	Payer Address	R	1	
110	N4	Payer City, State, ZIP Code	R	1	
120	REF	Additional Payer Identification	S	4	
130	PER	Payer Contact Information	S	1	
Loop	ID:	1000B Payee Identification			1
080	N1	Payee Identification	R	1	
100	N3	Payee Address	S	1	
110	N4	Payee City, State, ZIP Code	S	1	
120	REF	Payee Additional Identification	S	>1	

TABLE 2 – Detail

Loop	ID:	2000 Header Number			>1
003	LX	Header Number	S	1	
005	TS3	Provider Summary Information	S	1	
007	TS2	Provider Supplemental Summary Information	S	1	
Loop	ID:	2100 Claim Payment Information			>1
010	CLP	Claim Payment Information	R	1	
020	CAS	Claim Adjustment	S	99	
030	NM1	Patient Name	R	1	
030	NM1	Insured Name	S	1	
030	NM1	Corrected Patient/Insured Name	S	1	
030	NM1	Service Provider Name	S	1	
030	NM1	Crossover Carrier Name	S	1	

030	NM1	Corrected Priority Payer Name	S	2	
033	MIA	Inpatient Adjudication Information	S	1	
035	MOA	Outpatient Adjudication Information	S	1	
040	REF	Other Claim Related Identification	S	5	
040	REF	Rendering Provider Identification	S	10	
050	DTM	Claim Date	S	4	
060	PER	Claim Contact Information	S	3	
062	AMT	Claim Supplemental Information	S	14	
064	QTY	Claim Supplemental Information Quantity	S	15	
Loop	ID:	2110 Service Payment Information			999
070	SVC	Service Payment Information	S	1	
080	DTM	Service Date	S	3	
090	CAS	Service Adjustment	S	99	
100	REF	Service Identification	S	7	
100	REF	Rendering Provider Information	S	10	
110	AMT	Service Supplemental Amount	S	12	
120	QTY	Service Supplemental Quantity	S	6	
130	LQ	Health Care Remark Codes	S	99	

TABLE 3 – Summary

010	PLB	Provider Adjustment	S	>1	
020	SE	Transaction Set 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	R	010	ISA				
B.3	Authorization Information Qualifier				R	ISA01		00 - No Authorization Information Present (ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF ADDITIONAL IDENTIFICATION INFORMATION.) 03 – Additional Date Identification
B.3	Authorization Information				R	ISA02		
B.4	Security Information Qualifier				R	ISA03		00 - No Security Information Present (ADVISED UNLESS SECURITY REQUIREMENTS MANDATE USE OF PASSWORD DATA.) 01 – Password
B.4	Security Information				R	ISA04		
B.4	Interchange ID Qualifier				R	ISA05		01 – Duns (Dun & Bradstreet) 14 – Duns Plus Suffix 20 – Health Industry Number (HIN) 27 – Carrier Identification Number as assigned by HCFA 28 – Fiscal Intermediary Identification Number as assigned by HCFA 29 – Medicare Provider and Supplier Identification Number as assigned by HCFA 30 – U.S. Federal Tax Identification Number 33 – National Association of Insurance Commissioners Company Code (NAIC) ZZ – Mutually Defined
B.4	Interchange Sender ID				R	ISA06		ID Code of Sender First Choice Health = Contact Payer GHC = GHNM GHO = OPNM Premera = Contact Payer Regence = Contact Payer Asuris = Contact Payer

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
B.4	Interchange ID Qualifier				R	ISA07		01 – Duns (Dun & Bradstreet) 14 – Duns Plus Suffix 20 – Health Industry Number (HIN) 27 – Carrier Identification Number as assigned by HCFA 28 – Fiscal Intermediary Identification Number as assigned by HCFA 29 – Medicare Provider and Supplier Identification Number as assigned by HCFA 30 – U.S. Federal Tax Identification Number 33 – National Association of Insurance Commissioners Company Code (NAIC) ZZ – Mutually Defined
B.5	Interchange Receiver ID				R	ISA08		ID Code of Receiver
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 T	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	HP	HP – Health Care Claim Payment/Advice (835)
B.8	Application Sender's Code				R	GS02		Code identifying party sending transmission, codes agreed to by trading partners First Choice Health = Contact Payer GHC = GHNM GHO = OPNM Premera = Contact Payer Regence = Contact Payer Asuris = Contact Payer
B.8	Application Receiver's Code				R	GS03		Code identifying party receiving transmission. Codes agreed to by trading partners
B.8	Date				R	GS04	CCYYMMDD	Creation Date

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
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	004010X091 A1	

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
43	Transaction Set Header	R	010	ST				
43	Transaction Set ID Code				R	ST01	835	Health Care Claim Payment/Advice
43	Transaction Set Control #				R	ST02		Assigned by sender
44	Financial Information	R	020	BPR				Use the BPR to address a single payment to a single payee. A payee may represent a single provider, a provider group, or multiple providers in a chain. The BPR contains mandatory information, even when it is not being used to move funds electronically.
45	Transaction Handling Code				R	BPR01		C – Payment Accompanies Remittance Advice D – Make Payment Only H – Notification Only I – Remittance Information Only P – Pronotification of Future Transfers U – Split Payment and Remittance X – Handling Party's Option to Split Payment and Remittance
46	Monetary Amount				R	BPR02		Total Actual Provider Payment Amount Use BPR02 for the total payment amount for this 835. The total payment amount for this 835 cannot exceed eleven characters, including decimals. Although the value can be zero, the 835 cannot be issued for less than zero dollars.
46	Credit/Debit Flag Code				R	BPR03	C	C – Credit D – Debit (NOT ADVISED)
46	Payment Method Code				R	BPR04		ACH – Automated Clearing House (ACH) BOP – Financial Institution Option CHK – Check FWT – Federal Reserve Funds/Wire Transfer – Nonrepetitive NON – Non-Payment Data
47	Payment Format Code				S	BPR05		When BPR04 is ACH, the recommended code values for BPR05 are CCP and DTX. When BPR04 is any other code, this data element should not be used. CCP – Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) CTX – Corporate Trade Exchange (CTX)(ACH)

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
48	(DFI) ID Number Qualifier				S	BPR06		Depository Financial Institution (DFI) Identification Number Qualifier BPR06 thru BPR09 relate to the originating financial institution and the originator's account (payer). This element is required when BPR04 is ACH, BOP or FWT. 01 - ABA Transit Routing Number including Check Digits (9 digits) 04 - Canadian Bank Branch and Institution Number
48	(DFI) Identification Number				S	BPR07		Sender DFI Identifier This element is required when BPR04 is ACH, BOP or FWT.
48	Account Number Qualifier				S	BPR08	DA	DA - Demand Deposit This element is required when BPR04 is ACH, BOP or FWT.
49	Account Number				S	BPR09		Sender Bank Account Number This element is required when BPR04 is ACH, BOP or FWT.
49	Originating Company Identifier				S	BPR10		Payer Identifier Must be the Federal Tax ID number, preceded by a "1". When BPR10 is used, it must be identical to TRN03. This element is required when BPR04 is ACH, BOP or FWT.
49	Originating Company Supplemental Code				S	BPR11		Use this code to further identify the payer by division or region. If used, this code must be identical to TRN04.
49	(DFI) ID Number Qualifier				S	BPR12		BPR12 through BPR15 relate to the receiving financial institution and the receiver's account. This element is required when BPR04 is ACH, BOP or FWT. 01 - ABA Transit Routing Number including Check Digits (9 digits) 04 - Canadian Bank Branch and Institution Number
50	(DFI) ID Number				S	BPR13		Receiver or Provider Bank ID Number This element is required when BPR04 is ACH, BOP or FWT.
50	Account Number Qualifier				S	BPR14		This element is required when BPR04 is ACH, BOP or FWT. DA - Demand Deposit SG - Savings

