



## 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)

# “Posting From & Troubleshooting the Transaction”

*Version:  
November 5, 2004*

## Getting an Electronic Version of this Document

An electronic version of this document, and other 835 related documents, can be found at [www.wahealthcareforum.org/hipaa/work\\_products.asp](http://www.wahealthcareforum.org/hipaa/work_products.asp). From the home page, the path is HIPAA Services, Work Products, Companion Documents for the HIPAA Transactions.

## Participants in the 835 Companion Document Initiative

Washington Healthcare Forum Services (The Forum) is a state-wide consortium of healthcare payer and provider organizations. The Forum focuses its efforts on simplifying administrative processes between health plans, hospitals, and medical groups. For additional information about The Forum see [www.wahealthcareforum.org](http://www.wahealthcareforum.org).

Health plans participating in this initiative include:

- *First Choice Health Administrators (TPA)*
- *Group Health Cooperative and Option Healthcare*
- *Premera Blue Cross*
- *Regence BlueShield*

Professional provider organizations participating in this initiative include:

- *The Everett Clinic*
- *Children's Hospital & Medical Center*
- *Group Health Cooperative*
- *Health Services Northwest*
- *Wenatchee Valley Medical Center*

## Intended Use of the 835 Companion Document

The Forum is publishing this Companion Document to accompany the Implementation Guide and Addenda for the ASC X12N Health Care Claim: Payment/Advice (835) Transaction.

A complete version on the Implementation Guide can be accessed at

[www.wpc-edi.com/hipaa/HIPAA\\_40.asp](http://www.wpc-edi.com/hipaa/HIPAA_40.asp).

*This Companion Document is designed to help provider organizations, e.g. medical practices, clinics, hospitals in their efforts to:*

- *Become familiar with the HIPAA transaction they will receive from participating health plans*
- *Develop software to automatically post information into their accounts from the HIPAA transaction*
- *Develop specification materials for vendors who will do the automatic posting from the HIPAA transaction*
- *Resolve possible issues that might arise in the process of posting from the HIPAA transaction.*

*This Companion Document should be a useful guide for provider organizations, and others that receive the 835 transaction **directly** from participating health plans (previously listed).*

This Companion Document is likely to become one part of any trading partner agreement between a provider organization, or electronic receiver, and a health plan. 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.

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.

*This Companion Document may be less useful when a provider organization, or other 835 transaction receiver, is not exchanging transactions directly with participating health plans. Information contained in this document **may not** apply to exchanges between:*

- Provider Organizations and public programs such as Medicare and Medicaid: Information about these programs is available at: **www.cms.gov**
- Provider Organizations and Clearinghouses: Providers should note that clearinghouses, and other intermediaries, may implement the transaction differently than what is outlined in this Companion Document. The clearinghouse may reformat the health plan's transaction before passing it along to the provider. This reformatting may add unforeseen complexity to the process of transaction exchange.

## Scope of the 835 Transaction

### Within Scope of this Document:

*This Companion Document focuses on the 835 Electronic Remittance Advice (RA). The intent of the 835 RA transaction is to allow providers to auto-post reimbursement information into their patient accounts.*

*Though not yet required by HIPAA, some health plans may be implementing an 835 EFT. Providers that are interested in receiving electronic funds transfer should contact their health plan trading partners.*

Outside Scope of this Document:

The following business functions are outside of the scope of the 835 Companion Document.

- Use of the 835 for communicating Explanation of Benefit (EOB) information to members
- Use of the 835 as a managed care capitation report. (Member roster information will not be included on the 835.)

Electronic 835 vs. a Paper Remittance Advice:

Health plans and providers will communicate, through business discussions, whether the provider wants to receive an 835 or a paper Remittance Advice. This communication is not supported via the 837 transaction.

The following table indicates the type of RA that each participating health plan will send to providers -- an 835 RA, a paper RA or both.

FCHA (TPA)	GHC	Premera	Regence
Providers will have a choice as to whether they want to receive an 835 a paper RA or both.	Providers will have a choice as to whether they want to receive an 835 a paper RA or both.	For the foreseeable future, a provider's choice will depend upon the system which processes the claim. For some systems, the providers will receive <b>both</b> an 835 and a paper RA. For other systems, they will choose <b>either</b> an 835 <b>or</b> a paper RA	Providers that receive an 835 will also receive a paper RA.

In those cases when both an 835 RA and a paper RA are received . . .

