



The Forum Companion Document

**For use with ANSI ASC X12N
Health Care Claim: Dental
Implementation Guide and Addenda**

Health Care Claim: Dental

837

ASC X12N 837 (004010X097A1)

“Expanded Data Requirements”

***Version:
April 05, 2005***

System Interface Mapping

The following matrix identifies the recommended usage of the data elements when the 837D transaction is interfaced with an information system. Where coded values for data elements are appropriate, codes are provided when the value set is small. Expanded codes for data elements can be found in the *Health Care Claim: Dental 837 ASC X12N 837 Implementation Guide (004010X097) and Addenda (004010X097A1)*.

The columns for the matrix are:

- **Page#:** The page number from the "National Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim: Dental 837 ASC X12N 837 (004010X097)" Rev May 2000.
- **Name:** Industry Name (from the Implementation Guide and Addenda) where available. If no industry name is available, the standard name is used. Any aliases shown in the Implementation Guide and Addenda are not always listed.
- **Seg. Reqmt:** (Segment Requirement): 'R' – Required, 'S' – Situational
- **Pos#:** Position Number (from Implementation Guide and Addenda)
- **Seg. ID:** Segment ID (from Implementation Guide and Addenda)
- **Data Element Usage:** A 'Not Used' in this column means that the Implementation Guide and Addenda dictate this data field is not to be used.
- **Data Element ID:** (from Implementation Guide and Addenda)
- **Qualifier:** A value appearing in this column indicates that the value is the preferred value. (Only single values for a data element appear in this column.)
- **Qualifier Description:** List of possible values. Values that are not relevant or pertinent to dental plans/health plans are designated in "outline" font with a strikethrough (e.g., ~~value~~). When and as appropriate, comments and conventions about usage appear in this column.

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

- *"Not reviewed for adjudication"* — This note is used when the data element is situational. While the use of this data element, and the information entered into it, must comply with the Implementation Guide and Addenda, the dental plan/health plan does not use this information to adjudicate the claim.
- *"Field must be populated with a valid value. It is not used for adjudication."* — This note is used when the data element is required. The use of this data element, and the information entered into it, must comply with the Implementation Guide and Addenda. The dental plan/health plan does not use this information to adjudicate the claim.

Description of the Layout of the Data

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

- Loop Headers are indicated with **CAPITAL LETTERS** in Grey Shading
- Major Segments within a Loop are indicated with CAPITAL LETTERS

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

Hierarchical Level Data Structure

The hierarchical level (HL) structure identifies and relates the participants involved in the transaction. The participants identified in the 837D transaction are generally Billing/Pay-To Provider, Subscriber, and Patient (when the patient is not the same person as the subscriber). The 0019 value in the BHT hierarchical structure code (BHT01) describes the appearance order of subsequent loops within the transaction set and refers to these participants, respectively, in the following terms:

- Information source (Billing Provider)
- Subscriber (can be the patient when the patient is the subscriber)
- Dependent (patient, when the patient is not the subscriber)

The term, 'Billing Provider', indicates the information source hierarchical level (HL).

The term, 'Patient', indicates the dependent HL.

ISA	INTERCHANGE CONTROL HEADER		
GS	ASSIGNED NUMBER		

TABLE 1 - Header

Pos	Seg	Name	Required	Max Use	Loop Repeat
005	ST	Transaction Set Header	R	1	
010	BHT	Beginning of Hierarchical Transaction	R	1	
015	REF	Transmission Type Identification	R	1	
Loop ID:		1000A Submitter Name			1
020	NM1	Submitter Name	R	1	
045	PER	Submitter EDI Contact Information	R	2	
Loop ID:		1000B Receiver Name			1
020	NM1	Receiver Name	R	1	

TABLE 2 - Detail

Loop ID:		2000A Billing/Pay-To Provider			>1
001	HL	Billing/Pay-To Provider Hierarchical Level	R	1	
003	PRV	Billing/Pay-To Provider Specialty Information	S	1	
010	CUR	Foreign Currency Information	S	1	
Loop ID:		2010AA Billing Provider Name			1
015	NM1	Billing Provider Name	R	1	
025	N3	Billing Provider Address	R	1	
030	N4	Billing Provider City/State/Zip Code	R	1	
035	REF	Billing Provider Secondary Address	S	8	
035	REF	Credit/Debit Card Billing Information	S	8	
Loop ID:		2010AB Pay-To Provider Name			1
015	NM1	Pay-To Provider Name	S	1	
025	N3	Pay-To Provider Address	R	1	
030	N4	Pay-To Provider City/State/ZIP Code	R	1	
035	REF	Pay-To Provider Secondary Identification	S	5	
Loop ID:		2000B Subscriber Hierarchical Level			>1
001	HL	Subscriber Hierarchical Level	R	1	
005	SBR	Subscriber Information	R	1	

Loop	ID:				
2010BA Subscriber Name					1
015	NM1	Subscriber Name	R	1	
025	N3	Subscriber Address	S	1	
030	N4	Subscriber City/State/ZIP Code	S	1	
032	DMG	Subscriber Demographic Information	S	1	
035	REF	Subscriber Secondary Identification	S	4	
035	REF	Property and Casualty Claim Number	S	1	
2010BB Payer Name					1
015	NM1	Payer Name	R	1	
025	N3	Payer Address	S	1	
030	N4	Payer City/State/ZIP Code	S	1	
035	REF	Payer Secondary Identification	S	3	
2010BC Credit/Debit Acct Holder Name					1
015	NM1	Credit/Debit Card Account Holder Name	S	1	
035	REF	Credit/Debit Card Information	S	3	
2000C Patient Hierarchical Level					>1
001	HL	Patient Hierarchical Level	S	1	
007	PAT	Patient Information	R	1	
2010CA Patient Name					1
015	NM1	Patient Name	R	1	
025	N3	Patient Address	R	1	
030	N4	Patient City/State/ZIP Code	R	1	
032	DMG	Patient Demographic Information	R	1	
035	REF	Patient Secondary Identification Number	S	5	
035	REF	Property and Casualty Claim Number	S	1	
2300 Claim Information					>1
130	CLM	Claim Information	R	1	
135	DTP	Admission Date	S	1	
135	DTP	Discharge Date	S	1	
135	DTP	Referral Date	S	1	
135	DTP	Accident Date	S	1	
135	DTP	Appliance Placement Date	S	5	
135	DTP	Service Date	S	1	
145	DN1	Orthodontic Total Months of Treatment	S	1	
159	DN2	Tooth Status	S	35	
155	PWK	Claim Supplemental Information	S	10	
175	AMT	Patient Amount Paid	S	1	
175	AMT	Credit/Debit Card Maximum Amount	S	1	
180	REF	Predetermination Identification	S	5	
180	REF	Original Reference Number (ICN/DCN)	S	1	

180	REF	Prior Authorization or Referral Number	S	2	
180	REF	Claim ID Number for Clearinghouses and Other Transmission Intermediaries	S	1	
190	NTE	Claim Note	S	20	
Loop	ID:	2310A Referring Provider Name			2
250	NM1	Referring Provider Name	S	1	
255	PRV	Referring Provider Specialty Information	S	1	
271	REF	Referring Provider Secondary Identification	S	5	
Loop	ID:	2310B Rendering Provider Name			1
250	NM1	Rendering Provider Name	S	1	
255	PRV	Rendering Provider Specialty Information	S	1	
271	REF	Rendering Provider Secondary Identification	S	5	
Loop	ID:	2310C Service Facility Name			1
250	NM1	Service Facility Name	S	1	
271	REF	Service Facility Secondary Identification	S	5	
Loop	ID:	2310D Assistant Surgeon Name			1
250	NM1	Assistant Surgeon Name	S	1	
255	PRV	Assistant Surgeon Specialty Information	S	1	
271	REF	Assistant Surgeon Secondary Identification	S	1	
Loop	ID:	2320 Other Subscriber Information			10
290	SBR	Other Subscriber Information	S	1	
295	CAS	Claim Level Adjustment	S	5	
300	AMT	Coordination of Benefits (COB) Payer Paid Amount	S	1	
300	AMT	Coordination of Benefits (COB) Approved Amount	S	1	
300	AMT	Coordination of Benefits (COB) Allowed Amount	S	1	
300	AMT	Diagnostic Related Group (DRG) Patient Responsibility Amount	S	1	
300	AMT	Coordination of Benefits (COB) Covered Amount	S	1	
300	AMT	Coordination of Benefits (COB) Discount Amount	S	1	
300	AMT	Coordination of Benefits (COB) Patient Paid Amount	S	1	
305	DMG	Other Insured Demographic Information	S	1	
310	OI	Other Insurance Coverage Information	R	1	
Loop	ID:	2330A Other Subscriber Name			1
325	NM1	Other Subscriber Name	R	1	

332	N3	Other Subscriber Address	S	1	
340	N4	Other Subscriber City/State/Zip Code	S	1	
355	REF	Other Subscriber Secondary Information	S	3	
Loop	ID:	2330B Other Payer Name		1	
325	NM1	Other Payer Name	R	1	
345	PER	Other Payer Contact Information	S	2	
350	DTP	Claim Paid Date	S	1	
355	REF	Other Payer Secondary Identification	S	3	
355	REF	Other Payer Prior Authorization or Referral Number	S	2	
355	REF	Other Payer Claim Adjustment Indicator	S	1	
Loop	ID:	2330C Other Payer Patient Information		1	
325	NM1	Other Payer Patient Information	S	1	
355	REF	Other Payer Patient Identification Number	S	3	
Loop	ID:	2330D Other Payer Referring Provider		1	
325	NM1	Other Payer Referring Provider	S	1	
355	REF	Other Payer Referring Provider Identification	S	3	
Loop	ID:	2330E Other Payer Rendering Provider		1	
325	NM1	Other Payer Service Facility Provider	S	1	
355	REF	Other Payer Service Facility Identification	S	3	
Loop	ID:	2400 Service Line Number			50
365	LX	Service Line Number	R	1	
380	SV3	Dental Service	R	1	
382	TOO	Tooth Information	S	32	
455	DTP	Service Date	S	1	
455	DTP	Prior Placement Date	S	1	
455	DTP	Appliance Placement Date	S	1	
455	DTP	Replacement Date	S	1	
460	QTY	Anesthesia Quantity	S	5	
470	REF	Service Predetermination Identification	S	1	
470	REF	Prior Authorization or Referral Number	S	2	
470	REF	Line Item Control Number	S	1	
475	AMT	Approved Amount	S	1	
475	AMT	Sales Tax Amount	S	1	
485	NTE	Line Note	S	10	
Loop	ID:	2420A Rendering Provider Name		1	
500	NM1	Rendering Provider Name	S	1	
505	PRV	Rendering Provider Specialty Information	S	1	
525	REF	Rendering Provider Secondary Identification	S	5	

Loop	ID:	2420B Other Payer Prior Authorization or Referral Number		1
500	NM1	Other Payer Prior Authorization or Referral Number	S	1
525	REF	Other Payer Prior Authorization or Referral Number	S	2
Loop	ID:	2420C Assistant Surgeon Name		1
500	NM1	Assistant Surgeon Name	S	1
505	PRV	Assistant Surgeon Specialty Information	S	1
525	REF	Assistant Surgeon Secondary Identification	S	1
Loop	ID:	2430 Service Line Adjudication Information		25
540	SVD	Service Line Adjudication Information	S	1
545	CAS	Service Line Adjustment	S	99
550	DTP	Service Adjudication Date	S	1
555	SE	Transaction Set Trailer	R	1

GE	FUNCTIONAL GROUP TRAILER
IEA	INTERCHANGE CONTROL TRAILER

ENVELOPE - Open

ENVELOPE - Open							
B.3	Interchange Control Header			ISA			
B.3	Authorization Information Qualifier			R	ISA01	00	00 - No Authorization Information Present
B.3	Authorization Information			R	ISA02		
B.4	Security Information Qualifier			R	ISA03	00	No Security Information Present
B.4	Security Information			R	ISA04		
B.4	Interchange ID Qualifier			R	ISA05		
B.4	Interchange Sender ID			R	ISA06		ID Code of Sender Identified in trading partner agreement.
B.4	Interchange ID Qualifier			R	ISA07		
B.5	Interchange Receiver ID			R	ISA08		ID Code of Receiver – Contact the following payers directly: Washington Dental Service First Choice Health Administrators Premera Blue Cross Regence BlueShield Asuris NW Health
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	0 – No acknowledgment requested
B.6	Usage Indicator			R	ISA15		P – Production Data T – Test Data
B.6	Component Element Separator			R	ISA16	:	This is the delimiter used to separate component data elements within a composite data structure
B.8	Functional Group Header			GS			
B.8	Functional Identifier Code			R	GS01	HC	HC – Health Care Claim (837)
B.8	Application Sender's Code			R	GS02		Code identifying party sending transmission, codes agreed to by trading partners
B.8	Application Receiver's Code			R	GS03		Code identifying party receiving transmission. Codes agreed to by trading partners. Contact the following payers directly: Washington Dental Service First Choice Health Administrators Premera Blue Cross Regence BlueShield Asuris NW Health
B.8	Date			R	GS04	CCYYMMDD	Creation Date
B.9	Time			R	GS05	HHMM	Creation Time
B.9	Group Control Number			R	GS06		Assigned number originated and maintained by the sender

B.9	Responsible Agency Code				R	GS07	X	Accredited Standards Committee X12
B.9	Version/Release/Industry Identifier Code				R	GS08	004010X097 A1	Draft Standards Approved for Publication by ASCx12 Procedures Review Board through October 1997, as published in this Implementation Guide.