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
50	Account Number				S	BPR15		Receiver or Provider Account Number This element is required when BPR04 is ACH, BOP or FWT.
50	Date				R	BPR16		Check Issue or EFT Effective Date See notes in implementation guide.
50	Business Function Code				Not Used	BPR17		Not Used
50	(DFI) ID Number Qualifier				Not Used	BPR18		Not Used
50	(DFI) Identification Number				Not Used	BPR19		Not Used
51	Account Number Qualifier				Not Used	BPR20		Not Used
51	Account Number				Not Used	BPR21		Not Used
52	Reassociation Trace Number	R	040	TRN				This segment's purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.
52	Trace Type Code				R	TRN01	1	1 – Current Transaction Trace Numbers
53	Reference Identification				R	TRN02		Check or EFT Trace Number This number must be unique within the sender/receiver relationship. This number is assigned by the sender. For example, if a payment is made by check, this number should be the check number. Note: For non-payment transactions this is a unique number generated by the transaction set originator.
53	Originating Company Identifier				R	TRN03		Payer Identifier Must contain the Federal Tax ID Number, preceded by a "1". When BPR10 is used, it must be identical to TRN03.
53	Reference Identification				S	TRN04		Originating Company Supplemental Code
54	Foreign Currency Information	S	050	CUR				Use the CUR segment in the 835 to specify the currency and exchange rate, if applicable, when the payment is not being made in United States dollars or when the payment is made in a currency different from that in the original claim.
55	Entity Identifier Code				R	CUR01	PR	PR – Payer (REQUIRED)
55	Currency Code				R	CUR02		Code Source: 5
55	Exchange Rate				S	CUR03		Value to be used as a multiplier conversion factor to convert monetary value from one currency to another.
55	Entity Identifier Code				Not Used	CUR04		Not Used
55	Currency Code				Not Used	CUR05		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
56	Currency Market/Exchange Code				Not Used	CUR06		Not Used
56	Date/Time Qualifier				Not Used	CUR07		Not Used
56	Date				Not Used	CUR08		Not Used
56	Time				Not Used	CUR09		Not Used
56	Date/Time Qualifier				Not Used	CUR10		Not Used
56	Date				Not Used	CUR11		Not Used
56	Time				Not Used	CUR12		Not Used
56	Date/Time Qualifier				Not Used	CUR13		Not Used
56	Date				Not Used	CUR14		Not Used
56	Time				Not Used	CUR15		Not Used
56	Date/Time Qualifier				Not Used	CUR16		Not Used
56	Date				Not Used	CUR17		Not Used
56	Time				Not Used	CUR18		Not Used
56	Date/Time Qualifier				Not Used	CUR19		Not Used
56	Date				Not Used	CUR20		Not Used
56	Time				Not Used	CUR21		Not Used
57	Receiver Identification	S	060	REF				Use this segment only when the receiver of the transaction is other than the payee (e.g., Clearing House or billing service ID).
57	Reference Identification Qualifier				R	REF01	EV	EV – Receiver Identification Number
57	Reference Identification				R	REF02		Receiver Identifier
57	Description				Not Used	REF03		Not Used
57	Reference Identifier				Not Used	REF04		Not Used
58	Version Identification	S	060	REF				Use this segment to report the version number of the adjudication system that generated the claim payments in this transaction.
58	Reference Identification Qualifier				R	REF01	F2	F2 – Version Code – Local
58	Reference Identification				R	REF02		Version Identification Code
59	Description				Not Used	REF03		Not Used
59	Reference Identifier				Not Used	REF04		Not Used
60	Production Date	S	070	DTM				Under most circumstances, this segment is expected to be sent. The production date must be supplied when the cutoff date of the adjudication system is different from the date of the 835.
60	Date/Time Qualifier				R	DTM01	405	405 – Production Use this code for the end date for the adjudication production cycle for claims included in this 835.
61	Date				R	DTM02		Production Date
61	Time				Not Used	DTM03		Not Used
61	Time Code				Not Used	DTM04		Not Used
61	Date Time Period Format Qualifier				Not Used	DTM05		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
61	Date Time Period				Not Used	DTM06		Not Used
62	Loop ID: 1000A Payer Identification	R	080	N1				Use this N1 loop to provide the name/address information for the payer. The payer's secondary identifying reference number should be provided in N104, if necessary.
62	Entity Identifier Code				R	N101	PR	PR – Payer
63	Name				S	N102		Payer Name Required if the National PlanID is not transmitted in N104.
63	Identification Code Qualifier				S	N103		XV – HCFA National Plan ID Required if the National PlanID is not transmitted in N104.
63	Identification Code				S	N104		Payer Identifier
63	Entity Relationship Code				Not Used	N105		Not Used
63	Entity Identifier Code				Not Used	N106		Not Used
64	Payer Address	R	100	N3				To specify the location of the named party.
64	Address Information				R	N301		Payer Address Line
64	Address Information				S	N302		Payer Address Line Required if a second address line exists.
65	Payer City, State, Zip Code	R	110	N4				To specify the geographic place of the named party.
65	City Name				R	N401		Payer City Name
65	State or Province Code				R	N402		Payer State Code
65	Postal Code				R	N403		Payer Postal Zone or Zip Code
65	Country Code				Not Used	N404		Not Used
66	Location Qualifier				Not Used	N405		Not Used
66	Location Identifier				Not Used	N406		Not Used
67	Additional Payer Identification	S	120	REF				Under most circumstances, this segment is not sent.
67	Reference Identification Qualifier				R	REF01		2U – Payer Identification Number EO – Submitter Identification Number HI – Health Industry Number (HIN) NF – National Association of Insurance Commissioners (NAIC) Code (ADVISED)
68	Reference Identification				R	REF02		Additional Payer Identifier
68	Description				Not Used	REF03		Not Used
68	Reference Identifier				Not Used	REF04		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
69	Payer Contact Information	S	130	PER				This should be used anytime the payee cannot be reasonably expected to know how to contact the payer about this remittance advice.
70	Contact Function Code		<i>Not Populated By Health Plan</i>		R	PER01	CX	CX – Payers Claim Office
70	Name			S	PER02			Payer Contact Name
70	Communication Number Qualifier			S	PER03			EM – Electronic Mail FX – Facsimile TE – Telephone
70	Communication Number			S	PER04			Payer Contact Communication Number
71	Communication Number Qualifier			S	PER05			EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
71	Communication Number			S	PER06			Payer Contact Communication Number
71	Communication Number Qualifier			S	PER07		EX	Use this code only to provide the extension for the previous communications contact number. EX – Telephone Extension
71	Communication Number			S	PER08			Payer Contact Communication Number
71	Contact Inquiry Reference			Not Used	PER09			Not Used
74	Loop ID: 1000B Payee Address	S		080	N			
72	Payee Identification	R	080	N1				Use this N1 loop to provide the name/address information of the payee. The identifying number should be provided in N104.
72	Entity Identifier Code				R	N101	PE	PE – Payee
73	Name				S	N102		Payee Name Required when N104 does not contain the National Provider Identifier.
73	Identification Code Qualifier				R	N103	FI	Required when N104 does not contain the National provider identifier. FI – Federal Taxpayer's Identification Number XX – HCFA National Provider Identifier
73	Identification Code				R	N104		Payee Identification Code
73	Entity Relationship Code				Not Used	N105		Not Used
73	Entity Identifier Code				Not Used	N106		Not Used
74	Address Information				R	N301		Payee Address Line
74	Address Information				S	N302		Payee Address Line Required if a second address line exists.
75	Payee City, State, Zip Code	S	110	N4				Using this segment is at the discretion of the payer contingent on the business needs of the payee (receiver).
75	City Name				R	N401		Payee City Name

