

HCFA IMPLEMENTATION GUIDE MEDICARE A COB TO 837 V30R51

837-HA Health Care Claim - HCFA Medicare Part A

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

IMPLEMENTATION NOTE:

This guide is an implementation of the ASC X12 837 V30R51 standard to send and/or receive the Medicare A Coordination of Benefits data. Please note that Although the ASC X-12 standard accommodates greater number of occurrences of segments, only those segments and elements indicated within this guide should be mapped for Medicare COB claims. The summary of segments indicates the layout of the ASC X12 standard and in the left margin you will see an indicator of N/U which indicates the segment is not used for the COB to 837 mapping. The indications of optional, conditional, or mandatory segments is for the X12 standard 837 format. To determine if a segment is optional, conditional, or mandatory for Medicare COB processing; reference the actual mapping portion of this guide. If the usage for a segment contains 'NOTE: Required', then the segment is considered 'Mandatory' for COB processing. Otherwise, the segment is optional or conditional as indicated.

For COB only: If Medicare is the primary payer, then the secondary payer would be the destination payer. If Medicare is the secondary payer, then the tertiary payer would be the destination payer. The destination payer will be mapped to the 2100 loop and the 2320 loop. All other payers will be mapped to the 2300 loop. There are some instances where Medicare information may appear within the 2300 loop and these are noted as such.

ISA (Interchange Header)	M	1	
GS (Functional group Start)	M	1	

ST Transaction Start	M	1	
BGN Beginning Segment	O	1	
REF Reference Numbers	O	3	
--- Loop ID: 1000 ---			
NM1 Individual or Organizational Name	O	1	10
N2 Additional Name Information	O	2	
N3 Address Information	O	2	
N4 Geographic Location	O	1	
N/U REF Reference Numbers	O	2	
PER Administrative Communications Con	O	2	

--- Loop ID: 2000 ---			
PRV Provider Information	M	1	>1

N/U	DTP	Date or Time or Period	0	5	
N/U	CUR	Currency	0	1	
--- Loop ID: 2010 -----+-----					
	NM1	Individual or Organizational Name	0	1	2
	N2	Additional Name Information	0	2	
	N3	Address Information	0	2	
	N4	Geographic Location	0	1	
N/U	REF	Reference Numbers	0	20	
	PER	Administrative Communications Con	0	2	
-----+-----					
--- Loop ID: 2010 -----+-----					
	NM1	Individual or Organizational Name	0	1	2
N/U	N2	Additional Name Information	0	2	
	N3	Address Information	0	2	
	N4	Geographic Location	0	1	
N/U	REF	Reference Numbers	0	20	
N/U	PER	Administrative Communications Con	0	2	
-----+-----					
--- Loop ID: 2100 -----+-----					
	SBR	Subscriber Information	M	1	>1
N/U	DTP	Date or Time or Period	0	5	
--- Loop ID: 2110 -----+-----					
N/U	NM1	Individual or Organizational Name	0	1	10
N/U	N2	Additional Name Information	0	2	
N/U	N3	Address Information	0	2	
N/U	N4	Geographic Location	0	1	
N/U	DMG	Demographic Information	0	1	
N/U	PER	Administrative Communications Con	0	2	
N/U	REF	Reference Numbers	0	5	
-----+-----					
--- Loop ID: 2200 -----+-----					
	PAT	Patient Information	M	1	>1
N/U	DTP	Date or Time or Period	0	5	
--- Loop ID: 2210 -----+-----					
	NM1	Individual or Organizational Name	0	1	10
N/U	N2	Additional Name Information	0	2	
	N3	Address Information	0	2	
	N4	Geographic Location	0	1	
	DMG	Demographic Information	0	1	
N/U	PER	Administrative Communications Con	0	2	
	REF	Reference Numbers	0	5	
-----+-----					
--- Loop ID: 2300 -----+-----					
	CLM	Health Claim	M	1	100
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	DTP	Date or Time or Period	0	150	
	CL1	Claim Codes	0	1	
N/U	DN1	Orthodontic Information	0	1	
N/U	DN2	Tooth Summary	0	35	
N/U	PWK	Paperwork	0	10	
N/U	CN1	Contract Information	0	1	
N/U	DSB	Disability Information	0	1	
N/U	UR	Peer Review Organization or Utili	0	1	
N/U	AMT	Monetary Amount	0	40	
N/U	AMT	Monetary Amount	0	40	
N/U	AMT	Monetary Amount	0	40	
N/U	AMT	Monetary Amount	0	40	

