



The Forum Companion Document

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

Health Care Claim: Institutional

837

ASC X12N 837 (004010X096A1)

“Expanded Data Requirements”

*Version:
November 8, 2003*

System Interface Mapping

The following matrix identifies the recommended usage of the data elements when the 837I 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: Institutional 837 ASC X12N 837 Implementation Guide (004010X096) and Addenda (004010X096A1)*.

The columns for the matrix are:

- **Page#:** The page number from the "National Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim: Institutional 837 ASC X12N 837 (004010X096)" Rev May 2000.
- **Name:** Industry Name (from the Implementation Guide and Addenda) where available. If no industry name is available, the standard name is used. Any aliases shown in the Implementation Guide and Addenda are not always listed.
- **Seg. Reqmt:** (Segment Requirement): 'R' – Required, 'S' – Situational
- **Pos#:** Position Number (from Implementation Guide and Addenda)
- **Seg. ID:** Segment ID (from Implementation Guide and Addenda)
- **Data Element Usage:** A 'Not Used' in this column means that the Implementation Guide and Addenda dictate this data field is not to be used.
- **Data Element ID:** (from Implementation Guide and Addenda)
- **Qualifier:** A value appearing in this column indicates that the value is the preferred value. (Only single values for a data element appear in this column.)
- **Qualifier Description:** List of possible values. Values that are not relevant or pertinent to health plans are designated in "outline" font with a strikethrough (e.g., ~~value~~). When and as appropriate, comments and conventions about usage appear in this column.

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

- *"Not used for 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 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. Same value is returned in corresponding response."* — 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 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.

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 elements 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 837I 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.

Notes

The 997 'Functional Acknowledgment' is included here as it is the means by which acknowledgments, errors, or not-found conditions are communicated back to the claims submitter. Please see pages B.15 — B.29 in the Implementation Guide for the source of these data. Note that this is described on page B.15 as a 'Draft Standard for Trial Use.' This is, therefore, a work in progress.

ISA	INTERCHANGE CONTROL HEADER
GS	FUNCTIONAL GROUP HEADER

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 — Billing/Pay-To Provider Hierarchical Level

Pos	Seg	Name	Required	Max Use	Loop Repeat
Loop ID:	2000A	Billing/Pay-To Provider Hierarchical Level			>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 Identification	S	8	
035	REF	Credit/Debit Card Billing Information	S	8	

Pos	Seg	Name	Required	Max Use	Loop Repeat
040	PER	Billing Provider Contact Information	S	2	
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	

TABLE 2 — Detail — Subscriber Hierarchical Level

Pos	Seg	Name	Required	Max Use	Loop Repeat
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 Information	S	4	
035	REF	Property and Casualty Claim Number	S	1	
180	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	1	
180	REF	Document Identification Code	S	2	
180	REF	Original Reference Number (ICN/DCN)	S	1	
180	REF	Investigational Device Exemption Number	S	1	
180	REF	Service Authorization Exception Code	S	1	
180	REF	Peer Review Organization (PRO) Approval Number	S	1	
180	REF	Prior Authorization or Referral Number	S	2	
180	REF	Medical Record Number	S	1	
180	REF	Demonstration Project Identifier	S	1	
185	K3	File Information	S	10	
190	NTE	Claim Note	S	10	
190	NTE	Billing Note	S	1	
216	CR6	Home Health Care Information	S	1	
220	CRC	Home Health Functional Limitations	S	3	

Pos	Seg	Name	Required	Max Use	Loop Repeat
220	CRC	Home Health Activities Permitted	S	3	
220	CRC	Home Health Mental Status	S	2	
231	HI	Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information	S	1	
231	HI	Diagnosis Related Grouping (DRG) Information	S	1	
231	HI	Other Diagnosis Information	S	2	
231	HI	Principal Procedure Information	S	1	
231	HI	Other Procedure Information	S	2	
231	HI	Occurrence Span Information	S	2	
231	HI	Occurrence Information	S	2	
231	HI	Value Information	S	2	
231	HI	Condition Information	S	2	
231	HI	Treatment Code Information	S	2	
240	QTY	Claim Quantity	S	4	
241	HCP	Claim Pricing/Repricing Information	S	1	
Loop ID:	2010BB	Credit/Debit Card Holder Name			1
015	NM1	Credit/Debit Card Holder Name	S	1	
035	REF	Credit/Debit Card Information	S	2	
Loop ID:	2010BC	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	
Loop ID:	2010BD	Responsible Party Name			1
015	NM1	Responsible Party Name	S	1	
025	N3	Responsible Party Address	R	1	
030	N4	Responsible Party City/State/ZIP Code	R	1	

TABLE 2 — Detail — Patient Hierarchical Level

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this, the claim information is said to “float”. Claim information is positioned in the same hierarchical level that describes its owner-participant — either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BD in the subscriber hierarchical level when the patient is the subscriber; it is placed at the patient/dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent. See 2.3.2.1, HL Segment, for details.

Pos	Seg	Name	Required	Max Use	Loop Repeat
Loop	ID:	2000C Patient Hierarchical Level			>1
001	HL	Patient Hierarchical Level	S	1	
007	PAT	Patient Information	R	1	
Loop	ID:	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	

TABLE 2a — Detail — Claim Information

Pos	Seg	Name	Required	Max Use	Loop Repeat
Loop	ID:	2300 Claim Information			100
130	CLM	Claim Information	R	1	
135	DTP	Discharge Hour	S	1	
135	DTP	Statement Dates	R	1	
135	DTP	Admission Date/Hour	S	1	
140	CL1	Institutional Claim Code	S	1	
155	PWK	Claim Supplemental Information	S	10	
160	CN1	Contract Information	S	1	
175	AMT	Payer Estimated Amount Due	S	1	
175	AMT	Patient Estimated Amount Due	S	1	
175	AMT	Patient Paid Amount	S	1	

Pos	Seg	Name	Required	Max Use	Loop Repeat
175	AMT	Credit/Debit Card Maximum Amount	S	1	
180	REF	Adjusted Repriced Claim Number	S	1	
180	REF	Repriced Claim Number	S	1	
180	REF	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	1	
180	REF	Document Identification Code	S	2	
180	REF	Original Reference Number (ICN/DCN)	S	1	
180	REF	Investigational Device Exemption Number	S	1	
180	REF	Service Authorization Exception Code	S	1	
180	REF	Peer Review Organization (PRO) Approval Number	S	1	
180	REF	Prior Authorization or Referral Number	S	2	
180	REF	Medical Record Number	S	1	
180	REF	Demonstration Project Identifier	S	1	
185	K3	File Information	S	10	
190	NTE	Claim Note	S	10	
190	NTE	Billing Note	S	1	
216	CR6	Home Health Care Information	S	1	
220	CRC	Home Health Functional Limitations	S	3	
220	CRC	Home Health Activities Permitted	S	3	
220	CRC	Home Health Mental Status	S	2	
231	HI	Principal, Admitting, E-Code and Patient Reason for Visit Diagnosis Information	S	1	
231	HI	Diagnosis Related Grouping (DRG) Information	S	1	
231	HI	Other Diagnosis Information	S	2	
231	HI	Principal Procedure Information	S	1	
231	HI	Other Procedure Information	S	2	
231	HI	Occurrence Procedure Information	S	2	
231	HI	Occurrence Span Information	S	2	
231	HI	Value Information	S	2	
231	HI	Condition Information	S	2	
231	HI	Treatment Code Information	S	2	
240	QTY	Claim Quantity	S	4	
241	HCP	Claim Pricing/Repricing Information	S	1	
Loop ID:	2305	Home Health Care Plan Information			6
242	CR7	Home Health Care Plan Information	S	1	

Pos	Seg	Name	Required	Max Use	Loop Repeat
243	HSD	Health Care Services Delivery	S	12	
Loop ID:	2310A	Attending Physician Name			1
250	NM1	Attending Physician Name	S	1	
255	PRV	Attending Physician Specialty Information	S	1	
271	REF	Attending Physician Secondary Identification	S	5	
Loop ID:	2310B	Operating Physician Name			1
250	NM1	Operating Physician Name	S	1	
271	REF	Operating Physician Secondary Identification	S	5	
Loop ID:	2310C	Other Provider Name			1
250	NM1	Other Provider Name	S	1	
271	REF	Other Provider Secondary Identification	S	5	
Loop ID:	2310E	Service Facility Name			1
250	NM1	Service Facility Name	S	1	
265	N3	Service Facility Address	R	1	
270	N4	Service Facility City/State/ZIP	R	1	
271	REF	Service Facility Secondary Identification	S	5	
Loop ID:	2320	Other Subscriber Information			10
290	SBR	Other Subscriber Information	S	1	
295	CAS	Claim Level Adjustments	S	5	
300	AMT	Payer Prior Payment	S	1	
300	AMT	Coordination of Benefits (COB) Total Allowed Amount	S	1	
300	AMT	Coordination of Benefits (COB) Total Submitted Charges	S	1	
300	AMT	Diagnostic Related Group (DRG) Outlier Amount	S	1	
300	AMT	Coordination of Benefits (COB) Total Medicare Paid Amount	S	1	
300	AMT	Medicare Paid Amount — 100%	S	1	
300	AMT	Medicare Paid Amount — 80%	S	1	
300	AMT	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	S	1	
300	AMT	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	S	1	
300	AMT	Coordination of Benefits (COB) Total Non-covered Amount	S	1	
300	AMT	Coordination of Benefits (COB) Total Denied Amount	S	1	

Pos	Seg	Name	Required	Max Use	Loop Repeat
305	DMG	Other Subscriber Demographic Information	S	1	
310	OI	Other Insurance Coverage Information	R	1	
315	MIA	Medicare Inpatient Adjudication Information	S	1	
320	MOA	Medicare Outpatient Adjudication Information	S	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 Identification	S	3	
Loop ID:	2330B	Other Payer Name			1
325	NM1	Other Payer Name	R	1	
332	N3	Other Payer Address	S	1	
340	N4	Other Payer City/State/ZIP Code	S	1	
350	DTP	Claim Adjudication Date	S	1	
355	REF	Other Payer Secondary Identification and Reference Number	S	2	
355	REF	Other Payer Prior Authorization or Referral Number	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 Attending Provider			2
325	NM1	Other Payer Attending Provider	S	1	
355	REF	Other Payer Attending Provider Identification	R	3	
Loop ID:	2330E	Other Payer Operating Provider			1
325	NM1	Other Payer Operating Provider	S	1	
355	REF	Other Payer Operating Provider Identification	R	3	
Loop ID:	2330F	Other Payer Other Provider			1
325	NM1	Other Payer Other Provider	S	1	
355	REF	Other Payer Other Provider Identification	R	3	
Loop ID:	2330H	Other Payer Service Facility Provider			1
325	NM1	Other Payer Service Facility Provider	S	1	
355	REF	Other Payer Service Facility Provider Identification	R	3	

TABLE 2b — Detail — Service Line Number

Pos	Seg	Name	Required	Max Use	Loop Repeat
Loop ID:	2400	Service Line Number			999
365	LX	Service Line Number	R	1	
375	SV2	Institutional Service Line	R	1	
420	PWK	Line Supplemental Information	S	5	
455	DTP	Service Line Date	S	1	
455	DTP	Assessment Date	S	1	
475	AMT	Service Tax Amount	S	1	
475	AMT	Facility Tax Amount	S	1	
492	HCP	Line Pricing/Repricing Information	S	1	
Loop ID:	2410	Drug Identification			25
494	LIN	Drug Identification	S	1	
495	CTP	Drug Pricing	S	1	
496	REF	Prescription Number	S	1	
Loop ID:	2420A	Attending Physician Name			1
500	NM1	Attending Physician Name	S	1	
525	REF	Attending Physician Secondary Identification	S	1	
Loop ID:	2420B	Operating Physician Name			1
500	NM1	Operating Physician Name	S	1	
525	REF	Operating Physician Secondary Identification	S	1	
Loop ID:	2420C	Other Provider Name			1
500	NM1	Other Provider Name	S	1	
525	REF	Other Provider Secondary Identification	S	1	
Loop ID:	2430	Service Line Adjudication Information			25
540	SVD	Line Adjudication Information	S	1	
545	CAS	Line Adjustment	S	99	
550	DTP	Line Adjudication Date	S	1	

Pos	Seg	Name	Required	Max Use	Loop Repeat
160	SE	Transaction Set Trailer	R	1	

	GE	FUNCTIONAL GROUP TRAILER			
	IEA	INTERCHANGE CONTROL TRAILER			

ENVELOPE — Open

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
B.3	Interchange Control Header			ISA				
B.3	Authorization Information Qualifier				R	ISA01	00	No Authorization Information Present
B.3	Authorization Information				R	ISA02		
B.4	Security Information Qualifier				R	ISA03	00	No Security Information Present
B.4	Security Information				R	ISA04		
B.4	Interchange ID Qualifier				R	ISA05	ZZ	Mutually Defined
B.4	Interchange Sender ID				R	ISA06		ID Code of Sender
B.4	Interchange ID Qualifier				R	ISA07	ZZ	Mutually Defined
B.5	Interchange Receiver ID				R	ISA08		ID Code of Receiver: FCHP = contact Health Plan FCHN = contact Health Plan GHC = 910511770 Premera = 00430 Regence = contact Health Plan Asuris NW Health = contact Health Plan
B.5	Interchange Date				R	ISA09		YYMMDD
B.5	Interchange Time				R	ISA10		HHMM
B.5	Interchange Control Standards Identifier				R	ISA11	U	U.S. EDI Community of ASC x12, TCDD, and UCS
B.5	Interchange Control Version Number				R	ISA12	00401	Draft Standards for Trial Use Approved for Publication by ASCx12 Procedures Board through October 1997
B.5	Interchange Control Number				R	ISA13		A control number assigned by the interchange sender
B.6	Acknowledgment Requested				R	ISA14	0	0 – No acknowledgment requested 1 – Interchange Acknowledgment Requested
B.6	Usage Indicator				R	ISA15	P T	P = Production Data T = Test Data
B.6	Component Element Separator				R	ISA16	:	This is the delimiter used to separate component data elements within a composite data structure
B.8	Functional Group Header			GS				
B.8	Functional 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

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
B.8	Application Receiver's Code				R	GS03		Code identifying party receiving transmission. Codes agreed to by trading partners ID Code of Receiver: FCH = contact Health Plan GHC = 910511770 Premera = 00430 Regence = contact Health Plan Asuris NW Health = contact Health Plan
B.8	Date				R	GS04	CCYYMMDD	Creation Date
B.9	Time				R	GS05	HHMM	Creation Time
B.9	Group Control Number				R	GS06		Assigned number originated and maintained by the sender
B.9	Responsible Agency Code				R	GS07	X	Accredited Standards Committee X12
B.9	Version/Release/Industry Identifier Code				R	GS08	004010X096 A1	Standards Approved for Publication by ASC X12 Procedures Review Board through May 2000, as published in the Implementation Guide and Addenda.

Table 1 — Header

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
56	Transaction Set Header	R	005	ST				<i>To indicate the start of a transaction set and to assign a control number</i>
56	Transaction Set ID Code				R	ST01	837	Health Care Claim
56	Transaction Set Control #				R	ST02		Assigned by requester
57	Beginning of Hierarchical Transaction	R	010	BHT				<i>To define the business hierarchical structure of the transaction set and identify the business application purpose and reference data, i.e., number, date, time.</i>
57	Hierarchical Structure Code				R	BHT01	0019	Information Source, Subscriber, Dependent (code specified in Implementation Guide and Addenda. Indicates the hierarchical structure of the records)
58	Transaction Set Purpose Code				R	BHT02		00 – Original 18 – Reissue
58	Reference Identification				R	BHT03		Assigned by the originator.
58	Date				R	BHT04		Transaction Set Creation Date CCYYMMDD
58	Time				R	BHT05		Transaction Set Creation Time HHMM, HHMMSS, HHMMSSD, or HHMMSSDD
59	Transaction Type Code				R	BHT06		Claim or Encounter Identifier CH – Chargeable (Payable Claim) RP – Reporting (Encounter)
60	Transmission Type Identification	R	015	REF				Transmission Type Identification
60	Reference Identification Qualifier				R	REF01	87	Functional Category
60	Reference Identification				R	REF02		Transmission Type 004010X096DA1 – pilot 004010X096A1 – production
60	Description				Not Used	REF03		Not Used
60	Reference Identifier				Not Used	REF04		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
61	Loop ID: 1000A Submitter Name	R	020	NM1				
62	Entity Identifier Code				R	NM101	41	41 – Submitter
62	Entity Type Qualifier				R	NM102		Entity Type Identifier 1 – Person 2 – Non–Person Entity
62	Name Last or Organization Name				R	NM103		Submitter Last or Organization Name
62	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.
62	Name Middle				S	NM105		Information Receiver Middle Name Required if additional name information is needed to identify the information receiver. Recommended if the value in the entity type qualifier is a person.
62	Name Prefix				Not Used	NM106		Not Used
62	Name Suffix				Not Used	NM107		Not Used
62	Identification Code Qualifier				R	NM108	46	46 – Electronic Transmitter Identification Number (ETIN)
63	Identification Code				R	NM109		Submitter Identifier
63	Entity Relationship Code				Not Used	NM110		Not Used
63	Entity Identifier Code				Not Used	NM111		Not Used
64	Loop ID: 1000A Submitter EDI Contact Information	R	045	PER				Information in this segment should point to the individual in the submitter organization who deals with data transmission issues.
65	Contact Function Code				R	PER01	IC	IC – Information Contact
65	Name				R	PER02		Submitter Contact Name
65	Communication Number Qualifier				R	PER03		Code identifying the type of communication number. ED – Electronic Data Interchange Access Number EM – Electronic Mail FX – Facsimile TE – Telephone
65	Communication Number				R	PER04		Complete communications number including country or area code when applicable.
65	Communication Number Qualifier				S	PER05		Code identifying the type of communication. Used when additional contact numbers are to be communicated. ED – Electronic Data Interchange Access Number EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos #	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
66	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.
66	Communication Number Qualifier				S	PER07		Code identifying the type of communication. Used when additional contact numbers are to be communicated. ED – Electronic Data Interchange Access Number EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
66	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.
66	Contact Inquiry Reference				Not Used	PER09		Not Used
67	Loop ID: 1000B Receiver Name	R	020	NM1				
68	Entity Identifier Code				R	NM101	40	40 – Receiver
68	Entity Type Qualifier				R	NM102	2	2 – Non–Person Entity
68	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"> • First Choice Health = FCH • Group Health = GHC • Premera Blue Cross = Premera • Regence BlueShield = Regence • Asuris NW Health = Asuris NW Health
68	Name First				Not Used	NM104		Not Used
68	Name Middle				Not Used	NM105		Not Used
68	Name Prefix				Not Used	NM106		Not Used
68	Name Suffix				Not Used	NM107		Not Used
68	Identification Code Qualifier				R	NM108	46	Information Receiver Identification Number 46 – Electronic Transmitter ID Number (ETIN)
68	Identification Code				R	NM109		Receiver Primary Identifier: FCHP = contact Health Plan FCHN = contact Health Plan GHC = 910511770 Premera = 00430 Regence = contact Health Plan Asuris NW Health = contact Health Plan
68	Entity Relationship Code				Not Used	NM110		Not Used
68	Entity Identifier Code				Not Used	NM111		Not Used

Table 2 — Detail — Billing/Pay-To Provider

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
69	Loop ID: 2000A Billing/Pay-To Provider Hierarchical Level	R	001	HL				Identifies original entity that submitted electronic claim/encounter. See Implementation Guide and Addenda Section 2.3.2.1.
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						Required when adjudication is known to be impacted by the provider taxonomy code, and the Service Facility Provider is the same entity as the Billing or Pay-To Provider. In these cases, the Rendering Provider is being identified at this level for all subsequent claims/encounters in this HL and Loop ID-2310E is not used.
71	Provider Code				R	PRV01		Code identifying the type of provider. BI – Billing PT – Pay-To
72	Reference Identification Qualifier				R	PRV02	ZZ	ZZ – Identifies Health Care Provider Taxonomy Code (provider specialty code). Code Set available on the Washington Publishing Company web site: http://www.wpc-edi.com .
72	Reference Identification				R	PRV03		Provider Taxonomy Code Alias: Provider Specialty Code Code Set available on the Washington Publishing Company web site: http://www.wpc-edi.com .
72	State or Province 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	Foreign Currency Information	S						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 Identifier Code				R	CUR01	85	85 – Billing Provider
74	Currency Code				R	CUR02		Code (Standard ISO) for country in whose currency the charges are specified.
74	Exchange Rate				Not Used	CUR03		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
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				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				Required Segment and Required Loop. This loop/segment identifies the Billing Entity.
77	Entity Identifier 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 UB92 Ref: 1, Line 1 (Provider Name, Address, & Telephone)
77	Name First				Not Used	NM104		Not Used
77	Name Middle				Not Used	NM105		Not Used
77	Name Prefix				Not Used	NM106		Not Used
77	Name Suffix				Not Used	NM107		Not Used
77	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims XX – HCFA National Provider ID If XX–NPI is used then EIN or SS number of the provider must be carried in the REF in this loop.
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	Billing Provider Address	R	025	N3				Address Information

