Rite Aid Corporation
835 Health Care Claim Payment/Advice
Version 005010X221A1

Functional Group ID=HP

Introduction:

This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Payment/Advice Transaction Set (835) for use within the context of the Electronic Data Interchange (EDI) environment. This transaction set can be used to make a payment, send an Explanation of Benefits (EOB) remittance advice, or make a payment and send an EOB remittance advice only from a health insurer to a health care provider either directly or via a financial institution.

Heading:

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
Must Use	0100	ST	Transaction Set Header	M	1		
Must Use	0200	BPR	Financial Information	M	1		
Must Use	0400	TRN	Reassociation Trace Number	O	1		c1
	0500	CUR	Foreign Currency Information	O	1		c2
	0600	REF	Receiver Identification	O	1		
	0600	REF	Version Identification	O	1		
	0700	DTM	Production Date	O	1		
			LOOP ID - 1000A			1	
Must Use	0800	N1	Payer Identification	O	1		c3
Must Use	1000	N3	Payer Address	O	1		
Must Use	1100	N4	Payer City, State, ZIP Code	O	1		
	1200	REF	Additional Payer Identification	O	4		
	1300	PER	Payer Business Contact Information	O	1		
Must Use	1300	PER	Payer Technical Contact Information	O	>1		
	1300	PER	Payer WEB Site	O	1		
			LOOP ID - 1000B			1	
Must Use	0800	N1	Payee Identification	O	1		
	1000	N3	Payee Address	O	1		
	1100	N4	Payee City, State, ZIP Code	O	1		
	1200	REF	Payee Additional Identification	O	>1		
	1400	RDM	Remittance Delivery Method	O	1		

Detail:

Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
		LOOP ID - 2000			>1	
0030	LX	Header Number	O	1		n1
0050	TS3	Provider Summary Information	O	1		
0070	TS2	Provider Supplemental Summary Information	O	1		

			LOOP ID - 2100			>1	
M	0100	CLP	Claim Payment Information	M	1		
	0200	CAS	Claims Adjustment	O	99		n2
Must Use	0300	NM1	Patient Name	O	1		
	0300	NM1	Insured Name	O	1		
	0300	NM1	Corrected Patient/Insured Name	O	1		
	0300	NM1	Service Provider Name	O	1		
	0300	NM1	Crossover Carrier Name	O	1		
	0300	NM1	Corrected Priority Payer Name	O	1		
	0300	NM1	Other Subscriber Name	O	1		
	0330	MIA	Inpatient Adjudication Information	O	1		
	0350	MOA	Outpatient Adjudication Information	O	1		
	0400	REF	Other Claim Related Identification	O	5		
	0400	REF	Rendering Provider Identification	O	10		
	0500	DTM	Statement From or To Date	O	2		
	0500	DTM	Coverage Expiration Date	O	1		
	0500	DTM	Claim Received Date	O	1		
	0600	PER	Claim Contact Information	O	2		
	0620	AMT	Claim Supplemental Information	O	13		
	0640	QTY	Claim Supplemental Information Quantity	O	14		
			LOOP ID - 2110			999	
	0700	SVC	Service Payment Information	O	1		
	0800	DTM	Service Date	O	2		n3
	0900	CAS	Service Adjustment	O	99		n4
	1000	REF	Service Identification	O	8		
	1000	REF	Line Item Control Number	O	1		
	1000	REF	Rendering Provider Information	O	10		
	1000	REF	HealthCare Policy Identification	O	5		
	1100	AMT	Service Supplemental Amount	O	9		
	1200	QTY	Service Supplemental Quantity	O	6		
	1300	LQ	Health Care Remark Codes	O	99		

Summary:

	Pos. No.	Seg. ID	Name	Req. Des.	Max.Use	Loop Repeat	Notes and Comments
	0100	PLB	Provider Adjustment	O	>1		
Must Use	0200	SE	Transaction Set Trailer	M	1		

Transaction Set Notes

1. The LX segment is used to provide a looping structure and logical grouping of claim payment information.
2. The CAS segment is used to reflect changes to amounts within Table 2.
3. The DTM segment in the SVC loop is to be used to express dates and date ranges specifically related to the service identified in the SVC segment.
4. The CAS segment is used to reflect changes to amounts within Table 2.

Transaction Set Comments

1. The TRN segment is used to uniquely identify a claim payment and advice.
2. The CUR segment does not initiate a foreign exchange transaction.

3. The N1 loop allows for name/address information for the payer and payee which would be utilized to address remittance(s) for delivery.

Segment: **ST** **Transaction Set Header**
Position: 0100
Loop:
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To indicate the start of a transaction set and to assign a control number
Syntax Notes:
Semantic Notes:
1 The transaction set identifier (ST01) is used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the Invoice Transaction Set).
2 The implementation convention reference (ST03) is used by the translation routines of the interchange partners to select the appropriate implementation convention to match the transaction set definition. When used, this implementation convention reference takes precedence over the implementation reference specified in the GS08.
Comments:
Notes: TR3 Example: ST*835*1234~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**ST01**	**143**	**Transaction Set Identifier Code** Code uniquely identifying a Transaction Set OD: 835W1__ST01__TransactionSetIdentifierCode The only valid value within this transaction set for ST01 is 835. 835 Health Care Claim Payment/Advice	**M**	**1 ID 3/3**
M	**ST02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: 835W1__ST02__TransactionSetControlNumber The Transaction Set Control Numbers in ST02 and SE02 must be identical. This unique number also aids in error resolution research. Start with a number, for example 0001, and increment from there. This number must be unique within a specific group and interchange, but it can be repeated in other groups and interchanges.	**M**	**1 AN 4/9**

Segment: **BPR** **Financial Information**
Position: 0200
Loop:
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To indicate the beginning of a Payment Order/Remittance Advice Transaction Set and total payment amount, or to enable related transfer of funds and/or information from payer to payee to occur
Syntax Notes:
1 If either BPR06 or BPR07 is present, then the other is required.
2 If BPR08 is present, then BPR09 is required.
3 If either BPR12 or BPR13 is present, then the other is required.
4 If BPR14 is present, then BPR15 is required.
5 If either BPR18 or BPR19 is present, then the other is required.
6 If BPR20 is present, then BPR21 is required.
Semantic Notes:
1 BPR02 specifies the payment amount.

2 When using this transaction set to initiate a payment, all or some of BPR06 through BPR16 may be required, depending on the conventions of the specific financial channel being used.
BPR06 and BPR07 relate to the originating depository financial institution (ODFI).

3 BPR08 is a code identifying the type of bank account or other financial asset.

4 BPR09 is the account of the company originating the payment. This account may be debited or credited depending on the type of payment order.

5 BPR10 shall be mutually established between the originating depository financial institution (ODFI) and the company originating the payment.

6 BPR12 and BPR13 relate to the receiving depository financial institution (RDFI).

7 BPR14 is a code identifying the type of bank account or other financial asset.

8 BPR15 is the account number of the receiving company to be debited or credited with the payment order.

9 BPR16 is the date the originating company intends for the transaction to be settled (i.e., Payment Effective Date).

10 BPR17 is a code identifying the business reason for this payment.

11 BPR18, BPR19, BPR20 and BPR21, if used, identify a third bank identification number and account to be used for return items only.

12 BPR20 is a code identifying the type of bank account or other financial asset.

Comments:

Notes: TR3 Notes: 1. Use the BPR to address a single payment to a single payee. A payee may represent a single provider, a provider group, or multiple providers in a chain. The BPR contains mandatory information, even when it is not being used to move funds electronically.
TR3 Example: BPR*C*150000*C*ACH*CTX*01*999999992*DA*123456*1512345678*999999999*01*999988880*DA*98765*20030901~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**BPR01**	**305**	**Transaction Handling Code** Code designating the action to be taken by all parties	**M**	**1**	**ID 1/2**
			OD: 835W1__BPR01__TransactionHandlingCode			
			C Payment Accompanies Remittance Advice Use this code to instruct your third party processor to move both funds and remittance detail together through the banking system.			
			D Make Payment Only Use this code to instruct your third party processor to move only funds through the banking system and to ignore any remittance information.			
			H Notification Only Use this code when the actual provider payment (BPR02) is zero and the transaction is not being used for Prenotification of Future Transfers. This indicates remittance information without any associated payment.			
			I Remittance Information Only Use this code to indicate to the payee that the remittance detail is moving separately from the payment.			
			P Prenotification of Future Transfers This code is used only by the payer and the banking system to initially validate account numbers before beginning an EFT relationship. Contact your VAB for additional information.			

			U	Split Payment and Remittance Use this code to instruct the third party processor to split the payment and remittance detail, and send each on a separate path.			
			X	Handling Party's Option to Split Payment and Remittance Use this code to instruct the third party processor to move the payment and remittance detail, either together or separately, based upon end point requests or capabilities.			
M	**BPR02**	**782**	**Monetary Amount** Monetary amount OD: 835W1__BPR02__TotalActualProviderPaymentAmount IMPLEMENTATION NAME: Total Actual Provider Payment Amount Use BPR02 for the total payment amount for this 835. The total payment amount for this 835 cannot exceed eleven characters, including decimals (99999999.99). Although the value can be zero, the 835 cannot be issued for less than zero dollars. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point).		**M**	**1**	**R 1/18**
M	**BPR03**	**478**	**Credit/Debit Flag Code** Code indicating whether amount is a credit or debit OD: 835W1__BPR03__CreditorDebitFlagCode IMPLEMENTATION NAME: Credit or Debit Flag Code		**M**	**1**	**ID 1/1**
			C	Credit Use this code to indicate a credit to the provider's account and a debit to the payer's account, initiated by the payer. In the case of an EFT, no additional action is required of the provider. Also use this code when a check is issued for the payment.			
			D	Debit Use this code to indicate a debit to the payer's account and a credit to the provider's account, initiated by the provider at the instruction of the payer. Extreme caution must be used when using Debit transactions. Contact your VAB for information about debit transactions. The rest of this segment and document assumes that a credit payment is being used.			
M	**BPR04**	**591**	**Payment Method Code** Code identifying the method for the movement of payment instructions OD: 835W1__BPR04__PaymentMethodCode		**M**	**1**	**ID 3/3**
			ACH	Automated Clearing House (ACH) Use this code to move money electronically through the ACH, or to notify the provider that an ACH transfer was requested. When this code is used, see BPR05 through BPR15 for additional requirements.			
			BOP	Financial Institution Option Use this code to indicate that the third party processor will choose the method of payment based upon end point requests or capabilities. When this code is used, see BPR05 through BPR15 for additional requirements.			

		CHK	Check Use this code to indicate that a check has been issued for payment.			
		FWT	Federal Reserve Funds/Wire Transfer - Nonrepetitive Use this code to indicate that the funds were sent through the wire system. When this code is used, see BPR05 through BPR15 for additional requirements.			
		NON	Non-Payment Data Use this code when the Transaction Handling Code (BPR01) is H, indicating that this is information only and no dollars are to be moved.			
BPR05	**812**	**Payment Format Code** Code identifying the payment format to be used SITUATIONAL RULE: Required when BPR04 is ACH. If not required by this implementation guide, do not send. OD: 835W1__BPR05__PaymentFormatCode		**O**	**1**	**ID 1/10**
		CCP	Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) Use the CCD+ format to move money and up to 80 characters of data, enough to reassociate dollars and data when the dollars are sent through the ACH and the data is sent on a separate path. The addenda must contain a copy of the TRN segment.			
		CTX	Corporate Trade Exchange (CTX) (ACH) Use the CTX format to move dollars and data through the ACH. The CTX format can contain up to 9,999 addenda records of 80 characters each. The CTX encapsulates the complete 835 and all envelope segments.			
BPR06	**506**	**(DFI) ID Number Qualifier** Code identifying the type of identification number of Depository Financial Institution (DFI) SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send. OD: 835W1__BPR06__DepositoryFinancialInstitutionDFIIdentificationNumberQualifier IMPLEMENTATION NAME: Depository Financial Institution (DFI) Identification Number Qualifier BPR06 through BPR09 relate to the originating financial institution and the originator's account (payer).		**X**	**1**	**ID 2/2**
		01	ABA Transit Routing Number Including Check Digits (9 digits) The ABA transit routing number is a unique number identifying every bank in the United States. CODE SOURCE 4: ABA Routing Number			
		04	Canadian Bank Branch and Institution Number CODE SOURCE 91: Canadian Financial Institution Branch and Institution Number			
BPR07	**507**	**(DFI) Identification Number** Depository Financial Institution (DFI) identification number		**X**	**1**	**AN 3/12**

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR07__SenderDFIIdentifier

IMPLEMENTATION NAME: Sender DFI Identifier

CODE SOURCE 60: (DFI) Identification Number

Use this number for the identifying number of the financial institution sending the transaction into the applicable network.

BPR08	**569**	**Account Number Qualifier**	**O**	**1**	**ID 1/3**

Code indicating the type of account

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR08__AccountNumberQualifier

Use this code to identify the type of account in BPR09.

DA Demand Deposit

BPR09	**508**	**Account Number**	**X**	**1**	**AN 1/35**

Account number assigned

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR09__SenderBankAccountNumber

IMPLEMENTATION NAME: Sender Bank Account Number

Use this number for the originator's account number at the financial institution.

BPR10	**509**	**Originating Company Identifier**	**O**	**1**	**AN 10/10**

A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR10__PayerIdentifier

IMPLEMENTATION NAME: Payer Identifier

BPR11	**510**	**Originating Company Supplemental Code**	**O**	**1**	**AN 9/9**

A code defined between the originating company and the originating depository financial institution (ODFI) that uniquely identifies the company initiating the transfer instructions

SITUATIONAL RULE: Required when BPR10 is present and the payee has a business need to receive further identification of the source of the payment (such as identification of the payer by division or region). If not required by this implementation guide, do not send.

OD: 835W1__BPR11__OriginatingCompanySupplementalCode

Use this code to further identify the payer by division or region. The element must be left justified and space filled to meet the minimum element size requirements. If used, this code must be identical to TRN04, excluding trailing spaces.

BPR12 **506** **(DFI) ID Number Qualifier** **X** **1** **ID 2/2**

Code identifying the type of identification number of Depository Financial Institution (DFI)

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR12__DepositoryFinancialInstitutionDFIIdentificationNumberQualifier

IMPLEMENTATION NAME: Depository Financial Institution (DFI) Identification Number Qualifier

BPR12 through BPR15 relate to the receiving financial institution and the receiver's account.

01	ABA Transit Routing Number Including Check Digits (9 digits) The ABA transit routing number is a unique number identifying every bank in the United States. CODE SOURCE 4: ABA Routing Number
04	Canadian Bank Branch and Institution Number CODE SOURCE 91: Canadian Financial Institution Branch and Institution Number

BPR13 **507** **(DFI) Identification Number** **X** **1** **AN 3/12**

Depository Financial Institution (DFI) identification number

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR13__ReceiverorProviderBankIDNumber

IMPLEMENTATION NAME: Receiver or Provider Bank ID Number

CODE SOURCE 60: (DFI) Identification Number

Use this number for the identifying number of the financial institution receiving the transaction from the applicable network.

BPR14 **569** **Account Number Qualifier** **O** **1** **ID 1/3**

Code indicating the type of account

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR14__AccountNumberQualifier

Use this code to identify the type of account in BPR15.

DA	Demand Deposit
SG	Savings

BPR15 **508** **Account Number** **X** **1** **AN 1/35**

Account number assigned

SITUATIONAL RULE: Required when BPR04 is ACH, BOP or FWT. If not required by this implementation guide, do not send.

OD: 835W1__BPR15__ReceiverorProviderAccountNumber

IMPLEMENTATION NAME: Receiver or Provider Account Number

Use this number for the receiver's account number at the financial institution.

Must Use	**BPR16**	**373**	**Date**	**O**	**1**	**DT 8/8**

Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year

OD: 835W1__BPR16__CheckIssueorEFTEffectiveDate

IMPLEMENTATION NAME: Check Issue or EFT Effective Date

Use this for the effective entry date. If BPR04 is ACH, this is the date that the money moves from the payer and is available to the payee. If BPR04 is CHK, this is the check issuance date. If BPR04 is FWT, this is the date that the payer anticipates the money to move. As long as the effective date is a business day, this is the settlement date. If BPR04 is 'NON', enter the date of the 835.

Segment: **TRN** **Reassociation Trace Number**
Position: 0400
Loop:
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To uniquely identify a transaction to an application
Syntax Notes:
Semantic Notes:
1 TRN02 provides unique identification for the transaction.
2 TRN03 identifies an organization.
3 TRN04 identifies a further subdivision within the organization.
Comments:
Notes: TR3 Notes: 1. This segment's purpose is to uniquely identify this transaction set and to aid in reassociating payments and remittances that have been separated.
TR3 Example: TRN*1*12345*1512345678*999999999~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**TRN01**	**481**	**Trace Type Code**	**M**	**1**	**ID 1/2**

Code identifying which transaction is being referenced

OD: 835W1__TRN01__TraceTypeCode

1 Current Transaction Trace Numbers

M	**TRN02**	**127**	**Reference Identification**	**M**	**1**	**AN 1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

OD: 835W1__TRN02__CheckorEFTTraceNumber

IMPLEMENTATION NAME: Check or EFT Trace Number

This number must be unique within the sender/receiver relationship. The number is assigned by the sender. If payment is made by check, this must be the check number. If payment is made by EFT, this must be the EFT reference number. If this is a nonpayment 835, this must be a unique remittance advice identification number.

See 1.10.2.3, Reassociation of Dollars and Data, for additional information.

Must Use	**TRN03**	**509**	**Originating Company Identifier**	**O**	**1**	**AN 10/10**

A unique identifier designating the company initiating the funds transfer instructions, business transaction or assigning tracking reference identification.

OD: 835W1__TRN03__PayerIdentifier

IMPLEMENTATION NAME: Payer Identifier

This must be a 1 followed by the payer's EIN (or TIN).

TRN04	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

SITUATIONAL RULE: Required when information beyond the Originating Company Identifier in TRN03 is necessary for the payee to identify the source of the payment. If not required by this implementation guide, do not send.

OD: 835W1__TRN04__OriginatingCompanySupplementalCode

IMPLEMENTATION NAME: Originating Company Supplemental Code

If both TRN04 and BPR11 are used, they must be identical, excluding trailing spaces. Since BPR11 has a min/max value of 9/9, whenever both are used, this element is restricted to a maximum size of 9.

Segment: **CUR** **Foreign Currency Information**
Position: 0500
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify the currency (dollars, pounds, francs, etc.) used in a transaction
Syntax Notes:
1 If CUR08 is present, then CUR07 is required.
2 If CUR09 is present, then CUR07 is required.
3 If CUR10 is present, then at least one of CUR11 or CUR12 is required.
4 If CUR11 is present, then CUR10 is required.
5 If CUR12 is present, then CUR10 is required.
6 If CUR13 is present, then at least one of CUR14 or CUR15 is required.
7 If CUR14 is present, then CUR13 is required.
8 If CUR15 is present, then CUR13 is required.
9 If CUR16 is present, then at least one of CUR17 or CUR18 is required.
10 If CUR17 is present, then CUR16 is required.
11 If CUR18 is present, then CUR16 is required.
12 If CUR19 is present, then at least one of CUR20 or CUR21 is required.
13 If CUR20 is present, then CUR19 is required.
14 If CUR21 is present, then CUR19 is required.
Semantic Notes:
Comments: **1** See Figures Appendix for examples detailing the use of the CUR segment.
Notes: Situational Rule: Required when the payment is not being made in US dollars. If not required by this implementation guide, do not send.