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
75	State or Province Code				R	N402		Payee State Code
76	Postal Code				R	N403		Payee Postal Zone or Zip Code
76	Country Code				S	N404		Required if country is other than USA.
76	Location Qualifier				Not Used	N405		Not Used
76	Location Identifier				Not Used	N406		Not Used
77	Payee Additional Identification	S	120	REF				Use this REF segment only when more than one identification number is required to identify the payee. Always use the ID number available in the N1 segment before using the REF segment.
77	Reference Identification Qualifier		<i>Not Populated By Health Plan</i>		R	REF01		0B – State License Number 1A – Blue Cross Provider Number (NOT ADVISED) 1B – Blue Shield Provider Number (NOT ADVISED) 1C – Medicare Provider Number (NOT ADVISED) 1D – Medicaid Provider Number (NOT ADVISED) 1E – Dentist License Number (NOT ADVISED) 1F – Anesthesia License Number (NOT ADVISED) 1G – Provider UPIN Number 1H – CHAMPUS ID Number (NOT ADVISED) D3 – National Association of Boards of Pharmacy Number G2 – Provider Commercial Number (NOT ADVISED) N5 – Provider Plan Network ID Number (NOT ADVISED) PQ – Payee Identification TJ – Federal Taxpayer’s Identification Number
78	Reference Identification				R	REF02		Additional Payee Identifier
78	Description				Not Used	REF03		Not Used
78	Reference Identifier				Not Used	REF04		Not Used

TABLE 2 - Detail

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
79	Loop ID: 2000 Header Number	S	003	LX				The LX segment is required whenever any information in the LX loop is included in the transaction. See Notes in implementation guide.
79	Assigned Number				R	LX01		Number assigned for differentiation within a transaction set.
80	Provider Summary Information	S	005	TS3				See Notes in implementation guide.
81	Reference Identification		<i>Not Populated By Health Plan</i>		R	TS301		Provider Identifier Use this number for the provider number.
81	Facility Code Value			R	TS302		Facility Type Code	
81	Date			R	TS303		Fiscal Period Date Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, use December 31 st of the current year.	
81	Quantity			R	TS304		Total Claim Count Use this number for the total number of claims.	
82	Monetary Amount			R	TS305		Total Claim Charge Amount Use this monetary amount for the total reported charges for all claims.	
82	Monetary Amount			S	TS306		Total Covered Charge Amount Use this monetary amount for the total covered charges. This is submitted charges less the non-covered charges.	
82	Monetary Amount			S	TS307		Total Noncovered Charge Amount Use this monetary amount for the total of non-covered charges.	
82	Monetary Amount			S	TS308		Total Denied Charge Amount Use this monetary amount for the total of denied charges.	
82	Monetary Amount			S	TS309		Total Provider Payment Amount Use this monetary amount for the total provider payment. The total provider payment amount includes the total of all interest paid. The amount can be less than zero.	
82	Monetary Amount			S	TS310		Total Interest Amount Use this monetary amount for the total amount of interest paid.	
82	Monetary Amount			S	TS311		Total Contractual Adjustment Amount Use this monetary amount for the total contractual adjustment.	
83	Monetary Amount			S	TS312		Total Gramm-Rudman Reduction Amount Use this monetary amount for the total Gramm-Rudman adjustment.	

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
83	Monetary Amount				S	TS313		Total MSP Payer Amount Use this monetary amount for the total MSP primary payer amount.
83	Monetary Amount				S	TS314		Total Blood Deductible Amount Use this monetary amount for the total blood deductible amount in dollars.
83	Monetary Amount				S	TS315		Total Non-Lab Charge Amount Use this monetary amount for the sum of non-lab charges.
83	Monetary Amount				S	TS316		Total Coinsurance Amount Use this monetary amount for the total coinsurance amount.
83	Monetary Amount				S	TS317		Total HCPCS Reported Charge Amount Use this monetary amount for the total of HCPCS reported charges.
83	Monetary Amount				S	TS318		Total HCPCS Payable Amount Use this monetary amount for the total HCPCS payable amount.
84	Monetary Amount				S	TS319		Total Deductible Amount Use this monetary amount for the total cash deductible.
84	Monetary Amount				S	TS320		Total Professional Component Amount Use this monetary amount for the total professional component amount. The professional component amount must also be reported in the CAS segment with a Claim Adjustment Reason Code value of 89.
84	Monetary Amount				S	TS321		Total MSP Patient Liability Met Amount Use this monetary amount for the total MSP patient liability met amount.
84	Monetary Amount				S	TS322		Total Patient Reimbursement Amount Use this monetary amount for the total patient reimbursement.
84	Quantity				S	TS323		Total PIP Claim Count Use this number for the total PIP number of claims.
84	Monetary Amount				S	TS324		Total PIP Adjustment Amount Use this monetary amount for the payment amount for PIP claims.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
85	Provider Supplemental Summary Information	S	007	TS2				Use the TS2 segment only after a TS3 segment. This segment provides summary information specific to an iteration of the LX loop. This segment is expected to be used only for Medicare Part A claims. All situational quantities and amount in this segment are required when the value of the item is different than zero. Each total is for that provider for this type of bill for this fiscal period.
86	Monetary Amount		<i>Not Populated By Health Plan</i>		S	TS201		Total DRG Amount For Medicare, this includes: operating federal-specific amount, operating hospital-specific amount, operating indirect Medical Education amount, and operating Disproportionate Share Hospital amount. It does not include any operating outlier amount.
86	Monetary Amount			S	TS202		Total Federal Specific Amount	
86	Monetary Amount			S	TS203		Total Hospital Specific Amount	
86	Monetary Amount			S	TS204		Total Disproportionate Share Amount	
86	Monetary Amount			S	TS205		Total Capital Amount For Medicare, this includes: capital federal-specific amount, hospital federal-specific amount, hold harmless amount, Indirect Medical Education amount, Disproportionate Share Hospital amount, and the exception amount. It does not include any capital outlier amount.	
87	Monetary Amount			S	TS206		Total Indirect Medical Education Amount	
87	Quantity			S	TS207		Total Outlier Day Count	
87	Monetary Amount			S	TS208		Total Day Outlier Amount	
87	Monetary Amount			S	TS209		Total Cost Outlier Amount	
87	Quantity			S	TS210		Average DRG Length of Stay	
87	Quantity			S	TS211		Total Discharge Count Use this number for the total number of discharges. For Medicare, this is the discharge count produced by PPS PRICER SOFTWARE.	
87	Quantity			S	TS212		Total Cost Report Day Count	
88	Quantity			S	TS213		Total Covered Day Count	
88	Quantity			S	TS214		Total Noncovered Day Count	
88	Monetary Amount			S	TS215		Total MSP Pass-Through Amount Use this amount for the total MSP pass through amount calculated for a non-Medicare payer.	
88	Quantity			S	TS216		Average DRG Weight	
88	Monetary Amount			S	TS217		Total PPS Capital FSP DRG Amount	