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
79	Address Information				R	N301		Billing Provider Address Line UB92 Ref: 1, Line 2 (Provider Name, Address, & Telephone)
79	Address Information				S	N302		Required if second address line exists
80	Billing Provider City/State/Zip Code	R	030	N4				Geographic Information
80	City Name				R	N401		Billing Provider City Name UB92 Ref: 1, Line 3 (Provider Name, Address, & Telephone)
81	State or Province Code				R	N402		Billing Provider State or Province Code
81	Postal Code				R	N403		Billing Provider Postal Code
81	Country Code				S	N404		Required when address is outside the U.S. UB92 Ref: 1, Line 4 Positions 23 – 25 (Provider Name, Address, & Telephone)
81	Location Qualifier				Not Used	N405		Not Used
81	Location Identifier				Not Used	N406		Not Used
82	Billing Provider Secondary Identification	S	035	REF				Required when a secondary identification number is necessary to identify the entity.
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 1G – Provider UPIN Number 1H – CHAMPUS Identification Number 1J – Facility ID Number B3 – Preferred Provider Organization Number BQ – Health Maintenance Organization Code Number E1 – Employer’s Identification Number FH – Clinic Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider 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	Credit/Debit Card Billing Information	S						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

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
85	Reference Identification Qualifier			REF	R	REF01		06 – System Number 8U – Bank Assigned Security Identifier EM – Electronic Payment Reference Number IJ – Standard Industry Classification (SIC) 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	Billing Provider Contact Information	S		PER				Required if this information is different than that contained in the Loop 1000A – Submitter PER segment.
88	Contact Function Code				R	PER01	IC	IC – Information Contact
88	Name				R	PER02		Billing Provider Contact Name
88	Communication Number Qualifier				R	PER03		Code identifying type of transmission EM – Electronic Mail FX – Facsimile TE – Telephone
88	Communication Number				R	PER04		Complete communication number including country and area code when applicable
89	Communication Number Qualifier				S	PER05		Code identifying the type of communication and used when additional contact numbers are to be communicated EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
89	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
89	Communication Number Qualifier				S	PER07		Code identifying the type of communication and used when additional contact numbers are to be communicated EM – Electronic Mail EX – Telephone Extension FX – Facsimile TE – Telephone
89	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
90	Contact Inquiry Reference				Not Used	PER09		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
91	Loop ID: 2010AB Pay-To Provider Name	S	015	NM1				Required Segment and Loop if the Pay-To Provider is a different entity than the Billing Provider.
92	Entity ID Code				R	NM101	87	87 – Pay-To Provider Use this code to indicate pay-To provider.
92	Entity Type Qualifier				R	NM102	2	2 – Non-Person Entity If entity is service provider then it is not necessary to use the Service Facility Provider NM1 loop, loop 2310D.
92	Name Last or Organization Name				R	NM103		Pay-To Provider Last or Organizational Name
92	Name First				Not Used	NM104		Not Used
92	Name Middle				Not Used	NM105		Not Used
92	Name Prefix				Not Used	NM106		Not Used
92	Name Suffix				Not Used	NM107		Not Used
92	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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>
93	Identification Code				R	NM109		Billing Provider Identifier
93	Entity Relationship Code				Not Used	NM110		Not Used
93	Entity Identifier Code				Not Used	NM111		Not Used
94	Pay-To Provider Address	R	025	N3				Address Information
94	Address Information				R	N301		Pay-To Provider Address Line
94	Address Information				S	N302		Required if second address line exists
95	Pay-To Provider City/State/Zip Code	R	030	N4				Geographic Information
95	City Name				R	N401		Pay-To Provider City Name
95	State or Province Code				R	N402		Pay-To Provider State or Province Code
95	Postal Code				R	N403		Pay-To Provider Postal Code
96	Country Code				S	N404		Required when address is outside the U.S.
96	Location Qualifier				Not Used	N405		Not Used
96	Location Identifier				Not Used	N406		Not Used
97	Pay-To Provider Secondary Identification	S	035	REF				Required when secondary identification number is necessary

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
97	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 1J – Facility ID Number B3 – Preferred Provider Organization Number BQ – Health Maintenance Organization Code Number E1 – Employer’s Identification Number FH – Clinic Number G2 – Provider commercial Number G5 – Provider Site Number LU – Location Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider Number
98	Reference Identification				R	REF02		Pay-To Provider Additional Identifier
98	Description				Not Used	REF03		Not Used
98	Reference Identifier				Not Used	REF04		Not Used

Table 2 — Detail — Subscriber

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
99	Loop ID: 200B Subscriber Hierarchical Level	R	001	HL				Identifies original entity that submitted electronic claim/encounter. See Implementation Guide and Addenda Section 2.3.2.1.
100	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.
100	Hierarchical Parent ID Number				R	HL02		Used to identify the specific hierarchical level to which this level is subordinate
100	Hierarchical Level Code				R	HL03	22	Subscriber

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
100	Hierarchical Child Code				R	HL04		0 – No subordinate HL Segment in this Hierarchical Structure 1 – Additional Subordinate HL Data Segment in this Hierarchical Structure 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.
101	Subscriber Information	R	005	SBR				
102	Payer Responsibility Sequence Number Code				R	SBR01		P – Primary S – Secondary T – Tertiary Code identifying the insurance carrier's level of responsibility for a payment of a claim. UB92 Ref: 50 – 66
103	Individual Relationship Code				S	SBR02	18	18 – Self Use this segment only when the subscriber is the same as the patient. UB92 Ref: 59 (A–C) Patient Relationship to Insured
103	Reference Identification				S	SBR03		Insured Group or Policy Number UB92 Ref: 62 (A–C) Insurance Group Number
103	Name				S	SBR04		Insured Group Name. Used only when no group number is reported in SBR03 UB92 Ref: 61 (A–C) Insured Group Name
103	Insurance Type Code				Not Used	SBR06		Not Used
103	Coordination of Benefits Code				Not Used	SBR06		Not Used
103	Yes/No Condition or Response Code				Not Used	SBR07		Not Used
104	Employment Status Code				Not Used	SBR08		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
104	Claim Filing Indicator Code <i>Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.</i>				S	SBR09		Required prior to mandated use of PlanID. Not used after PlanID is mandated. 09 – Self-pay 10 – Central Certification 11 – Other Non-Federal Programs 12 – PPO 13 – Point of Service 14 – Exclusive Provider Org. 15 – Indemnity Insurance 16 – HMO Medicare Risk AM – Automobile Medical BL – Blue Cross/Blue Shield CH – Champus CI – Commercial Insur. Co. DS – Disability HM – HMO LI – Liability LM – Liability Medical MA – Medicare Part A MB – Medicare Part B MC – Medicaid OF – Other Fed Program TV – Title V VA – Veteran Administration Plan WC – Workers' Compensation Health Claim ZZ – Mutually Defined
108	Loop ID: 2010BA Subscriber Name	R	015	NM1				In workers compensation or other property and casualty claims, the "subscriber" may be a non-person entity (i.e., the employer). However, this varies by state.
109	Entity ID Code				R	NM101	IL	IL – Insured or Subscriber
109	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
109	Name Last or Organization Name				R	NM103		Subscriber Last Name UB92 Reference [UB92 Name]: 58 (A-C) [Insured's Name]
109	Name First				S	NM104		Subscriber First Name UB92 Reference [UB92 Name]: 58 (A-C) [Insured's Name]
109	Name Middle				S	NM105		Subscriber Middle Name UB92 Reference [UB92 Name]: 58 (A-C) [Insured's Name]
110	Name Prefix				Not Used	NM106		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
110	Name Suffix				S	NM107		Subscriber 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.
110	Identification Code Qualifier				S	NM108	MI	MI – Member Identification Number ZZ – Mutually Defined This data element is required when NM102 equals one (1).
110	Identification Code				S	NM109		Subscriber Primary Identifier UB92 Reference [UB92 Name]: 60 (A–C) [Certificate/Social Security Number/Health Insurance Claim/ Identification Number]
110	Entity Relationship Code				Not Used	NM110		Not Used
111	Entity Identifier Code				Not Used	NM111		Not Used
112	Subscriber Address	S	025	N3				This segment is required when the Patient is the same person as the Subscriber. Required when Loop ID 2000B, SBR02– 18 (self).
112	Address Information				R	N301		Subscriber Address Line UB92 Reference [UB92 Name]: 84, Line b [Remarks]
112	Address Information				S	N302		Required if second address line exists
113	Subscriber City/State/Zip Code	S	030	N4				Required when Patient is the same person as the Subscriber.
113	City Name				R	N401		Subscriber City Name
114	State or Province Code				R	N402		Subscriber State or Province Code
114	Postal Code				R	N403		Subscriber Provider Postal Code
114	Country Code				S	N404		Required when address is outside the U.S.
114	Location Qualifier				Not Used	N405		Not Used
114	Location Identifier				Not Used	N406		Not Used
115	Subscriber Demographic Information	S	032	DMG				This segment is required when the Patient is the same person as the Subscriber. Required when Loop ID 2000B, SBR02– 18 (self)
115	Date Time Period Format Qualifier				R	DMG01	D8	D8 – Date Expressed in Format CCYYMMDD
116	Date Time Period				R	DMG02		Subscriber Birth Date
116	Gender Code				R	DMG03		F – Female M – Male U – Unknown Subscriber Gender Code
116	Marital Status Code				Not Used	DMG04		Not Used
116	Race or Ethnicity Code				Not Used	DMG05		Not Used
116	Citizenship Status Code				Not Used	DMG06		Not Used
116	Country Code				Not Used	DMG07		Not Used
116	Basis of Verification Code				Not Used	DMG08		Not Used
116	Quantity				Not Used	DMG09		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description		
117	Subscriber Secondary Identification	S	<i>Not Used For Adjudication</i> REF					Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109.		
117	Reference Identification Qualifier				R	REF01	Y4	1W – Member Identification Number 23 – Client Number IG – Insurance Policy Number SY – Social Security Number: SY may not be used for Medicare		
118	Reference Identification				R	REF02		Subscriber Supplemental Identifier		
118	Description				Not Used	REF03		Not Used		
118	Reference Identifier				Not Used	REF04		Not Used		
119	Property and Casualty Claim Number	S						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. Not required for HIPAA.		
120	Reference Identification Qualifier				R	REF01	Y4	Y4 – Agency Claim Number		
120	Reference Identification				R	REF02		Property Casualty Claim Number		
120	Description				Not Used	REF03		Not Used		
120	Reference Identifier				Not Used	REF04		Not Used		
121	Loop ID: 2010BB Credit/Debit Card Account Holder Name	R			015	NM1				The information carried under this segment must never be sent to the payer.
122	Entity ID Code				<i>Not Used For Adjudication</i> NM1		R	NM101	AO	AO – Account Of See Appendix G, Credit/Debit Card Use, for details.
122	Entity Type Qualifier		R	NM102				1 – Person 2 – Non–Person Entity		
122	Name Last or Organization Name		S	NM103				Credit or Debit Card Holder Last or Organizational Name		
122	Name First		S	NM104						
122	Name Middle		S	NM105						
122	Name Prefix		Not Used	NM106				Not Used		
122	Name Suffix		S	NM107						
123	Identification Code Qualifier		R	NM108			MI	MI – Member Identification Number		
123	Identification Code		R	NM109				Credit/Debit Card Account Number		
123	Entity Relationship Code		Not Used	NM110				Not Used		
123	Entity Identifier Code		Not Used	NM111				Not Used		
124	Credit/Debit Card 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		
124	Reference Identification Qualifier				R	REF01		AB – Acceptable Source Purchaser ID BB – Authorization Number		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
125	Reference Identification				R	REF02		Credit or Debit Card Authorization Number
125	Description				Not Used	REF03		Not Used
125	Reference Identifier				Not Used	REF04		Not Used
126	Loop ID: 2010BC Payer Name	S	015	NM1				This is the destination payer.
127	Entity ID Code				R	NM101	PR	PR – Payer
127	Entity Type Qualifier				R	NM102	2	2 – Non–Person Entity
127	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"> • First Choice Health Plan = FCHP • First Choice Health Network = FCHN • Group Health = GHC • Premera Blue Cross = Premera • Regence Blue Shield = Regence • Asuris NW Health =Asuris NW Health
127	Name First				Not Used	NM104		Not Used
127	Name Middle				Not Used	NM105		Not Used
127	Name Prefix				Not Used	NM106		Not Used
127	Name Suffix				Not Used	NM107		Not Used
127	Identification Code Qualifier				R	NM108	PI	PI – Payer Identification XV – HCFA National Plan ID
128	Identification Code				R	NM109		Payer Primary ID: FCHP = contact Health Plan FCHN = contact Health Plan GHC = 910511770 Premera = 00430 Regence = contact Health Plan Regence NW Health = contact Health Plan
128	Entity Relationship Code				Not Used	NM110		Not Used
128	Entity Identifier Code				Not Used	NM111		Not Used
129	Payer Address	S	025	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).
129	Address Information				R	N301		Payer Address Line
129	Address Information				S	N302		Required if second address line exists
130	Payer City/State/Zip Code	S	030	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).
130	City Name				R	N401		Payer City Name
131	State or Province Code				R	N402		Payer State or Province Code
131	Postal Code				R	N403		Payer Postal Code
131	Country Code				S	N404		Required when address is outside the U.S.
131	Location Qualifier				Not Used	N405		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
131	Location Identifier				Not Used	N406		Not Used
132	Payer Secondary Identification	S	Not Used For Adjudication 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.
132	Reference Identification Qualifier				R	REF01		2U – Payer Identification Number FY – Claim Office Number NF – National Association of Insurance Commissioners (NAIC) Code TJ – Federal Taxpayer's Identification Number
133	Reference Identification				R	REF02		Payer Additional Identifier
133	Description				Not Used	REF03		Not Used
133	Reference Identifier				Not Used	REF04		Not Used
134	Loop ID: 2010BD Responsible Party Name	S	015	NM1				In general terms,, the responsible party is someone who is not the subscriber/patient but who has financial responsibility for the bill.
135	Entity ID Code		Not Used For Adjudication NM1		R	NM101	QD	QD – Responsible Party
135	Entity Type Qualifier				R	NM102		1 – Person 2 – Non–Person Entity
135	Name Last or Organization Name				R	NM103		Payer Name UB92 Reference [UB92 Name]: 50 (A–C) [Payer Identification]
135	Name First				S	NM104		Responsible Party First Name; Reqd if NM102 = 1.
135	Name Middle				S	NM105		Responsible Party Middle Name; Reqd if NM102 = 1 and is known.
135	Name Prefix				Not Used	NM106		Not Used
135	Name Suffix				S	NM107		Responsible Party Suffix Name; Reqd. if known.
135	Identification Code Qualifier				Not Used	NM108		Not Used
135	Identification Code				Not Used	NM109		Not Used
135	Entity Relationship Code				Not Used	NM110		Not Used
135	Entity Identifier Code				Not Used	NM111		Not Used
136	Responsible Party address	R	N3					
136	Address Information				R	N301		Responsible Party Address Line
136	Address Information				S	N302		Required if second address line exists
137	Responsible Party City/State/Zip Code	R	N4					
137	City Name				R	N401		Responsible Party City Name
137	State or Province Code				R	N402		Responsible Party State or Province Code
137	Postal Code				R	N403		Responsible Party Postal Code
138	Country Code				S	N404		Required when address is outside the U.S.
138	Location Qualifier		Not Used	N405		Not Used		
138	Location Identifier		Not Used	N406		Not Used		

Table 2 — Detail — Patient

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
139	Loop ID: 2000C Patient Hierarchical Level	S	001	HL				This HL is required when the patient is a different person than the subscriber. See Implementation Guide and Addenda Section 2.3.2.1.
140	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.
140	Hierarchical Parent ID Number				R	HL02		Used to identify the specific hierarchical level to which this level is subordinate
140	Hierarchical Level Code				R	HL03	23	Dependent
140	Hierarchical Child Code				R	HL04	0	0 – No subordinate HL Segment in this Hierarchical Structure
141	Patient Information	R	007	PAT				
142	Individual Relationship Code				R	PAT01		Patients Relationship to Insured UB92 Reference [UB92 Name]: 59 (A–C) [Patient Relationship to Insured] 01 – Spouse 04 – Grandfather or Grandmother 05 – Grandson or Granddaughter 07 – Nephew or Niece 10 – Foster Child 15 – Ward 17 – Stepson or Stepdaughter 19 – Child 20 – Employee 21 – Unknown 22 – Handicapped Dependent 23 – Sponsored Dependent 24 – Dependent of a Minor Dependent 29 – Significant Other 32 – Mother 33 – Father 36 – Emancipated Minor 39 – Organ Donor 41 – Injured Plaintiff 43 – Child Where Insured Has No Financial Responsibility 53 – Life Partner G8 – Other Relationship
143	Patient Location Code				Not Used	PAT02		Not Used
143	Employment Status Code				Not Used	PAT03		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
143	Student Status Code				Not Used	PAT04		Not Used
144	Date Time Period Format Qualifier				Not Used	PAT05		Not Used
144	Date Time Period				Not Used	PAT06		Not Used
144	Unit or Basis for Measurement Code				Not Used	PAT07		Not Used
144	Weight				Not Used	PAT08		Not Used
144	Yes/No Condition or Response Code				Not Used	PAT09	Y	Not Used
145	Loop ID: 2010CA Patient Name	R	015	NM1				
146	Entity ID Code				R	NM101	QC	QC – Patient
146	Entity Type Qualifier				R	NM102	1	1 – Person
146	Name Last or Organization Name				R	NM103		Patient Last Name UB92 Reference [UB92 Name]: 12 [Patient Name]
146	Name First				R	NM104		Patient First Name UB92 Reference [UB92 Name]: 12 [Patient Name]
146	Name Middle				S	NM105		Patient Middle Name Reqd. when NM102=1 and Middle Name/Initial is known.
146	Name Prefix				Not Used	NM106		Not Used
146	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.
147	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
147	Identification Code				S	NM109		Patient Primary Identifier UB92 Reference [UB92 Name]: 60 (A–C) [Certificate/Social Security Number/ Health Insurance Claim/ Identification Number]
147	Entity Relationship Code				Not Used	NM110		Not Used
147	Entity Identifier Code				Not Used	NM111		Not Used
148	Patient Address	R	025	N3				
148	Address Information				R	N301		UB92 Reference [UB92 Name]: 13 [Patient Address]
148	Address Information				S	N302		UB92 Reference [UB92 Name]: 13 [Patient Address] Required if second address line exists
149	Patient City/State/Zip Code	R	030	N4				
149	City Name				R	N401		Patient City Name UB92 Reference [UB92 Name]: 13 [Patient Address]
150	State or Province Code				R	N402		Patient State or Province Code UB92 Reference [UB92 Name]: 13 [Patient Address]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
150	Postal Code				R	N403		Patient Provider Postal Code UB92 Reference [UB92 Name]: 13 [Patient Address]
150	Country Code				S	N404		Required when address is outside the U.S.
150	Location Qualifier				Not Used	N405		Not Used
150	Location Identifier				Not Used	N406		Not Used
151	Patient Demographic Information	R	032	DMG				
151	Date Time Period Format Qualifier				R	DMG01	D8	D8 – Date Expressed in Format CCYYMMDD
152	Date Time Period				R	DMG02		Patient Birth Date UB92 Reference [UB92 Name]: 14 [Patient Birthdate]
152	Gender Code				R	DMG03		F – Female M – Male U – Unknown Patient Gender Code UB92 Reference [UB92 Name]: 15 [Patient Sex]
152	Marital Status Code				Not Used	DMG04		Not Used
152	Race or Ethnicity Code				Not Used	DMG05		Not Used
152	Citizenship Status Code				Not Used	DMG06		Not Used
152	Country Code				Not Used	DMG07		Not Used
152	Basis of Verification Code				Not Used	DMG08		Not Used
152	Quantity				Not Used	DMG09		Not Used
153	Patient Secondary Identification Number	S	035	REF				This segment is required when an additional identification number is needed.
153	Reference Identification Qualifier				R	REF01		1W – Member Identification Number 23 – Client Number IG – Insurance Policy Number SY – Social Security Number: SY may not be used for Medicare
154	Reference Identification				R	REF02		Patient Secondary Identifier
154	Description				Not Used	REF03		Not Used
154	Reference Identifier				Not Used	REF04		Not Used
155	Property and Casualty Claim Number	S						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 required for HIPAA.
155	Reference Identification Qualifier				R	REF01	Y4	Y4 – Agency Claim Number
156	Reference Identification				R	REF02		Property Casualty Claim Number
156	Description				Not Used	REF03		Not Used
156	Reference Identifier				Not Used	REF04		Not Used