TR3 Notes: 1. When the CUR segment is not present, the currency of payment is defined as US dollars.
TR3 Example: CUR*PR*CAD~

Data Element Summary

	Ref. Des.	Data Element	Name			Attributes
M	**CUR01**	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**

Code identifying an organizational entity, a physical location, property or an individual

OD: 835W1__CUR01__EntityIdentifierCode

			PR	Payer		
M	**CUR02**	**100**	**Currency Code**		**M**	**1 ID 3/3**
			Code (Standard ISO) for country in whose currency the charges are specified			
			OD: 835W1__CUR02__CurrencyCode CODE SOURCE 5: Countries, Currencies and Funds This is the currency code for the payment currency.			

Segment: **REF** **Receiver Identification**
Position: 0600
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when the receiver of the transaction is other than the payee (e.g., a clearinghouse or billing service). If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. This is the business identification information for the transaction receiver. This may be different than the EDI address or identifier of the receiver. This is the initial receiver of the transaction. This information must not be updated if the transaction is routed through multiple intermediaries, such as clearinghouses, before reaching the payee.
TR3 Example: REF*EV*1235678~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**REF01**	**128**	**Reference Identification Qualifier**		**M**	**1 ID 2/3**
			Code qualifying the Reference Identification			
			OD: 835W1__REF01__ReferenceIdentificationQualifier			
			EV	Receiver Identification Number A unique number identifying the organization/site location designated to receive the current transmitted transaction set		
Must Use	**REF02**	**127**	**Reference Identification**		**X**	**1 AN 1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
			OD: 835W1__REF02__ReceiverIdentifier IMPLEMENTATION NAME: Receiver Identifier ALIAS: Receiver Identification			

Segment: **REF** **Version Identification**
Position: 0600
Loop:

Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when necessary to report the version number of the adjudication system that generated the claim payments in order for the payer to resolve customer service questions from the payee. If not required by this implementation guide, do not send.

TR3 Notes: 1. Update this reference number whenever a change in the version or release number affects the 835. (This is not the ANSI ASCX12 version number as reported in the GS segment.)
TR3 Example: REF*F2*FS3.21~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification OD: 835W1__REF01__ReferenceIdentificationQualifier F2 Version Code - Local Identifies the release of a set of information or requirements to distinguish from the previous or future sets that may differ; the release in question is on the local level	**M**	**1**	**ID 2/3**
Must Use	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1__REF02__VersionIdentificationCode IMPLEMENTATION NAME: Version Identification Code	**X**	**1**	**AN 1/50**

Segment: **DTM** **Production Date**
Position: 0700
Loop:
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes: **1** At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the cut off date of the adjudication system remittance run is different from the date of the 835 as identified in the related GS04 element. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. If your adjudication cycle completed on Thursday and your 835 is produced on Saturday, you are required to populate this segment with Thursday's date.

TR3 Example: DTM*405*20020317~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**DTM01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time OD: 835W1__DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier 405 Production Used to identify dates and times that operations or processes were performed	**M**	**1 ID 3/3**
Must Use	**DTM02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1__DTM02__ProductionDate IMPLEMENTATION NAME: Production Date Report the end date for the adjudication production cycle for claims included in this 835.	**X**	**1 DT 8/8**

Segment: **N1** **Payer Identification**
Position: 0800
Loop: 1000A Must Use
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes:
1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments:
1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: TR3 Notes: 1. Use this N1 loop to provide the name/address information for the payer.

2. The payer's secondary identifying reference number is provided in N104, if necessary.
TR3 Example: N1*PR*INSURANCE COMPANY OF TIMBUCKTU*XV*8888888888~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**N101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_1000A_N101__EntityIdentifierCode PR Payer	**M**	**1 ID 2/3**
Must Use	**N102**	**93**	**Name** Free-form name OD: 835W1_1000A_N102__PayerName IMPLEMENTATION NAME: Payer Name	**X**	**1 AN 1/60**

	N103	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**
			Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when the National PlanID is mandated for use. If not required by this implementation guide, may be providedat the sender's discretion, but cannot be required by the receiver. OD: 835W1_1000A_N103__IdentificationCodeQualifier			
			XV Centers for Medicare and Medicaid Services PlanID Required if the National PlanID is mandated for use. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID			
	N104	**67**	**Identification Code**	**X**	**1**	**AN 2/80**
			Code identifying a party or other code SITUATIONAL RULE: Required when the National PlanID is mandated for use. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver. OD: 835W1_1000A_N104__PayerIdentifier IMPLEMENTATION NAME: Payer Identifier			

Segment: **N3** **Payer Address**
Position: 1000
Loop: 1000A Must Use
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: TR3 Example: N3*100 MAIN STREET~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**N301**	**166**	**Address Information** Address information OD: 835W1_1000A_N301__PayerAddressLine IMPLEMENTATION NAME: Payer Address Line	**M**	**1**	**AN 1/55**
	N302	**166**	**Address Information** Address information SITUATIONAL RULE: Required when a second address line exists. If not required by this implementation guide, do not send. OD: 835W1_1000A_N302__PayerAddressLine IMPLEMENTATION NAME: Payer Address Line	**O**	**1**	**AN 1/55**

Segment: **N4** **Payer City, State, ZIP Code**
Position: 1100

Loop: 1000A Must Use
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
1 Only one of N402 or N407 may be present.
2 If N406 is present, then N405 is required.
3 If N407 is present, then N404 is required.
Semantic Notes:
Comments:
1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2 N402 is required only if city name (N401) is in the U.S. or Canada.
Notes: TR3 Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
Must Use	**N401**	**19**	**City Name** Free-form text for city name OD: 835W1_1000A_N401__PayerCityName IMPLEMENTATION NAME: Payer City Name	**O**	**1**	**AN 2/30**
	N402	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send. OD: 835W1_1000A_N402__PayerStateCode IMPLEMENTATION NAME: Payer State Code CODE SOURCE 22: States and Provinces	**X**	**1**	**ID 2/2**
	N403	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send. OD: 835W1_1000A_N403__PayerPostalZoneorZIPCode IMPLEMENTATION NAME: Payer Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	**O**	**1**	**ID 3/15**
	N404	**26**	**Country Code** Code identifying the country SITUATIONAL RULE: Required when the address is outside the United States of America. If not required by this implementation guide, do not send. OD: 835W1_1000A_N404__CountryCode CODE SOURCE 5: Countries, Currencies and Funds	**X**	**1**	**ID 2/3**

Use the alpha-2 country codes from Part 1 of ISO 3166.

N407	**1715**	**Country Subdivision Code**	**X**	**1**	**ID 1/3**

Code identifying the country subdivision

SITUATIONAL RULE: Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send.

OD: 835W1_1000A_N407__CountrySubdivisionCode

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

Segment: **REF** **Additional Payer Identification**
Position: 1200
Loop: 1000A Must Use
Level: Heading
Usage: Optional
Max Use: 4
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional payer identification numbers beyond those in the TRN and Payer N1 segments are needed. If not required by this implementation guide, do not send.

TR3 Notes: 1. The ID available in the TRN and N1 segments must be used before using the REF segment.
TR3 Example: REF*2U*98765~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**REF01**	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**

Code qualifying the Reference Identification

OD: 835W1_1000A_REF01__ReferenceIdentificationQualifier

2U	Payer Identification Number
	For Medicare carriers or intermediaries, use this qualifier for the Medicare carrier or intermediary ID number. For Blue Cross and Blue Shield Plans, use this qualifier for the Blue Cross Blue Shield association plan code.
EO	Submitter Identification Number
	A unique number identifying the submitter of the transaction set
	This is required when the original transaction sender is not the payer or is identified by an identifier other than those already provided. This is not updated by third parties between the payer and the payee. An example of a use for this qualifier is when identifying a clearinghouse that created the 835 when

			the health plan sent a proprietary format to the clearinghouse.				
			HI	Health Industry Number (HIN)			
				CODE SOURCE 121: Health Industry Number			
			NF	National Association of Insurance Commissioners (NAIC) Code A unique number assigned to each insurance company			
				This is the preferred value when identifying the payer. CODE SOURCE 245: National Association of Insurance Commissioners (NAIC) Code			
Must Use	**REF02**	**127**	**Reference Identification**		**X**	**1**	**AN 1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			OD: 835W1_1000A_REF02__AdditionalPayerIdentifier IMPLEMENTATION NAME: Additional Payer Identifier				

Segment: **PER** **Payer** **Business Contact Information**
Position: 1300
Loop: 1000A Must Use
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes: **1** If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when there is a business contact area that would apply to this remittance and all the claims. If not required by this implementation guide, do not send.

TR3 Notes: 1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number always includes the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (800) 555-1212 would be represented as 8005551212). The extension number, when applicable, is identified in the next element pair (Communications Number Qualifier and Communication Number) immediately after the telephone number.
TR3 Example: PER*CX*JOHN WAYNE*TE*8005551212~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**PER01**	**366**	**Contact Function Code**	**M**	**1**	**ID 2/2**
			Code identifying the major duty or responsibility of the person or group named			
			OD: 835W1_1000A_PER01__ContactFunctionCode			
			CX Payers Claim Office Location responsible for paying bills related to medical care received			
	PER02	**93**	**Name**	**O**	**1**	**AN 1/60**

Free-form name

SITUATIONAL RULE: Required when it is necessary to identify an individual or other contact point to discuss information related to this transaction. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER02__PayerContactName

IMPLEMENTATION NAME: Payer Contact Name

Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).

PER03	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER03__CommunicationNumberQualifier

EM	Electronic Mail
FX	Facsimile
TE	Telephone

PER04	**364**	**Communication Number**	**X**	**1**	**AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER04__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER05	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a second communication contactnumber is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER05__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension
	When used, the value following this code is the extension for the preceding communications contact number.
FX	Facsimile
TE	Telephone

PER06	**364**	**Communication Number**	**X**	**1**	**AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER06__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER07	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER07__CommunicationNumberQualifier

EX Telephone Extension

PER08 **364** **Communication Number** **X** **1** **AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER08__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

Segment: **PER** **Payer Technical Contact Information**
Position: 1300
Loop: 1000A Must Use
Level: Heading
Usage: Must Use
Max Use: >1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: TR3 Notes: 1. Required to report technical contact information for this remittance advice.
TR3 Example: PER*BL*JOHN WAYNE*TE*8005551212*EX*123~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**PER01**	**366**	**Contact Function Code** **M** **1** **ID 2/2** Code identifying the major duty or responsibility of the person or group named OD: 835W1_1000A_PER01__ContactFunctionCode BL Technical Department	
	PER02	**93**	**Name** **O** **1** **AN 1/60** Free-form name SITUATIONAL RULE: Required when it is necessary to identify an individual or other contact point to discuss technical information related to this transaction. If not required by this implementation guide, do not send. OD: 835W1_1000A_PER02__PayerTechnicalContactName IMPLEMENTATION NAME: Payer Technical Contact Name Use this data element when the name of the individual to contact is not already defined or is different than the name within the prior name segment (e.g. N1 or NM1).	

PER03	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER03__CommunicationNumberQualifier

EM	Electronic Mail
TE	Telephone
	Recommended
UR	Uniform Resource Locator (URL)
	Use only when there is no central telephone number for the payer entity.

PER04	**364**	**Communication Number**	**X**	**1**	**AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a contact communication number is to be transmitted. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER04__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER05	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER05__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension
	When used, the value following this code is the extension for the preceding communications contact number.
FX	Facsimile
TE	Telephone
UR	Uniform Resource Locator (URL)

PER06	**364**	**Communication Number**	**X**	**1**	**AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER06__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

PER07	**365**	**Communication Number Qualifier**	**X**	**1**	**ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when a second communication contact number is needed. If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER07__CommunicationNumberQualifier

EM	Electronic Mail
EX	Telephone Extension
	When used, the value following this code is the extension for the preceding communications contact

number.

FX Facsimile

UR Uniform Resource Locator (URL)

PER08 **364** **Communication Number** **X** **1** **AN 1/256**

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_1000A_PER08__PayerContactCommunicationNumber

IMPLEMENTATION NAME: Payer Contact Communication Number

Segment: **PER** **Payer WEB Site**
Position: 1300
Loop: 1000A Must Use
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes: **1** If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when any 2110 loop Healthcare Policy REF segment is used. If not required by this implementation guide, do not send.

This is a direct link to the policy location of the un-secure website.
TR3 Example: PER*IC**UR*www.anyhealthplan.com/policies.html~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**PER01**	**366**	**Contact Function Code** **M** **1** **ID 2/2** Code identifying the major duty or responsibility of the person or group named OD: 835W1_1000A_PER01__ContactFunctionCode IC Information Contact	
Must Use	**PER03**	**365**	**Communication Number Qualifier** **X** **1** **ID 2/2** Code identifying the type of communication number OD: 835W1_1000A_PER03__CommunicationNumberQualifier UR Uniform Resource Locator (URL)	
Must Use	**PER04**	**364**	**Communication Number** **X** **1** **AN 1/256** Complete communications number including country or area code when applicable OD: 835W1_1000A_PER04__CommunicationNumber This is the payer's WEB site URL where providers can find policy and other related information.	

Segment: **N1** **Payee Identification**

Position: 0800
Loop: 1000B Must Use
Level: Heading
Usage: Must Use
Max Use: 1
Purpose: To identify a party by type of organization, name, and code
Syntax Notes:
1 At least one of N102 or N103 is required.
2 If either N103 or N104 is present, then the other is required.
Semantic Notes:
Comments:
1 This segment, used alone, provides the most efficient method of providing organizational identification. To obtain this efficiency the "ID Code" (N104) must provide a key to the table maintained by the transaction processing party.
2 N105 and N106 further define the type of entity in N101.
Notes: TR3 Notes: 1. Use this N1 loop to provide the name/address information of the payee. The identifying reference number is provided in N104.

TR3 Example: N1*PE*MID-STATE MENTAL HOSPITAL*XX*12345678~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**N101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_1000B_N101__EntityIdentifierCode	**M**	**1**	**ID 2/3**
			PE Payee			
Must Use	**N102**	**93**	**Name** Free-form name OD: 835W1_1000B_N102__PayeeName IMPLEMENTATION NAME: Payee Name	**X**	**1**	**AN 1/60**
Must Use	**N103**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_1000B_N103__IdentificationCodeQualifier	**X**	**1**	**ID 1/2**
			FI Federal Taxpayer's Identification Number Required if provider is not mandated by NPI. For individual providers as payees, use this qualifier to represent the Social Security Number.			
			XV Centers for Medicare and Medicaid Services PlanID This is REQUIRED when the National Health Plan Identifier is mandated for use and the payee is a health plan. This only applies in cases of post payment recovery. See section 1.10.2.16 (Post Payment Recovery) for further information. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID			
			XX Centers for Medicare and Medicaid Services National Provider Identifier This is REQUIRED when the National Provider Identifier is mandated for use and the payee is a covered health care provider under the mandate. CODE SOURCE 537: Centers for Medicare and Medicaid			

			Services National Provider Identifier			
Must Use	**N104**	**67**	**Identification Code** Code identifying a party or other code OD: 835W1_1000B_N104__PayeeIdentificationCode IMPLEMENTATION NAME: Payee Identification Code	**X**	**1**	**AN 2/80**

Segment: **N3** **Payee Address**
Position: 1000
Loop: 1000B Must Use
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify the location of the named party
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the sender needs to communicate the payee address to a transaction receiver, e.g., a VAN or a clearinghouse. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
TR3 Example: N3*SUITE 200*1000 MAIN STREET~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**N301**	**166**	**Address Information** Address information OD: 835W1_1000B_N301__PayeeAddressLine IMPLEMENTATION NAME: Payee Address Line	**M**	**1**	**AN 1/55**
	N302	**166**	**Address Information** Address information SITUATIONAL RULE: Required when a second address line exists. If not required by this implementation guide, do not send. OD: 835W1_1000B_N302__PayeeAddressLine IMPLEMENTATION NAME: Payee Address Line	**O**	**1**	**AN 1/55**

Segment: **N4** **Payee City, State, ZIP Code**
Position: 1100
Loop: 1000B Must Use
Level: Heading
Usage: Optional
Max Use: 1
Purpose: To specify the geographic place of the named party
Syntax Notes:
1 Only one of N402 or N407 may be present.
2 If N406 is present, then N405 is required.
3 If N407 is present, then N404 is required.
Semantic Notes:
Comments:
1 A combination of either N401 through N404, or N405 and N406 may be adequate to specify a location.
2 N402 is required only if city name (N401) is in the U.S. or Canada.

Notes: Situational: Required when the sender needs to communicate the payee address to a transaction receiver, e.g., a VAN or a clearinghouse. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
TR3 Example: N4*KANSAS CITY*MO*64108~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
Must Use	**N401**	**19**	**City Name** Free-form text for city name OD: 835W1_1000B_N401__PayeeCityName IMPLEMENTATION NAME: Payee City Name	**O**	**1**	**AN 2/30**
	N402	**156**	**State or Province Code** Code (Standard State/Province) as defined by appropriate government agency SITUATIONAL RULE: Required when the address is in the United States of America, including its territories, or Canada. If not required by this implementation guide, do not send. OD: 835W1_1000B_N402__PayeeStateCode IMPLEMENTATION NAME: Payee State Code CODE SOURCE 22: States and Provinces	**X**	**1**	**ID 2/2**
	N403	**116**	**Postal Code** Code defining international postal zone code excluding punctuation and blanks (zip code for United States) Required when the address is in the United States of America, including its territories, or Canada, or when a postal code exists for the country in N404. If not required by this implementation guide, do not send. OD: 835W1_1000B_N403__PayeePostalZoneorZIPCode IMPLEMENTATION NAME: Payee Postal Zone or ZIP Code CODE SOURCE 51: ZIP Code CODE SOURCE 932: Universal Postal Codes	**O**	**1**	**ID 3/15**
	N404	**26**	**Country Code** Code identifying the country SITUATIONAL RULE: Required when the address is outside the United States of America. If not required by this implementation guide, do not send. OD: 835W1_1000B_N404__CountryCode CODE SOURCE 5: Countries, Currencies and Funds Use the alpha-2 country codes from Part 1 of ISO 3166.	**X**	**1**	**ID 2/3**
	N407	**1715**	**Country Subdivision Code** Code identifying the country subdivision SITUATIONAL RULE: Required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc. If not required by this implementation guide, do not send. OD: 835W1_1000B_N407__CountrySubdivisionCode	**X**	**1**	**ID 1/3**

CODE SOURCE 5: Countries, Currencies and Funds

Use the country subdivision codes from Part 2 of ISO 3166.

Segment: **REF** **Payee Additional Identification**
Position: 1200
Loop: 1000B Must Use
Level: Heading
Usage: Optional
Max Use: >1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when identification of the payee is dependent upon an identification number beyond that supplied in the N1 segment. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.
TR3 Example: REF*PQ*12345678~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes		
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification OD: 835W1_1000B_REF01__ReferenceIdentificationQualifier 0B State License Number D3 National Council for Prescription Drug Programs Pharmacy Number CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number PQ Payee Identification TJ Federal Taxpayer's Identification Number This information must be in the N1 segment unless the National Provider ID or the National Health Plan Identifier was used in N103/04. For individual providers as payees, use this number to represent the Social Security Number. TJ also represents the Employer Identification Number (EIN). According to the IRS, TIN and EIN can be used interchangeably.	**M**	**1**	**ID 2/3**
Must Use	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_1000B_REF02__AdditionalPayeeIdentifier IMPLEMENTATION NAME: Additional Payee Identifier	**X**	**1**	**AN 1/50**

Segment: **RDM** **Remittance Delivery Method**
Position: 1400
Loop: 1000B Must Use
Level: Heading

Usage: Optional
Max Use: 1
Purpose: To identify remittance delivery when remittance is separate from payment
Syntax Notes:
1 If either C04003 or C04004 is present, then the other is required.
2 If either C04005 or C04006 is present, then the other is required.
3 If either C04003 or C04004 is present, then the other is required.
4 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
Comments:
1 RDM02 is used to contain the name of a third party processor if needed, who would be the first recipient of the remittance.
2 RDM03 contains the operative communication number for the delivery method specified in RDM01 (i.e. fax phone number and mail address).
3 RDM04 and RDM05 allow for additional room to convey further routing information beyond what is given in RDM03.
Notes: Situational Rule: Required when BPR01 = U or X; and the remittance is to be sent separately from the payment. The payer is responsible to provide the bank with the instructions on how to deliver the remittance information, if not required by this implementation guide, do not send.