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
88	Monetary Amount				S	TS218		Total PPS Capital HSP DRG Amount
88	Monetary Amount				S	TS219		Total PPS DSH DRG Amount
89	Loop ID: 2100 Claim Payment Information	R	010	CLP				To supply information common to all services of a claim.
89	Claim Submitter's Identifier				R	CLP01		Patient Control Number See notes in implementation guide.
90	Claim Status Code				R	CLP02		1 – Processed as Primary 2 – Processed as Secondary 3 – Processed as Tertiary 4 – Denied 5 – Pended (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it. 10 – Received, but not in process (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it. 13 – Suspended (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it. 15 – Suspended – investigation with field (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it. 16 – Suspended – return with material (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it. 17 – Suspended – review pending (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it. 19 – Processed as Primary, Forwarded to Additional Payer(s) 20 – Processed as Secondary, Forwarded to Additional Payer(s) 21 – Processed as Tertiary, Forwarded to Additional Payer(s) 22 – Reversal of Previous Payment 23 – Not Our Claim, Forwarded to Additional Payer(s) 25 – Predetermination Pricing Only – No Payment 27 – Reviewed (NOT ADVISED) – Claims with this status should be reported in the Claim Status (277) transaction when the payer implements it.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
91	Monetary Amount				R	CLP03		Total Claim Charge Amount See notes in implementation guide.
91	Monetary Amount				R	CLP04		Claim Payment Amount See notes in implementation guide.
91	Monetary Amount				S	CLP05		Patient Responsibility Amount See notes in implementation guide.
92	Claim Filing Indicator Code				R	CLP06		See notes in implementation guide. 12 – PPO (Use this code for Blue Cross/Blue Shield par arrangements.) 13 – Point of Service 14 – Exclusive Provider Organization (EPO) 15 – Indemnity Insurance (Use this code for Blue Cross/Blue Shield non-par arrangements.) 16 – HMO Medicare Risk AM – Automobile Medical CH – Champus DS – Disability HM – Health Maintenance Organization (HMO) LM – Liability Medical MA – Medicare Part A MB – Medicare Part B MC – Medicaid OF – Other Federal Program (Use this code for the Black Lung Program.) TV – Title V VA – Veteran Administration Plan WC – Workers' Compensation Health Claim
93	Reference Identification				S	CLP07		Payer Claim Control Number Use this number for the payer's internal control number. This number must apply to the entire claim. Report service variations at the SVC loop. This must be provided whenever the PAYER assigns an internal claim number and desires this reference from the provider as a part of any customer service contact or appeal process.
93	Facility Code Value				S	CLP08		Facility Type Code State the facility code here when the submitted code has been modified through adjudication. This code is expected to be from the same code list as that identified in the original claim. This number was received in CLM05-1 of the 837 claim.
93	Claim Frequency Type Code				S	CLP09		This data element is specific to institutional claims and is required when it was received on the original claim. This does not apply to other types of claims. This number was received in CLM05-2 of the 837 claim.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
93	Patient Status Code				Not Used	CLP10		Not Used
93	Diagnosis Related Group (DRG) Code				S	CLP11		This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims.
93	Quantity		Not Populated By Health Plan		S	CLP12		Diagnosis Related Group (DRG) Weight This data element is specific to institutional claims and is required when adjudication considers the DRG. This does not apply to other types of claims. Use this number for the DRG Weight.
94	Percent				S	CLP13		Discharge Fraction This data element is specific to institutional claims and is required when considered in the adjudication process. This does not apply to other types of claims. Use this number for the discharge fraction.
95	Claim Adjustment	S	020	CAS				See notes in Implementation guide.
97	Claim Adjustment Group Code				R	CAS01		Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the implementation guide for additional information. (This does not mean that the adjustments must be reported in this order.) CO – Contractual Obligations CR – Correction and Reversals OA – Other Adjustments PI – Payer Initiated Reductions PR – Patient Responsibility
97	Claim Adjustment Reason Code				R	CAS02		Code Source 139: Claim Adjustment Reason Code
97	Monetary Amount				R	CAS03		Adjustment Amount Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04.
98	Quantity				S	CAS04		Adjustment Quantity A positive value decreases the paid units of service, and a negative number increases the paid units. This element may be used only when the units of service are being adjusted.
98	Claim Adjustment Reason Code				S	CAS05		Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
98	Monetary Amount				S	CAS06		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
98	Quantity				S	CAS07		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
98	Claim Adjustment Reason Code				S	CAS08		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
99	Monetary Amount				S	CAS09		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
99	Quantity				S	CAS10		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
99	Claim Adjustment Reason Code				S	CAS11		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
99	Monetary Amount				S	CAS12		Adjustment Amount Used when additional adjustments apply within the group identified in CAS01.
99	Quantity				S	CAS13		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
100	Claim Adjustment Reason Code				S	CAS14		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
100	Monetary Amount				S	CAS15		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
100	Quantity				S	CAS16		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
100	Claim Adjustment Reason Code				S	CAS17		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
100	Monetary Amount				S	CAS18		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
101	Quantity				S	CAS19		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
102	Patient Name	R	030	NM1				Provide the patient's identification number in NM109.
102	Entity Identifier Code				R	NM101	QC	QC – Patient
103	Entity Type Qualifier				R	NM102	1	1 – Person
103	Name Last or Organization Name				R	NM103		Patient Last Name
103	Name First				R	NM104		Patient First Name
103	Name Middle				S	NM105		Patient Middle Name
103	Name Prefix				Not Used	NM106		Not Used
103	Name Suffix				S	NM107		Patient Name Suffix The suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.
103	Identification Code Qualifier				S	NM108	MI	Required if the patient identifier is known or was reported on the health care claim. 34 – Social Security Number HN – Health Insurance Claim (HIC) Number (ADVISED) II – United States National Individual Identifier This code is not part of the ASC X12 004010 release. Use this code if mandated in a final Federal Rule. MI – Member Identification Number MR – Medicaid Recipient Identification Number
104	Identification Code				S	NM109		Patient Identifier Required if the patient identifier is known or was reported on the health care claim.
104	Entity Relationship Code				Not Used	NM110		Not Used
104	Entity Identifier Code				Not Used	NM111		Not Used
105	Insured Name	S	030	NM1				Use this NM1 segment to identify the insured or subscriber whenever the insured or subscriber is different from the patient. Any necessary identification number should be provided in NM109. In the case of Medicare and Medicaid, the insured patient is always the subscriber and this segment should not be used.
106	Entity Identifier Code				R	NM101	IL	IL – Insured or Subscriber
106	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
106	Name Last or Organization Name				S	NM103		Subscriber Last Name
106	Name First				S	NM104		Subscriber First Name Required when the subscriber is a person (NM102=1).