TABLE 1 - Header

53	Transaction Set Header	R	005	ST				To indicate the start of a transaction set and to assign a control number.
53	Transaction Set ID Code				R	ST01	837	837 Health Care Claim
53	Transaction Set Control #				R	ST02		Assigned by the originator
54	Beginning of Hierarchical Transaction	R	010	BHT				To define the business hierarchical structure of the transaction set and identifies the business application purpose and reference data, i.e. number, date, and time.
54	Hierarchical Structure Code				R	BHT01	0019	Information Source, Subscriber, Dependent (<i>code specified in Impl. Guide. Indicates the hierarchical structure of the records</i>)
55	Transaction Set Purpose Code				R	BHT02		00 – Original 18 – Reissue
55	Reference Identification				R	BHT03		Assigned by the originator
55	Date				R	BHT04		Transaction Set Creation Date CCYYMMDD
56	Time				R	BHT05		Transaction Set Creation Time HHMM, HHMMSS, or HHMMSSD or HHMMSSDD
56	Transaction Type Code				R	BHT06		CH – Chargeable (Payable Claim) RP – Reporting (Encounter)
57	TRANSMISSION TYPE IDENTIFICATION	R	015	REF				Transmission Type Identification
57	Reference Identification Qualifier				R	REF01	87	Functional Category
57	Reference Identification				R	REF02	004010X097A1	Transmission Type 004010X097DA1 – pilot 004010X097A1 – production
58	Description				Not Used	REF03		Not Used
58	Reference Identifier				Not Used	REF04		Not Used
59	Loop ID: 1000A SUBMITTER NAME	R	020	NM1				
60	Entity ID Code				R	NM101	41	Submitter
60	Entity Type Qualifier				R	NM102		Entity Type Identifier 1 – Person 2 – Non-Person Entity
60	Name Last or Organization Name				R	NM103		Submitter Last Name or Organization Name
60	Name First				S	NM104		Submitter First Name The first name is required when the value in NM102 is '1' and the person has a first name.

60	Name Middle				S	NM105		Submitter Middle Name Required if additional name information is needed to identify the Submitter. Recommended if the value in the entity type qualifier is a person.
60	Name Prefix				Not Used	NM106		Not Used
60	Name Suffix				Not Used	NM107		Not Used
60	Identification Code Qualifier				R	NM108	46	46- Electronic Transmitter Identification Number (ETIN)
61	Identification Code				R	NM109		Submitter Identifier
61	Entity Relationship Code				Not Used	NM110		Not Used
61	Entity Identifier Code				Not Used	NM111		Not Used
63	Loop ID: 1000A Submitter Contact Information	R	045	PER				Information in this segment should point to the individual in the submitter organization who deals with data transmission issues.
64	CONTACT FUNCTION CODE			PER	R	PER01	IC	IC – Information Contact
64	Name				R	PER02		Submitter Contact Name
64	Communication Number Qualifier			Not Reviewed for Adjudication	R	PER03		Code identifying type of communication number ED – EDI Access Number EM – Electronic Mail FX – Facsimile TE – Telephone
64	Communication Number				R	PER04		Complete communication number including country and area code when applicable
65	Communication Number Qualifier				S	PER05		Code identifying the type of communication and used when additional contact numbers are to be communicated ED – EDI Access Number EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
65	Communication Number				S	PER06		Complete communication number including country and area code when applicable. This data element is required when the submitter needs to convey additional submitter contact information
65	Communication Number Qualifier				S	PER07		Code identifying the type of communication and used when additional contact numbers are to be communicated ED – EDI Access Number EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone

65	Communication Number				S	PER08		Complete communication number including country and area code when applicable. This data element is required when the submitter needs to convey additional submitter contact information
65	Contact Inquiry Reference				Not Used	PER09		Not Used
66	Loop ID: 1000B RECEIVER NAME	R	020	NM1				
67	ENTITY ID CODE				R	NM101	40	40 – Receiver
67	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
67	Name Last or Organization Name				R	NM103		Receiver Name – Note: participating plans will specify the name by which they will be represented. I.e., <ul style="list-style-type: none"> • Washington Dental Service • First Choice Health Administrators • Premera Blue Cross • Regence BlueShield • Asuris NW Health This will need to be specified in TPA's
67	Name First				Not Used	NM104		Not Used
67	Name Middle				Not Used	NM105		Not Used
67	Name Prefix				Not Used	NM106		Not Used
67	Name Suffix				Not Used	NM107		Not Used
67	Identification Code Qualifier				R	NM108	46	46 – Electronic Transmitter Identification Number (ETIN)
67	Identification Code				R	NM109		Code Identifying a party or other code. Contact the following payers directly: Washington Dental Service First Choice Health Administrators Premera Blue Cross Regence BlueShield Asuris NW Health
67	Entity Relationship Code				Not Used	NM110		Not Used
67	Entity Identifier Code				Not Used	NM111		Not Used

TABLE 1 - Detail

69	Loop ID: 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL	R	001	HL				Identifies original entity that submitted electronic claim/encounter.
70	Hierarchical ID Number				R	HL01		Unique sequentially assigned positive number for each specific occurrence of the HL segment within a transaction set. It should begin with 1 and be incremented by 1 for each subsequent HL segment within the transaction set.
70	Hierarchical Parent ID Number				Not Used	HL02		Not Used
70	Hierarchical Level Code				R	HL03	20	20 – Information Source
70	Hierarchical Child Code				R	HL04	1	1 – Additional Subordinate HL Data Segment in this Hierarchical Structure
71	Billing/Pay-To Provider Specialty Information	S	PRV					Required when adjudication is known to be impacted by the provider taxonomy code, and the Rendering Provider is the same entity as the Billing and/or Pay-to Provider.
71	Provider Code		<i>Not Reviewed for Adjudication</i>		R	PRV01		Code identifying type of provider BI – Billing PT – Pay-To
72	Reference Identification Qualifier				R	PRV02	ZZ	ZZ – Mutually Defined ZZ is used to identify “Health Care Provider Taxonomy” code list (provider specialty code).
72	Reference Identification				R	PRV03		Provider Taxonomy Code
72	State or Providence Code				Not Used	PRV04		Not Used
72	Provider Specialty Information				Not Used	PRV05		Not Used
72	Provider Organization Code				Not Used	PRV06		Not Used
73	Loop ID: 2000A FOREIGN CURRENCY INFORMATION	S	CUR					For ability to submit claims in foreign countries. Absence of this segment means that claim is submitted in currency normally used by the receiver for processing the claim.
74	Entity ID Code		<i>Not Reviewed for Adjudication</i>		R	CUR01	85	85 – Billing Provider
74	Currency Code				R	CUR02		Standard ISO code for country in whose currency the charges are specified.
74	Exchange Rate				Not Used	CUR03		Not Used
74	Entity Identifier Code				Not Used	CUR04		Not Used
74	Currency Code				Not Used	CUR05		Not Used
74	Currency Market/Exchange Code				Not Used	CUR06		Not Used
74	Date/Time Qualifier				Not Used	CUR07		Not Used
75	Date				Not Used	CUR08		Not Used

75	Time		<i>Not Reviewed for Adjudication</i>		Not Used	CUR09		Not Used
75	Date/Time Qualifier				Not Used	CUR10		Not Used
75	Date				Not Used	CUR11		Not Used
75	Time				Not Used	CUR12		Not Used
75	Date/Time Qualifier				Not Used	CUR13		Not Used
75	Date				Not Used	CUR14		Not Used
75	Time				Not Used	CUR15		Not Used
75	Date/Time Qualifier				Not Used	CUR16		Not Used
75	Date				Not Used	CUR17		Not Used
75	Time				Not Used	CUR18		Not Used
75	Date/Time Qualifier				Not Used	CUR19		Not Used
75	Date				Not Used	CUR20		Not Used
75	Time				Not Used	CUR21		Not Used
76	Loop ID: 2010AA BILLING PROVIDER NAME	R			015	NM1		
77	Entity ID Code				R	NM101	85 85 – Billing Provider Use this code to indicate billing provider, billing submitter, and encounter reporting entity.	
77	Entity Type Qualifier				R	NM102	1 – Person 2 – Non-Person Entity	
77	Name Last or Organization Name				R	NM103	Billing Provider Last or Organizational Name	
77	Name First				S	NM104	Billing Provider First Name	
77	Name Middle				S	NM105	Billing Provider Middle Name	
77	Name Prefix				Not Used	NM106	Not Used	
77	Name Suffix				S	NM107	Billing Provider Suffix Name	
77	Identification Code Qualifier				R	NM108	24 – Employer's Identification Number 34 – Social Security Number XX – HCFA National Provider ID (required value if the NPI is mandated for use).	
78	Identification Code				R	NM109	Billing Provider Identifier	
78	Entity Relationship Code				Not Used	NM110	Not Used	
78	Entity Identifier Code				Not Used	NM111	Not Used	
79	Loop ID: 2010AA BILLING PROVIDER ADDRESS	R	025	N3			Address Information	
79	Address Information				R	N301	Billing Provider Address Line	
79	Address Information				S	N302	Required if second address line exists	

80	Loop ID: 2010AA BILLING PROVIDER CITY/STATE/ZIP	R	030	N4			Geographic Information
80	City Name				R	N401	Billing Provider City Name
81	State or Province Code				R	N402	Billing Provider State or Province Code
82	Postal Code				R	N403	Billing Provider Postal Code
82	Country Code				S	N404	Required when address is outside the U.S.
82	Location Qualifier				Not Used	N405	Not Used
82	Location Identifier				Not Used	N406	Not Used
83	Loop ID: 2010AA BILLING PROVIDER SECONDARY IDENTIFICATION	S	035	REF			Required when secondary identification number is necessary.
83	Reference Identification Qualifier				R	REF01	0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number E1 – Employer’s Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number SY – Social Security Number TJ – Federal Taxpayer’s Identification Number
84	Reference Identification				R	REF02	Billing Provider Additional Identifier
84	Description				Not Used	REF03	Not Used
84	Reference Identifier				Not Used	REF04	Not Used
85	Loop ID: 2010AA CREDIT/DEBIT CARD BILLING INFORMATION	S		REF			The information in this segment must never be sent to the payer and is only for use between provider and a service offering patient collection services. See Appendix G
85	Reference Identification Qualifier			Not Reviewed for Adjudication	R	REF01	06 – System Number 8U – Bank Assigned Security Identifier EM – Electronic Payment Reference Number IJ – Standard Industry Classification Code LU – Location Number RB – Rate Code Number ST – Store Number TT – Terminal Code
86	Reference Identification				R	REF02	Billing Provider Credit Card Identifier