Table 2a — Detail — Claim Information

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
157	Loop ID: 2300 Claim Information	R	130	CLM				The developers of the implementation guide and Addenda 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.
158	Claim Submitter's Identifier				R	CLM01		Identifier used to track a claim from creation by the health care provider through payment. The number that the submitter transmits in this position is echoed back to the submitter in the 835 and other transactions. Recommend patient control number. UB92 Reference [UB92 Name]: 3 [Patient Control 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 nor returned by any receiving system.
159	Monetary Amount				R	CLM02		Total amount of all submitted charges of service segments for this claim. Zero may be a valid amount. This amount is the total of the SV2 segments, with the exception of Revenue Code 001. UB92 Reference [UB92 Name]: 47 (Revenue Code 001)
159	Claim Filing Indicator Code				Not Used	CLM03		Not Used
159	Non–Institutional Claim Type Code				Not Used	CLM04		Not Used
159	Health Care Service Location Information				R	CLM05		Identifies type of bill related to the location at which a health care service was rendered.
159	Facility Code Value				R	CLM05–1		Code identifying the type of facility where services were performed. UB92 Reference [UB92 Name]: 4, Positions 1–2 [Type of Bill]
159	Facility Code Qualifier				R	CLM05–2	A	A – Uniform Billing Claim Form Bill Type Code identifying the type of facility referenced
159	Claim Frequency Type Code				R	CLM05–3		Code specifying the frequency of the claim UB92 Reference [UB92 Name]: 4, Position 3 [Type of Bill]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
160	Yes/No Condition or Response Code				R	CLM06		N – No Y – Yes Provider Signature on File
160	Provider Accept Assignment Code				S	CLM07		A – Assigned C – Not Assigned Code indicates whether the provider accepts Medicare Assignment
160	Yes/No Condition or Response Code				R	CLM08		N – No Y – Yes Use this value as an assignment of benefits indicator. "Y" indicates that the insured or authorized person authorizes benefits to be assigned to the provider. "N" indicates that benefits have not been assigned to the provider. UB92 Reference [UB92 Name]: 53 (A–C) [Assignment of Benefits Certification Indicator]
161	Release of Information Code				R	CLM09		A – Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization I – Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes M – The Provider has Limited or Restricted Ability to Release Data Related to a Claim N – No, Provider is Not Allowed to Release Data O – On file at Payer or at Plan Sponsor Y – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
161	Patient Signature Source Code				Not Used	CLM10		Not Used
161	Related Causes Information				Not Used	CLM11		Not Used
163	Special Program Code				Not Used	CLM12		Not Used
163	Yes/No Condition or Response Code				Not Used	CLM13		Not Used
163	Level of Service Code				Not Used	CLM14		Not Used
163	Yes/No Condition or Response Code				Not Used	CLM15		Not Used
163	Provider Agreement Code				Not Used	CLM16		Not Used
163	Claim Status Code				Not Used	CLM17		Not Used
163	Yes/No Condition or Response Code Note: Field must be populated with a valid value; it is not used for adjudication. Same value is returned when applicable.				R	CLM18		N – No Y – Yes Explanation of Benefits (EOB) Indicator. A "Y" value indicates that a paper EOB is requested; an "N" value indicates that no paper EOB is requested.
163	Claim Submission Reason Code				Not Used	CLM19		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
164	Delay Reason Code				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 This element may be used if a particular claim is being transmitted in response to a request for information (e.g., a 277), and the response has been delayed. Required when claim is submitted late (past contracted date of filing limitations) and any of the codes listed above apply.
165	Discharge Hour	S	135	DTP				This segment is required on all final inpatient claims/encounters.
165	Date/Time Qualifier				R	DTP01	096	096 – Discharge
165	Date Time Period Format Qualifier				R	DTP02	TM	TM – Time Expressed in Format HHMM
166	Date Time Period				R	DTP03		Discharge Hour UB92 Reference [UB92 Name]: 21 [Discharge Hour]
167	Statement Dates	R	135	DTP				
167	Date/Time Qualifier				R	DTP01	434	434 – Statement
167	Date Time Period Format Qualifier				R	DTP02		D8 – Date Expressed in Format CCYYMMDD RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD Use RD8 in DTP02 if it is necessary to indicate Begin/End for From/To statement dates.
168	Date Time Period				R	DTP03		Statement From or To Date UB92 Reference [UB92 Name]: 6 (From) and (Through) [Statement Covers Period]
169	Admission Date/Hour	S	135	DTP				This segment is required on all Inpatient claims.
169	Date/Time Qualifier				R	DTP01	435	435 – Admission
169	Date Time Period Format Qualifier				R	DTP02	DT	DT – Date and Time Expressed in Format CCYYMMDDHHMM
170	Date Time Period				R	DTP03		Admission Date and Hour UB92 Reference [UB92 Name]: 17 [Admission/Start of Care Date] 18 [Admission Hour]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
171	Institutional Claim Code	S	140	CL1				This segment is required when reporting hospital based admission and Medicare outpatient registrations on claims/encounters. It may be used when provider wishes to communicate this information on non-Medicare outpatient claims/encounters.
171	Admission Type Code				S	CL101		Code indicating the priority of this admission Required when patient is being admitted to the hospital for inpatient services. UB92 Reference [UB92 Name]: 19 [Type of Admission]
172	Admission Source Code				S	CL102		Required for all inpatient admissions. Required on Medicare Outpatient registrations for diagnostic testing services. UB92 Reference [UB92 Name]: 20 [Source of Admission]
172	Patient Status Code				S	CL103		Code indicating patient status as of the "statement covers through date". This element is required for inpatient claims/encounters. UB92 Reference [UB92 Name]: 22 [Patient Status]
172	Nursing Home Residential Status Code				Not Used	CL104		Not Used
173	Claim Supplemental Information	S						The PWK segment is required if there is paper documentation supporting this claim. The PWK segment can be used to identify paperwork that is being held at the provider's office but that is not being sent with the claim.
174	Report Type Code				R	PWK01		AS – Admission Summary B2 – Prescription B3 – Physician Order B4 – Referral Form CT – Certification DA – Dental Models DG – Diagnostic Report DS – Discharge Summary EB – EOB (COB or Medicare Secondary Payer) MT – Models NN – Nursing Notes OB – Operative Note OZ – Support Data for Claim PN – Physical Therapy Notes PO – Prosthetics or Orthotic Certification PZ – Physical Therapy Certification RB – Radiology Films RR – Radiology Reports RT – Report of Tests and Analysis Report

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
174	Report Transmission Code		CN1		R	PWK02		AA – Available on Request at Provider Site BM – By Mail EL – Electronically Only EM – E-Mail FX – By Fax
175	Report Copies Needed				Not Used	PWK03		Not Used
175	Entity Identifier Code				Not Used	PWK04		Not Used
175	Identification Code Qualifier				S	PWK05	AC	AC – Attachment Control Number This data element is required when PWK02 DOES NOT equal 'AA'.
175	Identification Code				S	PWK06		Attachment Control Number Required if PWK02 equals BM, EL, EM or FX.
175	Description				S	PWK07		This data element is used to add any additional information about the attachment described in this segment.
175	Actions Indicated				Not Used	PWK08		Not Used
175	Request Category Code				Not Used	PWK09		Not Used
176	Contract Information	S						Required if the provider is contractually obligated to provide contract information on this claim.
176	Contract Type Code				R	CN101		01 – Diagnosis Related Group (DRG) 02 – Per Diem 03 – Variable Per Diem 04 – Flat 05 – Capitated 06 – Percent 09 – Other
177	Monetary Amount		AMT		S	CN102		Required if provider is contractually obligated to provide this information on the claim.
177	Percent				S	CN103		Contract Percentage Required if provider is contractually obligated to provide this information on the claim.
177	Reference Identification				S	CN104		Contract Code Required if provider is contractually obligated to provide this information on the claim.
177	Terms Discount Percent				S	CN105		Terms Discount Percentage Required if provider is contractually obligated to provide this information on the claim.
177	Version Identifier				S	CN106		Contract Version Identifier Required if provider is contractually obligated to provide this information on the claim.
178	Payer Estimated Amount Due	S						This segment is required when the Payer Estimated Amount Due is applicable to this claim.
178	Amount Qualifier Code			R	AMT01	C5	C5 – Claim Amount Due – Estimated	
179	Monetary Amount			R	AMT02		UB92 Reference [UB92 Name]: 55 (A-C) [Estimated Amount Due]	
179	Credit/Debit Flag Code			Not Used	AMT03		Not Used	

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
180	Patient Estimated Amount Due	S						This segment is required when the Patient Responsibility Amount is applicable to this claim.
180	Amount Qualifier Code				R	AMT01	F3	F3 – Patient Responsibility – Estimated
181	Monetary Amount				R	AMT02		UB92 Reference [UB92 Name]: 55, Patient Line [Estimated Amount Due]
181	Credit/Debit Flag Code				Not Used	AMT03		Not Used
182	Patient Paid Amount	S	175	AMT				This segment is required when the Patient Paid Amount is applicable to this claim.
182	Amount Qualifier Code				R	AMT01	F5	F5 – Patient Amount Paid
183	Monetary Amount				R	AMT02		UB92 Reference [UB92 Name]: 54, Line P [Prior Payments – Payers and Patient]
183	Credit/Debit Flag Code				Not Used	AMT03		Not Used
184	Credit/Debit Card Maximum Amount	S						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.
184	Amount Qualifier Code			AMT	R	AMT01	MA	MA – Maximum Amount
184	Monetary Amount				R	AMT02		Credit or Debit Card Maximum Amount
184	Credit/Debit Flag Code				Not Used	AMT03		Not Used
185	Adjusted Repriced Claim Number	S		REF				Reference numbers at this position apply to the entire claim. This segment is required when Repricers need to attach their own claim identification to a previously adjusted (resubmitted) claim they are processing.
185	Reference Identification Qualifier				R	REF01	9C	9C – Adjusted Repriced Claim Reference Number
185	Reference Identification				R	REF02		Adjusted Repriced Claim Reference Number
185	Description				Not Used	REF03		Not Used
185	Reference Identifier				Not Used	REF04		Not Used
186	Repriced Claim Number	S						Reference numbers at this position apply to the entire claim. This segment is required when the Repricers need to attach their own claim identification to a claim they are processing.
186	Reference Identification Qualifier				R	REF01	9A	9A – Repriced Claim Reference Number
186	Reference Identification				R	REF02		Repriced Claim Reference Number
186	Description				Not Used	REF03		Not Used
186	Reference Identifier				Not Used	REF04		Not Used
187	Claim Identification Number for Clearinghouses and Other Transmission Intermediaries	S	180	REF				Used only by transmission intermediaries (Value-Added Networks, Automated Clearing Houses, and others) who need to attach their own unique claim number. This number can be used to facilitate front-end acknowledgements such as the 277 Health Care Payer Unsolicited Claim Status.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
187	Reference Identification Qualifier				R	REF01	D9	D9 – Claim Number Number assigned by clearinghouse/VAN/etc.
188	Reference Identification				R	REF02		Value Added Network Trace Number
188	Description				Not Used	REF03		Not Used
188	Reference Identifier				Not Used	REF04		Not Used
189	Document Identification Code	S						Reference numbers at this position apply to the entire claim. This segment is used to convey submittal of HCFA–485 and HCFA–486 data OR HCFA–486 data only.
189	Reference Identification Qualifier				R	REF01	DD	DD – Document Identification Code
189	Reference Identification				R	REF02		Document Control Identifier
190	Description				Not Used	REF03		Not Used
190	Reference Identifier				Not Used	REF04		Not Used
191	Original Reference Number (ICN/DCN)	S	180	REF				Reference numbers at this position apply to the entire claim. This segment is used to convey the control number assigned to the original bill by the payer to identify a unique claim.
191	Reference Identification Qualifier				R	REF01	F8	F8 – Original Reference Number
192	Reference Identification				R	REF02		Payer's Claim Original Reference Number UB92 Reference [UB92 Name]: 37 (A–C) [Internal Control Number (ICN)/ Document Control Number (DCN)]
192	Description				Not Used	REF03		Not Used
192	Reference Identifier				Not Used	REF04		Not Used
193	Investigational Device Exemption Number	S						Required only on claims involving an FDA assigned investigation device exemption (IDE) number. Only one IDE per claim is to be reported.
193	Reference Identification Qualifier				R	REF01	LX	LX – Qualified Products List
193	Reference Identification				R	REF02		Investigational Device Exemption Identifier
194	Description				Not Used	REF03		Not Used
194	Reference Identifier				Not Used	REF04		Not Used
195	Service Authorization Exception Code	S						Used only in claims where providers are required by state law (e.g., N.Y. State Medicaid) to obtain authorization for specific services but, for the reasons listed in REF02, performed the service without obtaining the service authorization. Check with your state Medicaid to see if this applies in your state.
195	Reference Identification Qualifier				R	REF01	4N	4N – Special Payment Reference Number

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
196	Reference Identification				R	REF02		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 Service Authorization Exception Code
196	Description				Not Used	REF03		Not Used
196	Reference Identifier				Not Used	REF04		Not Used
197	Peer Review Organization (PRO) Approval Number	S						Required when an external Peer Review Organization assigns an Approval Number to services deemed medically necessary by that organization.
197	Reference Identification Qualifier				R	REF01	G4	G4 – Peer Review Organization (PRO) Approval Number
197	Reference Identification				R	REF02		Peer Review Authorization Number
197	Description				Not Used	REF03		Not Used
197	Reference Identifier				Not Used	REF04		Not Used
198	Prior Authorization for Referral Number	S	180	REF				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.
198	Reference Identification Qualifier				R	REF01		9F – Referral Number G1 – Prior Authorization Number
199	Reference Identification				R	REF02		Prior Authorization Number UB92 Reference [UB92 Name]: 63 (A–C) [Treatment Authorization Code]
199	Description				Not Used	REF03		Not Used
199	Reference Identifier				Not Used	REF04		Not Used
200	Medical Record Number	S	180	REF				Required if provider needs to identify for future inquiries the actual medical record of the patient identified in either Loop ID – 2010BA or 2010CA for this episode of care. Used if provider utilizes this information in a 276 – Claim Status Inquiry in order to receive and process a 277 – Claim Status Response.
200	Reference Identification Qualifier				R	REF01	EA	EA – Medical Record Identification Number
201	Reference Identification				R	REF02		Medical Record Number
201	Description				Not Used	REF03		Not Used
201	Reference Identifier				Not Used	REF04		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
202	Demonstration Project Identifier	S	REF	Not Used For Adjudication				Required on claims/encounters where a demo project is being billed/reported. This information is specific to the destination payer reported in the 2010BC loop. If other payers have a similar number, report that information in the 2330 loop which holds that payer's information.
202	Reference Identification Qualifier				R	REF01	P4	P4 – Project Code
202	Reference Identification				R	REF02		Demonstration Project Identifier
203	Description				Not Used	REF03		Not Used
203	Reference Identifier				Not Used	REF04		Not Used
204	File Information	S	K3					K3 used as an emergency kludge (fix-it) in the case of an unexpected data requirement by a state regulatory authority. This segment may only be required if a state concludes it must use the K3 to meet an emergency legislative requirement AND the administering state agency or other state organization has contacted the X12N workgroup to determine that there is no method to meet the requirement.
204	Fixed Format Information				R	K301		Data in fixed format agreed upon by sender and receiver
204	Record Format Code				Not Used	K302		Not Used
204	Composite Unit of Measure		NTE		Not Used	K303		Not Used
205	Claim Note	S						Information in the NTE segment in Loop ID-2300 applies to the entire claim unless overridden by information in the NTE segment in Loop ID-2400. The developers of the Implementation Guide and Addenda discourage using narrative information within the 837. Trading partners who require narrative information with claims are encouraged to codify that information within the X12 environment. Required only when provider deems it necessary to transmit information not otherwise supported in this implementation.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
206	Note Reference Code				R	NTE01		ALG – Allergies DCP – Goals, Rehabilitation Potential, or Discharge Plans DGN – Diagnosis Description DME – Durable Medical Equipment (DME) and Supplies MED – Medications NTR – Nutritional Requirements ODT – Orders for Disciplines and Treatments RHB – Functional Limitations, Reason Homebound, or Both RLH – Reasons Patient Leaves Home RNH – Times and Reasons Patient Not at Home SET – Unusual Home, Social Environment, or Both SFM – Safety Measure SPT – Supplementary Plan of Treatment UPI – Updated Information
207	Description				R	NTE02		UB92 Reference [UB92 Name]: 84 [Remarks]
208	Billing Note	S	190	NTE				This segment is used to convey additional information necessary to adjudicate the claim. [For accident and COB-related information.] Required when: (1) State regulations mandate information not identified elsewhere within the claim set; or (2) in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set.
208	Note Reference Code				R	NTE01	ADD	ADD – Additional Information
209	Description				R	NTE02		UB92 Reference [UB92 Name]: 84 [Remarks]
210	Home Health Care Information	S						This segment is required for Home Health claims when applicable.
211	Prognosis Code				R	CR601		1 – Poor 2 – Guarded 3 – Fair 4 – Good 5 – Very Good 6 – Excellent 7 – Less than 6 Months to Live 8 – Terminal
211	Date				R	CR602		Service From Date
211	Date Time Period Format Qualifier				S	CR603	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
212	Date Time Period				S	CR604		Home Health Certification Period Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.
212	Date				R	CR605		Date of Onset or Exacerbation of Principal Diagnosis
212	Yes/No Condition or Response Code				R	CR606		N – No U – Unknown Y – Yes “Y” indicates patient is receiving care in a 1861J1 (skilled nursing) facility. “N” indicates patient is not receiving care in a 1861J1 facility. “U” indicates it is unknown whether or not the patient is receiving care in a 1861J1 facility. UB92 Reference [UB92 Name]
213	Yes/No Condition or Response Code				R	CR607		N – No Y – Yes “Y” indicates patient is covered by Medicare. “N” indicates patient is not covered by Medicare.
213	Certification Type Code				R	CR608		I – Initial R – Renewal S – Revised Required on claims/encounters when a certification for Home Health Services was previously or is being submitted to the destination payer.
213	Date				S	CR609		This data element is required when a surgical procedure was performed on the patient.
214	Product/Service ID Qualifier				S	CR610		HC – HCFA Common Procedural Coding System (HCPCS) Codes ID – International Classification of Diseases Clinical Modification (ICD–9–CM) – Procedure This data element is required when a surgical procedure was performed on the patient.
214	Medical Code Value				S	CR611		Surgical Procedure Code This data element is required when a surgical procedure was performed on the patient.
214	Date				S	CR612		The date the agency received the verbal orders from the physician for start of care. This data element is required when the Provider has the Physician Order Date information on file.
215	Date				S	CR613		The date that the patient was last seen by the physician. This data element is required when the Provider has the Last Visit Date information on file.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
215	Date				S	CR614		The date of the home health agency's most recent contact with the physician. This data element is required when the Provider has the Physician Contact Date information on file.
215	Date Time Period Format Qualifier				S	CR615	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD This data element is required when a hospital admission occurred to the patient.
215	Date Time Period				S	CR616		The date–range of the most recent inpatient stay. This data element is required when a hospital admission occurred to the patient.
216	Patient Location Code				R	CR617		A – Acute Care Facility B – Boarding Home C – Hospice D – Intermediate Care Facility E – Long–term or Extended Care Facility F – Not Specified G – Nursing Home H – Sub–acute Care Facility L – Other Location M – Rehabilitation Facility O – Outpatient Facility R – Residential Treatment Facility S – Skilled Nursing Home T – Rest Home The type of facility from which the patient was most recently discharged.
216	Date				S	CR618		The date of onset or exacerbation of the secondary diagnosis. This data element is required when a second diagnosis code is present on this claim.
217	Date				S	CR619		The date of onset or exacerbation of the tertiary diagnosis. This data element is required when a third diagnosis code is present on this claim.
217	Date				S	CR620		The date of onset or exacerbation of the quaternary diagnosis. This data element is required when a fourth diagnosis code is present on this claim.
217	Date				S	CR621		The date of onset or exacerbation of the quintuplicate diagnosis. This data element is required when a fifth diagnosis code is present on this claim.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
218	Home health Functional Limitations	S		CRC				The CRC segment in Loop ID–2300 applies to the entire claim unless it is overridden by a CRC segment at the service line level in Loop ID–2400 with the same value in CRC01. This segment is required to convey Home Health Plan of Treatment information when applicable.
218	Code Category				R	CRC01	75	75 – Functional Limitations
219	Yes/No Condition or Response Code				R	CRC02		N – No Y – Yes “Y” indicates the condition codes in CRC03 through CRC07 apply “N” indicates the condition codes in CRC03 through CRC07 do not apply.
219	Condition Indicator				R	CRC03		AA – Amputation AL – Ambulation Limitations BL – Bowel Limitations, Bladder Limitations, or both CO – Contracture DY – Dyspnea with Minimal Exertion EL – Endurance Limitations HL – Hearing Limitations LB – Legally Blind OL – Other Limitation PA – Paralysis SL – Speech Limitations Functional Limitation Code
220	Condition Indicator				S	CRC04		See CRC03 for codes. This data element is required when more than one Functional Limitation Code is applicable to the patient.
220	Condition Indicator				S	CRC05		See CRC04.
220	Condition Indicator				S	CRC06		See CRC04.
220	Condition Indicator				S	CRC07		See CRC04.
221	Home Health Activities Permitted	S						This segment is required to convey Home Health Plan of Treatment information when applicable.
221	Code Category				R	CRC01	76	76 – Activities Permitted
222	Yes/No Condition or Response Code				R	CRC02		N – No Y – Yes “Y” indicates the condition codes in CRC03 through CRC07 apply “N” indicates the condition codes in CRC03 through CRC07 do not apply