TR3 Notes: 1. Payer should coordinate this process with their Originating Depository Financial Institution (ODFI).

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**RDM01**	**756**	**Report Transmission Code** Code defining timing, transmission method or format by which reports are to be sent OD: 835W1_1000B_RDM01__ReportTransmissionCode BM By Mail When used, RDM02 must be used. When BM is used, the remittance information will be mailed to the payee at the address identified in this 1000B loop. EM E-Mail Use with encrypted e-mail. FT File Transfer Use with FTP communications. OL On-Line Use with secured hosted or other electronic delivery.	**M 1 ID 1/2**
	RDM02	**93**	**Name** Free-form name SITUATIONAL RULE: Required when RDM01 = BM. If not required by this implementation guide, do not send. OD: 835W1_1000B_RDM02__Name When BM is used, the remittance information will be mailed to the attention of this person at the payee's address identified in this 1000B loop.	**O 1 AN 1/60**
	RDM03	**364**	**Communication Number** Complete communications number including country or area code when applicable SITUATIONAL RULE: Required when RDM01 equals EM, FT, or OL. If not required by this implementation guide, do not send.	**O 1 AN 1/256**

OD: 835W1_1000B_RDM03__CommunicationNumber

Contains URL web address or e-mail address.

Segment: **LX** **Header Number**
Position: 0030
Loop: 2000 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To reference a line number in a transaction set
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when claim/service information is being provided in the transaction. If not required by this implementation guide, do not send.

TR3 Notes: 1. The purpose of LX01 is to provide an identification of a particular grouping of claims for sorting purposes.

2. In the event that claim/service information must be sorted, the LX segment must precede each series of claim level and service level segments. This number is intended to be unique within each transaction.
TR3 Example: LX*1~
TR3 Example: LX*110210~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**LX01**	**554**	**Assigned Number** Number assigned for differentiation within a transaction set OD: 835W1_2000_LX01__AssignedNumber	**M**	**1 N0 1/6**

Segment: **TS3** **Provider Summary Information**
Position: 0050
Loop: 2000 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply provider-level control information
Syntax Notes:
Semantic Notes:
1 TS301 is the provider number.
2 TS303 is the last day of the provider's fiscal year.
3 TS304 is the total number of claims.
4 TS305 is the total of reported charges.
5 TS306 is the total of covered charges.
6 TS307 is the total of noncovered charges.
7 TS308 is the total of denied charges.
8 TS309 is the total provider payment.
9 TS310 is the total amount of interest paid.
10 TS311 is the total contractual adjustment.
11 TS312 is the total Gramm-Rudman Reduction.
12 TS313 is the total Medicare Secondary Payer (MSP) primary payer amount.
13 TS314 is the total blood deductible amount in dollars.

14 TS315 is the summary of non-lab charges.
15 TS316 is the total coinsurance amount.
16 TS317 is the Health Care Financing Administration Common Procedural Coding System (HCPCS) reported charges.
17 TS318 is the total Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
18 TS319 is the total deductible amount.
19 TS320 is the total professional component amount.
20 TS321 is the total Medicare Secondary Payer (MSP) patient liability met.
21 TS322 is the total patient reimbursement.
22 TS323 is the total periodic interim payment (PIP) number of claims.
23 TS324 is total periodic interim payment (PIP) adjustment.

Comments:

Notes: Situational Rule: Required for Medicare Part A or when payers and payees outside the Medicare Part A community need to identify provider subsidiaries whose remittance information is contained in the 835 transactions transmitted to a single provider entity [i.e., the corporate office of a hospital chain]. If not required by this implementation guide, do not send.

TR3 Notes: 1. TS301 identifies the subsidiary provider.

2. The remaining mandatory elements (TS302 through TS305) must be valid with appropriate data, as defined by the TS3 segment.

3. Only Medicare Part A uses data elements TS313, TS315, TS317, TS318 and TS320 through TS324. Each monetary amount element is for that provider for this facility type code for loop 2000.
TR3 Example: TS3*123456*11*20021031*10*130957.66~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes		
M	**TS301**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2000_TS301__ProviderIdentifier IMPLEMENTATION NAME: Provider Identifier This is the provider number.	**M**	**1**	**AN 1/50**
M	**TS302**	**1331**	**Facility Code Value** Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. OD: 835W1_2000_TS302__FacilityTypeCode IMPLEMENTATION NAME: Facility Type Code When reporting a TS3 segment for professional claims and the claims are not all for the same place of service, report a place of service of 11 (Office) as the default value. When reporting a TS3 segment for pharmaceutical claims and the claims are not all for the same place of service, report a place of service of 99 (Other unlisted facility) as the default value.	**M**	**1**	**AN 1/2**
M	**TS303**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1_2000_TS303__FiscalPeriodDate	**M**	**1**	**DT 8/8**

			IMPLEMENTATION NAME: Fiscal Period Date Use this date for the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known, use December 31st of the current year.			
M	**TS304**	**380**	**Quantity** Numeric value of quantity	**M**	**1**	**R 1/15**
			OD: 835W1_2000_TS304__TotalClaimCount IMPLEMENTATION NAME: Total Claim Count This is the total number of claims.			
M	**TS305**	**782**	**Monetary Amount** Monetary amount	**M**	**1**	**R 1/18**
			OD: 835W1_2000_TS305__TotalClaimChargeAmount IMPLEMENTATION NAME: Total Claim Charge Amount This is the total reported charges for all claims. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all 782 elements.			
	TS313	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
			SITUATIONAL RULE: Required when the Total MSP Payer Amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS313__TotalMSPPayerAmount IMPLEMENTATION NAME: Total MSP Payer Amount See TR3 note 3.			
	TS315	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
			SITUATIONAL RULE: Required when the Total Non-Lab charge amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS315__TotalNonLabChargeAmount IMPLEMENTATION NAME: Total Non-Lab Charge Amount See TR3 note 3.			
	TS317	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
			SITUATIONAL RULE: Required when the Total HCPCS Reported Charge Amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS317__TotalHCPCSReportedChargeAmount IMPLEMENTATION NAME: Total HCPCS Reported Charge Amount See TR3 note 3.			
	TS318	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**

		SITUATIONAL RULE: Required when the total HCPCS payable amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS318__TotalHCPCSPayableAmount IMPLEMENTATION NAME: Total HCPCS Payable Amount See TR3 note 3.			
TS320	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when the total professional component amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS320__TotalProfessionalComponentAmount IMPLEMENTATION NAME: Total Professional Component Amount The professional component amount must also be reported in the CAS segment with a Claim Adjustment Reason Code value of 89. See TR3 note 3.			
TS321	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when the total MSP patient liability met is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS321__TotalMSPPatientLiabilityMetAmount IMPLEMENTATION NAME: Total MSP Patient Liability Met Amount See TR3 note 3.			
TS322	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when the total patient reimbursement is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS322__TotalPatientReimbursementAmount IMPLEMENTATION NAME: Total Patient Reimbursement Amount See TR3 note 3.			
TS323	**380**	**Quantity** Numeric value of quantity	**O**	**1**	**R 1/15**
		SITUATIONAL RULE: Required when the Total PIP Claim Count is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS323__TotalPIPClaimCount IMPLEMENTATION NAME: Total PIP Claim Count See TR3 note 3.			
TS324	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when the total PIP adjustment amount is not zero. If not required by this implementation guide, do not send.			

OD: 835W1_2000_TS324__TotalPIPAdjustmentAmount

IMPLEMENTATION NAME: Total PIP Adjustment Amount

See TR3 note 3.

Segment: **TS2** **Provider Supplemental Summary Information**
Position: 0070
Loop: 2000 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To provide supplemental summary control information by provider fiscal year and bill type
Syntax Notes:
Semantic Notes:

1 TS201 is the total diagnosis related group (DRG) amount.
2 TS202 is the total federal specific amount.
3 TS203 is the total hospital specific amount.
4 TS204 is the total disproportionate share amount.
5 TS205 is the total capital amount.
6 TS206 is the total indirect medical education amount.
7 TS207 is the total number of outlier days.
8 TS208 is the total day outlier amount.
9 TS209 is the total cost outlier amount.
10 TS210 is the diagnosis related group (DRG) average length of stay.
11 TS211 is the total number of discharges.
12 TS212 is the total number of cost report days.
13 TS213 is the total number of covered days.
14 TS214 is total number of non-covered days.
15 TS215 is the total Medicare Secondary Payer (MSP) pass- through amount calculated for a non-Medicare payer.
16 TS216 is the average diagnosis-related group (DRG) weight.
17 TS217 is the total prospective payment system (PPS) capital, federal-specific portion, diagnosis-related group (DRG) amount.
18 TS218 is the total prospective payment system (PPS) capital, hospital-specific portion, diagnosis-related group (DRG) amount.
19 TS219 is the total prospective payment system (PPS) disproportionate share, hospital diagnosis-related group (DRG) amount.

Comments:
Notes: Situational Rule: Required for Medicare Part A. If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment provides summary information specific to an iteration of the LX loop (Table 2).

2. Each element represents the total value for the provider/bill type combination in this loop 2000 iteration.
TR3 Example: TS2*59786*55375.77~

Data Element Summary

Ref. Des.	Data Element	Name		Attributes
TS201	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the value of the Total DRG amount is not zero. If not required by this implementation guide, do not send.	**O**	**1 R 1/18**

		OD: 835W1_2000_TS201__TotalDRGAmount IMPLEMENTATION NAME: Total DRG Amount This includes: operating federal-specific amount, operating hospital-specific amount, operating Indirect Medical Education amount, and operating Disproportionate Share Hospital amount. It does not include any operating outlier amount. See TR3 note 2.			
TS202	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when total federal specific amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS202__TotalFederalSpecificAmount IMPLEMENTATION NAME: Total Federal Specific Amount See TR3 note 2.	**O**	**1**	**R 1/18**
TS203	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when total hospital specific amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS203__TotalHospitalSpecificAmount IMPLEMENTATION NAME: Total Hospital Specific Amount See TR3 note 2.	**O**	**1**	**R 1/18**
TS204	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when total disproportionate share amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS204__TotalDisproportionateShareAmount IMPLEMENTATION NAME: Total Disproportionate Share Amount See TR3 note 2.	**O**	**1**	**R 1/18**
TS205	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when total capital amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS205__TotalCapitalAmount IMPLEMENTATION NAME: Total Capital Amount This includes: capital federal-specfic amount, hospital federalspecfic amount, hold harmless amount, Indirect Medical Education amount, Disproportionate Share Hospital amount, and the exception amount. It does not include any capital outlier amount. See TR3 note 2.	**O**	**1**	**R 1/18**

TS206	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when total indirect medical education amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS206__TotalIndirectMedicalEducationAmount IMPLEMENTATION NAME: Total Indirect Medical Education Amount See TR3 note 2.			
TS207	**380**	**Quantity**	**O**	**1**	**R 1/15**
		Numeric value of quantity SITUATIONAL RULE: Required when total outlier day count is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS207__TotalOutlierDayCount IMPLEMENTATION NAME: Total Outlier Day Count See TR3 note 2.			
TS208	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when the value of the total day outlier amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS208__TotalDayOutlierAmount IMPLEMENTATION NAME: Total Day Outlier Amount See TR3 note 2.			
TS209	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when the value of the total cost outlier amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS209__TotalCostOutlierAmount IMPLEMENTATION NAME: Total Cost Outlier Amount See TR3 note 2.			
TS210	**380**	**Quantity**	**O**	**1**	**R 1/15**
		Numeric value of quantity SITUATIONAL RULE: Required when the value of the average DRG length of stay is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS210__AverageDRGLengthofStay IMPLEMENTATION NAME: Average DRG Length of Stay See TR3 note 2.			
TS211	**380**	**Quantity**	**O**	**1**	**R 1/15**
		Numeric value of quantity SITUATIONAL RULE: Required when the value of the total discharge count is not zero. If not required by this implementation guide, do not send.			

		OD: 835W1_2000_TS211__TotalDischargeCount IMPLEMENTATION NAME: Total Discharge Count This is the discharge count produced by PPS PRICER SOFTWARE. See TR3 note 2.			
TS212	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when the value of the total cost report day count is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS212__TotalCostReportDayCount IMPLEMENTATION NAME: Total Cost Report Day Count See TR3 note 2.	**O**	**1**	**R 1/15**
TS213	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when the value of the total covered day count is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS213__TotalCoveredDayCount IMPLEMENTATION NAME: Total Covered Day Count See TR3 note 2.	**O**	**1**	**R 1/15**
TS214	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when the value of the total noncovered day count is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS214__TotalNoncoveredDayCount IMPLEMENTATION NAME: Total Noncovered Day Count See TR3 note 2.	**O**	**1**	**R 1/15**
TS215	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the value of the total MSP Passthrough amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS215__TotalMSPPassThroughAmount IMPLEMENTATION NAME: Total MSP Pass-Through Amount See TR3 note 2.	**O**	**1**	**R 1/18**
TS216	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when the value of the average DRG Weight is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS216__AverageDRGweight IMPLEMENTATION NAME: Average DRG weight	**O**	**1**	**R 1/15**

		See TR3 note 2.			
TS217	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the value of the total PPS capital FSP (Federal-specific Portion) DRG amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS217__TotalPPSCapitalFSPDRGAmount IMPLEMENTATION NAME: Total PPS Capital FSP DRG Amount See TR3 note 2.	**O**	**1**	**R 1/18**
TS218	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the value of the total PPS Capital HSP (Hospital-specific Portion) DRG Amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS218__TotalPPSCapitalHSPDRGAmount IMPLEMENTATION NAME: Total PPS Capital HSP DRG Amount See TR3 note 2.	**O**	**1**	**R 1/18**
TS219	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the value of the Total PPS Capital DSH (Disproportionate Share, Hospital) DRG amount is not zero. If not required by this implementation guide, do not send. OD: 835W1_2000_TS219__TotalPPSDSHDRGAmount IMPLEMENTATION NAME: Total PPS DSH DRG Amount See TR3 note 2.	**O**	**1**	**R 1/18**

Segment: **CLP** **Claim Payment Information**
Position: 0100
Loop: 2100 Optional
Level: Detail
Usage: Must Use
Max Use: 1
Purpose: To supply information common to all services of a claim
Syntax Notes:
Semantic Notes:
1 CLP03 is the amount of submitted charges this claim.
2 CLP04 is the amount paid this claim.
3 CLP05 is the patient responsibility amount.
4 CLP07 is the payer's internal control number.
5 CLP12 is the diagnosis-related group (DRG) weight.
6 CLP13 is the discharge fraction.
7 CLP14 is the patient authorization to coordinate benefits. A "Y" indicates that the authorization exists; an "N" indicates that the authorization does not exist.
Comments:
Notes: TR3 Notes: 1. For CLP segment occurrence limitations, see section 1.3.2, Other Usage Limitations.
R3 Example: CLP*7722337*1*211366.97*138018.4**12*119932404007801~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**CLP01**	**1028**	**Claim Submitter's Identifier** Identifier used to track a claim from creation by the health care provider through payment OD: 835W1_2100_CLP01__PatientControlNumber IMPLEMENTATION NAME: Patient Control Number Use this number for the patient control number assigned by the provider. If the patient control number is not present on the incoming claim, enter a single zero. The value in CLP01 must be identical to any value received as a Claim Submitter's Identifier on the original claim (CLM01 of the ANSI ASC X12 837, if applicable). This data element is the primary key for posting the remittance information into the provider's database. In the case of pharmacy claims, this is the prescription reference number (field 402-02 in the NCPDP 5.1 format).	**M 1 AN 1/38**
M	**CLP02**	**1029**	**Claim Status Code** Code identifying the status of an entire claim as assigned by the payor, claim review organization or repricing organization OD: 835W1_2100_CLP02__ClaimStatusCode To determine the full claim status reference Claim adjustment reason codes in the CAS segment in conjunction with this claim status code.	**M 1 ID 1/2**

1	Processed as Primary
	Use this code if the claim was adjudicated by the current payer as primary regardless of whether any part of the claim was paid.
2	Processed as Secondary
	Use this code if the claim was adjudicated by the current payer as secondary regardless of whether any part of the claim was paid.
3	Processed as Tertiary
	Use this code if the claim was adjudicated by the current payer as tertiary (or subsequent) regardless of whether any part of the claim was paid.
4	Denied
	Usage of this code would apply if the Patient/Subscriber is not recognized, and the claim was not forwarded to another payer.
19	Processed as Primary, Forwarded to Additional Payer(s)
	When this code is used, the Crossover Carrier Name NM1 segment is required.
20	Processed as Secondary, Forwarded to Additional Payer(s)
	When this code is used, the Crossover Carrier Name NM1 segment is required.
21	Processed as Tertiary, Forwarded to Additional Payer(s)
	When this code is used, the Crossover Carrier Name NM1 segment is required.
22	Reversal of Previous Payment
	See section 1.10.2.8 for usage information.
23	Not Our Claim, Forwarded to Additional Payer(s)
	Usage of this code would apply if the

			patient/subscriber is not recognized, the claim was not adjudicated by the payer, but other payers are known and the claim has been forwarded to another payer. When this code is used, the Crossover Carrier Name NM1 segment is required.			
			25 Predetermination Pricing Only - No Payment			
M	**CLP03**	**782**	**Monetary Amount** Monetary amount	**M**	**1**	**R 1/18**
			OD: 835W1_2100_CLP03__TotalClaimChargeAmount IMPLEMENTATION NAME: Total Claim Charge Amount See 1.10.2.1, Balancing, in this implementation guide for additional information. Use this monetary amount for the submitted charges for this claim. The amount can be positive, zero or negative. An example of a situation with a negative charge is a reversal claim. See section 1.10.2.8 for additional information. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.			
M	**CLP04**	**782**	**Monetary Amount** Monetary amount	**M**	**1**	**R 1/18**
			OD: 835W1_2100_CLP04__ClaimPaymentAmount IMPLEMENTATION NAME: Claim Payment Amount See 1.10.2.1, Balancing, in this implementation guide for additional information. See section 1.10.2.9 for information about interest considerations. Use this monetary amount for the amount paid for this claim. It can be positive, zero or negative, but the value in BPR02 may not be negative.			
	CLP05	**782**	**Monetary Amount** Monetary amount	**O**	**1**	**R 1/18**
			SITUATIONAL RULE: Required when the patient's responsibility is greater than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_CLP05__PatientResponsibilityAmount IMPLEMENTATION NAME: Patient Responsibility Amount Amounts in CLP05 must have supporting adjustments reflected in CAS segments at the 2100 (CLP) or 2110 (SVC) loop level with a Claim Adjustment Group (CAS01) code of PR (Patient Responsibility). Use this monetary amount for the payer's statement of the patient responsibility amount for this claim, which can include such items as deductible, non-covered services, co-pay and co-insurance. This is not used for reversals. See section 1.10.2.8, Reversals and Corrections, for additional information.			
Must Use	**CLP06**	**1032**	**Claim Filing Indicator Code** Code identifying type of claim	**O**	**1**	**ID 1/2**
			OD: 835W1_2100_CLP06__ClaimFilingIndicatorCode			

For many providers to electronically post the 835 remittance data to their patient accounting systems without human intervention, a unique, provider-specific insurance plan code is needed. This code allows the provider to separately identify and manage the different product lines or contractual arrangements between the payer and the provider. Because most payers maintain the same Originating Company Identifier in the TRN03 or BPR10 for all product lines or contractual relationships, the CLP06 is used by the provider as a table pointer in combination with the TRN03 or BPR10 to identify the unique, provider-specific insurance plan code needed to post the payment without human intervention. The value should mirror the value received in the original claim (2-005 SBR09 of the 837), if applicable, or provide the value as assigned or edited by the payer. For example the BL from the SBR09 in the 837 would be returned as 12, 13, 15, in the 835 when more details are known. The 837 SBR09 code CI (Commercial Insurance) is generic, if through adjudication the specific type of plan is obtained a more specific code must be returned in the 835.