86	Description				Not Used	REF03	Not Used
86	Reference Identifier				Not Used	REF04	Not Used
87	Loop ID: 2010AB PAY-TO PROVIDER NAME	S	015	NM1			Required segment and Loop if Pay-to Provider is different from Billing Provider.
88	Entity ID Code		Not Reviewed for Adjudication		R	NM101	87 87 – Pay-to Provider Use this code to indicate pay-to provider.
88	Entity Type Qualifier				R	NM102	1 – Person 2 – Non-Person Entity
88	Name Last or Organization Name				R	NM103	Pay-to Provider Last or Organizational Name
88	Name First				S	NM104	Pay-to Provider First
89	Name Middle				Not Used	NM105	Pay-to Provider Middle Name
89	Name Prefix				S	NM106	Not Used
89	Name Suffix				S	NM107	Pay-to Provider Suffix
89	Identification Code Qualifier				R	NM108	24 – Employer’s Identification Number 34 – Social Security Number XX – HCFA National Provider ID <i>If XX-NPI is used then EIN or SS number of the provider must be carried in the REF in this loop.</i>
89	Identification Code				R	NM109	Billing Provider Identifier
89	Entity Relationship Code				Not Used	NM110	Not Used
89	Entity Identifier Code		N3	Not Used	NM111	Not Used	
91	Loop ID: 2010AB PAY-TO PROVIDER ADDRESS	R					Address Information
91	Address Information				R	N301	Pay-to Provider Address Line
91	Address Information		N4		S	N302	Required if second address line exists
92	Loop ID: 2010AB PAY-TO PROVIDER CITY/STATE/ZIP CODE	R					Geographic Information
92	City Name				R	N401	Pay-to Provider City Name
93	State or Province Code		Not Reviewed for Adjudication		R	N402	Pay-to Provider State or Province Code
93	Postal Code				R	N403	Pay-to Provider Postal Code
93	Country Code				S	N404	Required when address is outside the U.S.
93	Location Qualifier				Not Used	N405	Not Used
93	Location Identifier		REF		Not Used	N406	Not Used
94	Loop ID: 2010AB PAY-TO PROVIDER SECONDARY IDENTIFICATION	S					Required when secondary identification number is necessary

95	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01	0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number EI – Employer’s Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number SY – Social Security Number TJ – Federal Taxpayer’s Identification Number
95	Reference Identification				R	REF02	Pay-to Provider Additional Identifier
95	Description				Not Used	REF03	Not Used
95	Reference Identifier				Not Used	REF04	Not Used
96	Loop ID: 2000B SUBSCRIBER HIERARCHICAL LEVEL	R	001	HL			If the insured and the patient are the same person, use this HL to identify the insured/patient, skip the subsequent (patient) HL, and proceed directly to Loop ID–2300.
97	Hierarchical ID Number				R	HL01	Unique number assigned by the sender to identify a particular data segment in a hierarchical structure.
97	Hierarchical Parent ID Number				R	HL02	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.
97	Hierarchical Level Code				R	HL03	22 Subscriber
97	Hierarchical Child Code				R	HL04	0 – No subordinate HL Segment in this Hierarchical Structure 1 – Additional Subordinate HL Data Segment in this Hierarchical Structure <i>Use “0” if the patient and there are no dependent claims and use “1” when claims/encounters for both subscriber and a dependent of theirs are being sent under the same billing provider HL.</i>
99	Loop ID: 2000B SUBSCRIBER INFORMATION	R	005	SBR			
99	Payer Responsibility Sequence Number Code				R	SBR01	P – Primary S – Secondary T – Tertiary
100	Individual Relationship Code				S	SBR02	18 – Self Required when the subscriber is the same person as the patient. If this subscriber is not the same person as the patient, do not use this element.
100	Reference Identification				S	SBR03	Insured Group or Policy Number

100	Name				S	SBR04		Insured Group Name. Used only when no group number is reported in SBR03
100	Insurance Type Code				Not Used	SBR05		Not Used
100	Coordination of Benefits Code				R	SBR06		1 – Coordination of Benefits 6 – No Coordination of Benefits
100	Yes/No Condition or Response Code				Not Used	SBR07		Not Used
100	Employment Status Code				Not Used	SBR08		Not Used
101	Claim Filing Indicator Code Note: Field must be populated with a valid value. It will not be reviewed for adjudication.				S	SBR09		Required prior to mandated use of PlanID. Not used after PlanID is mandated. 09 – Self-pay 11 – Other Non-Federal Programs 12 – PPO 13 – Point of Service 14 – Exclusive Provider Org. 15 – Indemnity Insurance 16 – HMO Medicare Risk 17 – Dental Maintenance Organization BL – Blue Cross/Blue Shield CH – Champus CI – Commercial Insur. Co. DS – Disability FI – Federal Employees Program HM – HMO LI – Liability LM – Liability Medical MB – Medicare Part B MC – Medicaid OF – Other Fed Program SA – Self-administered Group VA – Veteran Administration Plan WC – Workers' Compensation Health Claim ZZ – Mutually Defined
103	Loop: 2010BA SUBSCRIBER NAME	R	015	NM1				In worker's compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.
104	Entity ID Code				R	NM101	IL	IL – Insured or Subscriber
104	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
104	Name Last or Organization Name				R	NM103		Subscriber Last Name
104	Name First				S	NM104		Subscriber First Name
104	Name Middle				S	NM105		Subscriber Middle Name

104	Name Prefix				Not Used	NM106		Not Used
105	Name Suffix				S	NM107		Subscriber Name Suffix
105	Identification Code Qualifier				S	NM108	MI	MI - Member Identification Number ZZ – Mutually Defined
106	Identification Code				S	NM109		Subscriber Primary Identifier
106	Entity Relationship Code				Not Used	NM110		Not Used
106	Entity Identifier Code				Not Used	NM111		Not Used
108	Loop: 2010BA SUBSCRIBER ADDRESS	S	025	N3				This segment is required when the Patient is the same person as the Subscriber. <i>Required when Loop ID 2000B, SBR02- 18 (self).</i>
108	Address Information				R	N301		Subscriber Address Line
108	Address Information				S	N302		Required if second address line exists
109	Loop: 2010BA SUBSCRIBER CITY/STATE/ZIP CODE	S	030	N4				Required when Patient is the same person as the Subscriber.
110	City Name				R	N401		Subscriber City Name
110	State or Province Code				R	N402		Subscriber State or Province Code
110	Postal Code				R	N403		Subscriber Provider Postal Code
110	Country Code				S	N404		Required when address is outside the U.S.
110	Location Qualifier				Not Used	N405		Not Used
110	Location Identifier				Not Used	N406		Not Used
111	Loop: 2010BA SUBSCRIBER DEMOGRAPHIC INFORMATION	S	032	DMG				This segment is required when the Patient is the same person as the Subscriber. <i>Required when Loop ID 2000B, SBR02- 18 (self)</i>
112	Date Time Period Format Qualifier				R	DMG01	D8	D8 – Date Expressed in Format CCYYMMDD
112	Date Time Period				R	DMG02		Subscriber Birth Date
112	Gender Code				R	DMG03		F – Female M – Male U – Unknown Subscriber Gender Code
112	Marital Status Code				Not Used	DMG04		Not Used
112	Race or Ethnicity Code				Not Used	DMG05		Not Used
112	Citizenship Status Code				Not Used	DMG06		Not Used
112	Country Code				Not Used	DMG07		Not Used
112	Basis of Verification Code				Not Used	DMG08		Not Used
112	Quantity				Not Used	DMG09		Not Used

113	Loop: 2010BA SUBSCRIBER SECONDARY IDENTIFICATION	S						Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.
113	Reference Identification Qualifier				R	REF01		1W - Member Identification Number 23 - Client Number IG - Insurance Policy Number SY - Social Security Number
114	Reference Identification				R	REF02		Subscriber Supplemental Identifier
114	Description				Not Used	REF03		Not Used
114	Reference Identifier				Not Used	REF04		Not Used
115	Loop: 2010BA PROPERTY AND CASUALTY CLAIM NUMBER	S	REF Not Reviewed for Adjudication					This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive number from property and casualty payer during eligibility determinations.
116	Reference Identification Qualifier				R	REF01	Y4	Y4 – Agency Claim Number
116	Reference Identification				R	REF02		Property Casualty Claim Number
116	Description				Not Used	REF03		Not Used
116	Reference Identifier				Not Used	REF04		Not Used
117	Loop ID: 2010BB PAYER NAME	R	015	NM1				This is the destination payer.
118	Entity ID Code				R	NM101	PR	PR – Payer
118	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
118	Name Last or Organization Name				R	NM103		Payer Name Note: participating plans will specify the name by which they will be represented. I.e., <ul style="list-style-type: none"> • Washington Dental Service=WDS • First Choice Health Administrators=FCHA • Premera Blue Cross=Premera • Regence Blue Shield = Regence • Asuris NW Health = Asuris NW Health
118	Name First				Not Used	NM104		Not Used
118	Name Middle				Not Used	NM105		Not Used
118	Name Prefix				Not Used	NM106		Not Used
118	Name Suffix				Not Used	NM107		Not Used
118	Identification Code Qualifier				R	NM108		PI – Payer Identification XV – HCFA National Plan ID

118	Identification Code				R	NM109		Payer Primary ID Washington Dental Service = 91062 FCHA= Contact Payer Premera Blue Cross = Contact Payer Regence Blue Shield = G00932 Asuris NW Health = G00932
118	Entity Relationship Code				Not Used	NM110		Not Used
119	Entity Identifier Code				Not Used	NM111		Not Used
121	Loop ID: 2010BB PAYER ADDRESS	S	N3					Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).
121	Address Information		Not Reviewed for Adjudication		R	N301		Payer Address Line
121	Address Information				S	N302		Required if second address line exists
122	Loop ID: 2010BB PAYER CITY/STATE/ZIP CODE	S	N4					Payer Address is required when the submitter intends for the claim to be printed on paper at the next EDI location (e.g., a clearinghouse).
122	City Name		Not Reviewed for Adjudication		R	N401		Payer City Name
123	State or Province Code				R	N402		Payer State or Province Code
123	Postal Code				R	N403		Payer Postal Code
123	Country Code				S	N404		Required when address is outside the U.S.
123	Location Qualifier				Not Used	N405		Not Used
123	Location Identifier				Not Used	N406		Not Used
124	Loop ID: 2010BB Payer Secondary Identification	S	REF					Required if additional identification numbers other than the primary identification number in NM108/09 in this loop are necessary to adjudicate the claim/encounter.
125	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01		2U - Payer Identification Number FY - Claim Office Number NF - National Association of Insurance Commissioners (NAIC) Code TJ - Federal Taxpayer's Identification Number
125	Reference Identification				R	REF02		Payer Additional Identifier
125	Description				Not Used	REF03		Not Used
125	Reference Identifier				Not Used	REF04		Not Used
126	Loop ID: 2010BC CREDIT/DEBIT CARD HOLD NAME	S	015	NM1				It is not intended that credit/debit card info be conveyed to a health care payer.
127	Entity ID Code		NM1		R	NM101	AO	AO - Account Of
127	Entity Type Qualifier				R	NM102		1 - Person 2 - Non-Person Entity

127	Name Last or Organization Name		Not Reviewed for Adjudication		R	NM103		Credit or Debit Card Holder Last or Organizational Name
127	Name First				S	NM104		Responsible Party First Name; Req. if NM102 = 1.
127	Name Middle				S	NM105		Responsible Party Middle Name; Req. if NM102 = 1 and is known.
127	Name Prefix				Not Used	NM106		Not Used
127	Name Suffix				S	NM107		Responsible Party Suffix Name; Req. if known.
128	Identification Code Qualifier				S	NM108	MI	MI - Member identification Number
128	Identification Code				S	NM109		Credit or Debit Card Number
128	Entity Relationship Code				Not Used	NM110		Not Used
128	Entity Identifier Code				Not Used	NM111		Not Used
130	Loop ID: 2010BC CREDIT/DEBIT CARD HOLD INFO	S						
130	Credit or Debit Card Authorization Number				R	REF01	BB	BB - Authorization Number
130	Credit or Debit Card Authorization Number				R	REF02		Required if second address line exists
131	Location Qualifier				Not Used	REF03		Not Used
131	Location Identifier		Not Used	REF04		Not Used		
132	Loop ID: 2000C PATIENT HIERARCHICAL LEVEL	S	001	HL			This HL is required when the patient is a different person than the subscriber.	
133	Hierarchical ID Number				R	HL01	Unique sequentially assigned positive number for each specific occurrence of the HL segment within a transaction set. It should begin with 1 and be incremented by 1 for each subsequent HL segment within the transaction set.	
133	Hierarchical Parent ID Number				R	HL02	Used to identify the specific hierarchical level to which this level is subordinate	
133	Hierarchical Level Code				R	HL03	23 Dependent	
133	Hierarchical Child Code				R	HL04	0 0 – No subordinate HL Segment in this Hierarchical Structure	
134	Loop ID: 2000C PATIENT INFORMATION	R	007	PAT				