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
222	Condition Indicator				R	CRC03		BR – Bedrest BRP (Bathroom Privileges) CA – Cane Required CB – Complete Bedrest CR – Crutches Required EP – Exercises Prescribed IH – Independent at Home NR – No Restrictions PW – Partial Weight Bearing TR – Transfer to Bed, or Chair, or Both UT – Up as Tolerated WA – Walker Required WR – Wheelchair Required Activities Permitted Code
223	Condition Indicator				S	CRC04		See CRC03 for codes. This data element is required when more than one Activities Permitted Code is applicable to the patient.
223	Condition Indicator				S	CRC05		See CRC04.
223	Condition Indicator				S	CRC06		See CRC04.
223	Condition Indicator				S	CRC07		See CRC04.
224	Home Health Mental Status	S						This segment is required to convey Home Health Plan of Treatment information when applicable.
224	Code Category				R	CRC01	77	77 – Mental Status
225	Yes/No Condition or Response Code				R	CRC02		N – No Y – Yes "Y" indicates the condition codes in CRC03 through CRC07 apply "N" indicates the condition codes in CRC03 through CRC07 do not apply
225	Condition Indicator				R	CRC03		AG – Agitated CM – Comatose DI – Disoriented DP – Depressed FO – Forgetful LE – Lethargic MC – Other Mental Condition OT – Oriented Mental Status Code
226	Condition Indicator				S	CRC04		See CRC03 for codes. This data element is required when more than one Mental Status Code is applicable to the patient.
226	Condition Indicator				S	CRC05		See CRC04.
226	Condition Indicator				S	CRC06		See CRC04.
226	Condition Indicator				S	CRC07		See CRC04.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
227	Principal, Admitting, E–Code and Patient Reason for Visit Diagnosis	S	231	HI				Required on all claims and encounters except claims for Religious Non–medical claims (Bill Types 4xx and 5xx) and hospital other (Bill Types 14x). The Admitting Diagnosis is required on all inpatient admission claims and encounters. An E–Code diagnosis is required whenever a diagnosis is needed to describe an injury, poisoning or adverse effect. The Patient Reason for Visit Diagnosis is required for all unscheduled outpatient visits.
227	Health Care Code Information				R	HI01		
228	Code List Qualifier Code				R	HI01–1	BK	BK – Principal Diagnosis
228	Industry Code				R	HI01–2		UB92 Reference [UB92 Name]: 67 [Principal Diagnosis Code]
228	Date Time Period Format Qualifier				Not Used	HI01–3		Not Used
228	Date Time Period				Not Used	HI01–4		Not Used
228	Monetary Amount				Not Used	HI01–5		Not Used
228	Quantity				Not Used	HI01–6		Not Used
228	Version Identifier				Not Used	HI01–7		Not Used
228	Health Care Code Information				S	HI02		Required for all unscheduled outpatient visits or upon the patient’s admission to the hospital.
228	Code List Qualifier Code				R	HI02–1		BJ – Admitting Diagnosis ZZ – Mutually Defined (ZZ used to indicate the “Patient Reason For Visit.”)
228	Industry Code				R	HI02–2		UB92 Reference [UB92 Name]: 76 [Admitting Diagnosis/Patient’s Reason for Visit]
228	Date Time Period Format Qualifier				Not Used	HI02–3		Not Used
228	Date Time Period				Not Used	HI02–4		Not Used
228	Monetary Amount				Not Used	HI02–5		Not Used
229	Quantity				Not Used	HI02–6		Not Used
229	Version Identifier				Not Used	HI02–7		Not Used
229	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co–existing conditions.
229	Code List Qualifier Code				R	HI03–1	BN	BN – United States Department of Health and Human Services, Office of Vital Statistics E–code
229	Industry Code				R	HI03–2		UB92 Reference [UB92 Name]: 77 [External Cause of Injury Code (E–code)]
229	Date Time Period Format Qualifier				Not Used	HI03–3		Not Used
229	Date Time Period				Not Used	HI03–4		Not Used
229	Monetary Amount				Not Used	HI03–5		Not Used
229	Quantity				Not Used	HI03–6		Not Used
229	Version Identifier				Not Used	HI03–7		Not Used
229	Health Care Code Information				Not Used	HI04		Not Used
229	Health Care Code Information				Not Used	HI05		Not Used
229	Health Care Code Information				Not Used	HI06		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
229	Health Care Code Information				Not Used	HI07		Not Used
229	Health Care Code Information				Not Used	HI08		Not Used
229	Health Care Code Information				Not Used	HI09		Not Used
229	Health Care Code Information				Not Used	HI10		Not Used
229	Health Care Code Information				Not Used	HI11		Not Used
229	Health Care Code Information				Not Used	HI12		Not Used
230	Diagnosis Related Group (DRG) Information	S	231	HI				DRG Information is required when an inpatient hospital is under DRG contract with a payer and the contract requires the provider to identify the DRG to the payer.
230	Health Care Code Information				R	HI01		Used when necessary to report multiple additional co-existing conditions.
230	Code List Qualifier Code				R	HI01-1	DR	DR – Diagnosis Related Group (DRG)
230	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 77 [External Cause of Injury Code (E-code)]
231	Date Time Period Format Qualifier				Not Used	HI01-3		Not Used
231	Date Time Period				Not Used	HI01-4		Not Used
231	Monetary Amount				Not Used	HI01-5		Not Used
231	Quantity				Not Used	HI01-6		Not Used
231	Version Identifier				Not Used	HI01-7		Not Used
231	Health Care Code Information				Not Used	HI02		Not Used
231	Health Care Code Information				Not Used	HI03		Not Used
231	Health Care Code Information				Not Used	HI04		Not Used
231	Health Care Code Information				Not Used	HI05		Not Used
231	Health Care Code Information				Not Used	HI06		Not Used
231	Health Care Code Information				Not Used	HI07		Not Used
231	Health Care Code Information				Not Used	HI08		Not Used
231	Health Care Code Information				Not Used	HI09		Not Used
231	Health Care Code Information				Not Used	HI10		Not Used
231	Health Care Code Information				Not Used	HI11		Not Used
231	Health Care Code Information				Not Used	HI12		Not Used
232	Other Diagnosis Information	S	231	HI				Required when other condition(s) co-exists with the principal diagnosis, co-exists at the time of admission or develops subsequently during the patient's treatment.
232	Health Care Code Information				R	HI01		
232	Code List Qualifier Code				R	HI01-1	BF	BF – Diagnosis
233	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
233	Date Time Period Format Qualifier				Not Used	HI01-3		Not Used
233	Date Time Period				Not Used	HI01-4		Not Used
233	Monetary Amount				Not Used	HI01-5		Not Used
233	Quantity				Not Used	HI01-6		Not Used
233	Version Identifier				Not Used	HI01-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
233	Health Care Code Information				S	HI02		Used when necessary to report multiple additional co-existing conditions.
233	Code List Qualifier Code				R	HI02-1	BF	BF – Diagnosis
233	Industry Code				R	HI02-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
234	Date Time Period Format Qualifier				Not Used	HI02-3		Not Used
234	Date Time Period Format Qualifier				Not Used	HI02-3		Not Used
234	Date Time Period				Not Used	HI02-4		Not Used
234	Monetary Amount				Not Used	HI02-5		Not Used
234	Quantity				Not Used	HI02-6		Not Used
234	Version Identifier				Not Used	HI02-7		Not Used
234	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co-existing conditions.
234	Code List Qualifier Code				R	HI03-1	BF	BF – Diagnosis
234	Industry Code				R	HI03-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
234	Date Time Period Format Qualifier				Not Used	HI03-3		Not Used
234	Date Time Period				Not Used	HI03-4		Not Used
234	Monetary Amount				Not Used	HI03-5		Not Used
234	Quantity				Not Used	HI03-6		Not Used
234	Version Identifier				Not Used	HI03-7		Not Used
234	Health Care Code Information				S	HI04		Used when necessary to report multiple additional co-existing conditions.
235	Code List Qualifier Code				R	HI04-1	BF	BF – Diagnosis
235	Industry Code				R	HI04-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
235	Date Time Period Format Qualifier				Not Used	HI04-3		Not Used
235	Date Time Period				Not Used	HI04-4		Not Used
235	Monetary Amount				Not Used	HI04-5		Not Used
235	Quantity				Not Used	HI04-6		Not Used
235	Version Identifier				Not Used	HI04-7		Not Used
235	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
235	Code List Qualifier Code				R	HI05-1	BF	BF – Diagnosis
235	Industry Code				R	HI05-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
236	Date Time Period Format Qualifier				Not Used	HI05-3		Not Used
236	Date Time Period				Not Used	HI05-4		Not Used
236	Monetary Amount				Not Used	HI05-5		Not Used
236	Quantity				Not Used	HI05-6		Not Used
236	Version Identifier				Not Used	HI05-7		Not Used
236	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
236	Code List Qualifier Code				R	HI06-1	BF	BF – Diagnosis