N/U	AMT	Monetary Amount	0	40	
N/U	AMT	Monetary Amount	0	40	
N/U	AMT	Monetary Amount	0	40	
N/U	AMT	Monetary Amount	0	40	
	AMT	Monetary Amount	0	40	
	AMT	Monetary Amount	0	40	
	REF	Reference Numbers	0	30	
N/U	REF	Reference Numbers	0	30	
N/U	REF	Reference Numbers	0	30	
	REF	Reference Numbers	0	30	
	REF	Reference Numbers	0	30	
	REF	Reference Numbers	0	30	
	REF	Reference Numbers	0	30	
N/U	REF	Reference Numbers	0	30	
N/U	REF	Reference Numbers	0	30	
N/U	REF	Reference Numbers	0	30	
N/U	K3	File Information	0	10	
	NTE	Note/Special Instruction	0	20	
	NTE	Note/Special Instruction	0	20	
N/U	CR1	Ambulance Certification	0	1	
N/U	CR2	Chiropractic Certification	0	1	
N/U	CR3	Durable Medical Equipment Certifi	0	1	
N/U	CR4	Enteral or Parenteral Therapy Cer	0	3	
N/U	CR5	Oxygen Therapy Certification	0	1	
	CR6	Home Health Care Certification	0	1	
N/U	CR8	Pacemaker Certification	0	1	
	CRC	Conditions Indicator	0	100	
	CRC	Conditions Indicator	0	100	
	CRC	Conditions Indicator	0	100	
	HI	Health Care Information Codes	0	25	
	HI	Health Care Information Codes	0	25	
	HI	Health Care Information Codes	0	25	
	HI	Health Care Information Codes	0	25	
	HI	Health Care Information Codes	0	25	
	HI	Health Care Information Codes	0	25	
	HI	Health Care Information Codes	0	25	
N/U	QTY	Quantity	0	10	
	QTY	Quantity	0	10	
	QTY	Quantity	0	10	
N/U	QTY	Quantity	0	10	
N/U	HCP	Health Care Pricing	0	1	
	---	Loop ID: 2305	-----+-----		
	CR7	Home Health Treatment Plan Certif	0	1	6
	HSD	Health Care Services Delivery	0	12	
	---	Loop ID: 2310	-----+-----		
	NM1	Individual or Organizational Name	0	1	9
N/U	PRV	Provider Information	0	1	
N/U	N2	Additional Name Information	0	2	
N/U	N3	Address Information	0	2	
	N4	Geographic Location	0	1	
	---	Loop ID: 2310	-----+-----		
	NM1	Individual or Organizational Name	0	1	9
	---	Loop ID: 2310	-----+-----		
	NM1	Individual or Organizational Name	0	1	9
	---	Loop ID: 2320	-----+-----		
	LE	Loop Trailer	0	1	
	LS	Loop Header	0	1	
	---	Loop ID: 2320	-----+-----		
	SBR	Subscriber Information	0	1	10
	CAS	Claims Adjustment	0	1	
	AMT	Monetary Amount	0	15	

N/U	CR1	Ambulance Certification	0	1	
N/U	CR2	Chiropractic Certification	0	5	
N/U	CR3	Durable Medical Equipment Certifi	0	1	
N/U	CR4	Enteral or Parenteral Therapy Cer	0	3	
N/U	CR5	Oxygen Therapy Certification	0	1	
N/U	CRC	Conditions Indicator	0	3	
	DTP	Date or Time or Period	0	15	
N/U	QTY	Quantity	0	5	
N/U	MEA	Measurements	0	20	
N/U	CN1	Contract Information	0	1	
N/U	REF	Reference Numbers	0	30	
N/U	AMT	Monetary Amount	0	15	
N/U	K3	File Information	0	10	
N/U	NTE	Note/Special Instruction	0	10	
N/U	PS1	Purchase Service	0	1	
N/U	HCP	Health Care Pricing	0	1	
--- Loop ID: 2410 ---					
N/U	LIN	Item Identification	0	1	10
N/U	CTP	Pricing Information	0	1	