- There will be differences between the 835 RA and the paper RA. These differences will include, but may not be limited to:

- the formatting will be different. The paper RA may contain more detail lines than the 835.
  - procedures codes may differ, as HIPAA does not mandate standard codes on paper claims
  - the reason codes will be different
- The total dollar amount of the remittance should be the same on the 835 and the corresponding paper remittance advice.

There is no standard format or convention for a paper Remittance Advice. These documents, which will be health plan specific, are outside of the scope of the 835 Companion Document.

## Helpful Hints for Posting From the 835 Transaction

This section of the 835 Companion Document provides hints that may be helpful in posting from an 835 transaction.

### 1. Structure of the transaction (GS-GE & ST-SE)

- There will be at least one GS-GE set and one or more ST-SE sets.
- Each ST-SE set will correspond to a single 'payment' for a specified provider organization (N1 segment in Loop 1000A) at a specified location (N3-N4 segments in Loop 1000B). The payment amount may be \$0.00 or a positive dollar amount, but will not be a negative dollar amount. This payment will be related to services from one billing provider (as designated on the 837)

### 2. Formatted Data in the Transaction

- Any character used in a data element will not be used as a delimiter, separator, or terminator. Ideally, the following characters will not be contained in data fields: asterisks, single ticks, double ticks, number sign, colon, and tilde (\*, `, ``, #, :, ~).
- By convention, preferred field delimiters are: '\*' (asterisk) for data element separator, ':' (colon) for sub-element separator, '~' (tilde) for segment terminator.
- If a name cannot be parsed into individual components (e.g., last name, first name, MI) in an NM1 segment, then NM102 will contain a '2' to indicate a non-person entity.

### 3. Staying Compliant With HIPAA Transaction Versions and Code Sets

- Per HIPAA regulations, health plans must submit, and provider organizations must be able to process, only the legally mandated version of the transaction. 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.
- Per HIPAA regulations, health plans must submit, and provider organizations must be able to process, the medical data code sets that are valid at the time the service was rendered. (The validity of the medical data code set is determined by the service 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.
- Current versions of many of the code sets are available at [www.wpc-edi.com/codes/](http://www.wpc-edi.com/codes/)

**4. When health plan system information takes precedence over claim information . . .**

- For data elements such as patient name, address etc., the health plan will populate the 835 with the data that is in their system, rather than the information that was submitted on the claim
- The Payee Identification Code (Loop 1000A - N104 -- pg 73 of the IG) will contain the tax id of the pay-to provider that is on record in the health plan's system (This is the tax id that was specified in the contract between the provider and the health plan). The payee name and address information (Loop 1000B, segments N3 & N4 -- (pgs 73-75 of the IG) may be different than the pay-to provider name and address that was indicated on the submitted claim. If the submitted pay-to name and address information is different than the information on file at the health plans for the submitted tax id, some health plans may report, on the 835, the information that is in their processing system rather than what was submitted on the claim.

**5. When an 835 contains information from paper claims . . .**

- A single 835 may contain Remittance Advice (RA) information for claims that were submitted on paper and/or in an 837 transaction. A single 835 may contain RA information for professional claims, institutional claims, and/or dental claims that were submitted by the provider organization.
- When an 835 contains information for claims that were sent on paper . . .
  - If the paper claim does not contain all of the fields that are required to be returned on the electronic 835, the health plan will populate the corresponding fields on the 835 with default values from their claims payment system.
  - If the paper claim contains a code that is not a HIPAA standard code, the health plan will either:
    - \* Process the claim using the submitted code (if the code is valid for the health plan) and will map the submitted code to a HIPAA standard code for reporting on the 835. The provider will see the HIPAA standard code on the 835 and not their submitted code.
    - \* Return, or in some cases deny, the claim for reason of a non-standard code.

Provider should check with each respective health plan to determine how this situation will be handled.

**6. When an 835 contains information from a split claim . . .**

There are cases when a health plan splits a claim (or a service line on a claim) and processes it as two or more separate claims. A table of the most common situations in

which health plans split claims can be found at the Forum's website, [www.wahealthcareforum.org](http://www.wahealthcareforum.org). The path is Admin Simplification / Claims Processing.

Per the HIPAA mandated Implementation Guide, when splitting a claim the health plans will report the RA information for each of the 'split' claims as separate entries on one or more 835s. In other words, though a provider may submit one claim or one service line, the RA information may appear as separate entries on one or more 835. Health plans will balance 835 entries to the claims as they appear in the health plans system, not as they were submitted by the provider. (These situations can occur when the submitted claim was a paper claim or an 837.)