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
236	Industry Code				R	HI06-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
236	Date Time Period Format Qualifier				Not Used	HI06-3		Not Used
236	Date Time Period				Not Used	HI06-4		Not Used
236	Monetary Amount				Not Used	HI06-5		Not Used
236	Quantity				Not Used	HI06-6		Not Used
236	Version Identifier				Not Used	HI06-7		Not Used
237	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.
237	Code List Qualifier Code				R	HI07-1	BF	BF – Diagnosis
237	Industry Code				R	HI07-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
237	Date Time Period Format Qualifier				Not Used	HI07-3		Not Used
237	Date Time Period				Not Used	HI07-4		Not Used
237	Monetary Amount				Not Used	HI07-5		Not Used
237	Quantity				Not Used	HI07-6		Not Used
237	Version Identifier				Not Used	HI07-7		Not Used
237	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
237	Code List Qualifier Code				R	HI08-1	BF	BF – Diagnosis
238	Industry Code				R	HI08-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
238	Date Time Period Format Qualifier				Not Used	HI08-3		Not Used
238	Date Time Period				Not Used	HI08-4		Not Used
238	Monetary Amount				Not Used	HI08-5		Not Used
238	Quantity				Not Used	HI08-6		Not Used
238	Version Identifier				Not Used	HI08-7		Not Used
238	Health Care Code Information				S	HI09		Used when necessary to report multiple additional co-existing conditions.
238	Code List Qualifier Code				R	HI09-1	BF	BF – Diagnosis
238	Industry Code				R	HI09-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
239	Date Time Period Format Qualifier				Not Used	HI09-3		Not Used
239	Date Time Period				Not Used	HI09-4		Not Used
239	Monetary Amount				Not Used	HI09-5		Not Used
239	Quantity				Not Used	HI09-6		Not Used
239	Version Identifier				Not Used	HI09-7		Not Used
239	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
239	Code List Qualifier Code				R	HI10-1	BF	BF – Diagnosis
239	Industry Code				R	HI10-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
239	Date Time Period Format Qualifier				Not Used	HI10-3		Not Used
239	Date Time Period				Not Used	HI10-4		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
239	Monetary Amount				Not Used	HI10-5		Not Used
239	Quantity				Not Used	HI10-6		Not Used
239	Version Identifier				Not Used	HI10-7		Not Used
239	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
240	Code List Qualifier Code				R	HI11-1	BF	BF – Diagnosis
240	Industry Code				R	HI11-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
240	Date Time Period Format Qualifier				Not Used	HI11-3		Not Used
240	Date Time Period				Not Used	HI11-4		Not Used
240	Monetary Amount				Not Used	HI11-5		Not Used
240	Quantity				Not Used	HI11-6		Not Used
240	Version Identifier				Not Used	HI11-7		Not Used
240	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
240	Code List Qualifier Code				R	HI12-1	BF	BF – Diagnosis
240	Industry Code				R	HI12-2		UB92 Reference [UB92 Name]: 68 – 75 [Other Diagnoses Codes]
241	Date Time Period Format Qualifier				Not Used	HI12-3		Not Used
241	Date Time Period				Not Used	HI12-4		Not Used
241	Monetary Amount				Not Used	HI12-5		Not Used
241	Quantity				Not Used	HI12-6		Not Used
241	Version Identifier				Not Used	HI12-7		Not Used
242	Principal Procedure Information	S	231	HI				Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated. Required on inpatient claims or encounters when a procedure was performed.
242	Health Care Code Information				R	HI01		Used when necessary to report multiple additional co-existing conditions.
242	Code List Qualifier Code				R	HI01-1		BP – Health Care Financing Administration Common Procedural Coding System Principal Procedure BR – International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure
243	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 80 [Principal Procedure Code and Date]
243	Date Time Period Format Qualifier				S	HI01-3	D8	D8 – Date Expressed in Format CCYYMMDD Use code D8 when the value in composite data element HI01-1 equals “BR”.
243	Date Time Period				S	HI01-4		UB92 Reference [UB92 Name]: 80, “DATE” field [Principal Procedure Code and Date]
243	Monetary Amount				Not Used	HI01-5		Not Used
243	Quantity				Not Used	HI01-6		Not Used
243	Version Identifier				Not Used	HI01-7		Not Used
243	Health Care Code Information				Not Used	HI02		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
243	Health Care Code Information				Not Used	HI03		Not Used
243	Health Care Code Information				Not Used	HI04		Not Used
243	Health Care Code Information				Not Used	HI05		Not Used
243	Health Care Code Information				Not Used	HI06		Not Used
243	Health Care Code Information				Not Used	HI07		Not Used
243	Health Care Code Information				Not Used	HI08		Not Used
243	Health Care Code Information				Not Used	HI09		Not Used
243	Health Care Code Information				Not Used	HI10		Not Used
243	Health Care Code Information				Not Used	HI11		Not Used
243	Health Care Code Information				Not Used	HI12		Not Used
244	Other Procedure Information	S	231	HI				Required on Home IV therapy claims or encounters when surgery was performed during the inpatient stay from which the course of therapy was initiated. Required on inpatient claims or encounters when additional procedures must be reported.
244	Health Care Code Information				R	HI01		Used when necessary to report multiple additional co-existing conditions.
244	Code List Qualifier Code				R	HI01-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
245	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
245	Date Time Period Format Qualifier				S	HI01-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
245	Date Time Period				S	HI01-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
245	Monetary Amount				Not Used	HI01-5		Not Used
245	Quantity				Not Used	HI01-6		Not Used
245	Version Identifier				Not Used	HI01-7		Not Used
245	Health Care Code Information				S	HI02		Used when necessary to report multiple additional co-existing conditions.
245	Code List Qualifier Code				R	HI02-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
246	Industry Code				R	HI02-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
246	Date Time Period Format Qualifier				S	HI02-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
246	Date Time Period				S	HI02-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
246	Monetary Amount				Not Used	HI02-5		Not Used
246	Quantity				Not Used	HI02-6		Not Used
246	Version Identifier				Not Used	HI02-7		Not Used
246	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co-existing conditions.
246	Code List Qualifier Code				R	HI03-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
246	Industry Code				R	HI03-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
247	Date Time Period Format Qualifier				S	HI03-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
247	Date Time Period				S	HI03-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
247	Monetary Amount				Not Used	HI03-5		Not Used
247	Quantity				Not Used	HI03-6		Not Used
247	Version Identifier				Not Used	HI03-7		Not Used
247	Health Care Code Information				S	HI04		Used when necessary to report multiple additional co-existing conditions.
247	Code List Qualifier Code				R	HI04-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
247	Industry Code				R	HI04-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
248	Date Time Period Format Qualifier				S	HI04-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
248	Date Time Period				S	HI04-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
248	Monetary Amount				Not Used	HI04-5		Not Used
248	Quantity				Not Used	HI04-6		Not Used
248	Version Identifier				Not Used	HI04-7		Not Used
248	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
248	Code List Qualifier Code				R	HI05-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
248	Industry Code				R	HI05-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
249	Date Time Period Format Qualifier				S	HI05-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
249	Date Time Period				S	HI05-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
249	Monetary Amount				Not Used	HI05-5		Not Used
249	Quantity				Not Used	HI05-6		Not Used
249	Version Identifier				Not Used	HI05-7		Not Used
249	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
249	Code List Qualifier Code				R	HI06-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
249	Industry Code				R	HI06-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
249	Date Time Period Format Qualifier				S	HI06-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
250	Date Time Period				S	HI06-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
250	Monetary Amount				Not Used	HI06-5		Not Used
250	Quantity				Not Used	HI06-6		Not Used
250	Version Identifier				Not Used	HI06-7		Not Used
250	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
250	Code List Qualifier Code				R	HI07-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
250	Industry Code				R	HI07-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
250	Date Time Period Format Qualifier				S	HI07-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
251	Date Time Period				S	HI07-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
251	Monetary Amount				Not Used	HI07-5		Not Used
251	Quantity				Not Used	HI07-6		Not Used
251	Version Identifier				Not Used	HI07-7		Not Used
251	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
251	Code List Qualifier Code				R	HI08-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
251	Industry Code				R	HI08-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
251	Date Time Period Format Qualifier				S	HI08-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
252	Date Time Period				S	HI08-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
252	Monetary Amount				Not Used	HI08-5		Not Used
252	Quantity				Not Used	HI08-6		Not Used
252	Version Identifier				Not Used	HI08-7		Not Used
252	Health Care Code Information				S	HI09		Used when necessary to report multiple additional co-existing conditions.
252	Code List Qualifier Code				R	HI09-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
252	Industry Code				R	HI09-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
252	Date Time Period Format Qualifier				S	HI09-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
252	Date Time Period				S	HI09-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
253	Monetary Amount				Not Used	HI09-5		Not Used
253	Quantity				Not Used	HI09-6		Not Used
253	Version Identifier				Not Used	HI09-7		Not Used
253	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
253	Code List Qualifier Code				R	HI10-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
253	Industry Code				R	HI10-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
253	Date Time Period Format Qualifier				S	HI10-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
253	Date Time Period				S	HI10-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
254	Monetary Amount				Not Used	HI10-5		Not Used
254	Quantity				Not Used	HI10-6		Not Used
254	Version Identifier				Not Used	HI10-7		Not Used
254	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
254	Code List Qualifier Code				R	HI11-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
254	Industry Code				R	HI11-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
254	Date Time Period Format Qualifier				S	HI11-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
254	Date Time Period				S	HI11-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
254	Monetary Amount				Not Used	HI11-5		Not Used
255	Quantity				Not Used	HI11-6		Not Used
255	Version Identifier				Not Used	HI11-7		Not Used
255	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
255	Code List Qualifier Code				R	HI12-1		BO – HCFA Common Procedural Coding System BQ – International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure
255	Industry Code				R	HI12-2		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
255	Date Time Period Format Qualifier				S	HI12-3	D8	D8 – Date Expressed in Format CCYYMMDD Required if the procedure code reported is ICD-9-CM in the preceding data element. Used if needed to report a procedure date when the code reported is HCPCS. If used, the immediately following element is required.
255	Date Time Period				S	HI12-4		UB92 Reference [UB92 Name]: 81 (A-E) [Other Procedure Codes and Dates]
255	Monetary Amount				Not Used	HI12-5		Not Used
255	Quantity				Not Used	HI12-6		Not Used
255	Version Identifier				Not Used	HI12-7		Not Used
256	Occurrence Span Information	S	231	HI				Required when occurrence span information applies to the claim or encounter.
256	Health Care Code Information				R	HI01		
256	Code List Qualifier Code				R	HI01-1	BI	BI – Occurrence Span
257	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
257	Date Time Period Format Qualifier				R	HI01-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
257	Date Time Period				R	HI01-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), “FROM” and “THROUGH” fields [Occurrence Span Code and Dates]
257	Monetary Amount				Not Used	HI01-5		Not Used
257	Quantity				Not Used	HI01-6		Not Used
257	Version Identifier				Not Used	HI01-7		Not Used
257	Health Care Code Information				S	HI02		Used when necessary to report multiple additional co-existing conditions.
257	Code List Qualifier Code				R	HI02-1	BI	BI – Occurrence Span
257	Industry Code				R	HI02-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
258	Date Time Period Format Qualifier				R	HI02-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
258	Date Time Period				R	HI02-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
258	Monetary Amount				Not Used	HI02-5		Not Used
258	Quantity				Not Used	HI02-6		Not Used
258	Version Identifier				Not Used	HI02-7		Not Used
258	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co-existing conditions.
258	Code List Qualifier Code				R	HI03-1	BI	BI – Occurrence Span
258	Industry Code				R	HI03-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
258	Date Time Period Format Qualifier				R	HI03-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
259	Date Time Period				R	HI03-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
259	Monetary Amount				Not Used	HI03-5		Not Used
259	Quantity				Not Used	HI03-6		Not Used
259	Version Identifier				Not Used	HI03-7		Not Used
259	Health Care Code Information				S	HI04		Used when necessary to report multiple additional co-existing conditions.
259	Code List Qualifier Code				R	HI04-1	BI	BI – Occurrence Span
259	Industry Code				R	HI04-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
259	Date Time Period Format Qualifier				R	HI04-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
259	Date Time Period				R	HI04-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
260	Monetary Amount				Not Used	HI04-5		Not Used
260	Quantity				Not Used	HI04-6		Not Used
260	Version Identifier				Not Used	HI04-7		Not Used
260	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
260	Code List Qualifier Code				R	HI05-1	BI	BI – Occurrence Span
260	Industry Code				R	HI05-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
260	Date Time Period Format Qualifier				R	HI05-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
260	Date Time Period				R	HI05-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
260	Monetary Amount				Not Used	HI05-5		Not Used
260	Quantity				Not Used	HI05-6		Not Used
260	Version Identifier				Not Used	HI05-7		Not Used
260	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
261	Code List Qualifier Code				R	HI06-1	BI	BI – Occurrence Span
261	Industry Code				R	HI06-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
261	Date Time Period Format Qualifier				R	HI06-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
261	Date Time Period				R	HI06-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
261	Monetary Amount				Not Used	HI06-5		Not Used
261	Quantity				Not Used	HI06-6		Not Used
261	Version Identifier				Not Used	HI06-7		Not Used
261	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.
261	Code List Qualifier Code				R	HI07-1	BI	BI – Occurrence Span
262	Industry Code				R	HI07-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
262	Date Time Period Format Qualifier				R	HI07-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
262	Date Time Period				R	HI07-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
262	Monetary Amount				Not Used	HI07-5		Not Used
262	Quantity				Not Used	HI07-6		Not Used
262	Version Identifier				Not Used	HI07-7		Not Used
262	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
262	Code List Qualifier Code				R	HI08-1	BI	BI – Occurrence Span
262	Industry Code				R	HI08-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
263	Date Time Period Format Qualifier				R	HI08-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
263	Date Time Period				R	HI08-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
263	Monetary Amount				Not Used	HI08-5		Not Used
263	Quantity				Not Used	HI08-6		Not Used
263	Version Identifier				Not Used	HI08-7		Not Used
263	Health Care Code Information				S	HI09		Used when necessary to report multiple additional co-existing conditions.
263	Code List Qualifier Code				R	HI09-1	BI	BI – Occurrence Span
263	Industry Code				R	HI09-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
263	Date Time Period Format Qualifier				R	HI09-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
263	Date Time Period				R	HI09-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
264	Monetary Amount				Not Used	HI09-5		Not Used
264	Quantity				Not Used	HI09-6		Not Used
264	Version Identifier				Not Used	HI09-7		Not Used
264	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
264	Code List Qualifier Code				R	HI10-1	BI	BI – Occurrence Span
264	Industry Code				R	HI10-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
264	Date Time Period Format Qualifier				R	HI10-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
264	Date Time Period				R	HI10-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
264	Monetary Amount				Not Used	HI10-5		Not Used
264	Quantity				Not Used	HI10-6		Not Used
264	Version Identifier				Not Used	HI10-7		Not Used
265	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
265	Code List Qualifier Code				R	HI11-1	BI	BI – Occurrence Span
265	Industry Code				R	HI11-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
265	Date Time Period Format Qualifier				R	HI11-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
265	Date Time Period				R	HI11-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
265	Monetary Amount				Not Used	HI11-5		Not Used
265	Quantity				Not Used	HI11-6		Not Used
265	Version Identifier				Not Used	HI11-7		Not Used
265	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
265	Code List Qualifier Code				R	HI12-1	BI	BI – Occurrence Span
266	Industry Code				R	HI12-2		UB92 Reference [UB92 Name]: 36 (a-b) [Occurrence Span Code and Dates]
266	Date Time Period Format Qualifier				R	HI12-3	RD8	RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
266	Date Time Period				R	HI12-4		Occurrence or Occurrence Span Code Associated Date UB92 Reference [UB92 Name]: 36 (a-b), "FROM" and "THROUGH" fields [Occurrence Span Code and Dates]
266	Monetary Amount				Not Used	HI12-5		Not Used
266	Quantity				Not Used	HI12-6		Not Used
266	Version Identifier				Not Used	HI12-7		Not Used
267	Occurrence Information	S	231	HI				Required when occurrence information applies to the claim or encounter.
267	Health Care Code Information				R	HI01		
267	Code List Qualifier Code				R	HI01-1	BH	BH – Occurrence
268	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
268	Date Time Period Format Qualifier				R	HI01-3	D8	D8 – Date Expressed in Format CCYYMMDD
268	Date Time Period				R	HI01-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
268	Monetary Amount				Not Used	HI01-5		Not Used
268	Quantity				Not Used	HI01-6		Not Used
268	Version Identifier				Not Used	HI01-7		Not Used
268	Health Care Code Information				S	HI02		Used when necessary to report multiple additional co-existing conditions.
268	Code List Qualifier Code				R	HI02-1	BH	BH – Occurrence
268	Industry Code				R	HI02-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
269	Date Time Period Format Qualifier				R	HI02-3	D8	D8 – Date Expressed in Format CCYYMMDD
269	Date Time Period				R	HI02-4		UB-92 Reference [UB-92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
269	Monetary Amount				Not Used	HI02-5		Not Used
269	Quantity				Not Used	HI02-6		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
269	Version Identifier				Not Used	HI02-7		Not Used
269	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co-existing conditions.
269	Code List Qualifier Code				R	HI03-1	BH	BH – Occurrence
269	Industry Code				R	HI03-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
270	Date Time Period Format Qualifier				R	HI03-3	D8	D8 – Date Expressed in Format CCYYMMDD
270	Date Time Period				R	HI03-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
270	Monetary Amount				Not Used	HI03-5		Not Used
270	Quantity				Not Used	HI03-6		Not Used
270	Version Identifier				Not Used	HI03-7		Not Used
270	Health Care Code Information				S	HI04		Used when necessary to report multiple additional co-existing conditions.
270	Code List Qualifier Code				R	HI04-1	BH	BH – Occurrence
270	Industry Code				R	HI04-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
271	Date Time Period Format Qualifier				R	HI04-3	D8	D8 – Date Expressed in Format CCYYMMDD
271	Date Time Period				R	HI04-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
271	Monetary Amount				Not Used	HI04-5		Not Used
271	Quantity				Not Used	HI04-6		Not Used
271	Version Identifier				Not Used	HI04-7		Not Used
271	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
271	Code List Qualifier Code				R	HI05-1	BH	BH – Occurrence
271	Industry Code				R	HI05-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
271	Date Time Period Format Qualifier				R	HI05-3	D8	D8 – Date Expressed in Format CCYYMMDD
272	Date Time Period				R	HI05-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
272	Monetary Amount				Not Used	HI05-5		Not Used
272	Quantity				Not Used	HI05-6		Not Used
272	Version Identifier				Not Used	HI05-7		Not Used
272	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
272	Code List Qualifier Code				R	HI06-1	BH	BH – Occurrence
272	Industry Code				R	HI06-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
272	Date Time Period Format Qualifier				R	HI06-3	D8	D8 – Date Expressed in Format CCYYMMDD
273	Date Time Period				R	HI06-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
273	Monetary Amount				Not Used	HI06-5		Not Used
273	Quantity				Not Used	HI06-6		Not Used
273	Version Identifier				Not Used	HI06-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
273	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.
273	Code List Qualifier Code				R	HI07-1	BH	BH – Occurrence
273	Industry Code				R	HI07-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
273	Date Time Period Format Qualifier				R	HI07-3	D8	D8 – Date Expressed in Format CCYYMMDD
274	Date Time Period				R	HI07-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
274	Monetary Amount				Not Used	HI07-5		Not Used
274	Quantity				Not Used	HI07-6		Not Used
274	Version Identifier				Not Used	HI07-7		Not Used
274	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
274	Code List Qualifier Code				R	HI08-1	BH	BH – Occurrence
274	Industry Code				R	HI08-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
274	Date Time Period Format Qualifier				R	HI08-3	D8	D8 – Date Expressed in Format CCYYMMDD
275	Date Time Period				R	HI08-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
275	Monetary Amount				Not Used	HI08-5		Not Used
275	Quantity				Not Used	HI08-6		Not Used
275	Version Identifier				Not Used	HI08-7		Not Used
275	Health Care Code Information				S	HI09		Used when necessary to report multiple additional co-existing conditions.
275	Code List Qualifier Code				R	HI09-1	BH	BH – Occurrence
275	Industry Code				R	HI09-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
275	Date Time Period Format Qualifier				R	HI09-3	D8	D8 – Date Expressed in Format CCYYMMDD
276	Date Time Period				R	HI09-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
276	Monetary Amount				Not Used	HI09-5		Not Used
276	Quantity				Not Used	HI09-6		Not Used
276	Version Identifier				Not Used	HI09-7		Not Used
276	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
276	Code List Qualifier Code				R	HI10-1	BH	BH – Occurrence
276	Industry Code				R	HI10-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
276	Date Time Period Format Qualifier				R	HI10-3	D8	D8 – Date Expressed in Format CCYYMMDD
277	Date Time Period				R	HI10-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
277	Monetary Amount				Not Used	HI10-5		Not Used
277	Quantity				Not Used	HI10-6		Not Used
277	Version Identifier				Not Used	HI10-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
277	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
277	Code List Qualifier Code				R	HI11-1	BH	BH – Occurrence
277	Industry Code				R	HI11-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
277	Date Time Period Format Qualifier				R	HI11-3	D8	D8 – Date Expressed in Format CCYYMMDD
278	Date Time Period				R	HI11-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
278	Monetary Amount				Not Used	HI11-5		Not Used
278	Quantity				Not Used	HI11-6		Not Used
278	Version Identifier				Not Used	HI11-7		Not Used
278	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
278	Code List Qualifier Code				R	HI12-1	BH	BH – Occurrence
278	Industry Code				R	HI12-2		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
278	Date Time Period Format Qualifier				R	HI12-3	D8	D8 – Date Expressed in Format CCYYMMDD
279	Date Time Period				R	HI12-4		UB92 Reference [UB92 Name]: 32 – 35 (a-b) [Occurrence Codes and Dates]
279	Monetary Amount				Not Used	HI12-5		Not Used
279	Quantity				Not Used	HI12-6		Not Used
279	Version Identifier				Not Used	HI12-7		Not Used
280	Value Information	S	231	HI				Required when value information applies to the claim or encounter.
280	Health Care Code Information				R	HI01		
280	Code List Qualifier Code				R	HI01-1	BE	BE – Value
281	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
281	Date Time Period Format Qualifier				Not Used	HI01-3		Not Used
281	Date Time Period				Not Used	HI01-4		Not Used
281	Monetary Amount				R	HI01-5		This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).
281	Quantity				Not Used	HI01-6		Not Used
281	Version Identifier				Not Used	HI01-7		Not Used
281	Health Care Code Information				S	HI02		Used when necessary to report multiple additional co-existing conditions.
281	Code List Qualifier Code				R	HI02-1	BE	BE – Value
281	Industry Code				R	HI02-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
281	Date Time Period Format Qualifier				Not Used	HI02-3		Not Used
281	Date Time Period				Not Used	HI02-4		Not Used
282	Monetary Amount				R	HI02-5		This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).
282	Quantity				Not Used	HI02-6		Not Used
282	Version Identifier				Not Used	HI02-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
282	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co-existing conditions.
282	Code List Qualifier Code				R	HI03-1	BE	BE – Value
282	Industry Code				R	HI03-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
282	Date Time Period Format Qualifier				Not Used	HI03-3		Not Used
282	Date Time Period				Not Used	HI03-4		Not Used
282	Monetary Amount				R	HI03-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
282	Quantity				Not Used	HI03-6		Not Used
282	Version Identifier				Not Used	HI03-7		Not Used
282	Health Care Code Information				S	HI04		Used when necessary to report multiple additional co-existing conditions.
283	Code List Qualifier Code				R	HI04-1	BE	BE – Value
283	Industry Code				R	HI04-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
283	Date Time Period Format Qualifier				Not Used	HI04-3		Not Used
283	Date Time Period				Not Used	HI04-4		Not Used
283	Monetary Amount				R	HI04-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
283	Quantity				Not Used	HI04-6		Not Used
283	Version Identifier				Not Used	HI04-7		Not Used
283	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
283	Code List Qualifier Code				R	HI05-1	BE	BE – Value
283	Industry Code				R	HI05-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
284	Date Time Period Format Qualifier				Not Used	HI05-3		Not Used
284	Date Time Period				Not Used	HI05-4		Not Used
284	Monetary Amount				R	HI05-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
284	Quantity				Not Used	HI05-6		Not Used
284	Version Identifier				Not Used	HI05-7		Not Used
284	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
284	Code List Qualifier Code				R	HI06-1	BE	BE – Value
284	Industry Code				R	HI06-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
284	Date Time Period Format Qualifier				Not Used	HI06-3		Not Used
284	Date Time Period				Not Used	HI06-4		Not Used
284	Monetary Amount				R	HI06-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
284	Quantity				Not Used	HI06-6		Not Used
284	Version Identifier				Not Used	HI06-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
285	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.
285	Code List Qualifier Code				R	HI07-1	BE	BE - Value
285	Industry Code				R	HI07-2		UB92 Reference [UB92 Name]: 39 - 41 (a-d) [Value Codes and Amounts]
285	Date Time Period Format Qualifier				Not Used	HI07-3		Not Used
285	Date Time Period				Not Used	HI07-4		Not Used
285	Monetary Amount				R	HI07-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
285	Quantity				Not Used	HI07-6		Not Used
285	Version Identifier				Not Used	HI07-7		Not Used
285	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
285	Code List Qualifier Code				R	HI08-1	BE	BE - Value
286	Industry Code				R	HI08-2		UB92 Reference [UB92 Name]: 39 - 41 (a-d) [Value Codes and Amounts]
286	Date Time Period Format Qualifier				Not Used	HI08-3		Not Used
286	Date Time Period				Not Used	HI08-4		Not Used
286	Monetary Amount				R	HI08-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
286	Quantity				Not Used	HI08-6		Not Used
286	Version Identifier				Not Used	HI08-7		Not Used
286	Health Care Code Information				S	HI09		Used when necessary to report multiple additional co-existing conditions.
286	Code List Qualifier Code				R	HI09-1	BE	BE - Value
286	Industry Code				R	HI09-2		UB92 Reference [UB92 Name]: 39 - 41 (a-d) [Value Codes and Amounts]
286	Date Time Period Format Qualifier				Not Used	HI09-3		Not Used
286	Date Time Period				Not Used	HI09-4		Not Used
287	Monetary Amount				R	HI09-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
287	Quantity				Not Used	HI09-6		Not Used
287	Version Identifier				Not Used	HI09-7		Not Used
287	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
287	Code List Qualifier Code				R	HI10-1	BE	BE - Value
287	Industry Code				R	HI10-2		UB92 Reference [UB92 Name]: 39 - 41 (a-d) [Value Codes and Amounts]
287	Date Time Period Format Qualifier				Not Used	HI10-3		Not Used
287	Date Time Period				Not Used	HI10-4		Not Used
287	Monetary Amount				R	HI10-5		This data element must contain the Value Code Amount when Hlxx-1 value equals BE (Value Code).
287	Quantity				Not Used	HI10-6		Not Used
287	Version Identifier				Not Used	HI10-7		Not Used
287	Version Identifier				Not Used	HI10-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
287	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
288	Code List Qualifier Code				R	HI11-1	BE	BE – Value
288	Industry Code				R	HI11-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
288	Date Time Period Format Qualifier				Not Used	HI11-3		Not Used
288	Date Time Period				Not Used	HI11-4		Not Used
288	Monetary Amount				R	HI11-5		This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).
288	Quantity				Not Used	HI11-6		Not Used
288	Version Identifier				Not Used	HI11-7		Not Used
288	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
288	Code List Qualifier Code				R	HI12-1	BE	BE – Value
288	Industry Code				R	HI12-2		UB92 Reference [UB92 Name]: 39 – 41 (a-d) [Value Codes and Amounts]
289	Date Time Period Format Qualifier				Not Used	HI12-3		Not Used
289	Date Time Period				Not Used	HI12-4		Not Used
289	Monetary Amount				R	HI12-5		This data element must contain the Value Code Amount when HIxx-1 value equals BE (Value Code).
289	Quantity				Not Used	HI12-6		Not Used
289	Version Identifier				Not Used	HI12-7		Not Used
290	Condition Information	S	231	HI				Required when condition information applies to the claim or encounter.
290	Health Care Code Information				R	HI01		
290	Code List Qualifier Code				R	HI01-1	BG	BG – Condition
291	Industry Code				R	HI01-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
291	Date Time Period Format Qualifier				Not Used	HI01-3		Not Used
291	Date Time Period				Not Used	HI01-4		Not Used
291	Monetary Amount				Not Used	HI01-5		Not Used
291	Quantity				Not Used	HI01-6		Not Used
291	Version Identifier				Not Used	HI01-7		Not Used
291	Health Care Code Information				S	HI02		Used when necessary to report multiple additional co-existing conditions.
291	Code List Qualifier Code				R	HI02-1	BG	BG – Condition
291	Industry Code				R	HI02-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
291	Date Time Period Format Qualifier				Not Used	HI02-3		Not Used
292	Date Time Period				Not Used	HI02-4		Not Used
292	Monetary Amount				Not Used	HI02-5		Not Used
292	Quantity				Not Used	HI02-6		Not Used
292	Version Identifier				Not Used	HI02-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
292	Health Care Code Information				S	HI03		Used when necessary to report multiple additional co-existing conditions.
292	Code List Qualifier Code				R	HI03-1	BG	BG – Condition
292	Industry Code				R	HI03-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
292	Date Time Period Format Qualifier				Not Used	HI03-3		Not Used
292	Date Time Period				Not Used	HI03-4		Not Used
292	Monetary Amount				Not Used	HI03-5		Not Used
292	Quantity				Not Used	HI03-6		Not Used
292	Version Identifier				Not Used	HI03-7		Not Used
292	Health Care Code Information				S	HI04		Used when necessary to report multiple additional co-existing conditions.
292	Code List Qualifier Code				R	HI04-1	BG	BG – Condition
293	Industry Code				R	HI04-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
293	Date Time Period Format Qualifier				Not Used	HI04-3		Not Used
293	Date Time Period				Not Used	HI04-4		Not Used
293	Monetary Amount				Not Used	HI04-5		Not Used
293	Quantity				Not Used	HI04-6		Not Used
293	Version Identifier				Not Used	HI04-7		Not Used
293	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
293	Code List Qualifier Code				R	HI05-1	BG	BG – Condition
293	Industry Code				R	HI05-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
293	Date Time Period Format Qualifier				Not Used	HI05-3		Not Used
294	Date Time Period				Not Used	HI05-4		Not Used
294	Monetary Amount				Not Used	HI05-5		Not Used
294	Quantity				Not Used	HI05-6		Not Used
294	Version Identifier				Not Used	HI05-7		Not Used
294	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
294	Code List Qualifier Code				R	HI06-1	BG	BG – Condition
294	Industry Code				R	HI06-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
294	Date Time Period Format Qualifier				Not Used	HI06-3		Not Used
294	Date Time Period				Not Used	HI06-4		Not Used
294	Monetary Amount				Not Used	HI06-5		Not Used
294	Quantity				Not Used	HI06-6		Not Used
294	Version Identifier				Not Used	HI06-7		Not Used
294	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.
294	Code List Qualifier Code				R	HI07-1	BG	BG – Condition