The 837 and 835 transaction code lists for this element are not identical by design. There are some business differences between the two transactions. When a code from the 837 is not available in the 835 another valid code from the 835 must be assigned by the payer.

12	Preferred Provider Organization (PPO)
	This code is also used for Blue Cross/Blue Shield participating provider arrangements.
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
	This code is also used for Blue Cross/Blue Shield non-participating provider arrangements.
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization
AM	Automobile Medical
CH	Champus
DS	Disability
HM	Health Maintenance Organization
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
	Use this code for the Black Lung Program.
TV	Title V
VA	Veterans Affairs Plan
WC	Workers' Compensation Health Claim
ZZ	Mutually Defined

Must Use **CLP07** **127** **Reference Identification** **O** **1** **AN 1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

OD: 835W1_2100_CLP07__PayerClaimControlNumber

IMPLEMENTATION NAME: Payer Claim Control Number

Use this number for the payer’s internal control number. This number must

		apply to the entire claim.			
CLP08	**1331**	**Facility Code Value** Code identifying where services were, or may be, performed; the first and second positions of the Uniform Bill Type Code for Institutional Services or the Place of Service Codes for Professional or Dental Services. SITUATIONAL RULE: Required when the information was received on the original claim. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver. OD: 835W1_2100_CLP08__FacilityTypeCode IMPLEMENTATION NAME: Facility Type Code Since professional or dental claims can have different place of service codes for services within a single claim, default to the place of service of the first service line when the service lines are not all for the same place of service. This number was received in CLM05-1 of the 837 claim.	**O**	**1**	**AN 1/2**
CLP09	**1325**	**Claim Frequency Type Code** Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type SITUATIONAL RULE: Required when the information was received on the original claim. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver. OD: 835W1_2100_CLP09__ClaimFrequencyCode IMPLEMENTATION NAME: Claim Frequency Code CODE SOURCE 235: Claim Frequency Type Code This number was received in CLM05-3 of the 837 Claim.	**O**	**1**	**ID 1/1**
CLP11	**1354**	**Diagnosis Related Group (DRG) Code** Code indicating a patient's diagnosis group based on a patient's illness, diseases, and medical problems SITUATIONAL RULE: Required for institutional claims when the claim was adjudicated using a DRG. If not required by this implementation guide, do not send. OD: 835W1_2100_CLP11__DiagnosisRelatedGroupDRGCode CODE SOURCE 229: Diagnosis Related Group Number (DRG)	**O**	**1**	**ID 1/4**
CLP12	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required for institutional claims when the claim was adjudicated using a DRG. If not required by this implementation guide, do not send. OD: 835W1_2100_CLP12__DiagnosisRelatedGroupDRGWeight IMPLEMENTATION NAME: Diagnosis Related Group (DRG) Weight This is the adjudicated DRG Weight.	**O**	**1**	**R 1/15**
CLP13	**954**	**Percentage as Decimal** Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%)	**O**	**1**	**R 1/10**

SITUATIONAL RULE: Required when a discharge fraction was applied in the adjudication process. If not required by this implementation guide, do not send.

OD: 835W1_2100_CLP13__DischargeFraction

IMPLEMENTATION NAME: Discharge Fraction

This is the adjudicated discharge fraction.

Segment: **CAS** **Claims Adjustment**
Position: 0200
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 99
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid
Syntax Notes:
1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2 If CAS06 is present, then CAS05 is required.
3 If CAS07 is present, then CAS05 is required.
4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5 If CAS09 is present, then CAS08 is required.
6 If CAS10 is present, then CAS08 is required.
7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8 If CAS12 is present, then CAS11 is required.
9 If CAS13 is present, then CAS11 is required.
10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11 If CAS15 is present, then CAS14 is required.
12 If CAS16 is present, then CAS14 is required.
13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14 If CAS18 is present, then CAS17 is required.
15 If CAS19 is present, then CAS17 is required.
Semantic Notes:
1 CAS03 is the amount of adjustment.
2 CAS04 is the units of service being adjusted.
3 CAS06 is the amount of the adjustment.
4 CAS07 is the units of service being adjusted.
5 CAS09 is the amount of the adjustment.
6 CAS10 is the units of service being adjusted.
7 CAS12 is the amount of the adjustment.
8 CAS13 is the units of service being adjusted.
9 CAS15 is the amount of the adjustment.
10 CAS16 is the units of service being adjusted.
11 CAS18 is the amount of the adjustment.
12 CAS19 is the units of service being adjusted.
Comments:
1 Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.
Notes: Situational Rule: Required when dollar amounts and/or quantities are being adjusted at the claim level. If not required by this implementation guide, do not send.

TR3 Notes: 1. Payers must use this CAS segment to report claim level adjustments that cause the amount paid to differ from the amount originally charged. See 1.10.2.1, Balancing, and 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.

2. See the SVC TR3 Note #1 for details about per diem adjustments.

3. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a specific Claim Adjustment Group Code (CAS01). The six iterations (trios) of the Adjustment Reason Code related to the Specific Adjustment Group Code must be exhausted before repeating a second iteration of the CAS segment using the same Adjustment Group Code. The first adjustment must be the first on-zero adjustment and is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05-CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).
TR3 Example: CAS*PR*1*793**3*25~
CAS*CO*131*250~

Data Element Summary

	Ref. Des.	Data Element	Name			Attributes
M	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment	**M**	**1**	**ID 1/2**
			OD: 835W1_2100_CAS01__ClaimAdjustmentGroupCode Evaluate the usage of group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, OA. See 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)			
			CO Contractual Obligations Use this code when a joint payer/payee contractual agreement or a regulatory requirement resulted in an adjustment.			
			OA Other adjustments Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.			
			PI Payor Initiated Reductions Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).			
			PR Patient Responsibility			
M	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**M**	**1**	**ID 1/5**
			OD: 835W1_2100_CAS02__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code Required to report a non-zero adjustment applied at the claim level for the claim adjustment group code reported in CAS01.			
M	**CAS03**	**782**	**Monetary Amount** Monetary amount	**M**	**1**	**R 1/18**
			OD: 835W1_2100_CAS03__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount			

		Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in CLP04. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.			
CAS04	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when the CAS02 adjustment reason code is related to non-covered days. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS04__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See section 1.10.2.4.1 for additional information. A positive value decreases the covered days, and a negative number increases the covered days.	**O**	**1**	**R 1/15**
CAS05	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS05__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code	**X**	**1**	**ID 1/5**
CAS06	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when CAS05 is present. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS06__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.	**X**	**1**	**R 1/18**
CAS07	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when CAS05 is present and is related to non-covered days. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS07__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.	**X**	**1**	**R 1/15**
CAS08	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**1**	**ID 1/5**

		SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS08__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code			
CAS09	**782**	**Monetary Amount** Monetary amount	**X**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when CAS08 is present. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS09__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.			
CAS10	**380**	**Quantity** Numeric value of quantity	**X**	**1**	**R 1/15**
		SITUATIONAL RULE: Required when CAS08 is present and is related to non-covered days. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS10__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.			
CAS11	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**X**	**1**	**ID 1/5**
		SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS11__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code			
CAS12	**782**	**Monetary Amount** Monetary amount	**X**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when CAS11 is present. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS12__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.			
CAS13	**380**	**Quantity** Numeric value of quantity	**X**	**1**	**R 1/15**
		SITUATIONAL RULE: Required when CAS11 is present and is related to non-covered days. If not required by this implementation guide, do not send.			

		OD: 835W1_2100_CAS13__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04			
CAS14	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS14__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code	**X**	**1**	**ID 1/5**
CAS15	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when CAS14 is present. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS15__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.	**X**	**1**	**R 1/18**
CAS16	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when CAS14 is present and is related to non-covered days. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS16__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.	**X**	**1**	**R 1/15**
CAS17	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS17__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code	**X**	**1**	**ID 1/5**
CAS18	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when CAS17 is present. If not required by this implementation guide, do not send. OD: 835W1_2100_CAS18__AdjustmentAmount	**X**	**1**	**R 1/18**

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

CAS19	**380**	**Quantity** Numeric value of quantity	**X**	**1**	**R 1/15**

SITUATIONAL RULE: Required when CAS17 is present and is related to non-covered days. If not required by this implementation guide, do not send.

OD: 835W1_2100_CAS19__AdjustmentQuantity

IMPLEMENTATION NAME: Adjustment Quantity

See CAS04.

Segment: **NM1** **Patient Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Must Use
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Comments: **1** NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: TR3 Notes: 1. Provide the patient's identification number in NM109.

2. This segment must provide the information from the original claim. For example, when the claim is submitted as an ASC X12 837 transaction, this is the 2010CA loop NM1 Patient name SEgment unles not present on the original claim, then it is the 2010BA loop NM1 Subscriber name segment.

3. The Corrected Patient/Insured Name NM1 segment identifies the adjudicated Insured Name and ID information if different than what was submitted on the claim.
TR3 Example: NM1*QC*1*SHEPHARD*SAM*O***HN*666666666A~

Data Element Summary

	Ref. Des.	Data Element	Name			Attributes
M	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual	**M**	**1**	**ID 2/3**
			OD: 835W1_2100_NM101__EntityIdentifierCode			
			QC Patient Individual receiving medical care			
M	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity	**M**	**1**	**ID 1/1**
			OD: 835W1_2100_NM102__EntityTypeQualifier			
			1 Person			
	NM103	**1035**	**Name Last or Organization Name** Individual last name or organizational name	**X**	**1**	**AN 1/60**

SITUATIONAL RULE: Required for all claims that are not Retail Pharmacy claims or for Retail Pharmacy claims when the information is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM103__PatientLastName

IMPLEMENTATION NAME: Patient Last Name

NM104	**1036**	**Name First**	**O**	**1**	**AN 1/35**

Individual first name

SITUATIONAL RULE: Required when the patient has a first name and it is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM104__PatientFirstName

IMPLEMENTATION NAME: Patient First Name

NM105	**1037**	**Name Middle**	**O**	**1**	**AN 1/25**

Individual middle name or initial

SITUATIONAL RULE: Required when the patient has a middle name or initial and it is known. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM105__PatientMiddleNameorInitial

IMPLEMENTATION NAME: Patient Middle Name or Initial

If this data element is used and contains only one character, it is assumed to represent the middle initial.

NM107	**1039**	**Name Suffix**	**O**	**1**	**AN 1/10**

Suffix to individual name

SITUATIONAL RULE: Required when this information is necessary for identification of the individual. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM107__PatientNameSuffix

IMPLEMENTATION NAME: Patient Name Suffix

An example of this is when a Junior and Senior are covered under the same subscriber.

NM108	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**

Code designating the system/method of code structure used for Identification Code (67)

SITUATIONAL RULE: Required when the patient identifier (NM109) is known or was reported on the healthcare claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM108__IdentificationCodeQualifier

34	Social Security Number
HN	Health Insurance Claim (HIC) Number Unique number assigned to individual for submitting claims covered by Medicare benefits
II	Standard Unique Health Identifier for each Individual in the United States Use this code if mandated in a final Federal Rule.
MI	Member Identification Number
MR	Medicaid Recipient Identification Number

Unique identification number assigned to each member covered under a subscriber's contract

NM109	**67**	**Identification Code**	**X**	**1**	**AN 2/80**

Code identifying a party or other code

SITUATIONAL RULE: Required when the patient identifier is known or was reported on the health care claim. If not required by this implementation guide, do not send.

OD: 835W1_2100_NM109__PatientIdentifier

IMPLEMENTATION NAME: Patient Identifier

Segment: **NM1** **Insured Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes: **1** NM102 qualifies NM103.
Comments: **1** NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when the original claim reported the insured or subscriber (for example 837 2010BA loop Subscriber Name NM1 Segment) this is different from the patient. If not required by this implementation guide, do not send.

TR3 Notes: 1. In the case of Medicare and Medicaid, the insured patient is always the subscriber and this segment is not used.

2. This segment contains the same information as reported on the claim (for example 837 2010BA loop Subscriber Name NM1 Segment when the patient was reported in the 2010CA loop Patient Name NM1 Segment).
TR3 Example: NM1*IL*1*SHEPARD*JESSICA****MI*999887777A~

Data Element Summary

	Ref. Des.	Data Element	Name			Attributes
M	**NM101**	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**
			Code identifying an organizational entity, a physical location, property or an individual			
			OD: 835W1_2100_NM101__EntityIdentifierCode			
			IL Insured or Subscriber			
M	**NM102**	**1065**	**Entity Type Qualifier**	**M**	**1**	**ID 1/1**
			Code qualifying the type of entity			
			OD: 835W1_2100_NM102__EntityTypeQualifier			
			1 Person			
			2 Non-Person Entity			
	NM103	**1035**	**Name Last or Organization Name**	**X**	**1**	**AN 1/60**
			Individual last name or organizational name			
			SITUATIONAL RULE: Required when the last name (NM102=1) or organization name (NM102=2) is known. If not required by this implementation guide, do			

			not send. OD: 835W1_2100_NM103__SubscriberLastName IMPLEMENTATION NAME: Subscriber Last Name				
	NM104	**1036**	**Name First** Individual first name SITUATIONAL RULE: Required when the subscriber is a person (NM102=1) and the first name is known. If not required by this implementation guide, do not send. OD: 835W1_2100_NM104__SubscriberFirstName IMPLEMENTATION NAME: Subscriber First Name	**O**	**1**	**AN 1/35**	
	NM105	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: Required when the subscriber is a person (NM102=1) and the middle name or initial is known. If not required by this implementation guide, do not send. OD: 835W1_2100_NM105__SubscriberMiddleNameorInitial IMPLEMENTATION NAME: Subscriber Middle Name or Initial If this data element is used and contains only one character, it is assumed to represent the middle initial.	**O**	**1**	**AN 1/25**	
	NM107	**1039**	**Name Suffix** Suffix to individual name SITUATIONAL RULE: Required when the subscriber is a person (NM102=1), the information is known and this information is necessary for identification of the individual. If not required by this implementation guide, do not send. OD: 835W1_2100_NM107__SubscriberNameSuffix IMPLEMENTATION NAME: Subscriber Name Suffix For example, use when necessary to differentiate between a Junior and Senior under the same contract.	**O**	**1**	**AN 1/10**	
Must Use	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_2100_NM108__IdentificationCodeQualifier FI Federal Taxpayer's Identification Number Not Used when NM102=1 II Standard Unique Health Identifier for each Individual in the United States Use this code if mandated in a final Federal Rule. MI Member Identification Number The code MI is intended to identify that the subscriber's identification number as assigned by the payer will be conveyed in NM109. Payers use different terminology to convey the same number, therefore, the 835 workgroup recommends using MI (Member Identification number) to convey the same	**X**	**1**	**ID 1/2**	

			categories of numbers as represented in the 837 IGs for the inbound claims.				
Must Use	**NM109**	**67**	**Identification Code** Code identifying a party or other code OD: 835W1_2100_NM109__SubscriberIdentifier IMPLEMENTATION NAME: Subscriber Identifier	**X**	**1**	**AN 2/80**

Segment: **NM1** **Corrected Patient/Insured Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when needed to provide corrected information about the patient or insured. If not required by this implementation guide, do not send.

TR3 Notes: 1. Since the patient is always the insured for Medicare and Medicaid, this segment always provides corrected patient information for Medicare and Medicaid. For other carriers, this will always be the corrected insured information.
TR3 Example: NM1*74*1*SHEPARD*SAMUEL*O***C*666666666A~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode 74 Corrected Insured	**M**	**1**	**ID 2/3**
M	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 1 Person 2 Non-Person Entity	**M**	**1**	**ID 1/1**
	NM103	**1035**	**Name Last or Organization Name** Individual last name or organizational name SITUATIONAL RULE: Required when the insured is a person (NM102=1) AND the submitted vs adjudicated data is different. If not required by this implementation guide, do not send. OD: 835W1_2100_NM103__CorrectedPatientorInsuredLastName IMPLEMENTATION NAME: Corrected Patient or Insured Last Name	**X**	**1**	**AN 1/60**
	NM104	**1036**	**Name First** Individual first name SITUATIONAL RULE: Required when the insured is a person (NM102=1) AND	**O**	**1**	**AN 1/35**

		the submitted vs adjudicated data is different. If not required by this implementation guide, do not send. OD: 835W1_2100_NM104__CorrectedPatientorInsuredFirstName IMPLEMENTATION NAME: Corrected Patient or Insured First Name			
NM105	**1037**	**Name Middle**	**O**	**1**	**AN 1/25**
		Individual middle name or initial SITUATIONAL RULE: Required when the insured is a person (NM102=1) AND the submitted vs adjudicated data is different AND the information is known. If not required by this implementation guide, do not send. OD: 835W1_2100_NM105__CorrectedPatientorInsuredMiddleName IMPLEMENTATION NAME: Corrected Patient or Insured Middle Name If this data element is used and contains only one character, it is assumed to represent the middle initial.			
NM107	**1039**	**Name Suffix**	**O**	**1**	**AN 1/10**
		Suffix to individual name SITUATIONAL RULE: Required when the insured is a person (NM102=1) and corrected information for the insured is available and this information is necessary for identification of the individual. If not required by this implementation guide, do not send. OD: 835W1_2100_NM107__CorrectedPatientorInsuredNameSuffix IMPLEMENTATION NAME: Corrected Patient or Insured Name Suffix			
NM108	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**
		Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when a value is reported in NM109. If not required by this implementation guide, do not send. OD: 835W1_2100_NM108__IdentificationCodeQualifier C Insured's Changed Unique Identification Number			
NM109	**67**	**Identification Code**	**X**	**1**	**AN 2/80**
		Code identifying a party or other code SITUATIONAL RULE: Required when the adjudicated patient/insured identification number is different than the identification submitted on the claim. If not required by this implementation guide, do not send. OD: 835W1_2100_NM109__CorrectedInsuredIdentificationIndicator IMPLEMENTATION NAME: Corrected Insured Identification Indicator			

Segment: **NM1** **Service Provider Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes: **1** If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.

3 If NM112 is present, then NM103 is required.

Semantic Notes: **1** NM102 qualifies NM103.

Comments: **1** NM110 and NM111 further define the type of entity in NM101.

2 NM112 can identify a second surname.

Notes: Situational Rule: Required when the rendering provider is different from the payee. If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment provides information about the rendering provider. An identification number is provided in NM109.