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description	
106	Name Middle				S	NM105		Subscriber Middle Name Required if the subscriber is a person (NM102=1) and the information is known.	
106	Name Prefix				Not Used	NM106		Not Used	
106	Name Suffix				S	NM107		Subscriber Name Suffix The suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber. Required if the subscriber is a person (NM102=1) and the information is known.	
107	Identification Code Qualifier				R	NM108	MI	34 – Social Security Number HN – Health Insurance Claim (HIC) Number MI – Member Identification Number – Use this number for the payer's ID number for the insured.	
107	Identification Code				R	NM109		Subscriber Identifier	
107	Entity Relationship Code				Not Used	NM110		Not Used	
107	Entity Identifier Code				Not Used	NM111		Not Used	
108	Corrected Patient/Insured Name	S	030	NM1				Use this NM1 segment to provide corrected information about the patient or insured. Because the patient is always the insured for Medicare and Medicaid, this segment always provides corrected patient information for Medicare and Medicaid. For other carriers, this will always be the corrected insured information.	
108	Entity Identifier Code		<i>Not Populated By Health Plan</i>		R	NM101	74	74 – Corrected Insured	
109	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity	
109	Name Last or Organization Name				S	NM103		Corrected Patient or Insured Last Name Required when corrected information for the insured is available.	
109	Name First				S	NM104		Corrected Patient or Insured First Name Required when corrected information for the insured is available. This element may only be used when NM102=1.	
109	Name Middle				S	NM105		Corrected Patient or Insured Middle Name Required when corrected information for the insured is available.	
109	Name Prefix				Not Used	NM106		Not Used	
109	Name Suffix				S	NM107		Corrected Patient or Insured Name Suffix Required when corrected information for the insured is available.	
109	Identification Code Qualifier					S	NM108	C	Required when a value is reported in NM109. C – Insured's Changed Unique Identification Number

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
110	Identification Code				S	NM109		Corrected Insured Identification Indicator Required when corrected information for the insured is available.
110	Entity Relationship Code				Not Used	NM110		Not Used
110	Entity Identifier Code				Not Used	NM111		Not Used
111	Service Provider Name	S	030	NM1				Use this NM1 segment to provide information about the rendering provider. Any reference number should be provided in NM109. This segment is required when the rendering provider is different from the Payee.
112	Entity Identifier Code				R	NM101	82	82 – Rendering Provider
112	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
112	Name Last or Organization Name				S	NM103		Rendering Provider Last or Organization Name Required when needed to confirm the identifier in NM109.
112	Name First				S	NM104		Rendering Provider First Name Required when needed to confirm the identifier in NM109.
112	Name Middle				S	NM105		Rendering Provider Middle Name
112	Name Prefix				Not Used	NM106		Not Used
112	Name Suffix				S	NM107		Rendering Provider Name Suffix The Suffix should be reported whenever this information is necessary for identification of the individual, for instance when a Junior and Senior are covered under the same subscriber.
113	Identification Code Qualifier				R	NM108		BD – Blue Cross Provider Number BS – Blue Shield Provider Number FI – Federal Taxpayer’s Identification Number (ADVISED) – For individual providers as payees, use this number to represent the Social Security Number. MC – Medicaid Provider Number PC – Provider Commercial Number SL – State License Number UP – Unique Physician Identification Number (UPIN) XX – HCFA National Provider Identifier
113	Identification Code				R	NM109		Rendering Provider Identifier
113	Entity Relationship Code				Not Used	NM110		Not Used
113	Entity Identifier Code				Not Used	NM111		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
114	Crossover Carrier Name	S	030	NM1				Use this NM1 segment to provide information about the crossover carrier. Provide any reference numbers in NM109. The crossover carrier is defined as any payer to which the claim is transferred for further payment after being finalized by the current payer.
114	Entity Identifier Code		Not Populated By Health Plan		R	NM101	TT	TT – Transfer To
115	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
115	Name Last or Organization Name				R	NM103		Coordination of Benefits Carrier Name Name of the crossover carrier associated with this claim.
115	Name First				Not Used	NM104		Not Used
115	Name Middle				Not Used	NM105		Not Used
115	Name Prefix				Not Used	NM106		Not Used
115	Name Suffix				Not Used	NM107		Not Used
115	Identification Code Qualifier				R	NM108		AD – Blue Cross Blue Shield Association Plan Code FI – Federal Taxpayer’s Identification Number NI – National Association of Insurance Commissioners (NAIC) Identification (ADVISED) PI – Payer Identification PP – Pharmacy Processor Number XV – HCFA National PlanID
115	Identification Code				R	NM109		Coordination of Benefits Carrier Identifier
115	Entity Relationship Code				Not Used	NM110		Not Used
115	Entity Identifier Code				Not Used	NM111		Not Used
116	Corrected Priority Payer Name	S	030	NM1				This segment is required when the current payer believes that another payer has priority for making a payment. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. It is not necessary to use the Crossover Carrier NM1 segment in addition to this segment.
116	Entity Identifier Code		Not Populated By Health Plan		R	NM101	PR	PR – Payer
117	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
117	Name Last or Organization Name				R	NM103		Corrected Priority Payer Name
117	Name First				Not Used	NM104		Not Used
117	Name Middle				Not Used	NM105		Not Used
117	Name Prefix				Not Used	NM106		Not Used
117	Name Suffix				Not Used	NM107		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
117	Identification Code Qualifier				R	NM108	AD FI NI PI PP XV	AD – Blue Cross Blue Shield Association Plan Code FI – Federal Taxpayer’s Identification Number NI – National Association of Insurance Commissioners (NAIC) Identification (ADVISED) PI – Payer Identification PP – Pharmacy Processor Number XV – HCFA National PlanID
117	Identification Code				R	NM109		Corrected Priority Payer Identification Number
117	Entity Relationship Code				Not Used	NM110		Not Used
117	Entity Identifier Code				Not Used	NM111		Not Used
118	Inpatient Adjudication Information	S	033	MIA				This segment should be generated by Medicare intermediaries. Either MIA or MOA will appear, but not both. This segment should not be used for covered days or lifetime reserve days. Use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Payers and Payees outside of Medicare community may need to use this segment.
119	Quantity		<i>Not Populated By Health Plan</i>		R	MIA01		Covered Days or Visits Count Implementers of this guideline always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.
119	Quantity			S	MIA02		PPS Operating Outlier Amount Additional payment for excessive cost incurred by provider.	
119	Quantity			S	MIA03		Lifetime Psychiatric Days Count	
120	Monetary Amount			S	MIA04		Claim DRG Amount	
120	Reference Identification			S	MIA05		Remark Code Used when a Remittance Remark Code applies to this claim.	
120	Monetary Amount			S	MIA06		Claim Disproportionate Share Amount	
120	Monetary Amount			S	MIA07		Claim MSP Pass-through Amount	
120	Monetary Amount			S	MIA08		Claim PPS Capital Amount	
120	Monetary Amount			S	MIA09		PPS-Capital FSP DRG Amount Use this monetary amount for the PPS capital, federal-specific portion DRG amount.	
120	Monetary Amount			S	MIA10		PPS-Capital HSP DRG Amount Use this monetary amount for the PPS capital, hospital-specific portion DRG amount.	