In those cases when an 835 contains information from an 837P claim that was split, health plans will do the following (to the extent that their system capabilities allow) . . .

- Line item control numbers submitted on the 837P should be included on the 835 as they appeared on the 837P even if the claim was split by the health plan.
- The contents of the 837P field 'Line Item Control Number – Reference Identification REF-02' (IG page #473) should appear in the 835 field 'Service Identification - Reference Identification REF-02 (IG page #155). The value of Reference Identification Qualifier REF-01 (IG page #154) should be '6R'.

#### **7. When an 835 contains information from a claim that does not balance . . .**

Situations may occur when the health plan is producing an 835 for a claim in which the sum of the service line charges do not equal the total charges at the claim level. In these cases the health plans can do one of the following:

- Adjust the total charge amount at the claim level so that it equals the sum of the service line charges, and
- May contact the provider depending upon the size of the discrepancy.

#### **8. When an 835 contains adjustment information . . .**

- Health plans have different business practices for handling adjustments, such as debit balances, interest payments, refunds, voids, etc. In some cases, these situations will be handled with CAS segments, in other cases the PLB segment will be used, and at times the adjustment will be handled outside of the 835 transaction. The *CAS segments* will be the primary method of reporting claim specific adjustment information, e.g. Prompt Pay Discount, write-offs, etc.. The CAS segment will also be used in those, hopefully, rare situations when an adjustment needs to be made to a claim so that an 835 balances.
- Ideally, the *PLB segment* will only be used in the following situations (though there may be other situations where a PLB is generated):

	To Report Interest	To Report Overpayment Recovery	To Report Balance Forward	Refunds
FCHA	Yes	N.A.	No	No <sup>*3</sup>
GHC	Yes	Yes <sup>*1</sup>	No	No <sup>*3</sup>
Premera	No	No	No	No <sup>*3</sup>
Regence	<sup>*2</sup>	<sup>*2</sup>	<sup>*2</sup>	<sup>*2</sup>

\*1 - The claim # or patient account number supplied by the provider should be contained in PLB03-02

\*2 - The PLB is used for adjustments that are NOT specific to a particular claim or service. More specifically, they are used for anything that increases or decreases the amount of the check being sent to the provider, like offsetting a previous overpayment, refund amounts, interest owed etc. PLB01 does contain the Tax ID and Provider Number

\*3 – Refunds will be processed outside of the adjudication system. They will not appear on an 835RA

The use of a PLB within the 835 will typically require a provider to do manual posting. To minimize manual posting, providers are requesting health plans use the PLB as infrequently as possible and to put as much information in the PLB as possible to identify the claim and/or the provider contract information.

- In the case of Capitation products, i.e. payments are made to providers on a per member – per month basis:

	Monthly PMPM Payments are made outside of the adjudication system and are NOT reported on an 835 RA	When services are rendered to a covered patient, the adjudication of that service will be reflected in a CAS segment on the 835 RA
FCHA	N.A.	N.A.
GHC	Yes	Yes
Premera	N.A.	N.A.
Regence	Yes	Yes

The Appendix contains a table that answers common questions about how each health plan will handle a number of different adjustments. Providers should contact the health plan for more specific information about how these, and other, situations will be handled

## 9. Possible variations in Loop 2100 Claim Payment Information and 2110 – Service Payment information

- Health plans may implement the CAS segment of Loops 2100 and 2110 differently. For the same Group Code (CAS01),
  - Some health plans may create a separate Claim Adjustment (CAS) for each adjustment trio, i.e. CAS02-CAS04
  - Other health plans may implement multiple adjustment trios in the same CAS segment. (The Implementation Guide allows for up to six adjustment trios to be packaged in a single CAS segment.)

Providers should check with each respective health plan to determine how this situation will be handled.

- In the case of Institutional Claims, Loop 2110 will be populated only if the health plan's payment system has line level adjustments for this claim.
- In the case of Professional Claims, the SVC segment of Loop 2110 will always be populated. If the claim was not paid in full as submitted by the provider, the CAS segment will be populated with the appropriate adjustment information.