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
295	Industry Code				R	HI07-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
295	Date Time Period Format Qualifier				Not Used	HI07-3		Not Used
295	Date Time Period				Not Used	HI07-4		Not Used
295	Monetary Amount				Not Used	HI07-5		Not Used
295	Quantity				Not Used	HI07-6		Not Used
295	Version Identifier				Not Used	HI07-7		Not Used
295	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
295	Code List Qualifier Code				R	HI08-1	BG	BG – Condition
295	Industry Code				R	HI08-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
295	Date Time Period Format Qualifier				Not Used	HI08-3		Not Used
296	Date Time Period				Not Used	HI08-4		Not Used
296	Monetary Amount				Not Used	HI08-5		Not Used
296	Quantity				Not Used	HI08-6		Not Used
296	Version Identifier				Not Used	HI08-7		Not Used
296	Health Care Code Information				S	HI09		Used when necessary to report multiple additional co-existing conditions.
296	Code List Qualifier Code				R	HI09-1	BG	BG – Condition
296	Industry Code				R	HI09-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
296	Date Time Period Format Qualifier				Not Used	HI09-3		Not Used
296	Date Time Period				Not Used	HI09-4		Not Used
296	Monetary Amount				Not Used	HI09-5		Not Used
296	Quantity				Not Used	HI09-6		Not Used
296	Version Identifier				Not Used	HI09-7		Not Used
296	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
296	Code List Qualifier Code				R	HI10-1	BG	BG – Condition
297	Industry Code				R	HI10-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
297	Date Time Period Format Qualifier				Not Used	HI10-3		Not Used
297	Date Time Period				Not Used	HI10-4		Not Used
297	Monetary Amount				Not Used	HI10-5		Not Used
297	Quantity				Not Used	HI10-6		Not Used
297	Version Identifier				Not Used	HI10-7		Not Used
297	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
297	Code List Qualifier Code				R	HI11-1	BG	BG – Condition
297	Industry Code				R	HI11-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
297	Date Time Period Format Qualifier				Not Used	HI11-3		Not Used
298	Date Time Period				Not Used	HI11-4		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
298	Monetary Amount				Not Used	HI11-5		Not Used
298	Quantity				Not Used	HI11-6		Not Used
298	Version Identifier				Not Used	HI11-7		Not Used
298	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
298	Code List Qualifier Code				R	HI12-1	BG	BG – Condition
298	Industry Code				R	HI12-2		UB92 Reference [UB92 Name]: 24 – 30 [Condition Codes]
298	Date Time Period Format Qualifier				Not Used	HI12-3		Not Used
298	Date Time Period				Not Used	HI12-4		Not Used
298	Monetary Amount				Not Used	HI12-5		Not Used
298	Quantity				Not Used	HI12-6		Not Used
298	Version Identifier				Not Used	HI12-7		Not Used
299	Treatment Code Information	S						Required when Home Health Agencies need to report Plan of Treatment information under various payer contracts.
299	Health Care Code Information			Not Used For Adjudication HI	R	HI01		
299	Code List Qualifier Code		R		HI01-1	TC	TC – Treatment Codes	
300	Industry Code		R		HI01-2		Treatment Codes CODE SOURCE 359	
300	Date Time Period Format Qualifier				Not Used	HI01-3	Not Used	
300	Date Time Period				Not Used	HI01-4	Not Used	
300	Monetary Amount				Not Used	HI01-5	Not Used	
300	Quantity				Not Used	HI01-6	Not Used	
300	Version Identifier				Not Used	HI01-7	Not Used	
300	Health Care Code Information				S	HI02	Used when necessary to report multiple additional co-existing conditions.	
300	Code List Qualifier Code				R	HI02-1	TC	TC – Treatment Codes
300	Industry Code				R	HI02-2	Treatment Codes CODE SOURCE 359	
300	Date Time Period Format Qualifier				Not Used	HI02-3	Not Used	
300	Date Time Period				Not Used	HI02-4	Not Used	
300	Monetary Amount				Not Used	HI02-5	Not Used	
300	Quantity				Not Used	HI02-6	Not Used	
300	Version Identifier				Not Used	HI02-7	Not Used	
300	Health Care Code Information				S	HI03	Used when necessary to report multiple additional co-existing conditions.	
300	Code List Qualifier Code				R	HI03-1	TC	TC – Treatment Codes
300	Industry Code				R	HI03-2	Treatment Codes CODE SOURCE 359	
301	Date Time Period Format Qualifier				Not Used	HI03-3	Not Used	
301	Date Time Period			Not Used	HI03-4	Not Used		
301	Monetary Amount			Not Used	HI03-5	Not Used		
301	Quantity			Not Used	HI03-6	Not Used		
301	Version Identifier			Not Used	HI03-7	Not Used		
301	Health Care Code Information			S	HI04	Used when necessary to report multiple additional co-existing conditions.		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
301	Code List Qualifier Code				R	HI04-1	TC	TC – Treatment Codes
301	Industry Code				R	HI04-2		Treatment Codes CODE SOURCE 359
301	Date Time Period Format Qualifier				Not Used	HI04-3		Not Used
301	Date Time Period				Not Used	HI04-4		Not Used
301	Monetary Amount				Not Used	HI04-5		Not Used
301	Quantity				Not Used	HI04-6		Not Used
301	Version Identifier				Not Used	HI04-7		Not Used
301	Health Care Code Information				S	HI05		Used when necessary to report multiple additional co-existing conditions.
301	Code List Qualifier Code				R	HI05-1	TC	TC – Treatment Codes
302	Industry Code				R	HI05-2		Treatment Codes CODE SOURCE 359
302	Date Time Period Format Qualifier				Not Used	HI05-3		Not Used
302	Date Time Period				Not Used	HI05-4		Not Used
302	Monetary Amount				Not Used	HI05-5		Not Used
302	Quantity				Not Used	HI05-6		Not Used
302	Version Identifier				Not Used	HI05-7		Not Used
302	Health Care Code Information				S	HI06		Used when necessary to report multiple additional co-existing conditions.
302	Code List Qualifier Code				R	HI06-1	TC	TC – Treatment Codes
302	Industry Code				R	HI06-2		Treatment Codes CODE SOURCE 359
302	Date Time Period Format Qualifier				Not Used	HI06-3		Not Used
302	Date Time Period				Not Used	HI06-4		Not Used
302	Monetary Amount				Not Used	HI06-5		Not Used
302	Quantity				Not Used	HI06-6		Not Used
302	Version Identifier				Not Used	HI06-7		Not Used
302	Health Care Code Information				S	HI07		Used when necessary to report multiple additional co-existing conditions.
302	Code List Qualifier Code				R	HI07-1	TC	TC – Treatment Codes
302	Industry Code				R	HI07-2		Treatment Codes CODE SOURCE 359
303	Date Time Period Format Qualifier				Not Used	HI07-3		Not Used
303	Date Time Period				Not Used	HI07-4		Not Used
303	Monetary Amount				Not Used	HI07-5		Not Used
303	Quantity				Not Used	HI07-6		Not Used
303	Version Identifier				Not Used	HI07-7		Not Used
303	Health Care Code Information				S	HI08		Used when necessary to report multiple additional co-existing conditions.
303	Code List Qualifier Code				R	HI08-1	TC	TC – Treatment Codes
303	Industry Code				R	HI08-2		Treatment Codes CODE SOURCE 359
303	Date Time Period Format Qualifier				Not Used	HI08-3		Not Used
303	Date Time Period				Not Used	HI08-4		Not Used
303	Monetary Amount				Not Used	HI08-5		Not Used
303	Quantity				Not Used	HI08-6		Not Used
303	Version Identifier				Not Used	HI08-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
303	Health Care Code Information		QTY		S	HI09		Used when necessary to report multiple additional co-existing conditions.
303	Code List Qualifier Code				R	HI09-1	TC	TC – Treatment Codes
304	Industry Code				R	HI09-2		Treatment Codes CODE SOURCE 359
304	Date Time Period Format Qualifier				Not Used	HI09-3		Not Used
304	Date Time Period				Not Used	HI09-4		Not Used
304	Monetary Amount				Not Used	HI09-5		Not Used
304	Quantity				Not Used	HI09-6		Not Used
304	Version Identifier				Not Used	HI09-7		Not Used
304	Health Care Code Information				S	HI10		Used when necessary to report multiple additional co-existing conditions.
304	Code List Qualifier Code				R	HI10-1	TC	TC – Treatment Codes
304	Industry Code				R	HI10-2		Treatment Codes CODE SOURCE 359
304	Date Time Period Format Qualifier				Not Used	HI10-3		Not Used
304	Date Time Period				Not Used	HI10-4		Not Used
304	Monetary Amount				Not Used	HI10-5		Not Used
304	Quantity				Not Used	HI10-6		Not Used
304	Version Identifier				Not Used	HI10-7		Not Used
304	Health Care Code Information				S	HI11		Used when necessary to report multiple additional co-existing conditions.
304	Code List Qualifier Code				R	HI11-1	TC	TC – Treatment Codes
304	Industry Code				R	HI11-2		Treatment Codes CODE SOURCE 359
305	Date Time Period Format Qualifier				Not Used	HI11-3		Not Used
305	Date Time Period				Not Used	HI11-4		Not Used
305	Monetary Amount				Not Used	HI11-5		Not Used
305	Quantity				Not Used	HI11-6		Not Used
305	Version Identifier				Not Used	HI11-7		Not Used
305	Health Care Code Information				S	HI12		Used when necessary to report multiple additional co-existing conditions.
305	Code List Qualifier Code				R	HI12-1	TC	TC – Treatment Codes
305	Industry Code				R	HI12-2		Treatment Codes CODE SOURCE 359
305	Date Time Period Format Qualifier				Not Used	HI12-3		Not Used
305	Date Time Period				Not Used	HI12-4		Not Used
305	Monetary Amount				Not Used	HI12-5		Not Used
305	Quantity				Not Used	HI12-6		Not Used
305	Version Identifier				Not Used	HI12-7		Not Used
306	Claim Quantity	S						

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
306	Quantity Qualifier				R	QTY01		CA – Covered – Actual CD – Co-insured – Actual LA – Life-time Reserve – Actual NA – Number of Non-covered Days
307	Quantity				R	QTY02		Claim Days Count
307	Composite Unit of Measure				R	QTY03		
307	Unit or Basis for Measurement Code				R	QTY03-1	DA	DA – Days
307	Exponent				Not Used	QTY03-2		Not Used
307	Multiplier				Not Used	QTY03-3		Not Used
307	Unit or Basis for Measurement Code				Not Used	QTY03-4		Not Used
307	Exponent				Not Used	QTY03-5		Not Used
307	Multiplier				Not Used	QTY03-6		Not Used
307	Unit or Basis for Measurement Code				Not Used	QTY03-7		Not Used
307	Exponent				Not Used	QTY03-8		Not Used
307	Multiplier				Not Used	QTY03-9		Not Used
307	Unit or Basis for Measurement Code				Not Used	QTY03-10		Not Used
307	Exponent				Not Used	QTY03-11		Not Used
307	Multiplier				Not Used	QTY03-12		Not Used
307	Unit or Basis for Measurement Code				Not Used	QTY03 – 13		Not Used
307	Exponent				Not Used	QTY03 – 14		Not Used
307	Multiplier				Not Used	QTY03 – 15		Not Used
307	Free-Form Message				Not Used	QTY04		Not Used
308	Claim Pricing/Repricing Information	S		HCP				For capitated encounters, pricing or repricing information usually is not applicable and is provided to qualify other information within the claim. This segment is used when the sender is required to provide the receiver with pricing or repricing information necessary to process the claim or encounter.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
309	Pricing Methodology				R	HCP01		00 – Zero Pricing (Not Covered Under Contract) 01 – Priced as Billed at 100% 02 – Priced at the Standard Fee Schedule 03 – Priced at a Contractual Percentage 04 – Bundled Pricing 05 – Peer Review Pricing 06 – Per Diem Pricing 07 – Flat Rate Pricing 08 – Combination Pricing 09 – Maternity Pricing 10 – Other Pricing 11 – Lower of Cost 12 – Ratio of Cost 13 – Cost Reimbursed 14 – Adjustment Pricing Trading partners need to agree on which codes to use in this element. There do not appear to be standard definitions for the code elements.
309	Monetary Amount				R	HCP02		Allowed Amount
310	Monetary Amount				R	HCP03		Repriced Saving Amount This data element is required when it is necessary to report Savings Amount on claims which have been priced or repriced.
310	Reference Identification				S	HCP04		Repricing Organization ID This data element is required when it is necessary to report Repricing Organization ID on claims which have been priced or repriced.
310	Rate				S	HCP05		Repricing Per Diem or Flat Rate Amount This data element is required when it is necessary to report Pricing Rate on claims which have been priced or repriced.
310	Reference Identification				S	HCP06		Approved DRG Code This data element is required when it is necessary to report Approved DRG Code on claims which have been priced or repriced.
310	Monetary Amount				S	HCP07		Repriced Approved Amount This data element is required when it is necessary to report Approved DRG Amount on claims which have been priced or repriced.
311	Product/Service ID				S	HCP08		Repriced Approved Revenue Code This data element is required when it is necessary to report Approved Revenue Code on claims which have been priced or repriced.
311	Product/Service ID Qualifier				S	HCP09	HC	Required when HCP10 exists. HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
311	Product/Service ID				S	HCP10		Repriced Approved HCPCS Code This data element is required when it is necessary to report Approved HCPCS Code on claims which have been priced or repriced.
311	Unit or Basis for Measurement Code				S	HCP11		DA – Days UN – Unit
312	Quantity				S	HCP12		Repriced Approved Service Unit Count This data element is required when it is necessary to report Approved Service Unit Count on claims which have been priced or repriced.
312	Reject Reason Code				S	HCP13		T1 – Cannot Identify Provider as TPO (Third Party Organization) Participant T2 – Cannot Identify Payer as TPO (Third Party Organization) Participant T3 – Cannot Identify Insured as TPO (Third Party Organization) Participant T4 – Payer Name or Identifier Missing T5 Certification Information Missing T6 – Claim does not contain enough information for re-pricing This data element is required when it is necessary to report Rejection Message on claims which have been priced or repriced.
312	Policy Compliance Code				S	HCP14		1 – Procedure Followed (Compliance) 2 – Not Followed – Call Not Made (Non-Compliance Call Not Made) 3 – Not Medically Necessary (Non-Compliance Non-Medically Necessary) 4 – Not Followed Other (Non-Compliance Other) 5 – Emergency Admit to Non-Network Hospital This data element is required when it is necessary to report Policy Compliance Code on claims which have been priced or repriced.
313	Exception Code				S	HCP15		1 – Non-Network Professional Provider in Network Hospital 2 – Emergency Care 3 – Services or Specialist not in Network 4 – Out-of-Service Area 5 – State Mandates 6 – Other This data element is required when it is necessary to report Exception Reason Code on claims which have been priced or repriced.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
314	Loop ID: 2305 Home Health Care Plan Information	S	242	CR7				This segment is required to convey Home Health Plan of Treatment information for this claim when applicable.
314	Discipline Type Code		<i>Not Used For Adjudication</i> CR7	CR7	R	CR701		AI – Home Health Aide MS – Medical Social Worker OT – Occupational Therapy PT – Physical Therapy SN – Skilled Nursing ST – Speech Therapy
315	Number				R	CR702		Visits Prior to Recertification Date Count
315	Number				R	CR703		Total Visits Projected This Certification Count
316	Health Care Services Delivery	S	HSD	CR7				Required on claims/encounters billing/reporting home health visits where further detail is necessary to clearly substantiate medical treatment.
317	Quantity Qualifier				S	HSD01		Required if the physician's order or prescription for the service contains the data.
317	Quantity				S	HSD02		Required if the physician's order or prescription for the service contains the data.
317	Unit or Basis for Measurement Code				S	HSD03		Required if the physician's order or prescription for the service Contains the data. DA – Days MO – Months Q1 – Quarter (Time) WK – Week
318	Sample Selection Modulus				S	HSD04		Required if the physician's order or prescription for the service contains the data.
318	Time Period Qualifier				S	HSD05		Absence of data indicates PRN orders. Required if the physician's order or prescription for the service contains the data. 7 – Day 35 – Week
318	Number of Periods		S	HSD06		Duration of Visits, Number of Units. Required if the physician's order or prescription for the service contains the data.		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
318	Ship/Delivery or Calendar Pattern Code				S	HSD07		1 – 1st Week of the Month 2 – 2nd Week of the Month 3 – 3rd Week of the Month 4 – 4th Week of the Month 5 – 5th Week of the Month 6 – 1st & 3rd Wks of Mo 7 – 2nd & 4th Wks of Mo 8 – 1st Working Day of Period 9 – Last Working Day of Period A – Mon through Fri B – Mon through Sat C – Mon through Sun D – Mon E – Tues F – Wed G – Thurs H – Fri J – Sat K – Sun L – Mon through Thurs N – As Directed O – Daily Mon. through Fri. S – Once Anytime Mon. through Fri. SA – Sun, Mon, Thurs, Fri, Sat SB – Tues through Sat SC – Sun, Wed, Thurs, Fri, Sat SD – Mon, Wed, Thurs, Fri, Sat SG – Tues through Fri SL – Mon, Tues and Thurs SP – Mon, Tues and Fri SX – Wed and Thurs SY – Mon, Wed and Thurs SZ – Tues, Thurs and Fri W – Whenever Necessary
320	Ship/Delivery Pattern Time Code				S	HSD08		D – A.M. E – P.M. F – As Directed
321	Loop ID: 2310A Attending Physician	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–2420 with the same value in NM101. Required on all inpatient claims or encounters. Required to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
322	Entity ID Code				R	NM101	71	The entity identifier in NM101 applies to all segments in Loop ID-2310. 71 – Attending Physician
322	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
322	Name Last or Organization Name				R	NM103		Attending Physician Last Name UB92 Reference [UB92 Name]: 82, Line b [Attending Physician ID]
322	Name First				S	NM104		UB92 Reference [UB92 Name]: 82, Line b [Attending Physician ID]
322	Name Middle				S	NM105		Required if NM102=1 and the middle name/initial of the person is known.
322	Name Prefix				Not Used	NM106		Not Used
323	Name Suffix				S	NM107		Required if known.
323	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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.
323	Identification Code				R	NM109		UB92 Reference [UB92 Name]: 82, Line a [Attending Physician ID]
323	Entity Relationship Code				Not Used	NM110		Not Used
323	Entity Identifier Code				Not Used	NM111		Not Used
324	Attending Physician Specialty Information Note: Segment must be populated with valid values. It is not used for adjudication. Same values is returned when applicable.	S	255	PRV				The PRV segment in Loop ID-2310 applies to the entire claim unless overridden on the service line level by the presence of a PRV segment with the same value in PRV01. Use code value AT to report the specialty of the attending physician. Use code value SU when the physician is responsible for the patient’s Home Health Plan of Treatment. Required when the billing provider is a billing service and taxonomy is known to impact the adjudication of the claim.
324	Provider Code Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.				R	PRV01		Code identifying type of provider AT – Attending SU – Supervising

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
325	Reference Identification Qualifier <i>Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.</i>				R	PRV02	ZZ	ZZ – Mutually Defined ZZ is used to identify “Health Care Provider Taxonomy” code list (provider specialty code).
325	Reference Identification <i>Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.</i>				R	PRV03		Provider Taxonomy Code. Code Set available on the Washington Publishing Company web site: http://www.wpc-edi.com .
325	State or Providence Code				Not Used	PRV04		Not Used
325	Provider Specialty Information				Not Used	PRV05		Not Used
325	Provider Organization Code				Not Used	PRV06		Not Used
326	Attending Physician 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.
326	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 E1 – Employer’s Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider Number
327	Reference Identification				R	REF02		Attending Physician Secondary Identifier
327	Description				Not Used	REF03		Not Used
327	Reference Identifier				Not Used	REF04		Not Used
328	Loop ID: 2310B Operating Physician	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–2420 with the same value in NM101. This segment is required when any surgical procedure code is listed on this claim.
329	Entity ID Code				R	NM101		The entity identifier in NM101 applies to all segments in Loop ID–2310.
							72	72 – Operating Physician
329	Entity Type Qualifier				R	NM102	1	1 – Person

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
329	Name Last or Organization Name				R	NM103		Operating Physician Last Name UB92 Reference [UB92 Name]: 83A, Line b [Other Physician ID]
329	Name First				S	NM104		Operating Physician First Name UB92 Reference [UB92 Name]: 83A, Line b [Other Physician ID]
329	Name Middle				S	NM105		Required if NM102=1 and the middle name/initial of the person is known by the provider.
329	Name Prefix				Not Used	NM106		Not Used
329	Name Suffix				S	NM107		Required if known.
330	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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.
330	Identification Code				R	NM109		UB92 Reference [UB92 Name]: 83A, Line a [Other Physician ID]
330	Entity Relationship Code				Not Used	NM110		Not Used
330	Entity Identifier Code				Not Used	NM111		Not Used
333	Operating Physician 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.
333	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 E1 – Employer’s Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare X6 – State Industrial Accident Provider Number
334	Reference Identification				R	REF02		Attending Physician Secondary Identifier
334	Description				Not Used	REF03		Not Used
334	Reference Identifier				Not Used	REF04		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
335	Loop ID: 2310C Other Provider Name	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–2420 with the same value in NM101. Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider.
336	Entity ID Code		<i>Not Used For Adjudication</i> NM1		R	NM101	73	The entity identifier in NM101 applies to all segments in Loop ID–2310. 73 – Other Physician
336	Entity Type Qualifier				R	NM102		1 – Person 2 – Non–Person Entity
336	Name Last or Organization Name				R	NM103		Other Physician Last Name UB92 Reference [UB92 Name]: 83B, Line b [Other Physician ID]
336	Name First				S	NM104		Other Physician First Name UB92 Reference [UB92 Name]: 83B, Line b [Other Physician ID]
337	Name Middle				S	NM105		Required if NM102=1 and the middle name/initial of the person is known by the provider.
337	Name Prefix				Not Used	NM106		Not Used
337	Name Suffix				S	NM107		Required if known.
337	Identification Code Qualifier				R	NM108		24 – Employer's Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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.
337	Identification Code				R	NM109		UB92 Reference [UB92 Name]: 83B, Line a [Other Physician ID]
337	Entity Relationship Code				Not Used	NM110		Not Used
337	Entity Identifier Code				Not Used	NM111		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
340	Reference Identification Qualifier		REF		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 EI – Employer’s Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider Number
341	Reference Identification				R	REF02		Other Provider Secondary Identifier
341	Description				Not Used	REF03		Not Used
341	Reference Identifier				Not Used	REF04		Not Used
349	Loop ID: 2310E Service Facility Name	S	250	NM1				This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-To Provider) loops.
350	Entity ID Code				R	NM101	FA	FA – Facility
350	Entity Type Qualifier				R	NM102	2	2 – Non–Person Entity
350	Name Last or Organization Name				R	NM103		Laboratory or Facility Name
350	Name First				Not Used	NM104		Not Used
350	Name Middle				Not Used	NM105		Not Used
350	Name Prefix				Not Used	NM106		Not Used
350	Name Suffix				Not Used	NM107		Not Used
350	Identification Code Qualifier				S	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims XX – HCFA National Provider ID
350	Identification Code				S	NM109		Laboratory or Facility Primary Identifier Required if either Employer’s Identification/Social Security Number or National Provider Identifier is known.
350	Entity Relationship Code				Not Used	NM110		Not Used
351	Entity Identifier Code				Not Used	NM111		Not Used
354	Service Facility Address	R	265	N3				
354	Address Information				R	N301		Laboratory or Facility Address Line
354	Address Information				S	N301		Required if second address line exists
355	Service Facility City/State/Zip Code	R	270	N4				
355	City Name				R	N401		Laboratory or Facility City Name
355	State or Province Code				R	N402		Laboratory or Facility State or Province Code
356	Postal Code				R	N403		Laboratory or Facility Postal Zone or ZIP Code

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
356	Country Code				S	N404		Required if the address is out of the U.S.
356	Location Qualifier				Not Used	N405		Not Used
356	Location Identifier				Not Used	N406		Not Used
357	Service Facility 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.
357	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 1J – Facility ID Number EI – Employer’s Identification Number FH – Clinic Number G2 – Provider Commercial Number G5 – Provider Site Number LU – Location Number N5 – Provider Plan Network Identification Number X5 – State Industrial Accident Provider Number
358	Reference Identification				R	REF02		Laboratory or Facility Secondary Identifier
358	Description				Not Used	REF03		Not Used
358	Reference Identifier				Not Used	REF04		Not Used
359	Loop ID: 2320 Other Subscriber Information	S	290	SBR				Required if other payers are known to potentially be involved in paying on this claim.
360	Payer Responsibility Sequence Number Code				R	SBR01		P – Primary S – Secondary T – Tertiary (Used to indicate “payer of last resort”.)