2. This information is provided to facilitate identification of the claim within a payee's system. Other providers (e.g., Referring provider, supervising provider) related to the claim but not directly related to the payment are not supported and are not necessary for claim identification.
TR3 Example: NM1*82*2******XX*12345678~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode 82 Rendering Provider	**M**	**1**	**ID 2/3**
M	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 1 Person 2 Non-Person Entity	**M**	**1**	**ID 1/1**
	NM103	**1035**	**Name Last or Organization Name** Individual last name or organizational name SITUATIONAL RULE: Required when a unique name is necessary for identification of the provider identified in NM109. If not required, may be provided at sender's discretion, but cannot be required by the receiver. OD: 835W1_2100_NM103__RenderingProviderLastorOrganizationName IMPLEMENTATION NAME: Rendering Provider Last or Organization Name	**X**	**1**	**AN 1/60**
	NM104	**1036**	**Name First** Individual first name SITUATIONAL RULE: Required when the Servicing Provider is a person (NM102=1), NM103 is used AND the information is known from systems of the sender. If not required by this implementation guide, do not send. OD: 835W1_2100_NM104__RenderingProviderFirstName IMPLEMENTATION NAME: Rendering Provider First Name	**O**	**1**	**AN 1/35**
	NM105	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: Required when the Servicing Provider is a person (NM102=1), NM103 is used AND the information is known from systems of the sender. If not required by this implementation guide, do not send. OD: 835W1_2100_NM105__RenderingProviderMiddleNameorInitial	**O**	**1**	**AN 1/25**

			IMPLEMENTATION NAME: Rendering Provider Middle Name or Initial If this data element is used and contains only one character, it represents the middle initial.				
	NM107	**1039**	**Name Suffix**	**O**	**1**	**AN**	**1/10**
			Suffix to individual name SITUATIONAL RULE: Required when the Servicing Provider is a person (NM102=1), NM103 is used and this information is necessary for identification of the individual, for instance when a Junior and Senior are both providers in the same practice. If not required by this implementation guide, do not send. OD: 835W1_2100_NM107__RenderingProviderNameSuffix IMPLEMENTATION NAME: Rendering Provider Name Suffix				
Must Use	**NM108**	**66**	**Identification Code Qualifier**	**X**	**1**	**ID**	**1/2**
			Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_2100_NM108__IdentificationCodeQualifier BD Blue Cross Provider Number Number assigned by Blue Cross Plan to a provider of services BS Blue Shield Provider Number Number assigned by Blue Shield Plan to a provider of services FI Federal Taxpayer's Identification Number This is the preferred ID until the National Provider ID is mandated and applicable. For individual providers as payees, use this qualifier to represent the Social Security Number. MC Medicaid Provider Number Number assigned to a health care provider for submitting claims covered by Medicaid benefits PC Provider Commercial Number Unique number assigned to the provider for submitting claims to commercial insurance carriers SL State License Number Number uniquely issued to provider by state licensing board UP Unique Physician Identification Number (UPIN) Number assigned to the provider by the National Registry for Medicare identification purposes XX Centers for Medicare and Medicaid Services National Provider Identifier Required value if the National Provider ID is mandated for use and the provider is a covered health care provider under the mandate. Otherwise, one of the other listed codes may be used. CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier				
Must Use	**NM109**	**67**	**Identification Code**	**X**	**1**	**AN**	**2/80**
			Code identifying a party or other code OD: 835W1_2100_NM109__RenderingProviderIdentifier IMPLEMENTATION NAME: Rendering Provider Identifier				

Segment: **NM1** **Crossover Carrier Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when the claim is transferred to another carrier or coverage (CLP02 equals 19, 20, 21 or 23). If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment provides information about the crossover carrier. Provide any reference numbers in NM109. The crossover carrier is defined as any payer to which the claim is transferred for further payment after being finalized by the current payer.
TR3 Example: NM1*TT*2*ACME INSURANCE*****XV*123456789~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode TT Transfer To	**M 1 ID 2/3**
M	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 2 Non-Person Entity	**M 1 ID 1/1**
Must Use	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name OD: 835W1_2100_NM103__CoordinationofBenefitsCarrierName IMPLEMENTATION NAME: Coordination of Benefits Carrier Name Name of the crossover carrier associated with this claim.	**X 1 AN 1/60**
Must Use	**NM108**	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) OD: 835W1_2100_NM108__IdentificationCodeQualifier AD Blue Cross Blue Shield Association Plan Code Unique 3-digit number assigned to independent Blue Cross or Blue Shield plans by Blue Cross/Blue Shield Association FI Federal Taxpayer's Identification Number NI National Association of Insurance Commissioners (NAIC) Identification This is the preferred ID until the National Plan ID is mandated and applicable.	**X 1 ID 1/2**

			PI	Payor Identification			
			PP	Pharmacy Processor Number Unique number assigned to each pharmacy for submitting claims			
			XV	Centers for Medicare and Medicaid Services PlanID Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID			
Must Use	**NM109**	**67**	**Identification Code** Code identifying a party or other code OD: 835W1_2100_NM109__CoordinationofBenefitsCarrierIdentifier IMPLEMENTATION NAME: Coordination of Benefits Carrier Identifier		**X**	**1**	**AN 2/80**

Segment: **NM1** **Corrected Priority Payer Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when current payer believes that another payer has priority for making a payment and the claim is not being automatically transferred to that payer. If not required by this implementation guide, do not send.

TR3 Notes: 1. Provide any reference numbers in NM109. Use of this segment identifies the priority payer. Do not use this segment when the Crossover Carrier NM1 segment is used.
TR3 Example: NM1*PR*2*ACME INSURANCE*****XV*123456789~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**NM101**	**98**	**Entity Identifier Code** Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode PR Payer	**M**	**1**	**ID 2/3**
M	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 2 Non-Person Entity	**M**	**1**	**ID 1/1**
Must Use	**NM103**	**1035**	**Name Last or Organization Name** Individual last name or organizational name OD: 835W1_2100_NM103__CorrectedPriorityPayerName	**X**	**1**	**AN 1/60**

IMPLEMENTATION NAME: Corrected Priority Payer Name

Must Use	**NM108**	**66**	**Identification Code Qualifier**	**X**	**1**	**ID 1/2**

Code designating the system/method of code structure used for Identification Code (67)

OD: 835W1_2100_NM108__IdentificationCodeQualifier

AD	Blue Cross Blue Shield Association Plan Code
	Unique 3-digit number assigned to independent Blue Cross or Blue Shield plans by Blue Cross/Blue Shield Association
FI	Federal Taxpayer's Identification Number
NI	National Association of Insurance Commissioners (NAIC) Identification
	This is the preferred ID until the National Plan ID is mandated and applicable.
PI	Payor Identification
PP	Pharmacy Processor Number
	Unique number assigned to each pharmacy for submitting claims
XV	Centers for Medicare and Medicaid Services PlanID
	Required if the National PlanID is mandated for use. Otherwise, one of the other listed codes may be used. CODE SOURCE 540: Centers for Medicare and Medicaid Services PlanID

Must Use	**NM109**	**67**	**Identification Code**	**X**	**1**	**AN 2/80**

Code identifying a party or other code

OD: 835W1_2100_NM109__CorrectedPriorityPayerIdentificationNumber

IMPLEMENTATION NAME: Corrected Priority Payer Identification Number

Segment: **NM1** **Other Subscriber Name**
Position: 0300
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To supply the full name of an individual or organizational entity
Syntax Notes:
1 If either NM108 or NM109 is present, then the other is required.
2 If NM111 is present, then NM110 is required.
3 If NM112 is present, then NM103 is required.
Semantic Notes:
1 NM102 qualifies NM103.
Comments:
1 NM110 and NM111 further define the type of entity in NM101.
2 NM112 can identify a second surname.
Notes: Situational Rule: Required when a corrected priority payer has been identified in another NM1 segment AND the name or ID of the other subscriber is known. If not required by this implementation guide, do not send.

TR3 Notes: 1. This is the name and ID number of the other subscriber when a corrected priority payer has been identified. When used, either the name or ID must be supplied. TR3 Example: NM1*GB*Smith*Jane~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**NM101**	**98**	**Entity Identifier Code**	**M**	**1**	**ID 2/3**

			Code identifying an organizational entity, a physical location, property or an individual OD: 835W1_2100_NM101__EntityIdentifierCode GB Other Insured				
M	**NM102**	**1065**	**Entity Type Qualifier** Code qualifying the type of entity OD: 835W1_2100_NM102__EntityTypeQualifier 1 Person 2 Non-Person Entity	**M**	**1**	**ID 1/1**
	NM103	**1035**	**Name Last or Organization Name** Individual last name or organizational name SITUATIONAL RULE: Required when known or when NM109 is not present. If not required by this implementation guide, do not send. OD: 835W1_2100_NM103__OtherSubscriberLastName IMPLEMENTATION NAME: Other Subscriber Last Name At least one of NM103 or NM109 must be present.	**X**	**1**	**AN 1/60**
	NM104	**1036**	**Name First** Individual first name SITUATIONAL RULE: Required when the Other Subscriber is a person (NM102=1), NM103 is present and the first name is known. If not required by this implementation guide, do not send. OD: 835W1_2100_NM104__OtherSubscriberFirstName IMPLEMENTATION NAME: Other Subscriber First Name	**O**	**1**	**AN 1/35**
	NM105	**1037**	**Name Middle** Individual middle name or initial SITUATIONAL RULE: Required when the Other Subscriber is a person (NM102=1) and the middle name or initial is known. If not required by this implementation guide, do not send. OD: 835W1_2100_NM105__OtherSubscriberMiddleNameorInitial IMPLEMENTATION NAME: Other Subscriber Middle Name or Initial When only one character is present this is assumed to be the middle initial.	**O**	**1**	**AN 1/25**
	NM107	**1039**	**Name Suffix** Suffix to individual name SITUATIONAL RULE: Required when the Other Subscriber is a person (NM102=1), the information is known and this information is necessary for identification of the individual. If not required by this implementation guide, do not send. OD: 835W1_2100_NM107__OtherSubscriberNameSuffix IMPLEMENTATION NAME: Other Subscriber Name Suffix	**O**	**1**	**AN 1/10**
	NM108	**66**	**Identification Code Qualifier** Code designating the system/method of code structure used for Identification Code (67) SITUATIONAL RULE: Required when NM109 is known. If not required by this implementation guide, do not send.	**X**	**1**	**ID 1/2**

		OD: 835W1_2100_NM108__IdentificationCodeQualifier				
		FI	Federal Taxpayer's Identification Number			
			Not Used when NM102=1.			
		II	Standard Unique Health Identifier for each Individual in the United States			
			Use this code if mandated in a final Federal Rule.			
		MI	Member Identification Number			
			Use this code when supplying the number used for identification of the subscriber in NM109.			
NM109	**67**	**Identification Code**		**X**	**1**	**AN 2/80**
		Code identifying a party or other code				
		SITUATIONAL RULE: Required when known or when NM103 is not present. If not required by this implementation guide, do not send. OD: 835W1_2100_NM109__OtherSubscriberIdentifier IMPLEMENTATION NAME: Other Subscriber Identifier At least one of NM103 or NM109 must be present.				

Segment: **MIA** **Inpatient Adjudication Information**
Position: 0330
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To provide claim-level data related to the adjudication of Medicare inpatient claims
Syntax Notes:
Semantic Notes:

1 MIA01 is the covered days.
2 MIA02 is the Prospective Payment System (PPS) Operating Outlier amount.
3 MIA03 is the lifetime psychiatric days.
4 MIA04 is the Diagnosis Related Group (DRG) amount.
5 MIA05 is the Claim Payment Remark Code. See Code Source 411.
6 MIA06 is the disproportionate share amount.
7 MIA07 is the Medicare Secondary Payer (MSP) pass-through amount.
8 MIA08 is the total Prospective Payment System (PPS) capital amount.
9 MIA09 is the Prospective Payment System (PPS) capital, federal specific portion, Diagnosis Related Group (DRG) amount.
10 MIA10 is the Prospective Payment System (PPS) capital, hospital specific portion, Diagnosis Related Group (DRG), amount.
11 MIA11 is the Prospective Payment System (PPS) capital, disproportionate share, hospital Diagnosis Related Group (DRG) amount.
12 MIA12 is the old capital amount.
13 MIA13 is the Prospective Payment System (PPS) capital indirect medical education claim amount.
14 MIA14 is hospital specific Diagnosis Related Group (DRG) Amount.
15 MIA15 is the cost report days.
16 MIA16 is the federal specific Diagnosis Related Group (DRG) amount.
17 MIA17 is the Prospective Payment System (PPS) Capital Outlier amount.
18 MIA18 is the indirect teaching amount.
19 MIA19 is the professional component amount billed but not payable.
20 MIA20 is the Claim Payment Remark Code. See Code Source 411.
21 MIA21 is the Claim Payment Remark Code. See Code Source 411.
22 MIA22 is the Claim Payment Remark Code. See Code Source 411.
23 MIA23 is the Claim Payment Remark Code. See Code Source 411.

24 MIA24 is the capital exception amount.

Comments:

Notes: Situational Rule: Required for all inpatient claims when there is a need to report Remittance Advice Remark Codes at the claim level or, the claim is paid by Medicare or Medicaid under the Prospective Payment System (PPS). If not required by this implementation guide, do not send.

TR3 Notes: 1. When used outside of the Medicare and Medicaid community only MIA01, 05, 20, 21, 22 and 23 may be used.

2. Either MIA or MOA may appear, but not both.

3. This segment must not be used for covered days or lifetime reserve days. For covered or lifetime reserve days, use the Supplemental Claim Information Quantities Segment in the Claim Payment Loop.

4. All situational quantities and/or monetary amounts in this segment are required when the value of the item is different than zero.
MIA*0***138018.4~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**MIA01**	**380**	**Quantity** Numeric value of quantity OD: 835W1_2100_MIA01__CoveredDaysorVisitsCount IMPLEMENTATION NAME: Covered Days or Visits Count Implementers utilizing the MIA segment always transmit the number zero. See the QTY segment at the claim level for covered days or visits count.	**M**	**1**	**R 1/15**
	MIA02	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when an additional payment is made for excessive cost incurred by the provider when the payer is Medicare or Medicaid and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA02__PPSOperatingOutlierAmount IMPLEMENTATION NAME: PPS Operating Outlier Amount See TR3 note 4. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.	**O**	**1**	**R 1/18**
	MIA03	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required for psychiatric claims when the payer is Medicare or Medicaid and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA03__LifetimePsychiatricDaysCount IMPLEMENTATION NAME: Lifetime Psychiatric Days Count	**O**	**1**	**R 1/15**

MIA04	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required for claims paid under a Diagnostic Related Group when the payer is Medicare or Medicaid and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA04__ClaimDRGAmount IMPLEMENTATION NAME: Claim DRG Amount			
MIA05	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when a claim level Claim Payment Remark Code applies to this claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA05__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code			
MIA06	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA06__ClaimDisproportionateShareAmount IMPLEMENTATION NAME: Claim Disproportionate Share Amount			
MIA07	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA07__ClaimMSPPassthroughAmount IMPLEMENTATION NAME: Claim MSP Pass-through Amount			
MIA08	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA08__ClaimPPSCapitalAmount IMPLEMENTATION NAME: Claim PPS Capital Amount			
MIA09	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA09__PPSCapitalFSPDRGAmount IMPLEMENTATION NAME: PPS-Capital FSP DRG Amount			

MIA10	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA10__PPSCapitalHSPDRGAmount IMPLEMENTATION NAME: PPS-Capital HSP DRG Amount	**O**	**1**	**R 1/18**
MIA11	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA11__PPSCapitalDSHDRGAmount IMPLEMENTATION NAME: PPS-Capital DSH DRG Amount	**O**	**1**	**R 1/18**
MIA12	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA12__OldCapitalAmount IMPLEMENTATION NAME: Old Capital Amount	**O**	**1**	**R 1/18**
MIA13	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA13__PPSCapitalIMEamount IMPLEMENTATION NAME: PPS-Capital IME amount	**O**	**1**	**R 1/18**
MIA14	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA14__PPSOperatingHospitalSpecificDRGAmount IMPLEMENTATION NAME: PPS-Operating Hospital Specific DRG Amount	**O**	**1**	**R 1/18**
MIA15	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA15__CostReportDayCount IMPLEMENTATION NAME: Cost Report Day Count	**O**	**1**	**R 1/15**
MIA16	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**

		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA16__PPSOperatingFederalSpecificDRGAmount IMPLEMENTATION NAME: PPS-Operating Federal Specific DRG Amount			
MIA17	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA17__ClaimPPSCapitalOutlierAmount IMPLEMENTATION NAME: Claim PPS Capital Outlier Amount	**O**	**1**	**R 1/18**
MIA18	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA18__ClaimIndirectTeachingAmount IMPLEMENTATION NAME: Claim Indirect Teaching Amount	**O**	**1**	**R 1/18**
MIA19	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA19__NonpayableProfessionalComponentAmount IMPLEMENTATION NAME: Nonpayable Professional Component Amount	**O**	**1**	**R 1/18**
MIA20	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA20__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code	**O**	**1**	**AN 1/50**
MIA21	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA21__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code	**O**	**1**	**AN 1/50**
MIA22	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**

		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA22__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code			
MIA23	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA23__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code			
MIA24	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when Medicare or Medicaid is the payer and the value is different than zero. If not required by this implementation guide, do not send. OD: 835W1_2100_MIA24__PPSCapitalExceptionAmount IMPLEMENTATION NAME: PPS-Capital Exception Amount			

Segment: **MOA** **Outpatient Adjudication Information**
Position: 0350
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting
Syntax Notes:
Semantic Notes:
1 MOA01 is the reimbursement rate.
2 MOA02 is the claim Health Care Financing Administration Common Procedural Coding System (HCPCS) payable amount.
3 MOA03 is the Claim Payment Remark Code. See Code Source 411.
4 MOA04 is the Claim Payment Remark Code. See Code Source 411.
5 MOA05 is the Claim Payment Remark Code. See Code Source 411.
6 MOA06 is the Claim Payment Remark Code. See Code Source 411.
7 MOA07 is the Claim Payment Remark Code. See Code Source 411.
8 MOA08 is the End Stage Renal Disease (ESRD) payment amount.
9 MOA09 is the professional component amount billed but not payable.
Comments:
Notes: Situational Rule: Required for outpatient/professional claims where there is a need to report a Remittance Advice Remark Code at the claim level or when the payer is Medicare or Medicaid and MOA01, 02, 08 or 09 are non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Either MIA or MOA may appear, but not both.

2. All situational quantities and/or monetary amounts in this segment are required when the value of the item is different than zero.
TR3 Example: MOA***MA01~

Data Element Summary

Ref. Des.	Data Element	Name	Attributes		
MOA01	**954**	**Percentage as Decimal** Percentage expressed as a decimal (e.g., 0.0 through 1.0 represents 0% through 100%) SITUATIONAL RULE: Required when the outpatient institutional claim reimbursement rate is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA01__ReimbursementRate IMPLEMENTATION NAME: Reimbursement Rate	**O**	**1**	**R 1/10**
MOA02	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when the outpatient institutional claim HCPCS Payable Amount is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA02__ClaimHCPCSPayableAmount IMPLEMENTATION NAME: Claim HCPCS Payable Amount Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.	**O**	**1**	**R 1/18**
MOA03	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when a Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA03__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code	**O**	**1**	**AN 1/50**
MOA04	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA04__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code	**O**	**1**	**AN 1/50**
MOA05	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send.	**O**	**1**	**AN 1/50**

		OD: 835W1_2100_MOA05__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code			
MOA06	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA06__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code			
MOA07	**127**	**Reference Identification**	**O**	**1**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier SITUATIONAL RULE: Required when an additional Claim Payment Remark Code applies to this entire claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA07__ClaimPaymentRemarkCode IMPLEMENTATION NAME: Claim Payment Remark Code			
MOA08	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when the outpatient institutional claim ESRD Payment Amount is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA08__ClaimESRDPaymentAmount IMPLEMENTATION NAME: Claim ESRD Payment Amount			
MOA09	**782**	**Monetary Amount**	**O**	**1**	**R 1/18**
		Monetary amount SITUATIONAL RULE: Required when the outpatient institutional claim Nonpayable Professional Component Amount is not zero for a Medicare or Medicaid claim. If not required by this implementation guide, do not send. OD: 835W1_2100_MOA09__NonpayableProfessionalComponentAmount IMPLEMENTATION NAME: Nonpayable Professional Component Amount			

Segment: **REF** **Other Claim Related Identification**
Position: 0400
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional reference numbers specific to the claim in

the CLP segment are provided to identify information used in the process of adjudicating this claim. If not required by this implementation guide, do not send.
TR3 Example: REF*EA*666123~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**1 ID 2/3**
			OD: 835W1_2100_REF01__ReferenceIdentificationQualifier		
			1L	Group or Policy Number	
				Use this code when conveying the Group Number in REF02.	
			1W	Member Identification Number	
				Unique identification number assigned to each member under a subscriber's contract	
			28	Employee Identification Number	
			6P	Group Number	
				This is the Other Insured Group Number. This is required when a Corrected Priority Payer is identified in the NM1 segment and the Group Number of the other insured for that payer is known.	
			9A	Repriced Claim Reference Number	
			9C	Adjusted Repriced Claim Reference Number	
			BB	Authorization Number	
				Proves that permission was obtained to provide a service	
				Use this qualifier only when supplying an authorization number that was assigned by the adjudication process and was not provided prior to the services. Do not use this qualifier when reporting the same number as reported in the claim as the prior authorization or re-authorization number.	
			CE	Class of Contract Code	
				See section 1.10.2.15 for information on the use of Class of Contract Code.	
			EA	Medical Record Identification Number	
				A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records	
			F8	Original Reference Number	
				When this is a correction claim and CLP07 does not equal the CLP07 value from the original claim payment, one iteration of this REF segment using this qualifier is REQUIRED to identify the original claim CLP07 value in REF02. See section 1.10.2.8, Reversals and Corrections, for additional information.	
			G1	Prior Authorization Number	
				An authorization number acquired prior to the submission of a claim	
				Use this qualifier when reporting the number received with the original claim as a preauthorization number (in the 837 that was at table 2, position 180, REF segment, using the same qualifier of G1).	