## 10. The 835 must be in balance . . .

From the X12N 835 Implementation Guide, the amounts reported in the 835, if present, **MUST** balance at three different levels - the service line, the claim, and the transaction

### Transaction Balancing

CLP04 = specific claim payment (Table 2 - Detail - ERA)

PLB04,06,08,10,12,14 = provider level adjustment (Table 3 - Summary)

BPR02 = total 835 payment (Table 1 - Header / EFT)

Formula: **(sum of CLP04) - (sum of PLB\_\_ ) = BPR02**

**(PLB can decrease payment, positive '+' number, or can increase payment, negative '-' number.)**

### Claim Balancing

CLP03 = total submitted charge for a claim

CAS03,06,...18 = adjustment(s) to the claim

CLP04 = total claim payment

Formula: **CLP03 - CAS\_\_ = CLP04**

Service Line Balancing

SVC02 = submitted charge for a service

CAS03,06...18 = adjustment(s) to the service

SVC03 = paid amount for service

Formula:        **SVC02 – CAS\_\_ = SVC03**

When service lines are presented, the total claim charge amount must equal the sum of the service line charges.

Formula:        **CLP03 = (sum of SVC02)**

**11. Code Lists are contained in the other 835 Companion Document titled ‘Health Plan Specific Data Requirements & Scenarios’**

List 139 – Claims Adjustment Reason Codes are contained as an Appendix to this Companion Document. It maps reason codes to group codes and indicates which of the possible codes each of the participating health plans intend to use.

Only Group Health Cooperative intends to use Remark Codes (Code List 411) in field LQ02 (Page #163 in IG). Contact Group Health for more information.

## Mapping of 835 fields to 837 fields

This table contains a mapping of important 837 data fields to the corresponding 835 data. This may not be an exhaustive mapping

835 field name	835 field	837 field	Comment
Reference Identification	2110 REF02	2400 REF02	must be returned if submitted on the 837. If the qualifier = 6R IN 2400 REF02 (PROVIDER CONTROL NUMBER) then return the matching number referenced in 2400 REF02.
Patient Control Number	2100 CLP01	2300 CLM01	must match what came on the 837. Health Plan will enter '0' is one was not received.
Claim Filing Indicator Code	2100 CLP06	2000B SBR09	match what came in on 837 or provide value as assigned by the payer
Facility Type Code	2100 CLP08	2300 CLM05-1	For Institutional claims only. Use this field if the submitted facility code has been modified through adjudication.
Claim Frequency Code	2100 CLP09	2300 CLM05-2	Required when it is received on the 837.
Product or Service ID Qualifier	2110 SVC06-1	P 2400 SV101-1 D 2400 SV301-1 I 2400 SV202-1	send if it is different than what is in SVC01-1
Procedure Code	2110 SVC06-2	P 2400 SV101-2 D 2400 SV301-2 I 2400 SV202-2	send if it is different than what is in SVC01-2
Procedure Modifier 1	2110 SVC06-3	P 2400 SV101-3 D 2400 SV301-3 I 2400 SV202-3	send if it is different than what is in SVC01-3
Procedure Modifier 2	2110 SVC06-4	P 2400 SV101-4 D 2400 SV301-4 I 2400 SV202-4	send if it is different than what is in SVC01-4
Procedure Modifier 3	2110 SVC06-5	P 2400 SV101-5 D 2400 SV301-5 I 2400 SV202-5	send if it is different than what is in SVC01-5
Procedure Modifier 4	2110 SVC06-6	P 2400 SV101-6 D 2400 SV301-6 I 2400 SV202-6	send if it is different than what is in SVC01-6
Procedure Code Description	2110 SVC06-7	P 2400 SV101-7 D 2400 SV301-7 I 2400 SV202-7	The 835 reads "Required when a description was received for the service on the original claim".

835 field name	835 field	837 field	Comment
			However, the 837's do not allow for a procedure code description. 'Not Used' on 837P 'Not Used' on 837D 'Not Used' on 837I
Original Units of Service Count	2110 SVC07	P 2400 SV104 D 2400 SV306 I 2400 SV205	send if it is different than what is in SVC05
Patient Identifier	2100 NM109	2010CA NM109? Or if the subscriber is the patient then 2010BA NM109	The 835 states that if we know a patient's ID or it was reported on the 837 then we are required to send this.