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
121	Monetary Amount				S	MIA11		PPS-Capital DSH DRG Amount Use this monetary amount for the PPS capital, disproportionate share, hospital DRG amount.
121	Monetary Amount				S	MIA12		Old Capital Amount
121	Monetary Amount				S	MIA13		PPS-Capital IME Amount Use this monetary amount for the PPS capital indirect medical education claim amount.
121	Monetary Amount				S	MIA14		PPS-Operating Hospital Specific DRG Amount Use this monetary amount for the PPS (operating)/ hospital-specific DRG amount.
121	Quantity				S	MIA15		Cost Report Day Count
121	Monetary Amount				S	MIA16		PPS-Operating Federal Specific DRG Amount
121	Monetary Amount				S	MIA17		Claim PPS Capital Outlier Amount This amount excludes the operating outlier amount, which is reflected in the AMT segment.
122	Monetary Amount				S	MIA18		Claim Indirect Teaching Amount
122	Monetary Amount				S	MIA19		Nonpayable Professional Component Amount Use this monetary amount for the professional component amount billed but not payable.
122	Reference Identification				S	MIA20		Remark Code
122	Reference Identification				S	MIA21		Remark Code
122	Reference Identification				S	MIA22		Remark Code
122	Reference Identification				S	MIA23		Remark Code
122	Monetary Amount				S	MIA24		PPS-Capital Exception Amount
123	Outpatient Adjudication Information	S	035	MOA				This segment should be generated by Medicare carriers or intermediaries. Either MIA or MOA will appear, but not both. All situational quantities and amounts in this segment are required when the value of the item is different than zero. Payers and payees outside of Medicare community may need to use this segment.
124	Percent				S	MOA01		Reimbursement Rate This does not apply to claims processed by Medicare Carriers.
124	Monetary Amount				S	MOA02		Claim HCPCS Payable Amount This does not apply to claims processed by Medicare Carriers.
124	Reference Identification				S	MOA03		Remark Code Used when a Remittance Remark Code applies to this claim.
124	Reference Identification				S	MOA04		Remark Code See MOA03. Used when additional remittance remarks apply to this claim.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
124	Reference Identification				S	MOA05		Remark Code See MOA03. Used when additional remittance remarks apply to this claim.
125	Reference Identification				S	MOA06		Remark Code See MOA03. Used when additional remittance remarks apply to this claim.
125	Reference Identification				S	MOA07		Remark Code See MOA03. Used when additional remittance remarks apply to this claim.
125	Monetary Amount				S	MOA08		Claim ESRD Payment Amount This does not apply to claims processed by Medicare Carriers.
125	Monetary Amount				S	MOA09		Nonpayable Professional Component Amount Use this monetary amount for the professional component amount billed but not payable. This does not apply to claims processed by Medicare Carriers.
126	Other Claim Related Identification	S	040	REF				Use this REF segment for reference numbers specific to the claim identified in the CLP segment. This is used to provide additional information used in the process of adjudicating this claim.
126	Reference Identification Qualifier				R	REF01		1L – Group or Policy Number 4W – Member Identification Number 9A – Repriced Claim Reference Number 9C – Adjusted Repriced Claim Reference Number A6 – Employee Identification Number BB – Authorization Number CE – Class of Contract Code EA – Medical Record Identification Number F8 – Original Reference Number G1 – Prior Authorization Number G3 – Predetermination of Benefits Identification Number IG – Insurance Policy Number SY – Social Security Number
127	Reference Identification				R	REF02		Other Claim Related Identifier
127	Description				Not Used	REF03		Not Used
127	Reference Identifier				Not Used	REF04		Not Used
128	Rendering Provider Identification	S	040	REF				This REF segment should be used to provide reference numbers that are not already identified in NM1 segments within the CLP loop. The NM1 segment should always contain the primary reference number. This segment should only be used when additional reference numbers were submitted on the original claim.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
128	Reference Identification Qualifier		<i>Not Populated By Health Plan</i>		R	REF01		1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1G – Provider UPIN Number 1H – CHAMPUS Identification Number D3 – National Association of Boards of Pharmacy Number G2 – Provider Commercial Number
129	Reference Identification				R	REF02		Rendering Provider Secondary Identifier
129	Description				Not Used	REF03		Not Used
129	Reference Identifier				Not Used	REF04		Not Used
130	Claim Date	S	050	DTM				Dates must be provided at the claim level, the service line level, or both. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear. When claim dates are not provided, service dates are required for every service line. When claim dates are provided, service dates are not required, but they may be used to “override” the claim dates for individual service lines.
131	Date/Time Qualifier				R	DTM01		036 – Expiration 050 – Received 232 – Claim Statement Period Start 233 – Claim Statement Period End
131	Date				R	DTM02		Claim Date Date expressed as CCYYMMDD.
131	Time				Not Used	DTM03		Not Used
131	Time Code				Not Used	DTM04		Not Used
131	Date Time Period Format Qualifier				Not Used	DTM05		Not Used
131	Date Time Period				Not Used	DTM06		Not Used
132	Claim Contact Information	S	060	PER				This segment should only be used when there is a claim specific communications contact instruction.
133	Contact Function Code				R	PER01	CX	CX – Payers Claim Office
133	Name				S	PER02		Claim Contact Name
133	Communication Number Qualifier				S	PER03		Required if a contact communications number is to be transmitted. EM – Electronic Mail FX – Facsimile TE – Telephone
133	Communication Number				S	PER04		Claim Contact Communication Number