N/U	LS	Loop Header	0	1	
--- Loop ID: 2420 ---					
	NM1	Individual or Organizational Name	0	1	10
N/U	PRV	Provider Information	0	1	
N/U	N2	Additional Name Information	0	2	
N/U	N3	Address Information	0	2	
N/U	N4	Geographic Location	0	1	
	REF	Reference Numbers	0	20	
N/U	PER	Administrative Communications Con	0	2	

N/U	LE	Loop Trailer	0	1	
--- Loop ID: 2430 ---					
	SVD	Service Line Adjudication	0	1	>1
	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	DTP	Date or Time or Period	0	9	

--- Loop ID: 2430 ---					
	SVD	Service Line Adjudication	0	1	>1
	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	DTP	Date or Time or Period	0	9	

--- Loop ID: 2430 ---					
N/U	SVD	Service Line Adjudication	0	1	>1
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	DTP	Date or Time or Period	0	9	

--- Loop ID: 2430 ---					
N/U	SVD	Service Line Adjudication	0	1	>1
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	CAS	Claims Adjustment	0	99	
N/U	DTP	Date or Time or Period	0	9	

SE		Transaction Set Trailer	M	1	

GE	Functional Group Trailer	M	1
IEA	Interchange Control Trailer	M	1

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SUMMARY OF CHANGES FROM 1A.CO (10/21/96 REVISION) TO 1A.C1

<u>Position/Segment</u>	<u>Description of Revision</u>
NA	MAP ONLY ONCE FROM THE FIRST OCCURRENCE OF A UB-92 71 RECORD
NA	Added ISA, GS, GE, and IEA segments
CR8	deleted
NA	Mappings have been updated for the UB-92 version 5.0
BGN	Updated map for BGN03
1-015-REF	Updated REF02 for 1A.C1
1-020-NM1	Updated map for NM109
1-25-N2	Updated map for N201
1-045-PER	PER02 is "not used"
2-005-PRV	Updated map for PRV03
2-045-SBR	Updated map for SBR09
2-090-PAT	Updated map for PAT03
2-105-N3	Updated map for N301 and N302
2-110-N4	Updated mapping
2-130-CLM	Updated map for CLM03
2-135.A-DTP	Updated DTP01 - DTP03
2-135.B-DTP	New
2-135.C-DTP	New
2-135.D-DTP	New
2-135.E-DTP	New
2-135.F-DTP	New
2-135.G-DTP	New
2-135.H-DTP	New
2-135.I-DTP	New
2-135.J-DTP	New
2-180-REF	Updated map for REF02
2-190-NTE	Updated NTE01 (see UB-92 specifications for codes)
2-216-CR6	Updated dates and mappings
2-220-CRC	Updated map for CRC03 (Functional Limitations)
2-220-CRC	Updated map for CRC03 (Activities Permitted)
2-220-CRC	Updated map for CRC03 (Mental Status)
2-231-HI	Updated dates and mapping (Procedure Codes)
2-231-HI	Updated dates and mapping (Occurrence Codes)
2-231-HI	Updated dates and mapping (Occurrence Span Codes)
2-250-NM1	Updated map for NM103 - NM105 (Attending Physician)
2-270-N4	Updated map for N403
2-250-NM1	Updated map for NM103 - NM105 (Operating Physician)
2-250-NM1	Deleted (Ordering Physician)
2-290-SBR	Updated map for SBR08
2-310-OI	Updated map for OI01

2-325-NM1 New (Contract Number)
 2-350-DTP Updated map for DTP02 and DTP03
 2-355-REF Updated map for REF02
 2-375-SV2 Updated mapping
 2-375-SV2 Removed syntax note R0102
 2-375-SV2 SV201 usage changed to mandatory
 2-455-DTP Updated
 2-540-SVD Updated map for SVD04 (52 Record)
 2-540-SVD Updated map for SVD02 (62 Record)

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X12 Segment Name: ISA Interchange Control Header

Loop: ----

Max. Use: 1

X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments

Usage: Mandatory

Example: ISA*00*.....*01*SECRET....*ZZ*MEDEX.....*ZZ*0305.....*9306
 02*1253*U*00305*00000905*1*T*~

Comments: The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire exchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire exchange. The white spaces in the example have been replaced by periods for clarity.