134	Individual Relationship Code				R	PAT01		Patients Relationship to Insured 01 – Spouse 19 – Child 20 – Employee 22 – Handicapped Dependent 29 – Significant Other 44 – Injured Plaintiff 53 – Life Partner 76 – Dependent
135	Patient Location Code				Not Used	PAT02		Not Used
135	Employment Status Code				Not Used	PAT03		Not Used
135	Student Status Code				S	PAT04		Student Status Code F - Full time N - Not a student P - Part time
135	Date Time Period Format Qualifier				Not Used	PAT05		Not Used
135	Date Time Period				Not Used	PAT06		Not Used
135	Unit or Basis for Measurement Code				Not Used	PAT07		Not Used
135	Weight				Not Used	PAT08		Not Used
135	Yes/No Condition or Response Code				Not Used	PAT09		Not Used
136	Loop: 2010CA PATIENT NAME	R	015	NM1				
136	Entity ID Code				R	NM101	QC	QC - Patient
137	Entity Type Qualifier				R	NM102	1	1 – Person
137	Name Last or Organization Name				R	NM103		Patient Last Name
137	Name First				R	NM104		Patient First Name
137	Name Middle				S	NM105		Patient Middle Name
137	Name Prefix				Not Used	NM106		Not Used
137	Name Suffix				S	NM107		Patient Name Suffix This data element is required when the NM102 equals one (1) and the name suffix is known. Examples: I, II, III, IV, Jr, Sr.
137	Identification Code Qualifier				S	NM108	MI	This data element is required when the Patient's Identifier is different from the Subscriber's Identifier. MI – Member Identification Number ZZ – Mutually Defined
138	Identification Code				S	NM109		Patient Primary Identifier
138	Entity Relationship Code				Not Used	NM110		Not Used
138	Entity Identifier Code				Not Used	NM111		Not Used

140	Loop ID: 2010CA PATIENT ADDRESS	R	025	N3				
140	Address Information				R	N301		Patient Address Line 1
140	Address Information				S	N302		Patient Address Line 2
141	Loop ID: 2010CA PATIENT CITY/STATE/ZIP CODE	R	030	N4				
142	City Name				R	N401		Patient City Name
142	State or Province Code				R	N402		Patient State or Province Code
142	Postal Code				R	N403		Patient Provider Postal Code
142	Country Code				S	N404		Required when address is outside the U.S.
142	Location Qualifier				Not Used	N405		Not Used
142	Location Identifier				Not Used	N406		Not Used
143	Loop ID: 2010CA PATIENT DEMOGRAPHIC INFORMATION	R	032	DMG				
143	Date Time Period Format Qualifier				R	DMG01	D8	D8 – Date Expressed in Format CCYYMMDD
144	Date Time Period				R	DMG02		Patient Birth Date
144	Gender Code				R	DMG03		Patient Gender Code F – Female M – Male U – Unknown
144	Marital Status Code				Not Used	DMG04		Not Used
144	Race or Ethnicity Code				Not Used	DMG05		Not Used
144	Citizenship Status Code				Not Used	DMG06		Not Used
144	Country Code				Not Used	DMG07		Not Used
144	Basis of Verification Code				Not Used	DMG08		Not Used
144	Quantity				Not Used	DMG09		Not Used
145	Loop ID: 2010CA PATIENT SECONDARY IDENTIFICATION NUMBER	S						This segment is required when an additional identification number is needed.
145	Reference Identification Qualifier				R	REF01		1W – Member Identification Number 23 – Client Number IG – Insurance Policy Number SY – Social Security Number
146	Reference Identification				R	REF02		Patient Secondary Identifier
146	Description				Not Used	REF03		Not Used
146	Reference Identifier				Not Used	REF04		Not Used

147	Loop ID: 2010CA PROPERTY AND CASUALTY CLAIM NUMBER	S	REF					This is a property and casualty payer-assigned claim number. It is required on property and casualty claims. Providers receive this number from the property and casualty payer during eligibility determinations or some other communication with that payer. It is placed here when the patient is not the subscriber (when patient is subscriber, it is placed in Loop ID 2010BA).
			Not Reviewed for Adjudication		R	REF01	Y4	Y4 – Agency Claim Number
148	Reference Identification Qualifier				R	REF02		Property Casualty Claim Number
148	Reference Identification				Not Used	REF03		Not Used
148	Description				Not Used	REF04		Not Used
148	Reference Identifier							
149	Loop: 2300 CLAIM INFORMATION	R	130	CLM				The developers of this implementation guide recommend that trading partners limit the size of the transaction (ST-SE envelope) to a maximum of 5000 CLM segments. There is no recommended limit to the number of ST-SE transactions within a GS-GE or ISA-IEA. Willing trading partners can agree to set limits higher.
150	Claim Submitter's Identifier				R	CLM01		Patient Account Number The MAXIMUM NUMBER OF CHARACTERS to be supported for this field is '20'. A Provider may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored or returned by any receiving system.
151	Monetary Amount				R	CLM02		Total Claim Charge Amount For encounter transmissions, zero may be a valid amount.
151	Claim Filing Indicator Code				Not Used	CLM03		Not Used
151	Non-Institutional Claim Type Code				Not Used	CLM04		Not Used
151	Health Care Service Location Information				R	CLM05		Identifies type of bill related to the location at which a health care service was rendered.

151	Facility Code Value				R	CLM05-1		Code identifying the type of facility where services were performed. 11 - Office 12 - Home 21 - Inpatient Hospital 22 - Outpatient Hospital 31 - Skilled Nursing Facility 35 - Adult Living Care Facility
151	Facility Code Qualifier				Not Used	CLM05-2		Not Used
151	Claim Frequency Type Code				R	CLM05-3		Claim Submission Reason Code
152	Yes/No Condition or Response Code				R	CLM06		Provider Signature on File N – No Y – Yes
152	Provider Accept Assignment Code				S	CLM07		Medicare Assignment Code A – Assigned C – Not Assigned P – Patient Refuses to Assign Benefits Code indicates whether the provider accepts Medicare Assignment.
153	Yes/No Condition or Response Code				R	CLM08		Benefits Assignment Certification Indicator N – No Y – Yes
153	Release of Information Code Note: Field must be populated with a valid value. It will not be reviewed by Health Plan. Same value will be returned when applicable.				R	CLM09		N – No, Provider is Not Allowed to Release Data Y – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
153	Patient Signature Source Code				Not Used	CLM10		Not Used
153	RELATED CAUSES INFORMATION				S	CLM11		CLM11-1, CLM11-2, or CLM11-3 are required when the condition being reported is accident or employment related.
153	Related-Causes Code				R	CLM11-1		Related Cause Code AA – Auto Accident EM – Employment OA – Other Accident
154	Related-Causes Code		Not Reviewed for Adjudication		S	CLM11-2		Related Cause Code AA – Auto Accident EM – Employment OA – Other Accident

154	Related-Causes Code				S	CLM11-3	Related Cause Code AA – Auto Accident EM – Employment OA – Other Accident
154	State or Province Code				S	CLM11-4	Auto Accident state or Province code This data element is required to be present when CLM11-1, CLM11-2 or CLM11-3 equals 'AA'.
154	Country Code				S	CLM11-5	This data element is required to be present when CLM11-4 is present and the accident occurred outside of the U.S.
155	Special Program Code				S	CLM12	01 – Early & Periodic Screening, Diagnosis, and Treatment (EPSDT) or Child Health Assessment Program (CHAP) 02 – Physically Handicapped Children's Program 03 – Special Federal Funding 05 – Disability
155	Yes/No Condition or Response Code				Not Used	CLM13	Not Used
155	Level of Service Code				Not Used	CLM14	Not Used
155	Yes/No Condition or Response Code				Not Used	CLM15	Not Used
155	Provider Agreement Code				Not Used	CLM16	Not Used
155	Claim Status Code				Not Used	CLM17	Not Used
155	Yes/No Condition or Response Code				Not Used	CLM18	Not Used
155	Claim Submission Reason Code				S	CLM19	PB Predetermination of Benefits Code PB - Predetermination of Dental Benefits CLM 19 is required when the entire claim is being submitted for predetermination of benefits

155	Delay Reason Code		Not Reviewed for Adjudication		S	CLM20		1 – Proof of Eligibility Unknown or Unavailable 2 – Litigation 3 – Authorization Delays 4 – Delay in Certifying Provider 5 – Delay in Supplying Billing Forms 6 – Delay in Delivery of Custom-made Appliances 7 – Third Party Processing Delay 8 – Delay in Eligibility Determination 9 – Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules 10 – Administration Delay in the Prior Approval Process 11 – Other Required when claim is submitted late (past contracted date of filing limitations) and any of the codes listed above apply.
157	Loop: 2300 ADMISSION DATE	S	135	DTP				This segment is required on Inpatient visit claims.
157	Date/Time Qualifier				R	DTP01	435	435 - Admission
157	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
157	Date Time Period				R	DTP03		Related Hospitalization Admission Date
158	Loop: 2300 DISCHARGE DATE	S	135	DTP				Required for inpatient claims when the patient was discharged from the facility and the discharge date is known
158	Date/Time Qualifier				R	DTP01	096	096 - Discharge
158	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
158	Date Time Period				R	DTP03		Discharge or End of Care Date
160	Loop: 2300 REFERRAL DATE	S	DTP Not Reviewed for Adjudication					This segment required when claim includes a referral
160	Date/Time Qualifier				R	DTP01	330	330 - Referral Date
160	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
160	Date Time Period				R	DTP03		Referral Date
161	Loop: 2300 ACCIDENT DATE	S	135	DTP				Required if CLM11-1, CLM11-2, OR CLM11-3 = AA, EM OR OA
161	Date/Time Qualifier				R	DTP01	439	439 - Accident
161	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
161	Date Time Period				R	DTP03		Accident Date
162	Loop: 2300 APPLIANCE PLACEMENT DATE	S	135	DTP				Required to report the date orthodontic appliances were placed

162	Date/Time Qualifier				R	DTP01	452	452 - Appliance Placement
162	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
162	Date Time Period				R	DTP03		Orthodontic Banding Date
164	Loop: 2300 SERVICE DATE	S	135	DTP				Required if all of the services on the claim/encounter were performed. This DTP should not be used if the claim is being submitted for Predetermination of benefits.
164	Date/Time Qualifier				R	DTP01	472	472 - Service
164	Date Time Period Format Qualifier				R	DTP02		D8 – Date Expressed in Format CCYYMMDD DT – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
164	Date Time Period				R	DTP03		Service Date
166	Loop: 2300 ORTHODONTIC TOTAL MONTHS OF TREATMENT	S	145	DN1				DN101, DN102 or DN103 must be present if reporting this segment
166	Quantity				S	DN101		Orthodontic Treatment Months Count
166	Quantity				S	DN102		Orthodontic Treatment Months Remaining Count
167	Yes/No Condition or Response Code				S	DN103		Question Response
167	Description				Not Used	DN103		Not Used
168	Loop: 2300 TOOTH STATUS	S	150	DN2				This DN2 segment is used to report a tooth status
168	Reference Identification				R	DN201		Tooth Number
168	Tooth Status Code				R	DN202		E - To be Extracted I - Impacted M - Missing
169	Quantity				Not Used	DN203		Not Used
169	Date Time Period Format Qualifier				Not Used	DN204		Not Used
169	Date Time Period				Not Used	DN205		Not Used
170	Loop: 2300 CLAIM SUPPLEMENTAL INFORMATION	S	155	PWK				The PWK segment is required if the provider will be sending paper documentation supporting this claim. The PWK segment is required to identify attachments that are sent electronically (PWK02=EL) but are transmitted in another functional group (e.g., 275) rather than by paper.