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
361	Individual Relationship Code				R	SBR02		01 – Spouse 04 – Grandfather or Grandmother 05 – Grandson or Granddaughter 07 – Nephew or Niece 10 – Foster Child 15 – Ward 17 – Stepson or Stepdaughter 18 – Self 19 – Child 20 – Employee 21 – Unknown 22 – Handicapped Dependent 23 – Sponsored Dependent 24 – Dependent of a Minor Dependent 29 – Significant Other 32 – Mother 33 – Father 36 – Emancipated Minor 39 – Organ Donor 40 – Cadaver Donor 41 – Injured Plaintiff 43 – Child Where Insured Has No Financial Responsibility 53 – Life Partner G8 – Other Relationship Use this code to specify the patient's relationship to the person insured.
363	Reference Identification				S	SBR03		Use this element to carry the subscriber's group number but not the number that uniquely identifies the subscriber.
363	Name				S	SBR04		This data element is required when the Provider has the Plan Name (Group Name) within their files.
363	Insurance Type Code				Not Used	SBR05		Not Used
363	Coordination of Benefits Code				Not Used	SBR06		Not Used
363	Yes/No Condition or Response Code				Not Used	SBR07		Not Used
363	Employment Status Code				Not Used	SBR08		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
363	Claim Filing Indicator Code <i>Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.</i>				S	SBR09		09 – Self-pay 10 – Central Certification 11 – Other Non-Federal Programs 12 – Preferred Provider Org. 13 – Point of Service 14 – Exclusive Provider Org. 15 – Indemnity Insurance 16 – HMO Medicare Risk AM – Automobile Medical BL – Blue Cross/Blue Shield CH – Champus CI – Commercial Insurance Co. DS – Disability HM – Health Maintenance Organization LI – Liability LM – Liability Medical MA – Medicare Part A MB – Medicare Part B MC – Medicaid OF – Other Federal Program TV – Title V VA – Veteran Administration Plan WC – Workers' Compensation Health Claim ZZ – Mutually Defined Required prior to mandated use of Plan ID. Not used after PlanID is mandated.
365	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.
367	Claim Adjustment Group Code				R	CAS01		CO – Contractual Obligations CR – Correction and Reversals OA – Other adjustments PI – Payer Initiated Reductions PR – Patient Responsibility Code identifying the general category of payment adjustment
367	Claim Adjustment Reason Code				R	CAS02		Code Source 139: Claim Adjustment Reason Code
367	Monetary Amount				R	CAS03		Adjustment Amount
367	Quantity				S	CAS04		Use this number for the units of service being adjusted.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
368	Claim Adjustment Reason Code				S	CAS05		Used when additional adjustment information applies to claim.
368	Monetary Amount				S	CAS06		
368	Quantity				S	CAS07		Use this number for the units of service being adjusted.
368	Claim Adjustment Reason Code				S	CAS08		Used when additional adjustment information applies to claim.
368	Monetary Amount				S	CAS09		
369	Quantity				S	CAS10		Use this number for the units of service being adjusted.
369	Claim Adjustment Reason Code				S	CAS11		Used when additional adjustment information applies to claim.
369	Monetary Amount				S	CAS12		
369	Quantity				S	CAS13		Use this number for the units of service being adjusted.
369	Claim Adjustment Reason Code				S	CAS14		Used when additional adjustment information applies to claim.
370	Monetary Amount				S	CAS15		
370	Quantity				S	CAS16		Use this number for the units of service being adjusted.
370	Claim Adjustment Reason Code				S	CAS17		Used when additional adjustment information applies to claim.
370	Monetary Amount				S	CAS18		
370	Quantity				S	CAS19		Use this number for the units of service being adjusted.
371	Payer Prior Payment	S	300	AMT				The amount this payer has paid to the provider towards this bill. This segment is required when the present payer has paid an amount to the provider towards this bill.
371	Amount Qualifier Code				R	AMT01	C4	C4 – Prior Payment – Actual
371	Monetary Amount				R	AMT02		UB92 Reference [UB92 Name]: 54 (A-C) [Prior Payments – Payers and Patient]
371	Credit/Debit Flag Code				Not Used	AMT03		Not Used
372	Coordination of Benefits (COB) Total Allowed Amount	S		Not Used For Adjudication AMT				This segment is for COB use. This segment is used to convey the COB Total Allowed Amount applicable to this claim when known.
372	Amount Qualifier Code				R	AMT01	B6	B6 – Allowed – Actual
372	Monetary Amount				R	AMT02		Allowed Amount
372	Credit/Debit Flag Code				Not Used	AMT03		Not Used
373	Coordination of Benefits (COB) Total Submitted Charges	S						This segment is for COB use. This segment is used to convey the COB Total Submitted Charges applicable to this claim when known.
373	Amount Qualifier Code				R	AMT01	T3	T3 – Total Submitted Charges

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
373	Monetary Amount				R	AMT02		Coordination of Benefits Total Submitted Charge Amount
373	Credit/Debit Flag Code				Not Used	AMT03		Not Used
374	Diagnostic Related Group (DRG) Outlier Amount	S						This segment is for COB use. This segment is used to convey the DRG Outlier Amount applicable to this claim when known.
374	Amount Qualifier Code				R	AMT01	ZZ	ZZ – Mutually Defined
375	Monetary Amount				R	AMT02		Claim DRG Outlier Amount
375	Credit/Debit Flag Code				Not Used	AMT03		Not Used
376	Coordination of Benefits (COB) Total Medicare Paid Amount	S	300	AMT				This segment is for COB use. This segment is used to convey the COB Total Medicare Paid Amount applicable to this claim when known.
376	Amount Qualifier Code				R	AMT01	N1	N1 – Net Worth
377	Monetary Amount				R	AMT02		Total Medicare Paid Amount
377	Credit/Debit Flag Code				Not Used	AMT03		Not Used
378	Medicare Paid Amount – 100%	S	300	AMT				This segment is for COB use. This segment is used to convey the COB Medicare Paid Amount –100% applicable to this claim when known.
378	Amount Qualifier Code				R	AMT01	KF	KF – Net Paid Amount
378	Monetary Amount				R	AMT02		Medicare Paid at 100% Amount
379	Credit/Debit Flag Code				Not Used	AMT03		Not Used
380	Medicare Paid Amount – 80%	S	300	AMT				This segment is for COB use. This segment is used to convey the COB Medicare Paid Amount –80% applicable to this claim when known.
380	Amount Qualifier Code				R	AMT01	PG	PG – Payoff
380	Monetary Amount				R	AMT02		Medicare Paid at 80% Amount
381	Credit/Debit Flag Code				Not Used	AMT03		Not Used
382	Coordination of Benefits (COB) Medicare A Trust Fund Paid Amount	S	300	AMT				This segment is for COB use. This segment is used to convey the COB Medicare A Trust Fund Paid Amount applicable to this claim when known.
382	Amount Qualifier Code				R	AMT01	AA	AA – Allocated
383	Monetary Amount				R	AMT02		Paid From Part A Medicare Trust Fund Amount
383	Credit/Debit Flag Code				Not Used	AMT03		Not Used
384	Coordination of Benefits (COB) Medicare B Trust Fund Paid Amount	S	300	AMT				This segment is for COB use. This segment is used to convey the COB Medicare B Trust Fund Paid Amount applicable to this claim when known.
384	Amount Qualifier Code				R	AMT01	B1	B1 – Benefit Amount
385	Monetary Amount				R	AMT02		Paid From Part B Medicare Trust Fund Amount
385	Credit/Debit Flag Code				Not Used	AMT03		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description		
386	Coordination of Benefits (COB) Total Non-Covered Amount	S	305	DMG	Not Used For Adjudication AMT			This segment is for COB use. This segment is used to convey the COB Total Non-Covered Amount applicable to this claim when known.		
386	Amount Qualifier Code					R	AMT01	A8	A8 – Noncovered Charges – Actual	
386	Monetary Amount					R	AMT02		Non-Covered Charge Amount	
386	Credit/Debit Flag Code					Not Used	AMT03		Not Used	
387	Coordination of Benefits (COB) Total Denied Amount	S								This segment is for COB use. This segment is used to convey the COB Total Denied Amount applicable to this claim when known.
387	Amount Qualifier Code					R	AMT01	YT	YT – Denied	
387	Monetary Amount					R	AMT02		Claim Total Denied Charge Amount	
387	Credit/Debit Flag Code					Not Used	AMT03		Not Used	
388	Other Subscriber Demographic Information	S								Required when 2330A – Other Subscriber Name NM102 = 1.
388	Date Time Period Format Qualifier				R	DMG01	D8	D8 – Date Expressed in Format CCYYMMDD		
389	Date Time Period				R	DMG02		Other Insured Birth Date		
389	Gender Code				R	DMG03		Other Insured Gender Code F – Female M – Male U – Unknown		
389	Marital Status Code				Not Used	DMG04		Not Used		
389	Race or Ethnicity Code				Not Used	DMG05		Not Used		
389	Citizenship Status Code				Not Used	DMG06		Not Used		
389	Country Code				Not Used	DMG07		Not Used		
389	Basis of Verification Code				Not Used	DMG08		Not Used		
389	Quantity				Not Used	DMG09		Not Used		
390	Other Insurance Coverage Information	R	310	OI				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.		
390	Claim Filing Indicator Code				Not Used	OI01		Not Used		
390	Claim Submission Reason Code				Not Used	OI02		Not Used		
390	Yes/No Condition or Response Code Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.				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		
391	Patient Signature Source Code				Not Used	OI04		Not Used		
391	Provider Agreement Code				Not Used	OI05		Not Used		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
391	Release of Information Code				R	OIO6		A – Appropriate Release of Information on File at Health Care Service Provider or at Utilization Review Organization I – Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes M – The Provider has Limited or Restricted Ability to Release Data Related to a Claim N – No, Provider is Not Allowed to Release Data O – On file at Payer or at Plan Sponsor Y – Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
392	Medicare Inpatient Adjudication Information	S						This segment is used to convey the Medicare Inpatient Adjudication Information if returned in the 835.
393	Quantity		Not Used For Adjudication MIA		R	MIA01		Covered Days or Visits Count
393	Quantity			S	MIA02		Lifetime Reserve Days Count Use this quantity to indicate the lifetime reserve days.	
393	Quantity			S	MIA03		Lifetime Psychiatric Days Count	
393	Monetary Amount			S	MIA04		Claim DRG Amount Use this amount to indicate the Diagnosis Related Group (DRG) amount.	
393	Reference Identification			S	MIA05		Remark Code. Use this reference identification for the Health Care Financing Administration claim payment remark code.	
393	Monetary Amount			S	MIA06		Use this amount to indicate the disproportionate share amount.	
394	Monetary Amount			S	MIA07		Use this amount to indicate the Medicare Secondary Payer (MSP) pass-through amount.	
394	Monetary Amount			S	MIA08		Use this amount to indicate the Total Prospective Payment System (PPS) capital amount.	
394	Monetary Amount			S	MIA09		Use this amount to indicate the Prospective Payment System (PPS) capital, federal-specific portion, Diagnosis Related Group (DRG) amount.	
394	Monetary Amount			S	MIA10		Use this amount to indicate the Prospective Payment System (PPS) capital, hospital-specific portion, Diagnosis Related Group (DRG) amount.	
394	Monetary Amount			S	MIA11		Use this amount to indicate the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.	
394	Monetary Amount			S	MIA12		Use this amount to indicate the old capital amount.	
395	Monetary Amount			S	MIA13		Use this amount to indicate the Prospective Payment System (PPS) capital indirect medical education claim amount.	
395	Monetary Amount			S	MIA14		Use this amount to indicate the hospital-specific, Diagnosis Related Group (DRG) amount.	

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
395	Quantity		MOA		S	MIA15		Cost Report Day Count
395	Monetary Amount				S	MIA16		Use this amount to indicate the federal-specific, Diagnosis Related Group (DRG) amount.
395	Monetary Amount				S	MIA17		Use this amount to indicate the Prospective Payment System (PPS) Capital Outlier amount.
395	Monetary Amount				S	MIA18		Claim Indirect Teaching Amount. Use this amount to indicate the indirect teaching amount.
395	Monetary Amount				S	MIA19		Nonpayable Professional Component Amount. Use this amount to indicate the professional component amount billed but not payable.
396	Reference Identification				S	MIA20		Use this reference identification for the Health Care Financing Administration claim payment remark code.
396	Reference Identification				S	MIA21		Use this reference identification for the Health Care Financing Administration claim payment remark code.
396	Reference Identification				S	MIA22		Use this reference identification for the Health Care Financing Administration claim payment remark code.
396	Reference Identification				S	MIA23		Use this reference identification for the Health Care Financing Administration claim payment remark code.
396	Monetary Amount				S	MIA24		Use this amount to indicate the capital exception amount.
397	Medicare Outpatient Adjudication Information	S						Required to convey the Medicare Outpatient Adjudication Information if returned in the Electronic Remittance Advice (835).
397	Percent				S	MOA01		Reimbursement Rate Required if returned on the Electronic Remittance Advice (835).
398	Monetary Amount				S	MOA02		Use this amount to indicate the Claim HCFA Common Procedural Coding System (HCPCS) payable amount. Required if returned on the Electronic Remittance Advice (835).
398	Reference Identification				S	MOA03		Use this reference identification for the HCFA claim payment remark code. Required if returned on the Electronic Remittance Advice (835).
398	Reference Identification				S	MOA04		Use this reference identification for the HCFA claim payment remark code. Required if returned on the Electronic Remittance Advice (835).
398	Reference Identification				S	MOA05		Use this reference identification for the HCFA claim payment remark code. Required if returned on the Electronic Remittance Advice (835).

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
399	Reference Identification				S	MOA06		Use this reference identification for the HCFA claim payment remark code. Required if returned on the Electronic Remittance Advice (835).
399	Reference Identification				S	MOA07		Use this reference identification for the HCFA claim payment remark code. Required if returned on the Electronic Remittance Advice (835).
399	Monetary Amount				S	MOA08		Use this amount to indicate the End Stage Renal Disease (ESRD) payment amount. Required if returned on the Electronic Remittance Advice (835).
399	Monetary Amount				S	MOA09		Use this amount to indicate the professional component amount billed but not payable. Required if returned on the Electronic Remittance Advice (835).
400	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.
401	Entity ID Code				R	NM101	IL	IL – Insured or Subscriber
401	Entity Type Qualifier				R	NM102		1 – Person 2 – Non–Person Entity
401	Name Last or Organization Name				R	NM103		Other Insured Last Name UB92 Reference [UB92 Name]: 58 (A–C) [Insured’s Name]
401	Name First				S	NM104		Other Insured First Name UB92 Reference [UB92 Name]: 58 (A–C) [Insured’s Name]
402	Name Middle				S	NM105		Other Insured Middle Name UB92 Reference [UB92 Name]: 58 (A–C) [Insured’s Name]
402	Name Prefix				Not Used	NM106		Not Used
402	Name Suffix				S	NM107		Required if known.
402	Identification Code Qualifier				R	NM108		MI – Member Identification Number ZZ – Mutually Defined
403	Identification Code				R	NM109		Other Insured Identifier UB92 Reference [UB92 Name]: 60 (A–C) [Certificate/SSN/ Health Insurance Claim/ Id Number]
403	Entity Relationship Code				Not Used	NM110		Not Used
403	Entity Identifier Code				Not Used	NM111		Not Used
404	Other Subscriber Address	S		Not				This segment is required when the Provider has the Other Subscriber Address information on file.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description		
404	Address Information		Used For Adjudication	N3	R	N301		Other Insured Address Line UB92 Reference [UB92 Name]: 84, Line b [Remarks]		
405	Address Information				S	N302		Required if second address line exists		
406	Other Subscriber City/State/Zip Code	S			N4				This segment is required when the associated N3 segment is present.	
406	City Name					R	N401		Other Insured City Name	
407	State or Province Code					R	N402		Other Insured State Code	
407	Postal Code					R	N403		Other Insured Postal Zone or ZIP Code	
407	Country Code					S	N404		Required when address is outside the U.S.	
407	Location Qualifier					Not Used	N405		Not Used	
407	Location Identifier					Not Used	N406		Not Used	
408	Other Subscriber Secondary Identification	S				REF				This segment is required when additional identification numbers are required.
408	Reference Identification Qualifier						R	REF01		1W – Member Identification Number 23 – Client Number IG – Insurance Policy Number SY – Social Security Number: SY may not be used for Medicare
409	Reference Identification						R	REF02		Other Insured Additional Identifier
409	Description						Not Used	REF03		Not Used
409	Reference Identifier		Not Used	REF04				Not Used		
410	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.	
410	Entity ID Code				R		NM101	PR – Payer		
411	Entity Type Qualifier				R		NM102	2 – Non–Person Entity		
411	Name Last or Organization Name				R	NM103	Other Payer Last or Organization Name			
411	Name First				Not Used	NM104	Not Used			
411	Name Middle				Not Used	NM105	Not Used			
411	Name Prefix				Not Used	NM106	Not Used			
411	Name Suffix				Not Used	NM107	Not Used			
411	Identification Code Qualifier <i>Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.</i>				R	NM108	PI – Payer Identification XV – Health Care Financing Administration National Plan ID			
411	Identification Code <i>Note: Field must be populated with a valid value. It is not used for adjudication. Same value is returned when applicable.</i>				R	NM109	This number must be identical to SVD01 (Loop ID – 2430) for COB.			
411	Entity Relationship Code				Not Used	NM110	Not Used			
411	Entity Identifier Code				Not Used	NM111	Not Used			

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description		
412	Other Payer Address	S	Not Used For Adjudication	N3				This segment is only to be used when the Provider needs to identify the address for paper claim printing purposes.		
412	Address Information				R	N301			Other Payer Address Line	
412	Address Information				S	N302			Other Payer Address Line. Required if a second address line exists.	
413	Other Payer City/State/Zip Code	S			R	N401			Other Payer City Name	
414	City Name				R	N402			Other Payer State Code	
414	State or Province Code				R	N403			Other Payer Postal Zone or ZIP Code	
414	Postal Code				S	N404			Required when address is outside the U.S.	
414	Country Code				Not Used	N405			Not Used	
414	Location Qualifier				Not Used	N406			Not Used	
415	Claim Adjudication Date	S			DTP					This segment is required when Loop-ID 2430 (Line Adjudication Date) is not used and this payer has adjudicated the claim.
415	Date/Time Qualifier					R	DTP01	573		573 – Date Claim Paid
415	Date Time Period Format Qualifier					R	DTP02	D8		D8 – Date Expressed in Format CCYYMMDD
415	Date Time Period				R	DTP03			Adjudication or Payment Date	
416	Other Payer Secondary Identification and Reference Number	S			REF					This segment is required when a secondary number is needed to identify the payer. Used when it is necessary to identify the 'other' payer's claim number in a payer-to-payer COB situation (use code F8).
416	Reference Identification Qualifier		R	REF01				2U – Payer Identification Number F8 – Original Reference Number FY – Claim Office Number NF – National Association of Insurance Commissioners (NAIC) Code TJ – Federal Taxpayer's Identification Number		
417	Reference Identification		R	REF02				Other Payer Secondary Identifier		
417	Description		Not Used	REF03				Not Used		
417	Reference Identifier		Not Used	REF04				Not Used		
418	Other Payer Prior Authorization or Referral Number	S						Used when the payer identified in this loop has given a prior authorization or referral number to this claim. Primarily, this element is used in payer-to-payer COB situations. There can only be a maximum of three REF segments in any one iteration of the 2330 loop.		
418	Reference Identification Qualifier			R	REF01			9F – Referral Number G1 – Prior Authorization Number		
419	Reference Identification			R	REF02			Other Payer Prior Authorization or Referral Number		
419	Description			Not Used	REF03			Not Used		
419	Reference Identifier			Not Used	REF04			Not Used		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description	
420	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.	
421	Entity ID Code		<i>Not Used For Adjudication</i> NM1		R	NM101	QC	QC – Patient	
421	Entity Type Qualifier				R	NM102	1	1 – Person	
421	Name Last or Organization Name				Not Used	NM103		Not Used	
421	Name First				Not Used	NM104		Not Used	
421	Name Middle				Not Used	NM105		Not Used	
421	Name Prefix				Not Used	NM106		Not Used	
421	Name Suffix				Not Used	NM107		Not Used	
421	Identification Code Qualifier				R	NM108		EI – Employee Identification Number MI – Member Identification Number	
421	Identification Code				R	NM109		Other Payer Patient Primary Identifier	
421	Entity Relationship Code				Not Used	NM110		Not Used	
421	Entity Identifier Code				Not Used	NM111		Not Used	
422	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.	
422	Reference Identification Qualifier				R	REF01		1W – Member Identification Number IG – Insurance Policy Number SY – Social Security Number: SY may not be used for Medicare	
423	Reference Identification				R	REF02		Other Payer Patient Secondary Identifier	
423	Description				Not Used	REF03		Not Used	
423	Reference Identifier				Not Used	REF04		Not Used	
424	Loop ID: 2330D Other Payer Attending Provider	S		325	NM1				Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
425	Entity ID Code			<i>Not Used For Adjudication</i> NM1		R	NM101	71	71 – Attending Physician
425	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity	
425	Name Last or Organization Name				Not Used	NM103		Not Used	
425	Name First				Not Used	NM104		Not Used	
425	Name Middle				Not Used	NM105		Not Used	
425	Name Prefix				Not Used	NM106		Not Used	
425	Name Suffix				Not Used	NM107		Not Used	
425	Identification Code Qualifier				R	NM108		EI – Employee Identification Number MI – Member Identification Number	