## **Answers to Common Questions about How Health Plans will handle Adjustments**

Question	First Choice Health Administrators Business Practice & 835 Representation	GHC Business Practice & 835 Representation	Premera Blue Cross Business Practice & 835 Representation	Regence BlueShield Business Practice & 835 Representation
1. Can a provider systematically designate whether they want overpayments from health plans to be handled via sending a refund check to the health plan or by having the health plan do a take-back? (e.g. via a flag in the health plan’s provider file)	No	No	No	<p>Yes</p> <p>There is a deduct indicator on the Provider File. If set, it forces the adjudicator to ask the provider for a refund instead of doing an automatic deduct.</p>
2. What is the standard operating procedure for handling overpayments to providers? Does the procedure vary depending upon whether the overpayment was identified by the provider or by the health plan?	<p><i>Practice:</i> If FC recognizes the overpayment, we will initiate a “takeback”.</p> <p><i>835 Representation:</i> The adjustment and correction claim will be reflected on the 835. CLP02 is set to “22” – Reversal of previous payment”.</p> <p><i>Practice:</i> If the provider recognizes the overpayment and sends in a refund, then FC will do a claim adjustment (to back out accumulators, etc).</p>	<p><i>Practice:</i> Providers should allow GHC to take back overpayments and only refund when specifically requested by GHC. However, if a provider chooses to refund the overpayment, GHC will acknowledge the refund and adjust the claim to reflect the return.</p> <p><i>835 Representation:</i> If a refund is received, CLP02 will indicate a reversal of the original payment with ‘22’ . PLB03 will indicate a refund using</p>	<p><i>Practice:</i> Letter goes out to provider requesting the refund. If the refund is received in 60 days, the claim is adjusted and the provider voucher reflects the correction. If the refund is not received in 60 days, PBC will set up a deduction from future payment.</p> <p><i>835 Representation:</i> The 835 will reflect the refund with the claim reference.</p>	<p><i>Practice:</i> Providers have the capability of sending the refund directly to Regence or contacting the payer to initiate the refund.</p> <p><i>835 Representation:</i> All refund adjustments will be reflected on the 835.</p>

Question	First Choice Health Administrators Business Practice & 835 Representation	GHC Business Practice & 835 Representation	Premera Blue Cross Business Practice & 835 Representation	Regence BlueShield Business Practice & 835 Representation
	<p><i>835 Representation:</i> In this scenario, reversals associated with a provider refund will NOT be reflected on the 835.</p>	<p>72 (PLB03-1). PLB03-2 will identify the GHC claim number and the patient control number as the trace number.</p>		
<p>3. How will the health plan provide supplemental payments on previously adjudicated (paid) claims?</p>	<p><i>Practice:</i> If a claim requires supplemental reimbursement, the claim will be reversed and corrected. The reversal will exist as a copy of the original payment, amounts as negative. Claim is paid as corrected either on the same claim or as a new claim.</p> <p><i>835 Representation:</i> The reversal is included in the 835 transaction. CLP02 is set to “22” – Reversal of Previous Payment. The corrected claim will either be paid under the original claim number or as a new claim.</p>	<p><i>Practice:</i> GHC will reverse the original payment and reprocess a new claim record.</p> <p><i>835 Representation:</i> CLP02 will indicate a reversal with ‘22’. All payments and CAS segments from the original processing will be signed negative. A corrected payment will be processed with the original claim number (ICN) adjustment indicator increased by 1</p>	<p><i>Practice:</i> PBC will reprocess the previous claim record and create a supplemental payment.</p> <p><i>835 Representation:</i> Dependent on the processing system you can receive one of the following: 1) The CAS segment will represent the amount previously paid with a category code of OA and reason code B13. 2) The reversal and the adjustment claim records are both included in the 835 transaction. The CLP02 will indicate a reversal with a 'Claim Status Code' of 22 and the subsequent CAS segment will represent the corrected payment.</p>	<p><i>Practice:</i> When an adjustment is entered, the system generates a reversal claim, which is a copy of the original claim with all amounts changed from positive to negative. An adjustment claim is then generated with charges as they should have appeared.</p> <p><i>835 Representation:</i> The reversal and the adjustment claim records are both included in the 835 transaction. The reversal has the original claim number. The adjustment has a new claim number. For the reversal, the claim status code in CLP02 is set to '22', "Reversal of Previous Payment"</p>

Question	First Choice Health Administrators Business Practice & 835 Representation	GHC Business Practice & 835 Representation	Premera Blue Cross Business Practice & 835 Representation	Regence BlueShield Business Practice & 835 Representation
<p>4. How will the health plan handle a take-back, i.e. a situation where the health plan discovers that it overpaid a provider and the health plan takes that overpayment out of a current claim?</p>	<p>Same as Item # 2.</p>	<p><i>Practice:</i> GHC will reverse the original payment and account for outstanding reversal amounts using the PLB segment.</p> <p><i>835 Representation:</i> CLP02 will indicate a reversal with '22'. All payments and CAS segments from the original processing will be signed negative .If needed any PLB03 will indicate an overpayment correction using WO (PLB03-1). PLB03-2 will identify the GHC claim number and patient control number as the trace number. Any reversal amount not applied to the current remit will be identified with a PLB signed negative (double negative is a positive). Reversal amounts applied to future remits will be identified with an unsigned PLB. (The PLB segment is defined as negative).</p>	<p>Same as #2</p>	<p>Same as above.</p>