Element Attributes	Data Element Usage	UB92 EMC VER.5 Mapping
ISA01 I01 ID 2 2 M	Authorization Information Qualifier Code to identify the type of information in the Authorization Information. Codes: 00 No Authorization Information Present (No Meaningful Information in I02) 03 Additional Data Identification	
ISA02 I02 AN 10 10 M	Authorization Information Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	
ISA03 I03 ID 2 2 M	Security Information Qualifier Code to identify the type of information in the Security Information. Codes: 00 No Security Information Present (No Meaningful Information in I04) 01 Password	
ISA04 I04 AN 10 10 M	Security Information This is used for identifying the security information about the	

interchange sender or the data in the interchange; the type of information is set by the Security Information Qualifier (I03)

ISA05 I05 ID 2 2 M	Interchange ID Qualifier Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Codes: 28 Fiscal Intermediary Number	
ISA06 I06 AN 15 15 M	Interchange Sender ID Transmission Submitter Identification Number. Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. The identification code assigned by the intermediary to the submitter of this transmission. Space fill the submitter number to the right for a total length of 15 characters. INTERMEDIARY NUMBER	02-13
ISA07 I05 ID 2 2 M	Interchange ID Qualifier Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified. Codes: ZZ Mutually Defined	
ISA08 I07 AN 15 15 M	Interchange Receiver ID Intermediary Identification Number. Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them. The identification assigned by Intermediary to the receiver of this file. INTERMEDIARY NUMBER.	
ISA09 I08 DT 6 6 M	Interchange Date File Creation Date Date of the interchange. Format YYMMDD.	
ISA10 I09 TM 4 4 M	Interchange Time File Creation Time Time of the interchange. Format HHMM. Use a minimum of four zeroes if there is no significant data for this field.	
ISA11 I10 ID 1 1 M	Interchange Control Standards Identifier Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer. Codes: U U.S. EDI Community of ASC X12, TDCC, and UCS	
ISA12 I11 ID 5 5 M	Interchange Control Version Number ANSI Version Code This version number covers the interchange control segments. The version code may vary, if or when HCFA chooses to adopt the next ASC X12	

Version. The correct value for this version is "00305".

Codes:

ISA13 I12 Interchange Control Number
N0 9 9 M A control number assigned by the interchange sender
The Interchange Control Number, ISA13, must be identical to the one found in the associated Interchange Trailer IEA02. Cannot be left blank.

ISA14 I13 Acknowledgment Requested
ID 1 1 M Code sent by the sender to request an interchange acknowledgment (TA1)
Codes:
0 No Acknowledgment Requested
1 Interchange Acknowledgment Requested

ISA15 I14 Test Indicator
ID 1 1 M Code to indicate whether data enclosed by this interchange envelope is test or production.
Codes:

P Production Data
T Test Data

ISA16 I15 Component Element Separator
AN 1 1 M This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator
Cannot be left blank. A ':' is recommended.

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X12 Segment Name: GS Functional Group Header

Loop: ----

Max. Use: 1

X12 Purpose: To indicate the beginning of a functional group and to provide control information

Usage: Mandatory

Example: GS*HC*MEDEX*0305*930602*1253*1*X*003051~

Comments: All fields must contain data.

Semantic Note: GS04 is the Group Date.

Semantic Note: GS05 is the Group Time.

Semantic Note: The data interchange control number GS06 in this header must be identical to the same data element in the associated Functional Group Trailer GE02.