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
134	Communication Number Qualifier				S	PER05		EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
134	Communication Number				S	PER06		Claim Contact Communication Number
134	Communication Number Qualifier				S	PER07	EX	Use this code only to provide the extension for the previous communications contact number. EX – Telephone Extension
134	Communication Number				S	PER08		Communication Number Extension
134	Contact Inquiry Reference				Not Used	PER09		Not Used
135	Claim Supplemental Information	S	062	AMT				Use this segment to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are non-zero.
135	Amount Qualifier Code				R	AMT01		AU – Coverage Amount – Use this monetary amount to report the total covered charges. D8 – Discount Amount – Prompt Pay Discount Amount DY – Per Day Limit F5 – Patient Amount Paid – Use this monetary amount for the amount the patient has already paid. I – Interest NL – Negative Ledger Balance – Used only by Medicare Part A and Medicare Part B. T – Tax T2 – Total Claim Before Taxes ZK – Federal Medicare or Medicaid Payment Mandate – Category 1 ZL – Federal Medicare or Medicaid Payment Mandate – Category 2 ZM – Federal Medicare or Medicaid Payment Mandate – Category 3 ZN – Federal Medicare or Medicaid Payment Mandate – Category 4 ZO – Federal Medicare or Medicaid Payment Mandate – Category 5 ZZ – Mutually Defined (NOT ADVISED) – Use this number for the operational cost or day outlier amount. (Used exclusively by Medicare Part A.)
136	Monetary Amount				R	AMT02		Claim Supplemental Information Amount
136	Credit/Debit Flag Code				Not Used	AMT03		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
137	Claim Supplemental Information Quantity	S	064	QTY				Use this segment to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific quantities identified in the QTY01 qualifier are non-zero.
137	Quantity Qualifier		<i>Not Populated By Health Plan</i>		R	QTY01		CA – Covered – Actual CD – Co-insured – Actual LA – Life-time Reserve – Actual LE – Life-time Reserve – Estimated NA – Number of Non-covered Days NE – Non-Covered – Estimated NR – Not Replaced Blood Units OU – Outlier Days PS – Prescription VS – Visits ZK – Federal Medicare or Medicaid Payment Mandate – Category 1 ZL – Federal Medicare or Medicaid Payment Mandate – Category 2 ZM – Federal Medicare or Medicaid Payment Mandate – Category 3 ZN – Federal Medicare or Medicaid Payment Mandate – Category 4 ZO – Federal Medicare or Medicaid Payment Mandate – Category 5
138	Quantity				R	QTY02		Claim Supplemental Information Quantity
138	Composite Unit of Measure				Not Used	QTY03		Not Used
138	Free-Form Message				Not Used	QTY04		Not Used
139	Loop ID: 2110 Service Payment Information	S	070	SVC				See Notes in implementation guide.
140	Composite Medical Procedure Identifier				R	SVC01		Use the adjudicated Medical Procedure Code.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
140	Product/Service ID Qualifier				R	SVC01-1		The value in SVC01-01 qualifies the values in SVC01-02,03,04,05, and SVC01-06. AD – American Dental Association Codes ER – Jurisdiction Specific Procedure and Supply Codes (this is specific to Workman’s Compensation Claims) HC – HCFA Common procedural Coding System (HCPCS) Codes – Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. ID – International Classification of Diseases Clinical Modification (ICD-9-CM) – Procedure IV – Home Infusion EDI Coalition (HIEC) Product/Service Code N1 – National Drug Code in 4-4-2 Format N2 – National Drug Code in 5-3-2 Format N3 – National Drug Code in 5-4-1 Format N4 – National Drug Code in 5-4-2 Format ND – National Drug Code (NDC) NU – National Uniform Billing Committee (NUBC) UB92 Codes RB – National Uniform Billing Committee (NUBC) UB82 Codes ZZ – Mutually Defined – This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code.
141	Product/Service ID				R	SVC01-2		Procedure Code
141	Procedure Modifier				S	SVC01-3		Procedure Modifier Required when procedure code modifiers apply to this service.
141	Procedure Modifier				S	SVC01-4		Procedure Modifier Required when procedure code modifiers apply to this service.
141	Procedure Modifier				S	SVC01-5		Procedure Modifier Required when procedure code modifiers apply to this service.
141	Procedure Modifier				S	SVC01-6		Procedure Modifier Required when procedure code modifiers apply to this service.
141	Description			<i>Not Populated By Health Plan</i>	S	SVC01-7		Procedure Code Description Used only when a description was received for the service on the original claim, and the adjudicated code is the submitted code.
142	Monetary Amount				R	SVC02		Line Item Charge Amount Use this monetary amount for the submitted service charge amount.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
142	Monetary Amount				R	SVC03		Line Item Provider Payment Amount Use this number for the service amount paid. The value in SVC03 should equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop.
142	Product/Service ID				S	SVC04		National Uniform Billing Committee Revenue Code Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If the original claim and adjudication only referenced an NUBC revenue code, that is supplied in SVC01 and this element is not used.
142	Quantity				S	SVC05		Units of Service Paid Count If not present, the value is assumed to be one.
142	Composite Medical Procedure Identifier				S	SVC06		This is REQUIRED when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. This is NOT USED when the submitted code is the same as the code on SVC01.
143	Product/Service ID Qualifier				R	SVC06-1		The value in SVC06-01 qualifies the values in SVC06-02,03,04,05, and SVC06-06. AD – American Dental Association Codes ER – Jurisdiction Specific Procedure and Supply Codes (this is specific to Workman's Compensation Claims) HC – HCFA Common procedural Coding System (HCPCS) Codes – Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. ID – International Classification of Diseases Clinical Modification (ICD-9-CM) – Procedure IV – Home Infusion EDI Coalition (HIEC) Product/Service Code N1 – National Drug Code in 4-4-2 Format N2 – National Drug Code in 5-3-2 Format N3 – National Drug Code in 5-4-1 Format N4 – National Drug Code in 5-4-2 Format ND – National Drug Code (NDC) NU – National Uniform Billing Committee (NUBC) UB92 Codes RB – National Uniform Billing Committee (NUBC) UB92 Codes ZZ – Mutually Defined – This is used to convey the Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code.
144	Product/Service ID				R	SVC06-2		Procedure Code