Question	First Choice Health Administrators Business Practice & 835 Representation	GHC Business Practice & 835 Representation	Premera Blue Cross Business Practice & 835 Representation	Regence BlueShield Business Practice & 835 Representation
		A corrected payment will be processed with the original claim number (ICN) adjustment indicator increased by 1.		
5. How will the health plan handle a refund check that is sent to the health plan by a provider?	<p><i>Practice:</i> Claim will be reversed internally. This is required to back out any accumulated amounts on the member record, such as copays, visit limits, etc. However, because we have received a refund this type of “takeback” is solely internal and will NOT be reflected on a 835.</p> <p><i>835 Representation:</i> Will not be reflected on the 835.</p>	<p><i>Practice:</i> GHC will acknowledge the refund and adjust the claim to reflect the return.</p> <p><i>835 Representation:</i> “Same as #2”</p>	<p><i>Practice:</i> The original claim will be reversed.</p> <p><i>835 Representation:</i> PLB03 will indicate a refund using 72.</p>	<p><i>Practice:</i> Same as above, except the refund amount (which is carried in the claim record) is shown on the voucher and affects the payment total.</p> <p><i>835 Representation:</i> Same as above, except the refund amounts for all claims within this 835 are added together and that total refund amount is reported under reason code 72 on the PLB provider adjustment segment.</p>
6. How will the health plan handle the voiding and reissue of a check that was never received by a provider?	<p><i>Practice:</i> Claim will be reversed internally. This is required to back out any accumulated amounts on the member record, such as copays, visit limits, etc. This takeback will not be reflected on an 835. Claim</p>	<p><i>Practice:</i> GHC will produce an adjusted claim record without reversing the original processing.</p> <p><i>835 Representation:</i> The original claim number (ICN) will increase the</p>	<p><i>Practice:</i> The cancel and reissue will generate a new check number and a new provider voucher.</p> <p><i>835 Representation:</i> The Cancel/Reissue will not be reflected on the</p>	<p><i>Practice:</i> The Cancel/Reissue is recorded in the Check Reconciliation System (CIBR). An examiner can view the reissue information/activity by transferring from the claims history screen to</p>

Question	First Choice Health Administrators Business Practice & 835 Representation	GHC Business Practice & 835 Representation	Premera Blue Cross Business Practice & 835 Representation	Regence BlueShield Business Practice & 835 Representation
	<p>will then be reprocessed/corrected as a new Claim.</p> <p><i>835 Representation:</i> Reversal will not be reflected on the 835.</p>	<p>adjustment indicator by 1 for the reprocessing.</p> <p>Do not post remits for checks you void.</p>	<p>835..</p>	<p>CIBR.</p> <p><i>835 Representation:</i> The Cancel/Reissue does not result in claim activity. Therefore, this is not reflected in vouchers, EOBs or 835 transactions.</p>
<p>7. How will internal adjustments, e.g. transfers of history from one ID to another, be reflected?</p>	<p><i>Practice:</i> Transfers of subscriber history are handled by the system but do not result in claim activity.</p> <p><i>835 Representation:</i> Transfers of subscriber history do not result in claim activity. Therefore, this is not reflected on vouchers, EOBs or the 835 transactions.</p>	<p><i>Practice:</i> GHC will reverse the original claim and re-adjudicate as a denial. A new claim will be processed under the correct ID.</p> <p><i>835 Representation:</i> CLP02 will indicate a reversal with '22'. All payments and CAS segments from the original processing will be signed negative. The original claim number (ICN) will increase the adjustment indicator by 1 for the reprocessing to deny. A new claim under the correct ID will be assigned a new claim number.</p>	<p><i>Practice:</i> Transfers of subscriber history are handled by the system but do not result in claim activity.</p> <p><i>835 Representation:</i> Transfers of subscriber history do not result in claim activity. Therefore, this is not reflected on vouchers, EOBs or the 835 transactions.</p>	<p><i>Practice:</i> Transfers of subscriber history are handled by the system but do not result in claim activity.</p> <p><i>835 Representation:</i> Transfers of subscriber history do not result in claim activity. Therefore, this is not reflected on vouchers, EOBs or the 835 transactions.</p>