X12 Comment: A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

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Element	Data Element Usage	UB92 EMC VER.5 Mapping
GS01 0479	Functional Identifier Code	

-----+-----+-----

ID 2 2 M	Code identifying a group of application related Transaction Sets. Codes: HC Health Care Claim (837)	
GS02 0142 AN 2 15 M	Application Sender's Code Transmission Submitter Identification Number Code identifying party sending transmission. Codes agreed to by trading partners. INTERMEDIARY NUMBER	02-13
GS03 0124 AN 2 15 M	Application Receiver's Code Code identifying party receiving transmission. Codes agreed to by trading partners. The identification code for the receiver of this transmission.	01-06, 01-07
GS04 0373 DT 6 6 M	Date Group Creation Date Date (YYMMDD). DATE OF RECEIPT.	
GS05 0337 TM 4 8 M	Time Group Creation Time Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99) Format HHMM. Use a minimum of four zeroes if there is no significant data for this field. FILE CREATION TIME.	
GS06 0028 NO 1 9 M	Group Control Number Assigned number originated and maintained by the sender. The group control number, GS06, must be identical to the one found in the associated function trailer GE02. Start with 1 and increment by 1 for each functional group within this interchange.	
GS07 0455 ID 1 2 M	Responsible Agency Code Code used in conjunction with Data Element 480 to identify the issuer of the standard. Codes: X Accredited Standards Committee X12	
GS08 0480 AN 1 12 M	Version / Release / Industry Identifier Code ANSI Version Code	

Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments. If code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user). If code in DE455 in GS segment is T, then other formats are allowed. The version code may vary, if or when HCFA chooses to adopt the next ASC X12 Version

Codes:

003051

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SEGMENT: ST Transaction Set Header
POSITION: 005
LEVEL: Header
LOOP: _____
> USAGE: Mandatory NOTE: Required
MAX USE: 1
PURPOSE: To indicate the start of a transaction set and to assign a control number
SEMANTIC: 1. The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the invoice transaction set).
> EXAMPLE: ST*837*112233~

DATA ELEMENT SUMMARY -----

ST01	143	TRANSACTION SET IDENTIFIER CODE	M ID 3/3
>		Code uniquely identifying a Transaction Set. Required 837 X12.86 Health Care Claim	
ST02	329	TRANSACTION SET CONTROL NUMBER	M AN 4/9
>		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set Required	

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SEGMENT: BGN Beginning Segment
POSITION: 010
LEVEL: Header
LOOP: _____
> USAGE: Optional NOTE: Required
MAX USE: 1
PURPOSE: To indicate the beginning of a transaction set.
SYNTAX: 1. C0504--If BGN05 is present, then BGN04 is required.
SEMANTIC: 1. BGN02 is the transaction set reference number.
2. BGN03 is the transaction set date.
3. BGN04 is the transaction set time.
4. BGN05 is the transaction set time qualifier.
5. BGN06 is the transaction set reference number of a previously sent transaction affected by the current

POSITION: 015
 LEVEL: Header
 LOOP: _____
 > USAGE: Optional NOTE: Required
 MAX USE: 3
 PURPOSE: To specify identifying numbers.
 SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
 > NOTES: 1. This segment conveys the version number for the provider
 > application system used to process the claims.
 > EXAMPLE: REF*F1*1A.C1~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
 Code qualifying the Reference Number.
 > Required
 > F1 Version Code - National
 > 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
 > national level.
 REF02 127 REFERENCE NUMBER C AN 1/30
 Reference number or identification number as defined for a
 particular Transaction Set, or as specified by the Reference
 Number Qualifier.
 > Required
 > Medicare A Implementation Guide Version Number
 > Use "1A.C1" for this version.
 REF03 352 DESCRIPTION C AN 1/80
 A free-form description to clarify the related data elements
 and their content.
 > Not Used

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SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: SUBMITTER NAME AND ID
 POSITION: 020
 LEVEL: Header
 LOOP: 1000 Repeat: 10
 > USAGE: Optional NOTE: Required
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational
 entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
 is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > NOTES: 1. To identify the submitter or billing service or
 > clearinghouse.
 > EXAMPLE: NM1*41*2*HOSPITAL BILLING SERVICE*****24*731234567~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
 Code identifying an organizational entity, a physical location,
 or an individual
 > Required
 > 41 Submitter
 > Entity transmitting transaction set.
 NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
 Code qualifying the type of entity.
 > Required
 > 2 Non-Person Entity

NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
 Individual last name or organizational name
 > Submitter Name
 > The name of the submitter to which the receiver should direct
 > inquiries regarding this file.
 > 01-09