171	Report Type Code				R	PWK01		B4 – Referral Form DA – Dental Models DG – Diagnostic Report EB – EOB (COB or Medicare Secondary Payer) OB – Operative Note OZ – Support Data for Claim P6 – Periodontal Charts RB – Radiology Films RR – Radiology Reports
171	Report Transmission Code				R	PWK02		AA – Available on Request at Provider Site BM – By Mail EL – Electronically Only EM – E-Mail FX – By Fax
171	Report Copies Needed				Not Used	PWK03		Not Used
171	Entity Identifier Code				Not Used	PWK04		Not Used
172	Identification Code Qualifier				S	PWK05	AC	AC – Attachment Control Number Required if PWK02=EM,EL,BM or FX
172	Identification Code				S	PWK06		Attachment Control Number
172	Description				Not Used	PWK07		Not Used
172	Actions Indicated				Not Used	PWK08		Not Used
172	Request Category Code				Not Used	PWK09		Not Used
173	Loop: 2300 PATIENT PAID AMOUNT	S	AMT					This segment is required when the Patient Paid Amount is applicable to this claim.
173	Amount Qualifier Code		Not Reviewed for Adjudication		R	AMT01	F5	F5 – Patient Amount Paid
173	Monetary Amount				R	AMT02		Patient Paid Amount
173	Credit/Debit Flag Code				Not Used	AMT03		Not Used
174	Loop: 2300 CREDIT/DEBIT CARD MAXIMUM AMOUNT	S	AMT					The information carried under this segment must never be sent to the payer. This information is only for use between a provider and a service organization offering patient collection services.
174	Amount Qualifier Code		Not Reviewed for Adjudication		R	AMT01	MA	MA – Maximum Amount
174	Monetary Amount				R	AMT02		Credit or Debit Card Maximum Amount
174	Credit/Debit Flag Code				Not Used	AMT03		Not Used
175	Loop: 2300 PREDETERMINATION IDENTIFICATION	S	180	REF				Reference numbers at this position apply to the entire claim. This REF segment is used to send the Predetermination of Benefits Identification Number for a claim that has been previously predetermined and is now being submitted for payment.
176	Reference Identification Qualifier				R	REF01	G3	G3 – Predetermination of Benefits Identification Number

176	Reference Identification				R	REF02		Predetermination of Benefits Identifier
176	Description				Not Used	REF03		Not Used
176	Reference Identifier				Not Used	REF04		Not Used
177	Loop: 2300 SERVICE AUTHORIZATION EXCEPTION CODE	S	180	REF				Used only in claims where providers are required by state law (e.g., New York State Medicaid) to obtain authorization for specific services, but for the reasons listed in REF02, performed the services without obtaining the service authorization.
177	Reference Identification Qualifier				R	REF01	4N	4N – Special Payment Reference Number
177	Reference Identification				R	REF02		Service Authorization Exception Code Allowable Vales for this element are: 1 - Immediate/Urgent Care 2 - Services rendered in a retroactive period 3 - Emergency care 4 - Client as temporary Medicaid 5 - Request from County for second opinion to recipient can work 6 - Request for override pending 7 - Special handling
178	Description				Not Used	REF03		Not Used
178	Reference Identifier				Not Used	REF04		Not Used
179	Loop: 2300 ORIGINAL REFERENCE NUMBER (ICN/DCN)	S	180	REF				Required when CLM05-3 (claim submission reason code) = 6,7, or 8 and the payer has assigned a payer number to the claim.
180	Reference Identification Qualifier				R	REF01	F8	F8 – Original Reference Number
180	Reference Identification				R	REF02		Claim Original Reference Number
180	Description				Not Used	REF03		Not Used
180	Reference Identifier				Not Used	REF04		Not Used
181	Loop: 2300 PRIOR AUTHORIZATION OR REFERRAL NUMBER	S	REF Not Reviewed for Adjudication					Required where services on this claim were preauthorized or where a referral is involved. Generally, preauthorization/referral numbers are those numbers assigned by the payer/UMO to authorize a service prior to its being performed.
182	Reference Identification Qualifier				R	REF01		9F – Referral Number G1 – Prior Authorization Number
182	Reference Identification				R	REF02		Prior Authorization Number
182	Description				Not Used	REF03		Not Used
182	Reference Identifier				Not Used	REF04		Not Used

183	Loop: 2300 CLAIM IDENTIFICATION NUMBER FOR CLEARINGHOUSES AND OTHER TRANSMISSION INTERMEDIARIES	S	180	REF				Used only by transmission intermediaries (automated clearinghouses and others) who need to attach their own unique claim number.	
184	Reference Identification Qualifier				R	REF01	D9	D9 – Claim Number	
184	Reference Identification				R	REF02		Value Added Network Trace Number	
184	Description				Not Used	REF03		Not Used	
184	Reference Identifier				Not Used	REF04		Not Used	
185	Loop: 2300 CLAIM NOTE	S						Required when: (1) state regulations mandate information not identified elsewhere within the claim set; or (2) to report periodontal charting information.	
186	Note Reference Code				R	NTE01		ADD – Additional Information	
186	Description				R	NTE02		Claim Note Text	
187	Loop: 2310A REFERRING PROVIDER	S	250	NM1				Information in Loop ID-2310 applies to the entire claim unless it is overridden on a service line by the presence of Loop ID-2410 with the same value in NM101. When there is only one referral on the claim, use code “DN – Referring Provider”. Use code “P3 –Primary Care Provider” in the second iteration of the loop to indicate the initial referral/order from the primary care provider or whatever provider wrote the initial referral/order for this patient’s episode of care being billed/reported in this transaction. Required if claim or encounter involved a referral/order.	
188	Entity ID Code		Not Reviewed for Adjudication	NM1	R	NM101		DN – Referring Provider P3 – Primary Care Provider	
188	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity	
188	Name Last or Organization Name					R	NM103		Referring Provider Last Name
188	Name First					S	NM104		Referring Provider First Name
189	Name Middle					S	NM105		Referring Provider Middle Name
189	Name Prefix					Not Used	NM106		Not Used
189	Name Suffix					S	NM107		Referring Provider Name Suffix

189	Identification Code Qualifier			R	NM108		24 – Employer’s Identification Number 34 – Social Security Number XX – HCFA National Provider ID Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.
189	Identification Code			R	NM109		Required if Employer’s Id/Social Security number, or National Provider Identifier is known.
189	Entity Relationship Code			Not Used	NM110		Not Used
189	Entity Identifier Code			Not Used	NM111		Not Used
190	Loop: 2310A REFERRING PROVIDER SPECIALTY INFORMATION	S	PRV Not Reviewed for Adjudication				Required when adjudication is known to be impacted by provider taxonomy code.
191	Provider Code			R	PRV01	RF	RF – Referring
191	Reference Identification Qualifier			R	PRV02	ZZ	ZZ is used to identify “Health Care Provider Taxonomy” code list (provider specialty code).
191	Reference Identification			R	PRV03		Provider Taxonomy Code
191	State or Providence Code			Not Used	PRV04		Not Used
191	Provider Specialty Information			Not Used	PRV05		Not Used
191	Provider Organization Code			Not Used	PRV06		Not Used
193	Loop: 2310A REFERRING PROVIDER SECONDARY IDENTIFICATION	S	REF Not Reviewed for Adjudication				Required if NM108/09 is not used.
194	Reference Identification Qualifier			R	REF01		0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number E1 – Employer’s Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number SY - Social Security Number (The social security number may not be used for Medicare.) TJ – Federal Taxpayer’s Identification Number
194	Reference Identification			R	REF02		Referring Provider Secondary Identifier
194	Description			Not Used	REF03		Not Used
194	REFERENCE IDENTIFIER			Not Used	REF04		Not Used

195	Loop ID: 2310B RENDERING PROVIDER NAME	S	250	NM1				Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to-Provider NM1 in the 2010AA/AB loops.
196	Entity ID Code				R	NM101	82	82 – Rendering Provider
196	Entity Type Qualifier				R	NM102		1 – Person Entity 2 – Non-Person Entity
196	Name Last or Organization Name				R	NM103		Rendering Provider Last or Organization Name
196	Name First				S	NM104		Rendering Provider First Name
196	Name Middle				S	NM105		Rendering Provider Middle Name
196	Name Prefix				Not Used	NM106		Not Used
196	Name Suffix				S	NM107		Rendering Provider Name Suffix
197	Identification Code Qualifier				S	NM108		24 – Employer’s Identification Number 34 – Social Security Number XX – HCFA National Provider ID
197	Identification Code				S	NM109		Rendering Provider Identifier
197	Entity Relationship Code				Not Used	NM110		Not Used
197	Entity Identifier Code				Not Used	NM111		Not Used
198	Loop ID: 2310B RENDERING PROVIDER SPECIALTY INFORMATION	S		PRV				Required when adjudication is known to be impacted by provider taxonomy code.
199	Provider Code				R	PRV01	PE	PE – Performing
199	Reference Identification Qualifier			Not Reviewed for Adjudication	R	PRV02	ZZ	ZZ – Mutually Defined ZZ is used to identify “Health Care Provider Taxonomy” code list (provider specialty code).
199	Reference Identification				R	PRV03		Provider Taxonomy Code
199	State or Providence Code				Not Used	PRV04		Not Used
199	Provider Specialty Information				Not Used	PRV05		Not Used
199	Provider Organization Code				Not Used	PRV06		Not Used
201	Loop ID: 2310B RENDERING PROVIDER SECONDARY IDENTIFICATION	S	271	REF				Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

202	Reference Identification Qualifier				R	REF01		0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number E1 – Employer’s Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number SY - Social Security Number (The social security number may not be used for Medicare.) TJ – Federal Taxpayer's Identification Number
202	Reference Identification				R	REF02		Rendering Provider Secondary Identifier
202	Description				Not Used	REF03		Not Used
202	Reference Identifier				Not Used	REF04		Not Used
203	Loop ID: 2310C SERVICE FACILITY LOCATION	S	250	NM1				Required if the service was rendered in Inpatient Hospital, Outpatient Hospital, Skilled Nursing Facility or Adult Living Care Facility (code values 21,22,31, or 35 in CLM05-1).
204	Entity ID Code				R	NM101	FA	FA – Facility
204	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
204	Name Last or Organization Name				R	NM103		Laboratory or Facility Name
204	Name First				Not Used	NM104		Not Used
204	Name Middle				Not Used	NM105		Not Used
204	Name Prefix				Not Used	NM106		Not Used
204	Name Suffix				Not Used	NM107		Not Used
204	Identification Code Qualifier				S	NM108		24 – Employer’s Identification Number 34 – Social Security Number XX – HCFA National Provider ID
204	Identification Code				S	NM109		Laboratory or Facility Primary Identifier
205	Entity Relationship Code				Not Used	NM110		Not Used
205	Entity Identifier Code				Not Used	NM111		Not Used
208	Loop ID: 2310C SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION	S	271	REF				Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.

208	Reference Identification Qualifier				R	REF01		0B – State License Number 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 G2 – Provider Commercial Number LU – Location Number TJ – Federal Taxpayer’s Identification Number X4 - Clinical Laboratory Improvement Amendment Number X5 - State Industrial Accident Provider Number
208	Reference Identification				R	REF02		Laboratory or Facility Secondary Identifier
208	Description				Not Used	REF03		Not Used
208	Reference Identifier				Not Used	REF04		Not Used
208	Loop ID: 2310D ASSISTANT SURGEON NAME	S	250	NM1				Required when the Assistant Surgeon information is needed to facilitate reimbursement of the claim
208	Entity ID Code		Not Reviewed for Adjudication	NM1	R	NM101	DD	DD – Assistant Surgeon
208	Entity Type Qualifier				R	NM102		1 – Person Entity 2 – Non-Person Entity
208	Name Last or Organization Name				R	NM103		Assistant Surgeon Last or Organization Name
208	Name First				S	NM104		Assistant Surgeon First Name
208	Name Middle				S	NM105		Assistant Surgeon Middle Name
208	Name Prefix				Not Used	NM106		Not Used
208	Name Suffix				S	NM107		Assistant Surgeon Name Suffix
208	Identification Code Qualifier				S	NM108		24 – Employer’s Identification Number 34 – Social Security Number XX – HCFA National Provider ID
208	Identification Code				S	NM109		Assistant Surgeon Identifier
208	Entity Relationship Code				Not Used	NM110		Not Used
208	Entity Identifier Code				Not Used	NM111		Not Used
208	Loop ID: 2310D ASSISTANT SURGEON SPECIALTY INFORMATION	S	Not Reviewed for Adjudication	PRV				Required when adjudication is known to be impacted by provider taxonomy code.
208	Provider Code				R	PRV01	AS	AS – Assistant Surgeon
208	Reference Identification Qualifier				R	PRV02	ZZ	ZZ – Mutually Defined ZZ is used to identify “Health Care Provider Taxonomy” code list (provider specialty code).
208	Reference Identification				R	PRV03		Provider Taxonomy Code

208	State or Providence Code				Not Used	PRV04	Not Used
208	Provider Specialty Information				Not Used	PRV05	Not Used
208	Provider Organization Code				Not Used	PRV06	Not Used
208	Loop ID: 2310D ASSISTANT SURGEON SECONDARY IDENTIFICATION	S	REF				Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NM109
			Not Reviewed for Adjudication				
208	Reference Identification Qualifier				R	REF01	0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number G2 – Provider Commercial Number LU – Location Number TJ – Federal Taxpayer's Identification Number X4 - Clinical Laboratory Improvement Amendment Number X5 - State Industrial Accident Provider Number
208	Reference Identification				R	REF02	Assistant Surgeon Secondary Identifier
208	Description				Not Used	REF03	Not Used
208	REFERENCE IDENTIFIER				Not Used	REF04	Not Used
209	Loop ID: 2320 OTHER SUBSCRIBER INFORMATION	S	290	SBR			Required if other payers are known to potentially be involved in paying on this claim.
210	Payer Responsibility Sequence Number Code				R	SBR01	P - Primary S - Secondary T – Tertiary (Used to indicate “payer of last resort”.)
210	Individual Relationship Code				R	SBR02	01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 22 – Handicapped Dependent 29 – Significant Other 76 – Dependent
210	Reference Identification				S	SBR03	Insured Group or Policy Number
211	Name				S	SBR04	Policy Name
211	Insurance Type Code				Not Used	SBR05	Not Used
211	Coordination of Benefits Code				Not Used	SBR06	Not Used
211	Yes/No Condition or Response Code				Not Used	SBR07	Not Used