			G3	Predetermination of Benefits Identification Number A number assigned by a third-party payer identifying the pre-treatment estimate			
			IG	Insurance Policy Number Use this code when conveying the Policy Number in REF02.			
			SY	Social Security Number			
Must Use	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2100_REF02__OtherClaimRelatedIdentifier IMPLEMENTATION NAME: Other Claim Related Identifier		**X**	**1**	**AN 1/50**

Segment: **REF** **Rendering Provider Identification**
Position: 0400
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 10
Purpose: To specify identifying information
Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when additional rendering provider identification numbers not already reported in the Provider NM1 segment for this claim were submitted on the original claim and impacted adjudication. If not required by this implementation guide, do not send.

TR3 Notes: 1. The NM1 segment always contains the primary reference number.
TR3 Example: REF*1C*12345678~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes		
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification OD: 835W1_2100_REF01__ReferenceIdentificationQualifier		**M**	**1**	**ID 2/3**
			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			
			D3	National Council for Prescription Drug Programs Pharmacy Number CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number			
			G2	Provider Commercial Number			

				A unique number assigned to a provider by a commercial insurer			
			LU	Location Number			
Must Use	**REF02**	**127**	**Reference Identification**		**X**	**1**	**AN 1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			OD: 835W1_2100_REF02__RenderingProviderSecondaryIdentifier IMPLEMENTATION NAME: Rendering Provider Secondary Identifier				

Segment: **DTM** **Statement From or To Date**
Position: 0500
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify pertinent dates and times
Syntax Notes: **1** At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the "Statement From or To Dates" are not supplied at the service (2110 loop) level. If not required by this implementation guide, may be provided at senders discretion, but cannot be required by the receiver.

TR3 Notes: 1. Dates at the claim level apply to the entire claim, including all service lines. Dates at the service line level apply only to the service line where they appear.

2. When claim dates are not provided, service dates are required for every service line.

3. When claim dates are provided, service dates are not required, but if used they override the claim dates for individual service lines.

4. For retail pharmacy claims, the Claim Statement Period Start Date is equivalent to the prescription filled date.

5. For predeterminations, where there is no service date, the value of DTM02 must be 19000101. Use only when the CLP02 value is 25 - Predetermination Pricing Only - No Payment.

6. When payment is being made in advance of services, the use of future dates is allowed.
TR3 Example: DTM*233*20020916~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes		
M	**DTM01**	**374**	**Date/Time Qualifier**	**M**	**1**	**ID 3/3**
			Code specifying type of date or time, or both date and time			
			OD: 835W1_2100_DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier			
			232 Claim Statement Period Start			
			If the claim statement period start date is conveyed without a subsequent claim statement period end date,			

				the end date is assumed to be the same as the start date. This date or code 233 is required when service level dates are not provided in the remittance advice.			
			233	Claim Statement Period End			
				If a claim statement period end date is conveyed without a claim statement period start date, then the start date is assumed to be different from the end date but not conveyed at the payer's discretion. See the note on code 232.			
Must Use	**DTM02**	**373**	**Date**		**X**	**1**	**DT 8/8**
			Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year				
			OD: 835W1_2100_DTM02__ClaimDate IMPLEMENTATION NAME: Claim Date				

Segment: **DTM** **Coverage Expiration Date**
Position: 0500
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes: **1** At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when payment is denied because of the expiration of coverage.
If not required by this implementation guide, do not send.
TR3 Example: DTM*036*20011001~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes		
M	**DTM01**	**374**	**Date/Time Qualifier**		**M**	**1**	**ID 3/3**
			Code specifying type of date or time, or both date and time				
			OD: 835W1_2100_DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier				
			036	Expiration Date coverage expires			
Must Use	**DTM02**	**373**	**Date**		**X**	**1**	**DT 8/8**
			Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year				
			OD: 835W1_2100_DTM02__Date This is the expiration date of the patient's coverage.				

Segment: **DTM** **Claim Received Date**
Position: 0500
Loop: 2100 Optional
Level: Detail
Usage: Optional

Max Use: 1
Purpose: To specify pertinent dates and times
Syntax Notes:
1 At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required whenever state or federal regulations or the provider contract mandate interest payment or prompt payment discounts based upon the receipt date of the claim by the payer. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.
TR3 Example: DTM*050*20011124~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**DTM01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time OD: 835W1_2100_DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier 050 Received	**M**	**1**	**ID 3/3**
Must Use	**DTM02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1_2100_DTM02__Date This is the date that the claim was received by the payer.	**X**	**1**	**DT 8/8**

Segment: **PER** **Claim Contact Information**
Position: 0600
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To identify a person or office to whom administrative communications should be directed
Syntax Notes:
1 If either PER03 or PER04 is present, then the other is required.
2 If either PER05 or PER06 is present, then the other is required.
3 If either PER07 or PER08 is present, then the other is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when there is a claim specific communications contact. If not required by this implementation guide, do not send.

TR3 Notes: 1. When the communication number represents a telephone number in the United States and other countries using the North American Dialing Plan (for voice, data, fax, etc.), the communication number always includes the area code and phone number using the format AAABBBCCCC. Where AAA is the area code, BBB is the telephone number prefix, and CCCC is the telephone number (e.g. (800)555-1212 would be represented as 8005551212). The extension number, when applicable, is identified in the next element pair (Communications Number Qualifier and Communication Number) immediately after the telephone number.
TR3 Example: PER*CX**TE*8005551212~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes
M	**PER01**	**366**	**Contact Function Code** Code identifying the major duty or responsibility of the person or group named OD: 835W1_2100_PER01__ContactFunctionCode CX Payers Claim Office Location responsible for paying bills related to medical care received	**M 1 ID 2/2**
	PER02	**93**	**Name** Free-form name SITUATIONAL RULE: Required when the name of the individual to contact is not already defined or is different than the name within the prior contact segment (PER). If not required by this implementation guide, do not send. OD: 835W1_2100_PER02__ClaimContactName IMPLEMENTATION NAME: Claim Contact Name	**O 1 AN 1/60**
Must Use	**PER03**	**365**	**Communication Number Qualifier** Code identifying the type of communication number OD: 835W1_2100_PER03__CommunicationNumberQualifier EM Electronic Mail FX Facsimile TE Telephone	**X 1 ID 2/2**
Must Use	**PER04**	**364**	**Communication Number** Complete communications number including country or area code when applicable OD: 835W1_2100_PER04__ClaimContactCommunicationsNumber IMPLEMENTATION NAME: Claim Contact Communications Number	**X 1 AN 1/256**
	PER05	**365**	**Communication Number Qualifier** Code identifying the type of communication number SITUATIONAL RULE: Required when required per ASC X12 syntax when PER06 is sent. If not required by this implementation guide, do not send. OD: 835W1_2100_PER05__CommunicationNumberQualifier EM Electronic Mail EX Telephone Extension When used, the value following this code is the extension for the preceding communications contact number. FX Facsimile TE Telephone	**X 1 ID 2/2**
	PER06	**364**	**Communication Number** Complete communications number including country or area code when applicable SITUATIONAL RULE: Required when a second claim specific communications contact number exists. If not required by this implementation guide, do not send. OD: 835W1_2100_PER06__ClaimContactCommunicationsNumber IMPLEMENTATION NAME: Claim Contact Communications Number	**X 1 AN 1/256**
	PER07	**365**	**Communication Number Qualifier**	**X 1 ID 2/2**

Code identifying the type of communication number

SITUATIONAL RULE: Required when required per ASC X12 syntax when PER08 is sent. If not required by this implementation guide, do not send.

OD: 835W1_2100_PER07__CommunicationNumberQualifier

EX Telephone Extension

PER08 364 Communication Number X 1 AN 1/256

Complete communications number including country or area code when applicable

SITUATIONAL RULE: Required when an extension applies to the previous communications contact number (PER06). If not required by this implementation guide, do not send.

OD: 835W1_2100_PER08__CommunicationNumberExtension

IMPLEMENTATION NAME: Communication Number Extension

Segment: **AMT** **Claim Supplemental Information**
Position: 0620
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 13
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.

2. Send/receive one AMT for each applicable non-zero value. Do not report any zero values.
TR3 Example: AMT*T*49~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount OD: 835W1_2100_AMT01__AmountQualifierCode AU Coverage Amount The dollar amount of property coverage provided by a specific policy contract Use this monetary amount to report the total covered charges. This is the sum of the original submitted provider charges that are considered for payment under the benefit provisions of the health plan. This excludes charges considered not covered (i.e. per day television or telephone charges) but includes reductions to payments of covered services (i.e. reductions for	**M**	**1 ID 1/3**

				amounts over fee schedule and patient deductibles).			
			D8	Discount Amount A reduction from the usual price Prompt Pay Discount Amount See section 1.10.2.9 for additional information.			
			DY	Per Day Limit			
			F5	Patient Amount Paid Monetary amount value already paid by one receiving medical care Use this monetary amount for the amount the patient has already paid.			
			I	Interest See section 1.10.2.9 for additional information.			
			NL	Negative Ledger Balance Used only by Medicare Part A and Medicare Part B.			
			T	Tax			
			T2	Total Claim Before Taxes The total monies requested for a single claim before any taxes were included Used only when tax also applies to the claim.			
			ZK	Federal Medicare or Medicaid Payment Mandate - Category 1			
			ZL	Federal Medicare or Medicaid Payment Mandate - Category 2			
			ZM	Federal Medicare or Medicaid Payment Mandate - Category 3			
			ZN	Federal Medicare or Medicaid Payment Mandate - Category 4			
			ZO	Federal Medicare or Medicaid Payment Mandate - Category 5			
M	**AMT02**	**782**	**Monetary Amount** Monetary amount	OD: 835W1_2100_AMT02__ClaimSupplementalInformationAmount IMPLEMENTATION NAME: Claim Supplemental Information Amount Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.	**M**	**1**	**R 1/18**

Segment: **QTY** **Claim Supplemental Information Quantity**
Position: 0640
Loop: 2100 Optional
Level: Detail
Usage: Optional
Max Use: 14
Purpose: To specify quantity information
Syntax Notes: **1** At least one of QTY02 or QTY04 is required.
2 Only one of QTY02 or QTY04 may be present.
Semantic Notes: **1** QTY04 is used when the quantity is non-numeric.
Comments:
Notes: Situational Rule: Required when the value of a specific quantity identified by the QTY01

qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.

2. Send one QTY for each non-zero value. Do not report any zero values.
TR3 Example: QTY*ZK*3~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity	**M**	**1 ID 2/2**
			OD: 835W1_2100_QTY01__QuantityQualifier		
			CA	Covered - Actual	
				Days covered on this service	
			CD	Co-insured - Actual	
			LA	Life-time Reserve - Actual	
				Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve	
			LE	Life-time Reserve - Estimated	
				Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is an estimate of the number of days in reserve	
			NE	Non-Covered - Estimated	
			NR	Not Replaced Blood Units	
			OU	Outlier Days	
			PS	Prescription	
			VS	Visits	
			ZK	Federal Medicare or Medicaid Payment Mandate - Category 1	
			ZL	Federal Medicare or Medicaid Payment Mandate - Category 2	
			ZM	Federal Medicare or Medicaid Payment Mandate - Category 3	
			ZN	Federal Medicare or Medicaid Payment Mandate - Category 4	
			ZO	Federal Medicare or Medicaid Payment Mandate - Category 5	
Must Use	**QTY02**	**380**	**Quantity** Numeric value of quantity	**X**	**1 R 1/15**
			OD: 835W1_2100_QTY02__ClaimSupplementalInformationQuantity IMPLEMENTATION NAME: Claim Supplemental Information Quantity		

Segment: **SVC** **Service Payment Information**
Position: 0700
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 1

Purpose: To supply payment and control information to a provider for a particular service

Syntax Notes:

Semantic Notes:

1 SVC01 is the medical procedure upon which adjudication is based.

2 SVC02 is the submitted service charge.

3 SVC03 is the amount paid this service.

4 SVC04 is the National Uniform Billing Committee Revenue Code.

5 SVC05 is the paid units of service.

6 SVC06 is the original submitted medical procedure.

7 SVC07 is the original submitted units of service.

Comments:

1 For Medicare Part A claims, SVC01 would be the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) Code (see code source 130) and SVC04 would be the Revenue Code (see code source 132).

Notes: Situational Rule: Required for all service lines in a professional, dental or outpatient claim priced at the service line level or whenever payment for any service line of the claim is different than the original submitted charges due to service line specific adjustments (excluding cases where the only service specific adjustment is for room per diem). If not required by this implementation guide, do not send.

TR3 Notes: 1. See section 1.10.2.1.1 (Service Line Balancing) for additional information.

2. The exception to the situational rule occurs with institutional claims when the room per diem is the only service line adjustment. In this instance, a claim level CAS adjustment to the per diem is appropriate (i.e., CAS*CO*78*25~). See section 1.10.2.4.1 for additional information.

3. See 1.10.2.6, Procedure Code Bundling and Unbundling, and section 1.10.2.1.1, Service Line Balancing, for important SVC segment usage information.
TR3 Example: SVC*HC:99214*100*80~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**SVC01**	**C003**	**Composite Medical Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers OD: 835W1_2110_SVC01_C003 This is the adjudicated medical procedure information. This code is a composite data structure.	**M**	**1**
M	**C00301**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234) 835W1_2110_SVC01_C00301_ProductorServiceIDQualifier IMPLEMENTATION NAME: Product or Service ID Qualifier The value in SVC01-1 qualifies the values in SVC01-2, SVC01-3, SVC01-4, SVC01-5, SVC01-6 and SVC01-7. AD — American Dental Association Codes This association's membership consists of U.S. dentists. It sets standards for the dental profession CODE SOURCE 135: American Dental Association ER — Jurisdiction Specific Procedure and Supply Codes CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes	**M**	**ID 2/2**

HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments
	Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. CODE SOURCE 130: Healthcare Common Procedural Coding System
HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code
	Medicare uses this code to reflect the Skilled Nursing Facility Group as well as the Home Health Agency Outpatient Prospective Payment System. CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities
IV	Home Infusion EDI Coalition (HIEC) Product/Service Code
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List
N4	National Drug Code in 5-4-2 Format 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size
	CODE SOURCE 240: National Drug Code by Format
N6	National Health Related Item Code in 4-6 Format
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names National Health Related Item Code in 4-6 Format Codes as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 240: National Drug Code by Format
NU	National Uniform Billing Committee (NUBC) UB92 Codes
	CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes
UI	U.P.C. Consumer Package Code (1-5-5)
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names U.P.C. Consumer Package Code (1-5-5) Codes as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA.
WK	Advanced Billing Concepts (ABC) Codes
	This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used in

			transactions covered under HIPAA by parties registered in the pilot project and their trading partners. CODE SOURCE 843: Advanced Billing Concepts (ABC) Codes			
M	**C00302**	**234**	**Product/Service ID** Identifying number for a product or service OD: 835W1_2110_SVC01_C00302_AdjudicatedProcedureCode IMPLEMENTATION NAME: Adjudicated Procedure Code This is the adjudicated procedure code or revenue code as identified by the qualifier in SVC01-1.	**M**		**AN 1/48**
	C00303	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC01_C00303_ProcedureModifier	**O**		**AN 2/2**
	C00304	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a second procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC01_C00304_ProcedureModifier	**O**		**AN 2/2**
	C00305	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a third procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC01_C00305_ProcedureModifier	**O**		**AN 2/2**
	C00306	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a fourth procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC01_C00306_ProcedureModifier	**O**		**AN 2/2**
M	**SVC02**	**782**	**Monetary Amount** Monetary amount OD: 835W1_2110_SVC02__LineItemChargeAmount IMPLEMENTATION NAME: Line Item Charge Amount Use this monetary amount for the submitted service charge amount. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.	**M**	**1**	**R 1/18**
Must Use	**SVC03**	**782**	**Monetary Amount** Monetary amount OD: 835W1_2110_SVC03__LineItemProviderPaymentAmount	**O**	**1**	**R 1/18**

			IMPLEMENTATION NAME: Line Item Provider Payment Amount Use this number for the service amount paid. The value in SVC03 must equal the value in SVC02 minus all monetary amounts in the subsequent CAS segments of this loop. See 1.10.2.1, Balancing, for additional information.				
	SVC04	**234**	**Product/Service ID** Identifying number for a product or service	**O**	**1**	**AN 1/48**	
			SITUATIONAL RULE: Required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC04__NationalUniformBillingCommitteeRevenueCode IMPLEMENTATION NAME: National Uniform Billing Committee Revenue Code If the original claim and adjudication only referenced an NUBC revenue code, that is supplied in SVC01 and this element is not used.				
	SVC05	**380**	**Quantity** Numeric value of quantity	**O**	**1**	**R 1/15**	
			SITUATIONAL RULE: Required when the paid units of service are different than one. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver. OD: 835W1_2110_SVC05__UnitsofServicePaidCount IMPLEMENTATION NAME: Units of Service Paid Count If not present, the value is assumed to be one.				
	SVC06	**C003**	**Composite Medical Procedure Identifier** To identify a medical procedure by its standardized codes and applicable modifiers	**O**	**1**		
			SITUATIONAL RULE: Required when the adjudicated procedure code provided in SVC01 is different from the submitted procedure code from the original claim. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C003 This code is a composite data structure. This is the Submitted Procedure Code information.				
M	**C00301**	**235**	**Product/Service ID Qualifier** Code identifying the type/source of the descriptive number used in Product/Service ID (234)	**M**		**ID 2/2**	
			OD: 835W1_2110_SVC06_C00301_ProductorServiceIDQualifier IMPLEMENTATION NAME: Product or Service ID Qualifier The value in SVC06-1 qualifies the value in SVC06-2, SVC06-3, SVC06-4, SVC06-5, SVC06-6 and SVC06-7.				
			AD American Dental Association Codes This association's membership consists of U.S. dentists. It sets standards for the dental profession CODE SOURCE 135: American Dental Association				
			ER Jurisdiction Specific Procedure and Supply Codes CODE SOURCE 576: Workers Compensation Specific Procedure and Supply Codes				

			HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare; primarily used for ambulatory surgical and other diagnostic departments Because the CPT codes of the American Medical Association are also level 1 HCPCS codes, they are reported under the code HC. CODE SOURCE 130: Healthcare Common Procedural Coding System		
			HP	Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code Medicare uses this code to reflect the Skilled Nursing Facility Group as well as the Home Health Agency Outpatient Prospective Payment System. CODE SOURCE 716: Health Insurance Prospective Payment System (HIPPS) Rate Code for Skilled Nursing Facilities		
			IV	Home Infusion EDI Coalition (HIEC) Product/Service Code This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names HIEC as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 513: Home Infusion EDI Coalition (HIEC) Product/Service Code List		
			N4	National Drug Code in 5-4-2 Format 5-digit manufacturer ID, 4-digit product ID, 2-digit trade package size CODE SOURCE 240: National Drug Code by Format		
			NU	National Uniform Billing Committee (NUBC) UB92 Codes CODE SOURCE 132: National Uniform Billing Committee (NUBC) Codes		
			WK	Advanced Billing Concepts (ABC) Codes This code set is not allowed for use under HIPAA at the time of this writing. The qualifier can only be used 1) If a new rule names Complimentary, Alternative, or Holistic Procedure Codes as an allowable code set under HIPAA. 2) For Property & Casualty claims/encounters that are not covered under HIPAA. CODE SOURCE 843: Complimentary, Alternative, or Holistic Procedure Codes		
M	**C00302**	**234**	**Product/Service ID** Identifying number for a product or service OD: 835W1_2110_SVC06_C00302_ProcedureCode IMPLEMENTATION NAME: Procedure Code	**M**	**AN 1/48**
	C00303	**1339**	**Procedure Modifier** This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a procedure code modifier applies to this	**O**	**AN 2/2**

		service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00303_ProcedureModifier			
C00304	**1339**	**Procedure Modifier**	**O**		**AN 2/2**
		This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a second procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00304_ProcedureModifier			
C00305	**1339**	**Procedure Modifier**	**O**		**AN 2/2**
		This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a third procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00305_ProcedureModifier			
C00306	**1339**	**Procedure Modifier**	**O**		**AN 2/2**
		This identifies special circumstances related to the performance of the service, as defined by trading partners SITUATIONAL RULE: Required when a fourth procedure code modifier applies to this service. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00306_ProcedureModifier			
C00307	**352**	**Description**	**O**		**AN 1/80**
		A free-form description to clarify the related data elements and their content SITUATIONAL RULE: Required when a description was received on the original service for a not otherwise classified procedure code. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC06_C00307_ProcedureCodeDescription IMPLEMENTATION NAME: Procedure Code Description			
SVC07	**380**	**Quantity**	**O**	**1**	**R 1/15**
		Numeric value of quantity SITUATIONAL RULE: Required when the paid units of service provided in SVC05 is different from the submitted units of service from the original claim. If not required by this implementation guide, do not send. OD: 835W1_2110_SVC07__OriginalUnitsofServiceCount IMPLEMENTATION NAME: Original Units of Service Count			

Segment: **DTM** **Service Date**
Position: 0800
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 2
Purpose: To specify pertinent dates and times
Syntax Notes: **1** At least one of DTM02 DTM03 or DTM05 is required.
2 If DTM04 is present, then DTM03 is required.
3 If either DTM05 or DTM06 is present, then the other is required.
Semantic Notes:

Comments:

Notes: Situational Rule: Required when claim level Statement From or Through Dates are not supplied or the service dates are not the same as reported at the claim level. If not required by this implementation guide, may be provided at sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. Dates at the service line level apply only to the service line where they appear.

2. If used for inpatient claims and no service date was provided on the claim then report the through date from the claim level.

3. When claim dates are not provided, service dates are required for every service line.

4. When claim dates are provided, service dates are not required, but if used they override the claim dates for individual service lines.

5. For retail pharmacy claims, the service date is equivalent to the prescription filled date.

6. For predeterminations, where there is no service date, the value of DTM02 must be 19000101. Use only when the CLP02 value is 25 - Predetermination Pricing Only - No Payment.

7. When payment is being made in advance of services, the use of future dates is allowed.
TR3 Example: DTM*472*20021031~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes		
M	**DTM01**	**374**	**Date/Time Qualifier** Code specifying type of date or time, or both date and time OD: 835W1_2110_DTM01__DateTimeQualifier IMPLEMENTATION NAME: Date Time Qualifier	**M**	**1**	**ID**	**3/3**
			150 Service Period Start This qualifier is required for reporting the beginning of multi-day services. If not required by this implementation guide, do not send.				
			151 Service Period End This qualifier is required for reporting the end of multi-day services. If not required by this implementation guide, do not send.				
			472 Service Begin and end dates of the service being rendered This qualifier is required to indicate a single day service. If not required by this implementation guide, do not send.				
Must Use	**DTM02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1_2110_DTM02__ServiceDate IMPLEMENTATION NAME: Service Date	**X**	**1**	**DT**	**8/8**

Segment: **CAS** **Service Adjustment**
Position: 0900
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 99
Purpose: To supply adjustment reason codes and amounts as needed for an entire claim or for a particular service within the claim being paid

Syntax Notes:
1 If CAS05 is present, then at least one of CAS06 or CAS07 is required.
2 If CAS06 is present, then CAS05 is required.
3 If CAS07 is present, then CAS05 is required.
4 If CAS08 is present, then at least one of CAS09 or CAS10 is required.
5 If CAS09 is present, then CAS08 is required.
6 If CAS10 is present, then CAS08 is required.
7 If CAS11 is present, then at least one of CAS12 or CAS13 is required.
8 If CAS12 is present, then CAS11 is required.
9 If CAS13 is present, then CAS11 is required.
10 If CAS14 is present, then at least one of CAS15 or CAS16 is required.
11 If CAS15 is present, then CAS14 is required.
12 If CAS16 is present, then CAS14 is required.
13 If CAS17 is present, then at least one of CAS18 or CAS19 is required.
14 If CAS18 is present, then CAS17 is required.
15 If CAS19 is present, then CAS17 is required.

Semantic Notes:
1 CAS03 is the amount of adjustment.
2 CAS04 is the units of service being adjusted.
3 CAS06 is the amount of the adjustment.
4 CAS07 is the units of service being adjusted.
5 CAS09 is the amount of the adjustment.
6 CAS10 is the units of service being adjusted.
7 CAS12 is the amount of the adjustment.
8 CAS13 is the units of service being adjusted.
9 CAS15 is the amount of the adjustment.
10 CAS16 is the units of service being adjusted.
11 CAS18 is the amount of the adjustment.
12 CAS19 is the units of service being adjusted.

Comments:
1 Adjustment information is intended to help the provider balance the remittance information. Adjustment amounts should fully explain the difference between submitted charges and the amount paid.

Notes: Situational Rule: Required when dollar amounts are being adjusted specific to the service or when the paid amount for a service line (SVC03) is different than the original submitted charge amount for the service (SVC02). If not required by this implementation guide, do not send.

TR3 Notes: 1. An example of this level of CAS is the reduction for the part of the service charge that exceeds the usual and customary charge for the service. See sections 1.10.2.1, Balancing, and 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information.

2. A single CAS segment contains six repetitions of the "adjustment trio" composed of adjustment reason code, adjustment amount, and adjustment quantity. These six adjustment trios are used to report up to six adjustments related to a specific Claim Adjustment Group Code (CAS01). The six iterations (trios) of the Adjustment Reason Code related to the Specific Adjustment Group Code must be exhausted before repeating a second iteration of the CAS segment using the same Adjustment Group Code. The first adjustment is reported in the first adjustment trio (CAS02-CAS04). If there is a second non-zero adjustment, it is reported in the second adjustment trio (CAS05- CAS07), and so on through the sixth adjustment trio (CAS17-CAS19).

TR3 Example: CAS*PR*1*793**3*25~
CAS*CO*131*250~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**CAS01**	**1033**	**Claim Adjustment Group Code** Code identifying the general category of payment adjustment	**M**	**1 ID 1/2**
			OD: 835W1_2110_CAS01__ClaimAdjustmentGroupCode Evaluate the usage of group codes in CAS01 based on the following order for their applicability to a set of one or more adjustments: PR, CO, PI, OA. See 1.10.2.4, Claim Adjustment and Service Adjustment Segment Theory, for additional information. (Note: This does not mean that the adjustments must be reported in this order.)		
			CO Contractual Obligations Use this code when a joint payer/payee agreement or a regulatory requirement has resulted in an adjustment.		
			OA Other adjustments Avoid using the Other Adjustment Group Code (OA) except for business situations described in sections 1.10.2.6, 1.10.2.7 and 1.10.2.13.		
			PI Payor Initiated Reductions Use this code when, in the opinion of the payer, the adjustment is not the responsibility of the patient, but there is no supporting contract between the provider and the payer (i.e., medical review or professional review organization adjustments).		
			PR Patient Responsibility		
M	**CAS02**	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made	**M**	**1 ID 1/5**
			OD: 835W1_2110_CAS02__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code Required to report a non-zero adjustment applied at the service level for the claim adjustment group code reported in CAS01.		
M	**CAS03**	**782**	**Monetary Amount** Monetary amount	**M**	**1 R 1/18**
			OD: 835W1_2110_CAS03__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount Use this monetary amount for the adjustment amount. A negative amount increases the payment, and a positive amount decreases the payment contained in SVC03 and CLP04. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.		
	CAS04	**380**	**Quantity** Numeric value of quantity	**O**	**1 R 1/15**
			SITUATIONAL RULE: Required when units of service are being adjusted. If not required by this implementation guide, do not send.		

		OD: 835W1_2110_CAS04__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity A positive number decreases paid units, and a negative value increases paid units.			
CAS05	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS05__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CAS02.	**X**	**1**	**ID 1/5**
CAS06	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when CAS05 is present. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS06__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.	**X**	**1**	**R 1/18**
CAS07	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when CAS05 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS07__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.	**X**	**1**	**R 1/15**
CAS08	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS08__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CAS02.	**X**	**1**	**ID 1/5**

CAS09	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when CAS08 is present. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS09__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.	**X**	**1**	**R 1/18**
CAS10	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when CAS08 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS10__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.	**X**	**1**	**R 1/15**
CAS11	**1034**	**Claim Adjustment Reason Code** Code identifying the detailed reason the adjustment was made SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS11__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CAS02.	**X**	**1**	**ID 1/5**
CAS12	**782**	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when CAS11 is present. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS12__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.	**X**	**1**	**R 1/18**
CAS13	**380**	**Quantity** Numeric value of quantity SITUATIONAL RULE: Required when CAS11 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS13__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.	**X**	**1**	**R 1/15**

CAS14	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**
		Code identifying the detailed reason the adjustment was made			
		SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS14__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CAS02.			
CAS15	**782**	**Monetary Amount**	**X**	**1**	**R 1/18**
		Monetary amount			
		SITUATIONAL RULE: Required when CAS14 is present. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS15__AdjustmentAmount IMPLEMENTATION NAME: Adjustment Amount See CAS03.			
CAS16	**380**	**Quantity**	**X**	**1**	**R 1/15**
		Numeric value of quantity			
		SITUATIONAL RULE: Required when CAS14 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS16__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.			
CAS17	**1034**	**Claim Adjustment Reason Code**	**X**	**1**	**ID 1/5**
		Code identifying the detailed reason the adjustment was made			
		SITUATIONAL RULE: Required when an additional non-zero adjustment, beyond what has already been supplied, applies to the service for the claim adjustment group code used in CAS01. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS17__AdjustmentReasonCode IMPLEMENTATION NAME: Adjustment Reason Code CODE SOURCE 139: Claim Adjustment Reason Code See CAS02.			
CAS18	**782**	**Monetary Amount**	**X**	**1**	**R 1/18**
		Monetary amount			
		SITUATIONAL RULE: Required when CAS17 is present. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS18__AdjustmentAmount			

IMPLEMENTATION NAME: Adjustment Amount

See CAS03.

	CAS19	**380**	**Quantity**	**X**	**1**	**R 1/15**
			Numeric value of quantity			
			SITUATIONAL RULE: Required when CAS17 is present and is related to a units of service adjustment. If not required by this implementation guide, do not send. OD: 835W1_2110_CAS19__AdjustmentQuantity IMPLEMENTATION NAME: Adjustment Quantity See CAS04.			

Segment: **REF** **Service Identification**
Position: 1000
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 8
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when related service specific reference identifiers were used in the process of adjudicating this service. If not required by this implementation guide, do not send.
TR3 Example: REF*RB*100~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification	**M**	**1**	**ID 2/3**
			OD: 835W1_2110_REF01__ReferenceIdentificationQualifier			
			1S Ambulatory Patient Group (APG) Number			
			APC Ambulatory Payment Classification			
			CODE SOURCE 468: Ambulatory Payment Classification			
			BB Authorization Number			
			Proves that permission was obtained to provide a service			
			E9 Attachment Code			
			Supplementary reference information			
			G1 Prior Authorization Number			
			An authorization number acquired prior to the submission of a claim			
			G3 Predetermination of Benefits Identification Number			
			A number assigned by a third-party payer identifying the pre-treatment estimate			
			LU Location Number			
			This is the Payer's identification for the provider location. This is REQUIRED when the specific site of			

service affected the payment of the claim.

RB Rate code number

Rate Code Number reflects Ambulatory Surgical Center (ASC) rate for Medicare, either 0, 50, 100 or 150%.

Must Use	**REF02**	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

OD: 835W1_2110_REF02__ProviderIdentifier

IMPLEMENTATION NAME: Provider Identifier

Segment: **REF** **Line Item Control Number**
Position: 1000
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 1
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when a Line Item Control Number was received on the original claim or when claim or service line splitting has occurred. If not required by this implementation guide, do not send.

TR3 Notes: 1. This is the Line Item Control Number submitted in the 837, which is utilized by the provider for tracking purposes. See section 1.10.2.11 and 1.10.2.14.1 for additional information on usage with split claims or services. Note - the value in REF02 can include alpha characters.
TR3 Example: REF*6R*A78910~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**REF01**	**128**	**Reference Identification Qualifier**	**M**	**1**	**ID 2/3**

Code qualifying the Reference Identification

OD: 835W1_2110_REF01__ReferenceIdentificationQualifier

6R Provider Control Number

Number assigned by information provider company for tracking and billing purposes

Must Use	**REF02**	**127**	**Reference Identification**	**X**	**1**	**AN 1/50**

Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier

OD: 835W1_2110_REF02__LineItemControlNumber

IMPLEMENTATION NAME: Line Item Control Number

Segment: **REF** **Rendering Provider Information**
Position: 1000
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 10

Purpose: To specify identifying information

Syntax Notes:
1 At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.

Semantic Notes:
1 REF04 contains data relating to the value cited in REF02.

Comments:

Notes: Situational Rule: Required when the rendering provider for this service is different than the rendering provider applicable at the claim level. If not required by this implementation guide, do not send.
TR3 Example: REF*HPI*1234567891~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification OD: 835W1_2110_REF01__ReferenceIdentificationQualifier	**M**	**1 ID 2/3**
			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 D3 National Council for Prescription Drug Programs Pharmacy Number CODE SOURCE 307: National Council for Prescription Drug Programs Pharmacy Number G2 Provider Commercial Number A unique number assigned to a provider by a commercial insurer HPI Centers for Medicare and Medicaid Services National Provider Identifier This qualifier is REQUIRED when the National Provider Identifier is mandated for use and the provider is a covered health care provider under that mandate. CODE SOURCE 537: Centers for Medicare and Medicaid Services National Provider Identifier SY Social Security Number TJ Federal Taxpayer's Identification Number		
Must Use	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2110_REF02__RenderingProviderIdentifier IMPLEMENTATION NAME: Rendering Provider Identifier	**X**	**1 AN 1/50**

Segment: **REF** **HealthCare Policy Identification**
Position: 1000
Loop: 2110 Optional
Level: Detail

Usage: Optional
Max Use: 5
Purpose: To specify identifying information
Syntax Notes: **1** At least one of REF02 or REF03 is required.
2 If either C04003 or C04004 is present, then the other is required.
3 If either C04005 or C04006 is present, then the other is required.
Semantic Notes: **1** REF04 contains data relating to the value cited in REF02.
Comments:
Notes: Situational Rule: Required when;
* The payment is adjusted in accordance with the Payer's published Healthcare Policy Code list and
* A Claim Adjustment Reason Code identified by the notation, "refer to 835 Healthcare Policy identification segment", in the Claim Adjustment Reason Code List is present in a related CAS segment and
* The payer has a published enumerated healthcare policy code list available to healthcare providers via an un-secure public website.
and
* The payer wishes to supply this policy detail to reduce provider inquiries. If not required by this implemenation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. Healthcare Policy - A clinical/statutory rule use to determine claim adjudication that cannot be explained by the sole use of a claim adjustment reason code in the CAS segment and Remittance Advise Remark code when appropriate.

2. The term Healthcare Policy is intended to include Medical Review Policy, Dental Policy Review, Property and Casualty Policies, Workers Comp Policies and Pharmacy Policies for example Medicare LMRP's.(Local Medicare Review policies) and NCD (National Coverage
Determinations).

3. This policy segment must not be used to provide a proprietary explanation code or reason for adjustment.

4. Supply the Healthcare policy identifier in REF02 as provided by the payer's published Healthcare policy code list. This policy code will be used to explain the policy used to process the claim which resulted in the adjusted payment.

5. If this segment is used, the PER (Payer Web Site) segment is required to provide an un-secure WEB contact point where the provider can access the payer's enumerated, published healthcare policy.
TR3 Example: REF*0K*L12345678910~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**REF01**	**128**	**Reference Identification Qualifier** Code qualifying the Reference Identification OD: 835W1_2110_REF01__ReferenceIdentificationQualifier 0K Policy Form Identifying Number	**M**	**1**	**ID 2/3**
Must Use	**REF02**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1_2110_REF02__HealthcarePolicyIdentification IMPLEMENTATION NAME: Healthcare Policy Identification	**X**	**1**	**AN 1/50**

Segment: **AMT** **Service Supplemental Amount**
Position: 1100
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 9
Purpose: To indicate the total monetary amount
Syntax Notes:
Semantic Notes:
Comments:
Notes: Situational Rule: Required when the value of any specific amount identified by the AMT01 qualifier is non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. This segment is used to convey information only. It is not part of the financial balancing of the 835.
TR3 Example: AMT*B6*425~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes		
M	**AMT01**	**522**	**Amount Qualifier Code** Code to qualify amount OD: 835W1_2110_AMT01__AmountQualifierCode		**M**	**1**	**ID 1/3**
			B6	Allowed - Actual Amount considered for payment under the provisions of the contract Allowed amount is the amount the payer deems payable prior to considering patient responsibility.			
			KH	Deduction Amount Late Filing Reduction			
			T	Tax			
			T2	Total Claim Before Taxes The total monies requested for a single claim before any taxes were included Use this monetary amount for the service charge before taxes. This is only used when there is an applicable tax amount on this service.			
			ZK	Federal Medicare or Medicaid Payment Mandate - Category 1			
			ZL	Federal Medicare or Medicaid Payment Mandate - Category 2			
			ZM	Federal Medicare or Medicaid Payment Mandate - Category 3			
			ZN	Federal Medicare or Medicaid Payment Mandate - Category 4			
			ZO	Federal Medicare or Medicaid Payment Mandate - Category 5			
M	**AMT02**	**782**	**Monetary Amount** Monetary amount OD: 835W1_2110_AMT02__ServiceSupplementalAmount IMPLEMENTATION NAME: Service Supplemental Amount Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the		**M**	**1**	**R 1/18**

decimal point). This applies to all subsequent 782 elements.