NM104 1036 NAME FIRST O AN 1/25
 Individual first name.
 > Not Used

NM105 1037 NAME MIDDLE O AN 1/25
 Individual middle name or initial.
 > Not Used

NM106 1038 NAME PREFIX O AN 1/10
 Prefix to individual name.
 > Not Used

NM107 1039 NAME SUFFIX O AN 1/10
 Suffix to individual name.
 > Not Used

NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
 Code designating the system/method of code structure used for
 Identification Code (67).
 > Required
 > Submitter/Biller Identifier
 24 Employer's Identification Number

NM109 67 IDENTIFICATION CODE C AN 2/20
 Code identifying a party or other code.
 > Required
 > Submitter Identifier
 > Identifies the submitter as defined by the receiver.
 > SUBMITTER EIN
 01-02

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SEGMENT: N2 Additional Name Information
 >WEDI NME: ADDITIONAL SUBMITTER NAME
 POSITION: 025
 LEVEL: Header
 LOOP: 1000
 USAGE: Optional
 MAX USE: 2
 PURPOSE: To specify additional names or those longer than 35 characters
 in length
 > NOTES: 1. This segment should be utilized only if NM103 is
 > insufficient in size.
 > EXAMPLE: N2*A VERY LONG NAME~

DATA ELEMENT SUMMARY -----

N201 93 NAME M AN 1/35
 Free-form name.
 > Required
 > Additional Submitter Name
 >

N202 93 NAME O AN 1/35
 Free-form name.
 > Additional Submitter Name

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SEGMENT: N3 Address Information
 >WEDI NME: SUBMITTER ADDRESS
 POSITION: 030
 LEVEL: Header

LOOP: 1000
USAGE: Optional
MAX USE: 2
PURPOSE: To specify the location of the named party
> EXAMPLE: N3*123 MAIN STREET~

DATA ELEMENT SUMMARY -----

N301 166 ADDRESS INFORMATION M AN 1/35
Address information
> Required
> Submitter Address 1
> The mailing address of the submitter of the claim file.
> 01-10
N302 166 ADDRESS INFORMATION O AN 1/35
Address information
> Not Used

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SEGMENT: N4 Geographic Location
>WEDI NME: SUBMITTER CITY, STATE, ZIP
POSITION: 035
LEVEL: Header
LOOP: 1000
USAGE: Optional
MAX USE: 1
PURPOSE: To specify the geographic place of the named party
SYNTAX: 1. C0605--If N406 is present, then N405 is required.
COMMENTS: A. A combination of either N401 through N404 (or N405 and
N406) may be adequate to specify a location.
B. N402 is required only if city name (N401) is in the USA or
Canada.
> EXAMPLE: N4*ANY TOWN*TX*75123~

DATA ELEMENT SUMMARY -----

N401 19 CITY NAME O AN 2/30
Free-form text for city name.
> Submitter City
> The city name of the submitter of the claim file.
> 01-11
N402 156 STATE OR PROVINCE CODE O ID 2/2
Code (Standard State/Province) as defined by appropriate
government agency.
> Submitter State
> 01-12
> See Appendix B for State Abbreviation Codes.
N403 116 POSTAL CODE O ID 3/11
Code defining international postal zone code excluding
punctuation and blanks (zip code for United States).
> Submitter ZIP Code
> The ZIP code of the submitter of the claim file.
> 01-13
N404 26 COUNTRY CODE O ID 2/3
Code identifying the country.
> Submitter Country Code
> The country in which the respective person or entity resides.
> 01-15
N405 309 LOCATION QUALIFIER C ID 1/2
Code identifying type of location.
> Not Used
N406 310 LOCATION IDENTIFIER O AN 1/30

> Code which identifies a specific location.
> Not Used

=====

SEGMENT: PER Administrative Communications Contact
>WEDI NME: SUBMITTER CONTACT
POSITION: 045
LEVEL: Header
LOOP: 1000
USAGE: Optional
MAX USE: 2
PURPOSE: To identify a person or office to whom administrative
communications should be directed
SYNTAX: 1. P0304--If either PER03 or PER04 is present, then the other
is required.
2. P0506--If either PER05 or PER06 is present, then the other
is required.
3. P0708--If either PER07 or PER08 is present, then the other
is required.
> EXAMPLE: PER*SM*JANE DOE*TE*2145551212~