211	Employment Status Code				Not Used	SBR08		Not Used
211	Claim Filing Indicator Code Note: Field must be populated with a valid value. It will not be reviewed by Health Plan.				S	SBR09		09 – Self-pay 11 – Other Non-Federal Programs 12 – Preferred Provider Org. 13 – Point of Service 14 – Exclusive Provider Org. 15 – Indemnity Insurance 16 – HMO Medicare Risk 17 – Dental Maintenance Organization BL – Blue Cross/Blue Shield CH – Champus CI – Commercial Insurance Co. DS – Disability FI – Federal Employees Program HM – Health Maintenance Organization LM – Liability Medical MB – Medicare Part B MC – Medicaid MH – Manage Care Non-HMO OF – Other Federal Program SA – Self-administered Group VA – Veteran Administration Plan WC – Workers' Compensation Health Claim ZZ – Mutually Defined (unknown)
215	Loop ID: 2320 CLAIM LEVEL ADJUSTMENT	S	295	CAS				Submitter should use this CAS segment to report prior payers claim level adjustments that cause the amount paid to differ from the amount originally charged. Required if claim has been adjudicated by payer identified in this loop and has claim level adjustment information. Codes and associated amount should come from 835 (Remittance Advice) received on the claim. If no previous payments have been made, omit this segment.
215	Claim Adjustment Group Code				R	CAS01		CO – Contractual Obligations CR – Correction and Reversals OA – Other adjustments PI – Payer Initiated Reductions PR – Patient Responsibility
215	Claim Adjustment Reason Code				R	CAS02		Claim Adjustment Reason Code Code Source 139:
215	Monetary Amount				R	CAS03		Adjustment Amount
215	Quantity				S	CAS04		Adjustment Quantity
215	Claim Adjustment Reason Code				S	CAS05		Claim Adjustment Reason Code Code Source 139:

216	Monetary Amount				S	CAS06		Adjustment Amount
216	Quantity				S	CAS07		Adjustment Quantity
216	Claim Adjustment Reason Code				S	CAS08		Claim Adjustment Reason Code Code Source 139:
216	Monetary Amount				S	CAS09		Adjustment Amount
216	Quantity				S	CAS10		Adjustment Quantity
217	Claim Adjustment Reason Code				S	CAS11		Claim Adjustment Reason Code Code Source 139:
217	Monetary Amount				S	CAS12		Adjustment Amount
218	Quantity				S	CAS13		Adjustment Quantity
218	Claim Adjustment Reason Code				S	CAS14		Claim Adjustment Reason Code Code Source 139:
218	Monetary Amount				S	CAS15		Adjustment Amount
219	Quantity				S	CAS16		Adjustment Quantity
219	Claim Adjustment Reason Code				S	CAS17		Claim Adjustment Reason Code Code Source 139:
219	Monetary Amount				S	CAS18		Adjustment Amount
219	Quantity				S	CAS19		Adjustment Quantity
220	Loop ID: 2320 COB PAYER PAID AMOUNT	S	300	AMT				Required if claim has been adjudicated by payer identified in this loop. It is acceptable to show "0" amount paid.
220	Amount Qualifier Code				R	AMT01	D	D – Payer Amount Paid
220	Monetary Amount				R	AMT02		Payer Paid Amount
220	Credit/Debit Flag Code				Not Used	AMT03		Not Used
221	Loop ID: 2320 COB APPROVED AMOUNT	S	300	AMT				Used only in payer to payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.
221	Amount Qualifier Code				R	AMT01	AAE	AAE - Approved Amount
221	Monetary Amount				R	AMT02		Approved Amount
221	Credit/Debit Flag Code				Not Used	AMT03		Not Used
222	Loop ID: 2320 COB ALLOWED AMOUNT	S	300	AMT				Used only in payer to payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.
222	Amount Qualifier Code				R	AMT01	B6	B6 - Allowed Amount
222	Monetary Amount				R	AMT02		Allowed Amount
222	Credit/Debit Flag Code				Not Used	AMT03		Not Used

223	Loop ID: 2320 COB PATIENT RESPONSIBILITY AMOUNT	S	300	AMT				Required if patient is responsible for payment according to another payer's adjudication. This is the amount of money which is the responsibility of the patient according to the payer identified in this loop.
223	Amount Qualifier Code				R	AMT01	F2	F2 – Patient Responsibility - Actual
223	Monetary Amount				R	AMT02		Patient Responsibility Amount
223	Credit/Debit Flag Code				Not Used	AMT03		Not Used
224	Loop ID: 2320 COB COVERED AMOUNT	S	300	AMT				Used only in payer to payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information.
224	Amount Qualifier Code				R	AMT01	AU	AU – Coverage Amount
224	Monetary Amount				R	AMT02		Covered Amount
224	Credit/Debit Flag Code				Not Used	AMT03		Not Used
225	Loop ID: 2320 COB DISCOUNT AMOUNT	S	300	AMT				Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.
225	Amount Qualifier Code				R	AMT01	D8	D8 – Discount Amount
225	Monetary Amount				R	AMT02		Other Payer Discount Amount
225	Credit/Debit Flag Code				Not Used	AMT03		Not Used
226	Loop ID: 2320 COB PATIENT PAID AMOUNT	S	300	AMT				Required if claim has been adjudicated by the payer identified in this loop and if this information was included in the remittance advice reporting those adjudication results.
226	Amount Qualifier Code				R	AMT01	F5	F5 – Patient Amount Paid
226	Monetary Amount				R	AMT02		Other Payer Patient Paid Amount
226	Credit/Debit Flag Code				Not Used	AMT03		Not Used
227	Loop ID: 2320 OTHER INSURED DEMOGRAPHIC INFORMATION	S	305	DMG				Required when 2330A - Other Subscriber Name NM102 = 1 (person).
227	Date Time Period Format Qualifier				R	DMG01	D8	D8 – Date Expressed in Format CCYYMMDD
228	Date Time Period				R	DMG02		Other Insured Birth Date
228	Gender Code				R	DMG03		Other Insured Gender Code F – Female M – Male U – Unknown
228	Marital Status Code				Not Used	DMG04		Not Used
228	Race or Ethnicity Code				Not Used	DMG05		Not Used
228	Citizenship Status Code				Not Used	DMG06		Not Used

228	Country Code				Not Used	DMG07		Not Used
228	Basis of Verification Code				Not Used	DMG08		Not Used
228	Quantity				Not Used	DMG09		Not Used
229	Loop ID: 2320 OTHER INSURANCE COVERAGE INFORMATION Note: Fields must be populated with a valid value. It will not be reviewed by Health Plan for adjudication. Same value will be returned when applicable.	R	OI Not Reviewed for Adjudication					All information contained in the OI segment applies only to the payer who is identified in the 2330B loop of this iteration of the 2320 loop. It is specific only to that payer.
229	Claim Filing Indicator Code				Not Used	OI01		Not Used
229	Claim Submission Reason Code				Not Used	OI02		Not Used
229	Yes/No Condition or Response Code				R	OI03		Benefits Assignment Certification Indicator A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider; an "N" value indicates benefits have not been assigned to the provider. N – No Y – Yes
230	Patient Signature Source Code				Not Used	OI04		Not Used
230	Provider Agreement Code				Not Used	OI05		Not Used
230	Release of Information Code Note: Field must be populated with a valid value. It will not be reviewed by Health Plan. Same value will be returned when applicable.				R	OI06		Release of Information Code N – No, Provider is Not Allowed to Release Data Y – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
231	Loop ID: 2330A OTHER SUBSCRIBER NAME	R	325	NM1				Submitters are required to send information on all known other subscribers in Loop ID 2330. The 2330A Loop is required when Loop ID 2320 - Other Subscriber Information is used. Otherwise, this loop is not used.
232	Entity ID Code				R	NM101	IL	IL – Insured or Subscriber
232	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
232	Name Last or Organization Name				R	NM103		Other Insured Last Name
232	Name First				S	NM104		Other Insured First Name
232	Name Middle				S	NM105		Other Insured Middle Name
232	Name Prefix				Not Used	NM106		Not Used

232	Name Suffix				S	NM107		Other Insured Name Suffix
233	Identification Code Qualifier				R	NM108		24 – Employer's Identification Number MI – Member Identification Number ZZ – Mutually Defined
233	Identification Code				R	NM109		Other Insured Identifier
233	Entity Relationship Code				Not Used	NM110		Not Used
233	Entity Identifier Code				Not Used	NM111		Not Used
235	Loop ID: 2330A OTHER SUBSCRIBER ADDRESS	S	N3					This segment is required when the Provider has the Other Subscriber Address information on file.
235	Address Information		Not Reviewed for Adjudication		R	N301		Other Insured Address Line 1
235	Address Information				S	N301		Other Insured Address Line 2
236	Loop ID: 2330A OTHER SUBSCRIBER CITY/STATE/ZIP CODE	S	N4					This segment is required when the associated N3 segment is present.
236	City Name		Not Reviewed for Adjudication		R	N401		Other Insured's City Name
237	State or Province Code				R	N402		Other Insured's State Code
237	Postal Code				R	N403		Other Insured's Postal Zone or ZIP Code
237	Country Code				S	N404		Other Insured's Country - Required when address is outside the U.S.
237	Location Qualifier		REF		Not Used	N405		Not Used
237	Location Identifier				Not Used	N406		Not Used
238	Loop ID: 2330A OTHER SUBSCRIBER SECONDARY INFORMATION	S	Not Reviewed for Adjudication					Required if additional identification numbers are necessary to adjudicate the claim/encounter.
238	Reference Identification Qualifier				R	REF01		1W – Member Identification Number 23 – Client Number IG – Insurance Policy Number SY – Social Security Number
239	Reference Identification				R	REF02		Other Insured Additional Identifier
239	Description				Not Used	REF03		Not Used
239	Reference Identifier				Not Used	REF04		Not Used
240	Loop ID: 2330B OTHER PAYER NAME	R	325	NM1				Submitters are required to send all known information on other payers in this Loop ID - 2330.
241	Entity ID Code				R	NM101	PR	PR – Payer
241	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
241	Name Last or Organization Name				R	NM103		Other Payer Last or Organization Name
241	Name First				Not Used	NM104		Not Used
241	Name Middle				Not Used	NM105		Not Used

241	Name Prefix				Not Used	NM106		Not Used	
241	Name Suffix				Not Used	NM107		Not Used	
241	Identification Code Qualifier				R	NM108		PI – Payer Identification XV – Health Care Financing Administration National Plan ID	
241	Identification Code				R	NM109		Other Payer Primary Identifier	
241	Entity Relationship Code				Not Used	NM110		Not Used	
241	Entity Identifier Code				Not Used	NM111		Not Used	
243	Loop ID: 2330B OTHER PAYER CONTACT INFORMATION	S		PER				This segment is used only in payer to payer COB situations. This segment may be completed by a payer who had adjudicated the claim and is passing it on to a secondary payer. It is not completed by submitting providers.	
244	Contact Function Code		Not Reviewed for Adjudication		R	PER01	IC	IC – Information Contact	
244	Name				R	PER02		Other Payer Contact Name	
244	Communication Number Qualifier					R	PER03		Code identifying type of communication number ED – EDI Access Number EM – Electronic Mail FX – Facsimile TE – Telephone
244	Communication Number					R	PER04		Complete communication number including country and area code when applicable
244	Communication Number Qualifier					S	PER05		ED – EDI Access Number EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
245	Communication Number					S	PER06		Complete communication number including country and area code when applicable
245	Communication Number Qualifier					S	PER07		ED – EDI Access Number EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
245	Communication Number					S	PER08		Complete communication number including country and area code when applicable
245	Contact Inquiry Reference					Not Used	PER09		Not Used
246	Loop ID: 2330B CLAIM PAID DATE	S		DTP				This segment is required when Loop-ID 2430 (Line Adjudication Date) is not used and this payer has adjudicated the claim.	
246	Date/Time Qualifier		Not Reviewed for Adjudication		R	DTP01	573	573 – Date Claim Paid	
246	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD	
246	Date Time Period					R	DTP03		Date Claim Paid

247	Loop ID: 2330B OTHER PAYER SECONDARY IDENTIFIER	S	REF				This segment is required when a secondary number is needed to identify the payer. The primary identification number should be carried in the NM109 of this loop.
247	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01	2U – Payer Identification Number D8 – Loss Report Number F8 – Original Reference Number FY – Claim Office Number NF – National Association of Insurance Commissioners (NAIC) Code TJ – Federal Taxpayer's Identification Number
248	Reference Identification				R	REF02	Other Payer Secondary Identifier
248	Description				Not Used	REF03	Not Used
248	Reference Identifier				Not Used	REF04	Not Used
249	Loop ID: 2330B OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER	S	REF				Used when the payer identified in this loop has given a prior authorization or referral number to this claim. This element is primarily used in payer-to-payer COB situations.
249	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01	9F – Referral Number G1 – Prior Authorization Number
249	Reference Identification				R	REF02	Other Payer Prior Authorization or Referral Number
249	Description				Not Used	REF03	Not Used
250	Reference Identifier				Not Used	REF04	Not Used
251	Loop ID: 2330B OTHER PAYER CLAIM ADJUSTMENT INDICATOR	S	REF				Used only in payer to payer COB. In that situation, the destination payer is secondary to the payer identified in this loop. Providers/other submitters do not use this segment.
252	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01	T4
252	Reference Identification				R	REF02	Other Payer Claim Adjustment Indicator
252	Description				Not Used	REF03	Not Used
252	Reference Identifier				Not Used	REF04	Not Used
253	Loop ID: 2330C OTHER PAYER PATIENT INFORMATION	S	325	NM1			Required when it is necessary, in COB situations, to send one or more payer-specific patient identification numbers. The patient identification number(s) carried in this iteration of the 2330C loop are those patient ID's which belong to non-destination (COB) payers. The patients ID(s) for the destination payer are carried in the 2010CA loop NM1 and REF segments.