Segment: **QTY** **Service Supplemental Quantity**
Position: 1200
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 6
Purpose: To specify quantity information
Syntax Notes: **1** At least one of QTY02 or QTY04 is required.
2 Only one of QTY02 or QTY04 may be present.
Semantic Notes: **1** QTY04 is used when the quantity is non-numeric.
Comments:
Notes: Situational Rule: Required when new Federal Medicare or Medicaid mandates require Quantity counts and value of specific quantities identified in the QTY01 qualifier are non-zero. If not required by this implementation guide, do not send.

TR3 Notes: 1. Use this segment to convey information only. It is not part of the financial balancing of the 835.
TR3 Example: QTY*ZL*3.75~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes	
M	**QTY01**	**673**	**Quantity Qualifier** Code specifying the type of quantity OD: 835W1_2110_QTY01__QuantityQualifier ZK Federal Medicare or Medicaid Payment Mandate - Category 1 ZL Federal Medicare or Medicaid Payment Mandate - Category 2 ZM Federal Medicare or Medicaid Payment Mandate - Category 3 ZN Federal Medicare or Medicaid Payment Mandate - Category 4 ZO Federal Medicare or Medicaid Payment Mandate - Category 5	**M**	**1**	**ID 2/2**
Must Use	**QTY02**	**380**	**Quantity** Numeric value of quantity OD: 835W1_2110_QTY02__ServiceSupplementalQuantityCount IMPLEMENTATION NAME: Service Supplemental Quantity Count	**X**	**1**	**R 1/15**

Segment: **LQ** **Health Care Remark Codes**
Position: 1300
Loop: 2110 Optional
Level: Detail
Usage: Optional
Max Use: 99
Purpose: To identify standard industry codes
Syntax Notes: **1** If LQ01 is present, then LQ02 is required.
Semantic Notes:
Comments:
Notes: Situational Rule: Required when remark codes or NCPDP Reject/Payment codes are necessary for the provider to fully understand the adjudication message for a given

service line. If not required by this implementation guide, may be provided at the sender's discretion, but cannot be required by the receiver.

TR3 Notes: 1. Use this segment to provide informational remarks only. This segment has no impact on the actual payment. Changes in claim payment amounts are provided in the CAS segments.
TR3 Example: LQ*HE*12345~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
Must Use	**LQ01**	**1270**	**Code List Qualifier Code** Code identifying a specific industry code list OD: 835W1_2110_LQ01__CodeListQualifierCode HE Claim Payment Remark Codes CODE SOURCE 411: Codes for Medicare and Medicaid Services RX National Council for Prescription Drug Programs Reject/Payment Codes CODE SOURCE 530: National Council for Prescription Drug Programs Reject/Payment Codes	**O**	**1 ID 1/3**
Must Use	**LQ02**	**1271**	**Industry Code** Code indicating a code from a specific industry code list OD: 835W1_2110_LQ02__RemarkCode IMPLEMENTATION NAME: Remark Code	**X**	**1 AN 1/30**

Segment: **PLB** **Provider Adjustment**
Position: 0100
Loop:
Level: Summary
Usage: Optional
Max Use: >1
Purpose: To convey provider level adjustment information for debit or credit transactions such as, accelerated payments, cost report settlements for a fiscal year and timeliness report penalties unrelated to a specific claim or service
Syntax Notes:
1 If either PLB05 or PLB06 is present, then the other is required.
2 If either PLB07 or PLB08 is present, then the other is required.
3 If either PLB09 or PLB10 is present, then the other is required.
4 If either PLB11 or PLB12 is present, then the other is required.
5 If either PLB13 or PLB14 is present, then the other is required.
Semantic Notes:
1 PLB01 is the provider number assigned by the payer.
2 PLB02 is the last day of the provider's fiscal year.
3 PLB03 is the adjustment information as defined by the payer.
4 PLB04 is the adjustment amount.
5 PLB05 is the adjustment information as defined by the payer.
6 PLB06 is the adjustment amount.
7 PLB07 is adjustment information as defined by the payer.
8 PLB08 is the adjustment amount.
9 PLB09 is adjustment information as defined by the payer.
10 PLB10 is the adjustment amount.
11 PLB11 is adjustment information as defined by the payer.
12 PLB12 is the adjustment amount.
13 PLB13 is adjustment information as defined by the payer.
14 PLB14 is the adjustment amount.
Comments:

Notes: Situational Rule: Required when reporting adjustments to the actual payment that are NOT
specific to a particular claim or service. If not required by this implementation guide, do not send.

TR3 Notes: 1. These adjustments can either decrease the payment (a positive number) or increase the payment (a negative number). Zero dollar adjustments are not allowed. Some examples of PLB adjustments are a Periodic Interim Payment (loans and loan repayment) or a capitation payment. Multiple adjustments can be placed in one PLB segment, grouped by the provider identified in PLB01 and the period identified in PLB02. Although the PLB reference numbers are not standardized, refer to 1.10.2.9 (Interest and Prompt Payment Discounts), 1.10.2.10 (Capitation and Related Payments or Adjustments), 1.10.2.12 (Balance Forward Processing), 1.10.2.16 (Post Payment Recovery) and 1.10.2.17 (Claim Overpayment Recovery) for code suggestions and usage guidelines.

2. The codes and notations under PLB03 and its components apply equally to PLB05, 07, 09, 11 and 13.
TR3 Example: PLB*1234567890*20000930*CV:9876514*-1.27~

Data Element Summary

	Ref. Des.	Data Element	Name	Attributes		
M	**PLB01**	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier OD: 835W1__PLB01__ProviderIdentifier IMPLEMENTATION NAME: Provider Identifier When the National Provider Identifier (NPI) is mandated and the provider is a covered health care provider under that mandate, this must be the NPI assigned to the provider. Until the NPI is mandated, this is the provider identifier as assigned by the payer.	**M**	**1**	**AN 1/50**
M	**PLB02**	**373**	**Date** Date expressed as CCYYMMDD where CC represents the first two digits of the calendar year OD: 835W1__PLB02__FiscalPeriodDate IMPLEMENTATION NAME: Fiscal Period Date This is the last day of the provider's fiscal year. If the end of the provider's fiscal year is not known by the payer, use December 31st of the current year.	**M**	**1**	**DT 8/8**
M	**PLB03**	**C042**	**Adjustment Identifier** To provide the category and identifying reference information for an adjustment OD: 835W1__PLB03_C042 This identifier is a composite data structure. The composite identifies the reason and identifying information for the related adjustment dollar amount (PLB04 for PLB03).	**M**	**1**	
M	**C04201**	**426**	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment OD: 835W1__PLB03_C04201_AdjustmentReasonCode	**M**		**ID 2/2**

50	Late Charge
	This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge
	This is the interest assessment for late filing.
72	Authorized Return
	This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee
	This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits
	This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and

	Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.
CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
	This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.

L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
	This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.
PL	Payment Final
	This is the final settlement.
RA	Retro-activity Adjustment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
RE	Return on Equity
SL	Student Loan Repayment
TL	Third Party Liability
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
WO	Overpayment Recovery
	This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.
WU	Unspecified Recovery

				Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).			
	C04202	127	**Reference Identification**		O		AN 1/50
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB03_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier Use when necessary to assist the receiver in identifying, tracking or reconcilling the adjustment. See sections 1.10.2.10 (Capitation and Related Payments), 1.10.2.5 (Advanced Payments and Reconciliation) and 1.10.2.12 (Balance Forward Processing) for further information.				
M	PLB04	782	**Monetary Amount**		M	1	R 1/18
			Monetary amount				
			OD: 835W1__PLB04__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason. Decimal elements will be limited to a maximum length of 10 characters including reported or implied places for cents (implied value of 00 after the decimal point). This applies to all subsequent 782 elements.				
	PLB05	C042	**Adjustment Identifier**		X	1	
			To provide the category and identifying reference information for an adjustment				
			SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send. OD: 835W1__PLB05_C042 See PLB03 for details.				
M	C04201	426	**Adjustment Reason Code**		M		ID 2/2
			Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment				
			OD: 835W1__PLB05_C04201_AdjustmentReasonCode				
			50	Late Charge			
				This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.			
			51	Interest Penalty Charge			
				This is the interest assessment for late filing.			
			72	Authorized Return			
				This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request			

	or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee
	This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits
	This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.
CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and

	Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
	This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
	This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump

			sum adjustment must be identified in PLB03-2.		
		OA	Organ Acquisition Passthru		
		OB	Offset for Affiliated Providers		
			Identification of the affiliated providers must be made on PLB03-2.		
		PI	Periodic Interim Payment		
			This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.		
		PL	Payment Final		
			This is the final settlement.		
		RA	Retro-activity Adjustment		
			This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.		
		RE	Return on Equity		
		SL	Student Loan Repayment		
		TL	Third Party Liability		
			This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.		
		WO	Overpayment Recovery		
			This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.		
		WU	Unspecified Recovery		
			Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).		
C04202	**127**	**Reference Identification**		**O**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
		SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB05_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier			

	PLB06	782	**Monetary Amount**	X	1	R 1/18
			Monetary amount			
			SITUATIONAL RULE: Required when PLB05 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB06__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.			
	PLB07	C042	**Adjustment Identifier**	X	1	
			To provide the category and identifying reference information for an adjustment			
			SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send. OD: 835W1__PLB07_C042 See PLB03 for details.			
M	C04201	426	**Adjustment Reason Code**	**M**		**ID 2/2**
			Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment			
			OD: 835W1__PLB07_C04201_AdjustmentReasonCode			
			50 Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.			
			51 Interest Penalty Charge This is the interest assessment for late filing.			
			72 Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.			
			90 Early Payment Allowance			
			AH Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.			
			AM Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.			
			AP Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative			

	value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.
CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation

	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
	This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
	This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive).

		This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.			
		PL Payment Final			
		This is the final settlement.			
		RA Retro-activity Adjustment			
		This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		RE Return on Equity			
		SL Student Loan Repayment			
		TL Third Party Liability			
		This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		WO Overpayment Recovery			
		This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.			
		WU Unspecified Recovery			
		Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).			
C04202	**127**	**Reference Identification** Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier	**O**		**AN 1/50**
		SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB07_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier			
PLB08	**782**	**Monetary Amount** Monetary amount	**X**	**1**	**R 1/18**
		SITUATIONAL RULE: Required when PLB07 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB08__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.			
PLB09	**C042**	**Adjustment Identifier** To provide the category and identifying reference information for an adjustment	**X**	**1**	
		SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send. OD: 835W1__PLB09_C042			

See PLB03 for details.

M	**C04201**	**426**	**Adjustment Reason Code**	**M**	**ID 2/2**

Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment

OD: 835W1__PLB09_C04201_AdjustmentReasonCode

50	Late Charge
	This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.
51	Interest Penalty Charge
	This is the interest assessment for late filing.
72	Authorized Return
	This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee
	This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits
	This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request

	or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.
CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.

L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
	This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
	This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.
PL	Payment Final
	This is the final settlement.
RA	Retro-activity Adjustment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
RE	Return on Equity
SL	Student Loan Repayment
TL	Third Party Liability
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional

			information.				
			WO	Overpayment Recovery			
			This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.				
			WU	Unspecified Recovery			
			Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).				
	C04202	**127**	**Reference Identification**		**O**		**AN 1/50**
			Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
			SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB09_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier				
	PLB10	**782**	**Monetary Amount**		**X**	**1**	**R 1/18**
			Monetary amount				
			SITUATIONAL RULE: Required when PLB09 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB10__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.				
	PLB11	**C042**	**Adjustment Identifier**		**X**	**1**	
			To provide the category and identifying reference information for an adjustment				
			SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send. OD: 835W1__PLB11_C042 See PLB03 for details.				
M	**C04201**	**426**	**Adjustment Reason Code**		**M**		**ID 2/2**
			Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment				
			OD: 835W1__PLB11_C04201_AdjustmentReasonCode				
			50	Late Charge			
			This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.				
			51	Interest Penalty Charge			
			This is the interest assessment for late filing.				
			72	Authorized Return			
			This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value.				

	This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
90	Early Payment Allowance
AH	Origination Fee
	This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.
AM	Applied to Borrower's Account
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.
AP	Acceleration of Benefits
	This is the accelerated payment amount or withholding. Withholding or payment identification is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.

CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.
FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
	This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
	This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician

			passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.		
		OA	Organ Acquisition Passthru		
		OB	Offset for Affiliated Providers		
			Identification of the affiliated providers must be made on PLB03-2.		
		PI	Periodic Interim Payment		
			This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.		
		PL	Payment Final		
			This is the final settlement.		
		RA	Retro-activity Adjustment		
			This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.		
		RE	Return on Equity		
		SL	Student Loan Repayment		
		TL	Third Party Liability		
			This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.		
		WO	Overpayment Recovery		
			This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.		
		WU	Unspecified Recovery		
			Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).		
C04202	**127**	**Reference Identification**		**O**	**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier			
		SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB11_C04202_ProviderAdjustmentIdentifier			

			IMPLEMENTATION NAME: Provider Adjustment Identifier			
	PLB12	782	**Monetary Amount** Monetary amount SITUATIONAL RULE: Required when PLB11 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB12__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.	X	1	R 1/18
	PLB13	C042	**Adjustment Identifier** To provide the category and identifying reference information for an adjustment SITUATIONAL RULE: Required when an additional adjustment not already reported applies to this remittance advice. If not required by this implementation guide, do not send. OD: 835W1__PLB13_C042 See PLB03 for details.	X	1	
M	C04201	426	**Adjustment Reason Code** Code indicating reason for debit or credit memo or adjustment to invoice, debit or credit memo, or payment OD: 835W1__PLB13_C04201_AdjustmentReasonCode	M		ID 2/2
			50 Late Charge This is the Late Claim Filing Penalty or Medicare Late Cost Report Penalty.			
			51 Interest Penalty Charge This is the interest assessment for late filing.			
			72 Authorized Return This is the provider refund adjustment. This adjustment acknowledges a refund received from a provider for previous overpayment. PLB03-2 must always contain an identifying reference number when the value is used. PLB04 must contain a negative value. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.			
			90 Early Payment Allowance			
			AH Origination Fee This is the claim transmission fee. This is used for transmission fees that are not specific to or dependent upon individual claims.			
			AM Applied to Borrower's Account See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. Use this code to identify the loan repayment amount. This is capitation specific.			
			AP Acceleration of Benefits This is the accelerated payment amount or withholding. Withholding or payment identification			

	is indicated by the sign of the amount in PLB04. A positive value represents a withholding. A negative value represents a payment.
B2	Rebate
	This adjustment code applies when a provider has remitted an overpayment to a health plan in excess of the amount requested by the health plan. The amount accepted by the health plan is reported using code 72 (Authorized Return) and offset by the amount with code WO (Overpayment Recovery). The excess returned by the provider is reported as a negative amount using code B2, returning the excess funds to the provider.
B3	Recovery Allowance
	This represents the check received from the provider for overpayments generated by payments from other payers. This code differs from the provider refund adjustment identified with code 72. This adjustment must always be offset by some other PLB adjustment referring to the original refund request or reason. For balancing purposes, the amount related to this adjustment reason code must be directly offset.
BD	Bad Debt Adjustment
	This is the bad debt passthrough.
BN	Bonus
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
C5	Temporary Allowance
	This is the tentative adjustment.
CR	Capitation Interest
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CS	Adjustment
	Provide supporting identification information in PLB03-2.
CT	Capitation Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
CV	Capital Passthru
CW	Certified Registered Nurse Anesthetist Passthru
DM	Direct Medical Education Passthru
E3	Withholding
	See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
FB	Forwarding Balance
	This is the balance forward. A negative value in PLB04 represents a balance moving forward to a future payment advice. A positive value represents a balance being applied from a previous payment advice. A reference number must be supplied in PLB03-2 for tracking purposes. See 1.10.2.12, Balance Forward Processing, for further information.

FC	Fund Allocation
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information. The specific fund must be identified in PLB03-2.
GO	Graduate Medical Education Passthru
HM	Hemophilia Clotting Factor Supplement
IP	Incentive Premium Payment
	This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
IR	Internal Revenue Service Withholding
IS	Interim Settlement
	This is the interim rate lump sum adjustment.
J1	Nonreimbursable
	This offsets the claim or service level data that reflects what could be paid if not for demonstration program or other limitation that prevents issuance of payment.
L3	Penalty
	The dollar value of the penalty assessed a business entity for a past due debt
	This is the capitation-related penalty. Withholding or release is identified by the sign in PLB04. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.
L6	Interest Owed
	The dollar value of interest owed a business entity for a past due payment
	This is the interest paid on claims in this 835. Support the amounts related to this adjustment by 2-062 AMT amounts, where AMT01 is "I".
LE	Levy
	IRS Levy
LS	Lump Sum
	This is the disproportionate share adjustment, indirect medical education passthrough, nonphysician passthrough, passthrough lump sum adjustment, or other passthrough amount. The specific type of lump sum adjustment must be identified in PLB03-2.
OA	Organ Acquisition Passthru
OB	Offset for Affiliated Providers
	Identification of the affiliated providers must be made on PLB03-2.
PI	Periodic Interim Payment
	This is the periodic interim lump sum payments and reductions (PIP). The payments are made to a provider at the beginning of some period in advance of claims. These payments are advances on the expected claims for the period. The reductions are the recovery of actual claims payments during the period. For instance, when a provider has a PIP payment, claims within this remittance advice covered by that payment would be offset using this code to remove the claim payment from the current check. The sign of the amount in

			PLB04 determines whether this is a payment (negative) or reduction (positive). This payment and recoupment is effectively a loan to the provider and loan repayment. See section 1.10.2.5, Advance Payments and Reconciliation, for additional information.			
		PL	Payment Final			
			This is the final settlement.			
		RA	Retro-activity Adjustment			
			This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		RE	Return on Equity			
		SL	Student Loan Repayment			
		TL	Third Party Liability			
			This is capitation specific. See 1.10.2.10, Capitation and Related Payments or Adjustments, for additional information.			
		WO	Overpayment Recovery			
			This is the recovery of previous overpayment. An identifying number must be provided in PLB03-2. See the notes on codes 72 and B3 for additional information about balancing against a provider refund.			
		WU	Unspecified Recovery			
			Medicare is currently using this code to represent penalty collections withheld for the IRS (an outside source).			
C04202	**127**	**Reference Identification**		**O**		**AN 1/50**
		Reference information as defined for a particular Transaction Set or as specified by the Reference Identification Qualifier				
		SITUATIONAL RULE: Required when a control, account or tracking number applies to this adjustment. If not required by this implementation guide, do not send. OD: 835W1__PLB13_C04202_ProviderAdjustmentIdentifier IMPLEMENTATION NAME: Provider Adjustment Identifier				
PLB14	**782**	**Monetary Amount**		**X**	**1**	**R 1/18**
		Monetary amount				
		SITUATIONAL RULE: Required when PLB13 is used. If not required by this implementation guide, do not send. OD: 835W1__PLB14__ProviderAdjustmentAmount IMPLEMENTATION NAME: Provider Adjustment Amount This is the adjustment amount for the preceding adjustment reason.				

Segment: **SE** **Transaction Set Trailer**
Position: 0200
Loop:
Level: Summary

Usage: Must Use
Max Use: 1
Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments)
Syntax Notes:
Semantic Notes:
Comments: **1** SE is the last segment of each transaction set.
Notes: TR3 Example: SE*45*1234~

Data Element Summary

	Ref. Des.	Data Element	Name		Attributes
M	**SE01**	**96**	**Number of Included Segments** Total number of segments included in a transaction set including ST and SE segments OD: 835W1__SE01__TransactionSegmentCount IMPLEMENTATION NAME: Transaction Segment Count	**M**	**1 N0 1/10**
M	**SE02**	**329**	**Transaction Set Control Number** Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set OD: 835W1__SE02__TransactionSetControlNumber The Transaction Set Control Numbers in ST02 and SE02 must be identical. The originator assigns the Transaction Set Control Number, which must be unique within a functional group (GS-GE). This unique number also aids in error resolution research.	**M**	**1 AN 4/9**