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description		
425	Identification Code		REF		R	NM109		Other Payer Patient Primary Identifier		
425	Entity Relationship Code				Not Used	NM110		Not Used		
425	Entity Identifier Code				Not Used	NM111		Not Used		
426	Other Payer Attending Provider Identification	R							Non-destination (COB) payers' provider identification number(s).	
426	Reference Identification Qualifier				R	REF01			1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1G – Provider UPIN Number 1H – CHAMPUS Identification Number E1 – Employer's Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number	
427	Reference Identification				R	REF02			Other Payer Attending Provider Identifier	
427	Description				Not Used	REF03			Not Used	
427	Reference Identifier				Not Used	REF04			Not Used	
428	Loop ID: 2330E Other Payer Operating Provider	S			325	NM1				Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.
429	Entity ID Code				<i>Not Used For Adjudication</i> NM1		R	NM101	72	72 – Operating Physician
429	Entity Type Qualifier		R	NM102			1	1 – Person		
429	Name Last or Organization Name		Not Used	NM103				Not Used		
429	Name First		Not Used	NM104				Not Used		
429	Name Middle		Not Used	NM105				Not Used		
429	Name Prefix		Not Used	NM106				Not Used		
429	Name Suffix		Not Used	NM107				Not Used		
429	Identification Code Qualifier		Not Used	NM108				Not Used		
429	Identification Code		Not Used	NM109				Not Used		
429	Entity Relationship Code		Not Used	NM110				Not Used		
429	Entity Identifier Code		Not Used	NM111				Not Used		
430	Other Payer Attending Provider Identification	R	REF					To specify identifying information.		
430	Reference Identification Qualifier				R	REF01			1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1G – Provider UPIN Number 1H – CHAMPUS Identification Number E1 – Employer's Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number	
431	Reference Identification				R	REF02		Other Payer Operating Provider Identifier		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description	
431	Description				Not Used	REF03		Not Used	
431	Reference Identifier				Not Used	REF04		Not Used	
432	Loop ID: 2330F Other Payer Other Provider	S	325	NM1				Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.	
433	Entity ID Code		<i>Not Used For Adjudication</i>	NM1	R	NM101	73	73 – Other Physician	
433	Entity Type Qualifier				R	NM102			1 – Person 2 – Non-Person Entity
433	Name Last or Organization Name				Not Used	NM103			Not Used
433	Name First				Not Used	NM104			Not Used
433	Name Middle				Not Used	NM105			Not Used
433	Name Prefix				Not Used	NM106			Not Used
433	Name Suffix				Not Used	NM107			Not Used
433	Identification Code Qualifier				Not Used	NM108			Not Used
433	Identification Code				Not Used	NM109			Not Used
433	Entity Relationship Code				Not Used	NM110			Not Used
433	Entity Identifier Code				Not Used	NM111			Not Used
434	Other Payer Other Provider Identification	R	REF					Non-destination (COB) payers' provider identification number(s).	
434	Reference Identification Qualifier			R	REF01			1A – Blue Cross Provider Number 1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number 1G – Provider UPIN Number 1H – CHAMPUS Identification Number E1 – Employer's Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare	
435	Reference Identification			R	REF02			Other Payer Other Provider Identifier	
435	Description			Not Used	REF03			Not Used	
435	Reference Identifier			Not Used	REF04			Not Used	
440	Loop ID: 2330H Other Payer Service Facility Provider	S	325	NM1				Used when it is necessary to send an additional payer-specific provider identification number for non-destination (COB) payers.	
441	Entity ID Code		<i>Not Used For Adjudication</i>	NM1	R	NM101	FA	FA – Facility	
441	Entity Type Qualifier				R	NM102	2		2 – Non-Person Entity
441	Name Last or Organization Name				Not Used	NM103			Not Used
441	Name First				Not Used	NM104			Not Used
441	Name Middle				Not Used	NM105			Not Used
441	Name Prefix				Not Used	NM106			Not Used
441	Name Suffix				Not Used	NM107			Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
441	Identification Code Qualifier		REF		Not Used	NM108		Not Used
441	Identification Code				Not Used	NM109		Not Used
441	Entity Relationship Code				Not Used	NM110		Not Used
441	Entity Identifier Code				Not Used	NM111		Not Used
442	Other Payer Service Facility Provider Identification	R						Non-destination (COB) payers' provider identification number(s).
442	Reference Identification Qualifier				R	REF01		1B – Blue Shield Provider Number 1C – Medicare Provider Number 1D – Medicaid Provider Number E1 – Employer's Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number
443	Reference Identification				R	REF02		Other Payer Service Facility Provider Identifier
443	Description				Not Used	REF03		Not Used
443	Reference Identifier				Not Used	REF04		Not Used

Table 2b — Detail — Service Line

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
444	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 are not returned in the 835 (Remittance Advice) transaction. It is used to indicate bundling/ unbundling in SVC06.
444	Assigned Number				R	LX01		This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.
445	Institutional Service Line	R	375	SV2				This segment is required for inpatient claims or outpatient or other claims that require procedure or drug information to be reported for claim adjudication.
446	Product/Service ID				R	SV201		Service Line Revenue Code UB92 Reference [UB92 Name]: 42 [Revenue Code]
446	Composite Medical Procedure Identifier				S	SV202		Service Line Procedure Code. This data element is required for outpatient claims when an appropriate HCPCS exists for the service line item. UB92 Reference [UB92 Name]: 44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]
446	Product/Service ID Qualifier				R	SV202-1		The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410. HC – HCFA Common Procedural Coding System (HCPCS) Codes IV – Home Infusion EDI Coalition (HIEC) Product/Service Code (not allowed for use under HIPAA at the time of the addenda, see notes in guide) ZZ – Mutually Defined
447	Product/Service ID				R	SV202-2		Procedure Code UB92 Reference [UB92 Name]: 44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]
447	Procedure Modifier				S	SV202-3		This data element is required when the Provider needs to convey additional clarification for the associated procedure code. UB92 Reference [UB92 Name]: 44 (HCPCS) [HCPCS/Rates/HIPPS Rate Codes]
447	Procedure Modifier				S	SV202-4		See SV202-3
448	Procedure Modifier				S	SV202-5		See SV202-3
448	Procedure Modifier				S	SV202-6		See SV202-3
448	Description				Not Used	SV202-7		Not Used

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
448	Monetary Amount				R	SV203		Service Line Charge Amount UB92 Reference [UB92 Name]: 47 [Total Charges (by Revenue Code Category)]
448	Unit or Basis for Measurement Code				R	SV204		DA – Days F2 – International Unit UN – Unit
449	Quantity				R	SV205		UB92 Reference [UB92 Name]: 46 [Units of Service]
449	Unit Rate				S	SV206		Service Line Rate Amount This data element is required when the associated revenue code is 100–219.
449	Monetary Amount				S	SV207		Service Line Non–Covered Charge Amount UB92 Reference [UB92 Name]: 48 [Non–Covered Charges]
449	Yes/No Condition or Response Code				Not Used	SV208		Not Used
449	Nursing Home Residential Status Code				Not Used	SV209		Not Used
449	Level of Care Code				Not Used	SV210		Not Used
452	Line Supplemental Information	S						The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST–SE envelope unless reporting Home Infusion (see codes AD & AF in PWK02).
453	Report Type Code				R	PWK01		AS – Admission Summary B2 – Prescription B3 – Physician Order B4 – Referral Form CT – Certification DA – Dental Models DG – Diagnostic Report DS – Discharge Summary EB – Explanation of Benefits (COB or Medicare Secondary Payer) MT – Models NN – Nursing Notes OB – Operative Note OZ – Support Data for Claim PN – Physical Therapy Notes PO – Prosthetics or Orthotic Certification PZ – Physical Therapy Certification RB – Radiology Films RR – Radiology Reports RT – Report of Tests and Analysis Report

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
454	Report Transmission Code				R	PWK02		Attachment Transmission Code AA – Available on Request at Provider Site AB – Previously Submitted to Payer AD – Certification Included in this Claim AF – Narrative Segment Included in this Claim AG – No Documentation is Required BM – By Mail EL – Electronically Only EM – E-Mail FX – By Fax
454	Report Copies Needed				Not Used	PWK03		Not Used
454	Entity Identifier Code				Not Used	PWK04		Not Used
454	Identification Code Qualifier				S	PWK05	AC	Required if PWK02 = “BM”, “EL”, “EM” or “FX” AC = Attachment Control Number
454	Identification Code				S	PWK06		Attachment Control Number Required if PWK02 = “BM”, “EL”, “EM” or “FX”
455	Description				Not Used	PWK07		Not Used
455	Actions Indicated				Not Used	PWK08		Not Used
455	Request Category Code				Not Used	PWK09		Not Used
456	Service Line Date	S	455	DTP				Required on outpatient claims when revenue, procedure, HIEC or drug codes are reported in the SV2 segment. In cases where a drug is being billed on a service line, the Date of Service DTP may be used to indicate the range of dates through which the drug is used by the patient. Use RD8 for this purpose. In cases where a drug is being billed on a service line, the Date of Service DTP is used to indicate the date the prescription was written (or otherwise communicated by the prescriber if not written). Assessment Date DTP is not used when this segment is present.
456	Date/Time Qualifier				R	DTP01	472	472 – Service
457	Date Time Period Format Qualifier				R	DTP02		D8 – Date Expressed in Format CCYYMMDD RD8 – Range of Dates Expressed in Format CCYYMMDD – CCYYMMDD
457	Date Time Period				R	DTP03		UB92 Reference [UB92 Name]: 45 [Service Date]

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description		
458	Assessment Date	S	Not Used For Adjudication DTP					Required when an assessment date is necessary (i.e., Medicare PPS processing). Refer to Code Source 132 National Uniform Billing Committee (NUBC) Codes for instructions on the use of this date. Service date DTP is not used when this segment is present.		
458	Date/Time Qualifier				R	DTP01	866	866 – Examination		
458	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD		
459	Date Time Period				R	DTP03		UB92 Reference [UB92 Name]: 45 [Service Date]		
460	Service Tax Amount	S			AMT				Required when a service tax/surcharge applies to the service being reported in SV201.	
460	Amount Qualifier Code						R	AMT01	GT	GT – Goods and Services Tax
460	Monetary Amount						R	AMT02		Service Tax Amount
460	Credit/Debit Flag Code						Not Used	AMT03		Not Used
461	Facility Tax Amount	S								Required when a service tax/surcharge applies to the service being reported in SV201.
461	Amount Qualifier Code						R	AMT01	N8	N8 – Miscellaneous Taxes
461	Monetary Amount		R	AMT02				Facility Tax Amount		
461	Credit/Debit Flag Code		Not Used	AMT03				Not Used		
461a A29	Line Pricing/Repricing Information	S	492	HCP			Used only by repricers as needed. This information is specific to the destination payer reported in the 2010BB loop.			
461a A30	Pricing Methodology				R	HCP01	Pricing/Repricing Methodology. Trading partners need to agree on which codes to use in this data element. There do not appear to be standard definitions for the code elements.			
461a A30	Monetary Amount				R	HCP02	Pricing/Repricing Allowed Amount			
461a A31	Monetary Amount				S	HCP03	Pricing/Repricing Saving Amount			
461a A31	Reference Identification				S	HCP04	Pricing/Repricing Organizational Identifier			
461a A31	Rate				S	HCP05	Pricing/Repricing Rate			
461a A31	Reference Identification				S	HCP06	Approved APG Code, Pricing			
461a A31	Monetary Amount				S	HCP07	Approved APG Amount, Pricing			
461a A32	Product/Service ID				S	HCP08	Approved Revenue Code			
461a A32	Product/Service ID Qualifier				S	HCP09	HC	Required when HCP10 exists. HC – HCPCS Codes		
461a A32	Product/Service ID				S	HCP10		Pricing/Repricing Approved Procedure Code		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
461a A32	Unit or Basis for Measurement Code				S	HCP11		DA – Days UN – Unit
461a A32	Quantity				S	HCP12		Pricing/Repricing Approved Units or Inpatient Days
461a A33	Reject Reason Code				S	HCP13		Reject Reason Code T1 – Cannot identify provider as TPO participant T2 – Cannot identify payer as TPO participant T3 – Cannot identify insured as TPO participant T4 – Payer name or identifier missing T5 – Certification information missing T6 – Claim does not contain enough information for repricing
461a A33	Policy Compliance Code				S	HCP14		1 – Procedure followed (compliance) 2 – Not followed – call not made (non-compliance call not made) 3 – Not medically necessary (non-compliance non-medically necessary) 4 – Not followed other (non-compliance other) 5 – Emergency admit to non-network hospital
461a A33	Exception Code				S	HCP15		1 – Non-network professional provider in network hospital 2 – Emergency care 3 – Services or specialist not in network 4 – Out-of-service area 5 – State mandates 6 – Other
461a A35	Loop ID: 2410 Drug Identification	S	494	LIN				The NDC number is used for reporting prescribed drugs and biologics when required by government regulation or, as deemed by the provider, to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410. Use Loop ID 2410 to specify billing/ reporting for drugs provided that may be part of the service(s) described in SV2.
461a A36	Assigned Identification				Not Used	LIN01		Not Used
461a A37	Product/Service ID Qualifier				R	LIN02		N4 – National Drug Code in 5-4-2 Format
461a A37	Product/Service ID				R	LIN03		National Drug Code
461a A37	Product/Service ID Qualifier & Product/Service ID				Not Used	LIN04 thru LIN31		See Addenda for requirements.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
461a A38	Drug Pricing	S	495			CTP		Required when it is necessary to provide a price specific to the NDC provided in LIN03 that is different than the price reported in SV203.
461a A38	Class of Trade Code				Not Used	CTP01		Not Used
461a A39	Price Identifier Code				Not Used	CTP02		Not Used
461a A39	Unit Price				R	CTP03		Drug Unit Price
461a A39	Quantity				R	CTP04		National Drug Unit Count
461a A39	Composite Unit of Measure				R	CTP05		Unit/Basis of Measurement
461a A39	Unit or Basis for Measurement Code				R	CTP05-1		Code Qualifier F2 – International Unit GR – Gram ML – Milliliter UN – Unit
461a A39	Unit or Basis for Measurement Code Exponent Multiplier				Not Used	CTP05-2 thru CPT05-15		See Addenda for requirements.
461a A39	Price Multiplier Qualifier				Not Used	CTP06		Not Used
461a A39	Multiplier				Not Used	CTP07		Not Used
461a A39	Monetary Amount				Not Used	CTP08		Not Used
461a A39	Basis of Unit Price Code				Not Used	CTP09		Not Used
461a A39	Condition Value				Not Used	CTP10		Not Used
461a A39	Multiple Price Quantity				Not Used	CTP11		Not Used
461a A40	Prescription Number	S	496			REF		Required if dispense of the drug has been done with an assigned Rx number.
461a A40	Reference Identification Qualifier				R	REF01		Code Qualifier XZ – Pharmacy Prescription Number
461a A41	Reference Identification				R	REF02		Prescription Number
461a A41	Description				Not Used	REF03		Not Used
461a A41	Reference Identifier				Not Used	REF04		Not Used
462	Loop ID: 2420A Attending Physician Name	S	500	NM1				Required when line level provider information is known to impact adjudication.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
463	Entity ID Code		Not Used For Adjudication	NM1	R	NM101	71	71 – Attending Physician The entity identifier in NM101 applies to all segments in Loop ID-2420.
463	Entity Type Qualifier				R	NM102		1 – Person 2 – Non-Person Entity
463	Name Last or Organization Name				R	NM103		Attending Provider Last Name
463	Name First				S	NM104		Required if NM102=1 (person).
463	Name Middle				S	NM105		Required if NM102=1 and the middle name/initial of the person is known.
463	Name Prefix				Not Used	NM106		Not Used
463	Name Suffix				S	NM107		Required if known.
463	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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.
464	Identification Code				R	NM109		Attending Provider Primary Identifier
464	Entity Relationship Code				Not Used	NM110		Not Used
464	Entity Identifier Code				Not Used	NM111		Not Used
467	Attending Physician Secondary Identification	S	REF					Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.
467	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 EI – Employer’s Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider Number
468	Reference Identification				R	REF02		Attending Physician Secondary Identifier
468	Description				Not Used	REF03		Not Used
468	Reference Identifier				Not Used	REF04		Not Used
469	Loop ID: 2420B Operating Physician Name	S	500	NM1				Required when line level provider information is known to impact adjudication.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
470	Entity ID Code		<i>Not Used For Adjudication</i>	NM1	R	NM101	72	72 – Operating Physician
470	Entity Type Qualifier				R	NM102	1	1 – Person
470	Name Last or Organization Name				R	NM103		Operating Physician Last Name
470	Name First				S	NM104		Operating Physician First Name
470	Name Middle				S	NM105		Required when the middle name/initial of the person is known.
470	Name Prefix				Not Used	NM106		Not Used
470	Name Suffix				S	NM107		Required if known.
470	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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.
471	Identification Code				R	NM109		Operating Physician Primary Identifier
471	Entity Relationship Code				Not Used	NM110		Not Used
471	Entity Identifier Code				Not Used	NM111		Not Used
474	Operating Physician Secondary Identification	S	REF				Required when a secondary identification number is necessary to identify the entity. The primary identification number should be carried in NM109 in this loop.	
474	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 E1 – Employer’s Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider Number	
475	Reference Identification			R	REF02		Operating Physician Secondary Identifier	
475	Description			Not Used	REF03		Not Used	
475	Reference Identifier			Not Used	REF04		Not Used	
476	Loop ID: 2420C Other Provider Name	S	500	NM1				Required when line level provider information is known to impact adjudication. Required when the claim/encounter involves an other provider such as, but not limited to: Referring Provider, Ordering Provider, Assisting Provider.

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
477	Entity ID Code		Not Used For Adjudication NM1		R	NM101	73	73 – Other Physician The entity identifier in NM101 applies to all segments in Loop ID–2420.
477	Entity Type Qualifier				R	NM102		1 – Person 2 – Non–Person Entity
477	Name Last or Organization Name				R	NM103		Other Provider Last Name
477	Name First				S	NM104		Other Provider First Name
477	Name Middle				S	NM105		Required if NM102=1 and the middle name/initial of the person is known.
477	Name Prefix				Not Used	NM106		Not Used
478	Name Suffix				S	NM107		Required if known.
478	Identification Code Qualifier				R	NM108		24 – Employer’s Identification Number 34 – Social Security Number: 34 cannot be used for Medicare claims 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.
478	Identification Code				R	NM109		Other Provider Identifier
478	Entity Relationship Code				Not Used	NM110		Not Used
478	Entity Identifier Code				Not Used	NM111		Not Used
481	Other Provider Secondary Identification	S	REF					Use this REF only when a second number is necessary to identify the provider. The primary identification must be contained in NM109.
481	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 E1 – Employer’s Identification Number G2 – Provider Commercial Number LU – Location Number N5 – Provider Plan Network Identification Number SY – Social Security Number: SY may not be used for Medicare X5 – State Industrial Accident Provider Number
482	Reference Identification				R	REF02		Other Provider Secondary Identifier
482	Description				Not Used	REF03		Not Used
482	Reference Identifier				Not Used	REF04		Not Used
490	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.
491	Identification Code				R	SVD01		Payer Identifier

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
491	Monetary Amount				R	SVD02		Service Line Paid Amount
491	Composite Medical Procedure Identifier				S	SVD03		Required when returned on an 835 payment for this claim or when needed to identify the service line adjudicated.
491	Product/Service ID Qualifier				R	SVD03-1		The NDC number is used for reporting prescribed drugs and biologics when required by government regulation, or as deemed by the provider to enhance claim reporting/adjudication processes. The NDC number is reported in the LIN segment of Loop ID-2410. HC – HCFA Common Procedural Coding System (HCPCS) Codes IV – Home Infusion EDI Coalition (HIEC) Product/Service Code (This code set is not allowed for use under HIPAA at the time of this addenda.) ZZ – Mutually Defined
492	Product/Service ID				R	SVD03-2		Procedure Code
492	Procedure Modifier				S	SVD03-3		Required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.
492	Procedure Modifier				S	SVD03-4		See SVD03-3
492	Procedure Modifier				S	SVD03-5		See SVD03-3
492	Procedure Modifier				S	SVD03-6		See SVD03-3
492	Description				S	SVD03-7		Required if SVC01-7 was returned in the 835 transaction.
492	Product/Service ID				R	SVD04		Service Line Revenue Code
493	Quantity				R	SVD05		Crosswalk from SVC05 in 835 or, if not present in 835, use original billed units.
493	Assigned Number				S	SVD06		Use the LX from this transaction which points to the bundled/unbundled line. Required if payer bundled/unbundled this service line.
494	Service Line Adjustment	S	545	CAS				Inpatient or Outpatient – Service Line Adjustments Submitters should use this CAS segment to report line level adjustments from prior payments, which cause the amount paid to differ from the amount originally charged. Required when the prior payment had service line adjustments reported on a remittance.
495	Claim Adjustment Group Code				R	CAS01		CO – Contractual Obligations CR – Correction and Reversals OA – Other adjustments PI – Payer Initiated Reductions PR – Patient Responsibility Code identifying the general category of payment adjustment
496	Claim Adjustment Reason Code				R	CAS02		

Page #	Industry Name (When available. Else ANSI name)	Seg. Reqmt	Pos#	Seg ID	Data Element Usage	Data Element ID	Qualifier	Qualifier Description
496	Monetary Amount				R	CAS03		Use this amount for the amount of adjustment. Use this amount for the charges applied to the preceding reason code.
496	Quantity				S	CAS04		Use this value for the quantity applied to the preceding reason code.
496	Claim Adjustment Reason Code				S	CAS05		See CAS02.
497	Monetary Amount				S	CAS06		Use this amount for the charges applied to the preceding reason code. See CAS03
497	Quantity				S	CAS07		Use this value for the quantity applied to the preceding reason code. See CAS04
497	Claim Adjustment Reason Code				S	CAS08		See CAS02
498	Monetary Amount				S	CAS09		See CAS03
498	Quantity				S	CAS10		See CAS04
498	Claim Adjustment Reason Code				S	CAS11		See CAS02
499	Monetary Amount				S	CAS12		See CAS03
499	Quantity				S	CAS13		See CAS04
499	Claim Adjustment Reason Code				S	CAS14		See CAS02
500	Monetary Amount				S	CAS15		See CAS03
500	Quantity				S	CAS16		See CAS04
500	Claim Adjustment Reason Code				S	CAS17		See CAS02
501	Monetary Amount				S	CAS18		See CAS03
501	Quantity				S	CAS19		See CAS04
502	Service Adjudication Date	S	550	DTP				This segment is required when Service line adjudication has been performed.
502	Date/Time Qualifier				R	DTP01	573	573 – Date Claim Paid
502	Date Time Period Format Qualifier				R	DTP02	D8	D8 – Date Expressed in Format CCYYMMDD
502	Date Time Period				R	DTP03		Service Adjudication or Payment Date
503	Transaction Set Trailer	R	555	SE				
503	Number of Included Segments				R	SE01		Total number of segments included in a transaction set including ST and SE segments.
503	Transaction Set Control Number				R	SE02		Data value in SE02 must be identical to ST02

ENVELOPE — Close

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