254	Entity ID Code				R	NM101	QC	QC – Patient
254	Entity Type Qualifier				R	NM102	1	1 – Person
254	Name Last or Organization Name				Not Used	NM103		Not Used
254	Name First				Not Used	NM104		Not Used
254	Name Middle				Not Used	NM105		Not Used
254	Name Prefix				Not Used	NM106		Not Used
254	Name Suffix				Not Used	NM107		Not Used
254	Identification Code Qualifier				R	NM108	MI	MI – Member Identification Number
254	Identification Code				R	NM109		Other Payer Patient Primary Identifier
254	Entity Relationship Code				Not Used	NM110		Not Used
254	Entity Identifier Code				Not Used	NM111		Not Used
255	Loop ID: 2330C OTHER PAYER PATIENT IDENTIFICATION NUMBER	S	REF					Used when a COB payer (listed in 2330B loop) has one or more proprietary patient identification numbers for this claim. The patient (name, DOB, etc) is identified in the 2010BA or 2010CA loop.
255	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01		1W – Member Identification Number 23 – Client Number IG – Insurance Policy Number SY – Social Security Number
256	Reference Identification				R	REF02		Other Payer Patient Primary Identifier
256	Description				Not Used	REF03		Not Used
256	Reference Identifier				Not Used	REF04		Not Used
257	Loop ID: 2330D OTHER PAYER REFERRING PROVIDER	S	325	NM1				Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
258	Entity ID Code		NM1		R	NM101		DN – Referring Provider P3 – Primary Care Provider
258	Entity Type Qualifier		Not Reviewed for Adjudication		R	NM102		1 – Person 2 – Non-Person Entity
258	Name Last or Organization Name				Not Used	NM103		Not Used
258	Name First				Not Used	NM104		Not Used
258	Name Middle				Not Used	NM105		Not Used
258	Name Prefix				Not Used	NM106		Not Used
258	Name Suffix				Not Used	NM107		Not Used
258	Identification Code Qualifier				Not Used	NM108		Not Used
258	Identification Code				Not Used	NM109		Not Used
258	Entity Relationship Code				Not Used	NM110		Not Used

258	Entity Identifier Code		REF		Not Used	NM111	Not Used
259	Loop ID: 2330D OTHER PAYER REFERRING PROVIDER IDENTIFICATION	R	Not Reviewed for Adjudication				Non-destination (COB) payers' provider identification number(s).
259	Reference Identification Qualifier				R	REF01	0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number E1 – Employer's Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number TJ – Federal Taxpayer's Identification Number
260	Reference Identification				R	REF02	Other Payer Referring Provider Identifier
260	Description				Not Used	REF03	Not Used
260	Reference Identifier				Not Used	REF04	Not Used
261	Loop ID: 2330E OTHER PAYER RENDERING PROVIDER	S	325	NM1			Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
262	Entity ID Code		NM1		R	NM101	82 82 – Rendering Provider
262	Entity Type Qualifier		Not Reviewed for Adjudication		R	NM102	1– Person Entity 2 – Non-Person Entity
262	Name Last or Organization Name				Not Used	NM103	Not Used
262	Name First				Not Used	NM104	Not Used
262	Name Middle				Not Used	NM105	Not Used
262	Name Prefix				Not Used	NM106	Not Used
262	Name Suffix				Not Used	NM107	Not Used
262	Identification Code Qualifier				Not Used	NM108	Not Used
262	Identification Code				Not Used	NM109	Not Used
262	Entity Relationship Code		REF		Not Used	NM110	Not Used
262	Entity Identifier Code				Not Used	NM111	Not Used
263	OTHER PAYER RENDERING PROVIDER IDENTIFICATION	S					Non-destination (COB) payers' provider identification number(s).

264	Reference Identification Qualifier		Not Reviewed for Adjudication		R	REF01	0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number EI – Employer’s Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number TJ – Federal Taxpayer’s Identification Number
264	Reference Identification				R	REF02	Other Payer Rendering Provider Identifier
264	Description				Not Used	REF03	Not Used
264	Reference Identifier				Not Used	REF04	Not Used
265	Loop ID: 2400 SERVICE LINE NUMBER	R	365	LX			The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter. The data in the LX is not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/ unbundling in SVC06.
265	Assigned Number				R	LX01	Line Counter This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.
266	Loop ID: 2400 DENTAL SERVICE	R	380	SV3			
266	Composite Product/Service Identifier				R	SV301	
266	Product/Service ID Qualifier				R	SV301-1	AD – American Dental Association Codes (CDT = Current Dental Terminology)
267	Product/Service ID				R	SV301-2	Procedure Code
267	Procedure Modifier		Not Reviewed for Adjudication		S	SV301--3	Procedure Code Modifier
267	Procedure Modifier				S	SV301-4	Procedure Code Modifier
267	Procedure Modifier				S	SV301-5	Procedure Code Modifier
268	Procedure Modifier				S	SV301-6	Procedure Code Modifier
268	Description				Not Used	SV301-7	Not Used
268	Monetary Amount				R	SV302	Line Item Charge Amount

268	Facility code Value				S	SV303	11 – Office 12 – Home 21 – Inpatient Hospital 22 – Outpatient Hospital 31 – Skilled Nursing Facility 35 – Adult Living Care Facility
268	Composite Oral Cavity Designation				S	SV304	
269	Oral Cavity Designation Code				R	SV304-1	00 - Entire Oral Cavity 01 - Maxillary Area 02 - Mandibular Area 09 - Other Area of Oral Cavity 10 - Upper Right Quadrant 20 - Upper Left Quadrant 30 - Lower Left Quadrant 40 - Lower Right Quadrant L - Left R - Right
269	Oral Cavity Designation Code		Not Reviewed for Adjudication		S	SV304-2	00 - Entire Oral Cavity 01 - Maxillary Area 02 - Mandibular Area 09 - Other Area of Oral Cavity 10 - Upper Right Quadrant 20 - Upper Left Quadrant 30 - Lower Left Quadrant 40 - Lower Right Quadrant L - Left R - Right
269	Oral Cavity Designation Code				S	SV304-3	00 - Entire Oral Cavity 01 - Maxillary Area 02 - Mandibular Area 09 - Other Area of Oral Cavity 10 - Upper Right Quadrant 20 - Upper Left Quadrant 30 - Lower Left Quadrant 40 - Lower Right Quadrant L - Left R - Right
269	Oral Cavity Designation Code				S	SV304-4	00 - Entire Oral Cavity 01 - Maxillary Area 02 - Mandibular Area 09 - Other Area of Oral Cavity 10 - Upper Right Quadrant 20 - Upper Left Quadrant 30 - Lower Left Quadrant 40 - Lower Right Quadrant L - Left R - Right

269	Oral Cavity Designation Code		Not Reviewed for Adjudication		S	SV304-5	00 - Entire Oral Cavity 01 - Maxillary Area 02 - Mandibular Area 09 - Other Area of Oral Cavity 10 - Upper Right Quadrant 20 - Upper Left Quadrant 30 - Lower Left Quadrant 40 - Lower Right Quadrant L - Left R - Right
270	Prosthesis, Crown or Inlay Code					SV305	Prosthesis, Crown or Inlay Code I - Initial Placement R - Replacement (If the SV305 = R, then the DTP segment in the 2400 loop for Prior Placement is Required).
270	Description				Not Used	SV307	Not Used
270	Copay Status Code				Not Used	SV308	Not Used
270	Provider Agreement Code				Not Used	SV309	Not Used
270	Yes/No Condition or Response Code				Not Used	SV310	Not Used
270	Composite Diagnosis Code Pointer				Not Used	SV311	Not Used
271	Loop ID: 2400 TOOTH INFORMATION	S	382	TOO			Required to report tooth number and/or tooth surface related to this procedure line
271	Code List Qualifier Code				R	TOO01	JP - National Standard Tooth Numbering System
272	Industry Code				S	TOO02	Tooth Code
272	Composite - Tooth Surface				S	TOO03	Required if the procedure code requires tooth surface codes.
272	Tooth Surface Code				R	TOO03-1	B - Buccal D - Distal F - Facial I - Incisal L - Lingual M - Mesial O - Occlusal
272	Tooth Surface Code				S	TOO03-2	B - Buccal D - Distal F - Facial I - Incisal L - Lingual M - Mesial O - Occlusal

272	Tooth Surface Code				S	TOO03-3		B - Buccal D - Distal F - Facial I - Incisal L - Lingual M - Mesial O - Occlusal
272	Tooth Surface Code				S	TOO03-4		B - Buccal D - Distal F - Facial I - Incisal L - Lingual M - Mesial O - Occlusal
272	Tooth Surface Code				S	TOO03-5		B - Buccal D - Distal F - Facial I - Incisal L - Lingual M - Mesial O - Occlusal
273	Loop ID: 2400 SERVICE LINE DATE	S	455	DTP				Required if the service date is different than the service date reported at the DTP segment in the 2300 loop and the service was performed.
273	Date/Time Qualifier				R	DTP01	472	472 – Service
273	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
274	Date Time Period				R	DTP03		Service Date
275	Loop ID: 2400 PRIOR PLACEMENT DATE	S	455	DTP				Required if the services performed are prosthetic services that were previously placed.
275	Date/Time Qualifier				R	DTP01	441	441 – Prior Placement
275	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
276	Date Time Period				R	DTP03		Prior Placement Date
277	Loop ID: 2400 APPLIANCE PLACEMENT DATE	S	455	DTP				Required if the orthodontic appliance placement date is different that the orthodontic appliance placement date in the DTP segment in the 2300 loop.
277	Date/Time Qualifier				R	DTP01	452	452 – Appliance Placement
277	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
278	Date Time Period				R	DTP03		Orthodontic Banding Date
279	Loop ID: 2400 REPLACEMENT DATE	S	455	DTP				This DTP segment should be used to report the date an orthodontic appliance was replaced.
279	Date/Time Qualifier				R	DTP01	446	446 – Replacement