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
144	Procedure Modifier				S	SVC06-3		Procedure Modifier Required when procedure code modifiers apply to this service.
144	Procedure Modifier				S	SVC06-4		Procedure Modifier Required when procedure code modifiers apply to this service.
144	Procedure Modifier				S	SVC06-5		Procedure Modifier Required when procedure code modifiers apply to this service.
144	Procedure Modifier				S	SVC06-6		Procedure Modifier Required when procedure code modifiers apply to this service.
144	Description				S	SVC06-7		Procedure Code Description Required when a description was received for the service on the original claim.
145	Quantity				S	SVC07		Original Units of Service Count This is REQUIRED when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. This is NOT USED when the submitted units is the same as the value in SVC05.
146	Service Date	S	080	DTM				See notes in Implementation Guide.
147	Date/Time Qualifier				R	DTM01		150 – Service Period Start – Use this code only for reporting the beginning of multi-day services. 151 – Service Period End – Use this code only for reporting the end of multi-day services. 472 – Service – ADVISED – Use this code to indicate a single day service.
147	Date				R	DTM02		Service Date Date expressed as CCYYMMDD.
147	Time				Not Used	DTM03		Not Used
147	Time Code				Not Used	DTM04		Not Used
147	Date Time Period Format Qualifier				Not Used	DTM05		Not Used
147	Date Time Period				Not Used	DTM06		Not Used
148	Service Adjustment	S	090	CAS				See notes in Implementation guide.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
150	Claim Adjustment Group Code				R	CAS01		Evaluate the group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, CR, OA. See 2.2.4, Claim Adjustment and Service Adjustment Segment Theory in the implementation guide for additional information. (This does not mean that the adjustments must be reported in this order.) CO – Contractual Obligations CR – Correction and Reversals OA – Other Adjustments PI – Payer Initiated Reductions PR – Patient Responsibility
150	Claim Adjustment Reason Code				R	CAS02		Code Source 139: Claim Adjustment Reason Code
150	Monetary Amount				R	CAS03		Adjustment Amount Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04.
150	Quantity				S	CAS04		Adjustment Quantity A positive value decreases the paid units of service, and a negative number increases the paid units. This element may be used only when the units of service are being adjusted.
151	Claim Adjustment Reason Code				S	CAS05		Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
151	Monetary Amount				S	CAS06		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
151	Quantity				S	CAS07		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
151	Claim Adjustment Reason Code				S	CAS08		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
151	Monetary Amount				S	CAS09		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
152	Quantity				S	CAS10		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
152	Claim Adjustment Reason Code				S	CAS11		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
152	Monetary Amount				S	CAS12		Adjustment Amount Used when additional adjustments apply within the group identified in CAS01.
152	Quantity				S	CAS13		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
152	Claim Adjustment Reason Code				S	CAS14		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
153	Monetary Amount				S	CAS15		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
153	Quantity				S	CAS16		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
153	Claim Adjustment Reason Code				S	CAS17		Adjustment Reason Code Code Source 139: Claim Adjustment Reason Code Used when additional adjustments apply within the group identified in CAS01.
153	Monetary Amount				S	CAS18		Adjustment Amount See CAS03. Used when additional adjustments apply within the group identified in CAS01.
153	Quantity				S	CAS19		Adjustment Quantity See CAS04. Used when additional adjustments apply within the group identified in CAS01.
154	Service Identification	S	100	REF				Use this REF segment for reference numbers specific to the service identified by the SVC segment. This is used to provide additional information used in the process of adjudicating this service.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
154	Reference Identification Qualifier				R	REF01		1S – Ambulatory Patient Group (APG) Number 6R – Provider Control Number – This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes, if submitted on the claim this must be returned on remittance advice. BB – Authorization Number E9 – Attachment Code G1 – Prior Authorization Number G3 – Predetermination of Benefits Identification Number LU – Location Number RB – Rate Code Number
155	Reference Identification				R	REF02		Provider Identifier
155	Description				Not Used	REF03		Not Used
155	Reference Identifier				Not Used	REF04		Not Used
156	Rendering Provider Information	S	100	REF				Use this REF segment for reference numbers specific to the service identified by the SVC segment. The provider-related reference number at this level should be the rendering provider number, but only if the provider number is specific to this particular service line.
156	Reference Identification Qualifier				R	REF01		1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1G – Provider UPIN Number 1H – CHAMPUS Identification Number 1J – Facility ID Number HPI – HCFA National Provider Identifier – Code Source 537 SY – Social Security Number TJ – Federal Taxpayer's Identification Number
157	Reference Identification				R	REF02		Rendering Provider Identifier
157	Description				Not Used	REF03		Not Used
157	Reference Identifier				Not Used	REF04		Not Used
158	Service Supplemental Amount	S	110	AMT				This segment is used to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific amounts identified in the AMT01 qualifier are non-zero.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
158	Amount Qualifier Code				R	AMT01		B6 – Allowed – Actual DY – Per Day Limit (NOT ADVISED) – Medicare uses this to report the provider per diem amount, where applicable. KH – Deduction Amount – Late Filing Reduction NE – Net Billed (NOT ADVISED) T – Tax T2 – Total Claim Before Taxes – Use this monetary amount for the service charge before taxes. ZK – Federal Medicare or Medicaid Payment Mandate – Category 1 ZL – Federal Medicare or Medicaid Payment Mandate – Category 2 ZM – Federal Medicare or Medicaid Payment Mandate – Category 3 ZN – Federal Medicare or Medicaid Payment Mandate – Category 4 ZO – Federal Medicare or Medicaid Payment Mandate – Category 5
159	Monetary Amount				R	AMT02		Service Supplemental Amount
159	Credit/Debit Flag Code				Not Used	AMT03		Not Used
160	Service Supplemental Quantity	S	120	QTY				Use this segment to convey information only. It is not part of the financial balancing of the 835. Use this segment only when the value of specific quantities identified in the QTY01 qualifier are non-zero.
161	Quantity Qualifier		<i>Not Populated By Health Plan</i>		R	QTY01		NE – Non-Covered – Estimated – Used this code for actual line item non-covered visits. ZK – Federal Medicare or Medicaid Payment Mandate – Category 1 ZL – Federal Medicare or Medicaid Payment Mandate – Category 2 ZM – Federal Medicare or Medicaid Payment Mandate – Category 3 ZN – Federal Medicare or Medicaid Payment Mandate – Category 4 ZO – Federal Medicare or Medicaid Payment Mandate – Category 5
161	Quantity			R	QTY02		Service Supplemental Quantity Count	
161	Composite Unit of Measure			Not Used	QTY03		Not Used	
161	Free-Form Message			Not Used	QTY04		Not Used	
162	Health Care Remark Codes	S	130	LQ				Use this segment to provide informational remarks only. This segment has no impact on the actual payment. Changes in claim payment amounts are provided in the CAS segments.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
162	Code List Qualifier Code				R	LQ01	HE	HE – Claim Payment Remark Codes – Code Source 411 RX – National Council for Prescription Drug Programs Reject/Payment Codes – Code Source 530
163	Industry Code				R	LQ02		Remark Code

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
164	Provider Adjustment	S	010	PLB				See Notes in implementation guide.
165	Reference Identification				R	PLB01		Provider Identifier Use this number for the provider identifier as assigned by the payer.
165	Date				R	PLB02		Fiscal Period Date Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31 st of the current year.
165	Adjustment Identifier				R	PLB03		This code is a composite data structure. The composite identifies the reason and identifying information for the adjustment dollar amount in PLB04.
165	Adjustment Reason Code				R	PLB03-1		See Implementation Guide for allowed values.
170	Reference Identification				S	PLB03-2		Provider Adjustment Identifier See notes in implementation guide.
170	Monetary Amount				R	PLB04		Provider Adjustment Amount Use this monetary amount for the adjustment amount for the preceding adjustment reason.
170	Adjustment Identifier				S	PLB05		See PLB03 for details. Used when additional adjustments apply.
170	Adjustment Reason Code				R	PLB05-1		Adjustment Reason Code
170	Reference Identification				S	PLB05-2		Provider Adjustment Identifier
170	Monetary Amount				S	PLB06		Provider Adjustment Amount Use this monetary amount for the adjustment amount for the preceding adjustment reason.
171	Adjustment Identifier				S	PLB07		See PLB03 for details. Used when additional adjustments apply.
171	Adjustment Reason Code				R	PLB07-1		Adjustment Reason Code
171	Reference Identification				S	PLB07-2		Provider Adjustment Identifier
171	Monetary Amount				S	PLB08		Provider Adjustment Amount Use this monetary amount for the adjustment amount for the preceding adjustment reason.
171	Adjustment Identifier				S	PLB09		See PLB03 for details. Used when additional adjustments apply.
171	Adjustment Reason Code				R	PLB09-1		Adjustment Reason Code
171	Reference Identification				S	PLB09-2		Provider Adjustment Identifier
171	Monetary Amount				S	PLB10		Provider Adjustment Amount Use this monetary amount for the adjustment amount for the preceding adjustment reason.
171	Adjustment Identifier				S	PLB11		See PLB03 for details. Used when additional adjustments apply.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
171	Adjustment Reason Code				R	PLB11-1		Adjustment Reason Code
172	Reference Identification				S	PLB11-2		Provider Adjustment Identifier
172	Monetary Amount				S	PLB12		Provider Adjustment Amount Use this monetary amount for the adjustment amount for the preceding adjustment reason.
172	Adjustment Identifier				S	PLB13		See PLB03 for details. Used when additional adjustments apply.
172	Adjustment Reason Code				R	PLB13-1		Adjustment Reason Code
172	Reference Identification				S	PLB13-2		Provider Adjustment Identifier
172	Monetary Amount				S	PLB14		Provider Adjustment Amount Use this monetary amount for the adjustment amount for the preceding adjustment reason.
173	Transaction Set Trailer	R	020	SE				To indicate the end of the transaction set.
173	Number of Included Segments				R	SE01		Transaction Segment Count Total number of segments included in a transaction set including ST and SE segments.
173	Transaction Set Control Number				R	SE02		The Transaction Set Control Numbers in ST02 and SE02 must be identical. The originator assigns the Transaction Set Control Number, which must be unique within a functional group (GS-GE).

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	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		Interchange Control Number