279	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD	
280	Date Time Period				R	DTP03		Replacement Date	
281	Loop ID: 2400 ANESTHESIA QUANTITY	S	460	QTY				Required on anesthesia service lines if one or more extenuating circumstances, coded in the QTY01, was present at the time of service	
281	Quantity Qualifier				R	QTY01		BF - Age Modifying Units EM - Emergency Modifying Units HM - Use of Hypothermia HO - Use of Hypotension HP - Use of Hyperbaric Pressurization P4 - Physical Status IV P5 - Physical Status V SG - Swan-Ganz	
282	Quantity				R	QTY02		Anesthesia Unit Count	
282	Composite Unit of Measure				Not Used	QTY03		Not Used	
282	Free Form Message				Not Used	QTY04		Not Used	
283	Loop ID: 2400 SERVICE PREDERMINATION IDENTIFICATION	S	REF					This segment should be used to send the line level Predetermination of benefits Identification Number for a service that was previously predetermined and is now being submitted for payment. G3 - Predetermination of Benefits Identification Number	
283	Reference Identifier Qualifier		Not Reviewed for Adjudication		R	REF01	G3		
283	Reference Identification				R	REF02			Predetermination of Benefits Identifier
283	Description				Not Used	REF03			Not Used
283	Reference Identifier				Not Used	REF04			Not Used
284	Loop ID: 2400 PRIOR AUTHORIZATION OR REFERRAL NUMBER	S			REF				
284	Reference Identifier Qualifier		Not Reviewed for Adjudication		R	REF01			
284	Reference Identification				R	REF02		Referral Number	
284	Description				Not Used	REF03		Not Used	
284	Reference Identifier				Not Used	REF04		Not Used	
285	Loop ID: 2400 LINE ITEM CONTROL NUMBER	S			470	REF			

285	Reference Identifier Qualifier				R	REF01		6R - Provider Control Number
286	Reference Identification				R	REF02		Line Item Control Number
286	Description				Not Used	REF03		Not Used
286	Reference Identifier				Not Used	REF04		Not Used
287	Loop ID: 2400 APPROVED AMOUNT	S	AMT					Used only in payer to payer COB situations by the payer who is sending this claim to another payer. Providers do not complete this information
287	Amount Qualifier Code		Not Reviewed for Adjudication		R	AMT01	AAE	AAE - Approved Amount
287	Monetary Amount				R	AMT01		Approved Amount
287	Credit/Debit Flag Code				Not Used	AMT01		Not Used
287	Loop ID: 2400 SALES TAX AMOUNT	S	AMT					Required if sales tax applies to service line and submitter is required to report that information to the receiver.
287	Amount Qualifier Code		Not Reviewed for Adjudication		R	AMT01	T	T - Tax
287	Monetary Amount				R	AMT01		Sales Tax Amount
287	Credit/Debit Flag Code				Not Used	AMT01		Not Used
288	Loop ID: 2400 LINE NOTE	S	485	NTE				Required if the submitter used a "Not Otherwise Classified" (NOC) or a "By Report" procedure code or to report the following information on this service line: Date of Initial Impression, Date of Initial Preparation Crown, Initial Preparation Crown Tooth Number or Initial Endodontic Treatment.
288	Note Reference Code				R	NTE01	ADD	ADD – Additional Information
288	Description				R	NTE02		Claim Note Text
289	Loop ID: 2420A RENDERING PROVIDER NAME	S	500	NM1				Required if the Referring Provider NM1 information is different than that carried in the 2310D (claim) loop.
290	Entity ID Code		NM1		R	NM101	82	82 - Rendering Provider
290	Entity Type Qualifier		Not Reviewed for Adjudication		R	NM102		1 – Person 2 – Non-Person Entity
290	Name Last or Organization Name				R	NM103		Rendering Provider Last Name
290	Name First				S	NM104		Rendering Provider First Name
290	Name Middle				S	NM105		Rendering Provider Middle Name
290	Name Prefix				Not Used	NM106		Not Used
290	Name Suffix				S	NM107		Rendering Provider Name Suffix

291	Identification Code Qualifier		PRV	R	NM108		24 – Employer’s Identification Number 34 – Social Security Number XX – HCFA National Provider ID Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.
291	Identification Code			R	NM109		Rendering Provider Identifier
291	Entity Relationship Code			Not Used	NM110		Not Used
291	Entity Identifier Code			Not Used	NM111		Not Used
292	Loop ID: 2420A RENDERING PROVIDER SPECIALTY INFORMATION	S		Not Reviewed for Adjudication			Required when adjudication is known to be impacted by provider taxonomy code.
292	Provider Code			R	PRV01	PE	PE - Performing
292	Reference Identification Qualifier			R	PRV02	ZZ	ZZ – Mutually Defined ZZ is used to identify “Health Care Provider Taxonomy” code list (provider specialty code).
293	Reference Identification			R	PRV03		Provider Taxonomy Code
293	State or Providence Code			Not Used	PRV04		Not Used
293	Provider Specialty Information			Not Used	PRV05		Not Used
293	Provider Organization Code		REF	Not Used	PRV06	Not Used	
295	Loop ID: 2420A RENDERING PROVIDER SECONDARY IDENTIFICATION	S	Not Reviewed for Adjudication				Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in the NM109.
295	Reference Identification Qualifier			R	REF01		0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number E1 – Employer’s Identification Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number SY – Social Security Number TJ – Federal Taxpayer’s Identification Number
296	Reference Identification			R	REF02		Rendering Provider Secondary Identifier
296	Description			Not Used	REF03		Not Used
296	REFERENCE IDENTIFIER			Not Used	REF04		Not Used

297	Loop ID: 2420B OTHER PAYER REFERRAL NUMBER	S	500	NM1				Required when it is necessary, in COB situations, to send a payer specific line level referral number. The payer-specific numbers carried in the REF in this loop belong to the non-destination (COB0 payer).
298	Entity ID Code		Not Reviewed for Adjudication	NM1	R	NM101	PR	PR - Payer
298	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity
298	Name Last or Organization Name				R	NM103		Other Payer Last or Organization Name
298	Name First				Not Used	NM104		Not Used
298	Name Middle				Not Used	NM105		Not Used
298	Name Prefix				Not Used	NM106		Not Used
298	Name Suffix				Not Used	NM107		Not Used
298	Identification Code Qualifier				R	NM108		PL – Payor Identification XV – Health Care Financing Administration National PlanID. Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used.
299	Identification Code				R	NM109		Other Payer Referral Number
299	Entity Relationship Code				Not Used	NM110		Not Used
299	Entity Identifier Code				Not Used	NM111		Not Used
300	Loop ID: 2420B OTHER PAYER PRIOR AUTHORIZATION OR REFERRAL NUMBER	S	Not Reviewed for Adjudication	REF				Used when COB payer has one or more line-level referral numbers for this service line. This segment should not be used for Predetermination of Benefits.
300	Reference Identification Qualifier				R	REF01		9F – Referral Number G1 – Prior Authorization Number
300	Reference Identification				R	REF02		Other Payer Prior Authorization or Referral Number
300	Description				Not Used	REF03		Not Used
300	REFERENCE IDENTIFIER				Not Used	REF04		Not Used
300	Loop ID: 2420C ASSISTANT SURGEON NAME	S	500	NM1				Required if the Referring Provider NM1 information is different than that carried in the 2310D (claim) loop.
300	Entity ID Code				R	NM101	DD	DD - Assistant Surgeon
300	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
300	Name Last or Organization Name				R	NM103		Assistant Surgeon Provider Last Name or Organization Name
300	Name First				S	NM104		Assistant Surgeon Provider First Name

300	Name Middle		Not Reviewed for Adjudication	S	NM105		Assistant Surgeon Provider Middle Name
300	Name Prefix			Not Used	NM106		Not Used
300	Name Suffix			S	NM107		Assistant Surgeon Provider Name Suffix
300	Identification Code Qualifier			R	NM108		24 – Employer's Identification Number 34 – Social Security Number XX – HCFA National Provider ID Required value if the National Provider ID is mandated for use. Otherwise, one of the other listed codes may be used.
300	Identification Code			R	NM109		Assistant Surgeon's Primary Identification Number
300	Entity Relationship Code			Not Used	NM110		Not Used
300	Entity Identifier Code			Not Used	NM111		Not Used
300	Loop ID: 2420C ASSISTANT SURGEON SPECIALTY INFORMATION	S	PRV				Required when the Assistant Surgeon specialty information is needed to facilitate reimbursement of the claim.
300	Provider Code		Not Reviewed for Adjudication	R	PRV01	AS	AS - Assistant Surgeon
300	Reference Identification Qualifier			R	PRV02	ZZ	ZZ – Mutually Defined ZZ is used to identify "Health Care Provider Taxonomy" code list (provider specialty code).
300	Reference Identification			R	PRV03		Provider Taxonomy Code
300	State or Providence Code			Not Used	PRV04		Not Used
300	Provider Specialty Information			Not Used	PRV05		Not Used
300	Provider Organization Code			Not Used	PRV06		Not Used
300	Loop ID: 2420C ASSISTANT SURGEON SECONDARY IDENTIFICATION	S	REF				Use this REF segment only if a second number is necessary to identify the provider. The primary identification number should be contained in the NMN109.
300	Reference Identification Qualifier		Not Reviewed for Adjudication	R	REF01		0B – State License Number 1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1E – Dentist License Number 1H – CHAMPUS Identification Number EI – Employer's Identification Number G2 – Provider Commercial Number LU – Location Number TJ – Federal Taxpayer's Identification Number X4 – Clinical Laboratory Improvement Amendment Number X5 – State Industrial Accident Provider Number

300	Reference Identification				R	REF02	Rendering Provider Secondary Identifier
300	Description				Not Used	REF03	Not Used
300	REFERENCE IDENTIFIER				Not Used	REF04	Not Used
301	Loop ID: 2430 SERVICE LINE ADJUDICATION INFORMATION	S	540	SVD			Required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.
302	Identification Code				R	SVD01	Other Payer Primary Identifier
302	Monetary Amount				R	SVD02	Service Line Paid Amount
302	COMPOSITE MEDICAL PROCEDURE IDENTIFIER				S	SVD03	
302	Product/Service ID Qualifier				R	SVD03-1	AD – American Dental Association Codes ZZ – Mutually Defined)jurisdictionally defined procedure and supply codes used for worker's compensation claims)
302	Product/Service ID				R	SVD03-2	Procedure Code
303	Procedure Modifier		Not Reviewed for Adjudication		S	SVD03-3	Required when a modifier clarifies/improves the reporting accuracy of the associated procedure codes.
303	Procedure Modifier			S	SVD03-4	Required when a modifier clarifies/improves the reporting accuracy of the associated procedure codes.	
303	Procedure Modifier			S	SVD03-5	Required when a modifier clarifies/improves the reporting accuracy of the associated procedure codes.	
303	Procedure Modifier			S	SVD03-6	Required when a modifier clarifies/improves the reporting accuracy of the associated procedure codes.	
303	Description				S	SVD03-7	Procedure Code Description
303	Product/Service ID				Not Used	SVD04	Not Used
303	Quantity				R	SVD05	Paid Service Unit Count Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.
304	Assigned Number				S	SVD06	Bundled or Unbundled Line Number Use the LX from this transaction, which points to the bundled/unbundled line.
305	Loop ID: 2430 SERVICE LINE ADJUSTMENT	S	CAS				Required if the payer identified in loop 2330B made line level adjustments which caused the amount paid to differ from the amount originally charged.

307	Claim Adjustment Group Code		Not Reviewed for Adjudication		R	CAS01	Adjustment Group Code CO - Contractual Obligations CR - Correction and Reversals OA - Other adjustments PI - Payer Initiated Reductions PR - Patient Responsibility	
307	Claim Adjustment Reason Code				R	CAS02	Adjustment Reason Code	
307	Monetary Amount				R	CAS03	Adjustment Amount	
307	Quantity				S	CAS04	Adjustment Quantity	
307	Claim Adjustment Reason Code				S	CAS05	See CAS02.	
308	Monetary Amount				S	CAS06	See CAS03	
308	Quantity				S	CAS07	See CAS04	
308	Claim Adjustment Reason Code				S	CAS08	See CAS02	
309	Monetary Amount				S	CAS09	See CAS03	
309	Quantity				S	CAS10	See CAS04	
309	Claim Adjustment Reason Code				S	CAS11	See CAS02	
309	Monetary Amount				S	CAS12	See CAS03	
310	Quantity				S	CAS13	See CAS04	
310	Claim Adjustment Reason Code				S	CAS14	See CAS02	
310	Monetary Amount				S	CAS15	See CAS03	
310	Quantity				S	CAS16	See CAS04	
311	Claim Adjustment Reason Code				S	CAS17	See CAS02	
311	Monetary Amount				S	CAS18	See CAS03	
311	Quantity				S	CAS19	See CAS04	
312	Loop ID: 2430 LINE ADJUDICATION DATE	S	DTP					
312	Date/Time Qualifier		Not Reviewed for Adjudication			DTP01	573	573 – Date Claim Paid
312	Date Time Period Format Qualifier					DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
312	Date Time Period					DTP03		Service Adjudication or Payment Date
313	Transaction Set Trailer	R	555	SE				
313	Number of Included Segments				R	SE01		Total number of segments included in a transaction set including ST and SE segments.
313	Transaction Set Control Number				R	SE02		Data value is SE02 must be identical to ST02

ENVELOPE - Close

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