DATA ELEMENT SUMMARY -----

PER01 366 CONTACT FUNCTION CODE M ID 2/2
Code identifying the major duty or responsibility of the person
or group named.
> Required
SM Submitting Contact

PER02 93 NAME O AN 1/35
Free-form name.
> Submitter Contact
> Identifies an individual responsible for issues that may arise
> concerning this submission. SUBMITTER NAME.
Not Used

PER03 365 COMMUNICATION NUMBER QUALIFIER C ID 2/2
Code identifying the type of communication number.
TE Telephone

PER04 364 COMMUNICATION NUMBER C AN 1/80
Complete communications number including country or area code
when applicable.
> Submitter Telephone Number
> The telephone number of the submitter of the claim file.
> 01-16

PER05 365 COMMUNICATION NUMBER QUALIFIER C ID 2/2
Code identifying the type of communication number.
FX Facsimile

PER06 364 COMMUNICATION NUMBER C AN 1/80
Complete communications number including country or area code
when applicable.
> Submitter Fax Number
> The Telefax number of the submitter of the claim file.
> 01-14

PER07 365 COMMUNICATION NUMBER QUALIFIER X ID 2/2
Code identifying the type of communication number.
> Not Used

PER08 364 COMMUNICATION NUMBER X AN 1/80
Complete communications number including country or area code
when applicable.
> Not Used

PER09 443 CONTACT INQUIRY REFERENCE O AN 1/20
Additional reference number or description to clarify a contact
number.

> Not Used

```
=====
SEGMENT: PRV Provider Information
>WEDI NME: BILLING PROVIDER
POSITION: 005
  LEVEL: Detail
  LOOP: 2000 Repeat: >1
> USAGE: Mandatory NOTE: Required
MAX USE: 1
PURPOSE: To specify the identifying characteristics of a provider
SYNTAX: 1. P0506--If either PRV05 or PRV06 is present, then the other
         is required.
SEMANTIC: 1. PRV05 qualifies PRV06.
> NOTES: 1. The Billing Provider is assumed to also be the Rendering
>          Provider for all claims, unless overridden in loop 2310 by a
>          NM101 containing code 82
> EXAMPLE: PRV*BI*1C*339999~
```

DATA ELEMENT SUMMARY -----

```
PRV01 1221 PROVIDER CODE M ID 1/3
Code indentifying the type of provider
> Required
  BI Billing
PRV02 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
> Required
  1C Medicare Provider Number
  ZZ Mutually Defined
  (National Provider Identifier)
PRV03 127 REFERENCE NUMBER M AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Required
> Medicare Provider Number
> The number assigned to the provider by the Medicare payor for
> Medicare identification purposes.
> 10-06; 30-24
PRV04 156 STATE OR PROVINCE CODE O ID 2/2
Code (Standard State/Province) as defined by appropriate
government agency.
> Not Used
PRV05 559 AGENCY QUALIFIER CODE C ID 2/2
Code identifying the agency assigning the code values.
> Not Used
PRV06 1222 PROVIDER SPECIALTY CODE C AN 1/3
Code indicating the primary specialty of the provider, as
defined by the receiver
> Not Used
PRV07 1223 PROVIDER ORGANIZATION CODE O ID 3/3
Code identifying the organizational structure of a provider
> Not Used
```

```
=====
SEGMENT: NM1 Individual or Organizational Name
>WEDI NME: BILLING PROVIDER NAME AND ID
POSITION: 015
```

LEVEL: Detail
 LOOP: 2010 Repeat: 2
 > USAGE: Optional NOTE: Recommended
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > NOTES: 1. When the Provider is identified by 2-005-PRV03, the entire loop 2010 may not be required. However, if any of the segments in the loop is needed, then NM1 must be present.
 > EXAMPLE: NM1*85*2*GOOD SAMARITAN HOSPITAL*****FI*05933311150002~

DATA ELEMENT SUMMARY -----

NM101	98	ENTITY IDENTIFIER CODE	M ID 2/2
		Code identifying an organizational entity, a physical location, or an individual	
>		Required	
		85 Billing Provider	
NM102	1065	ENTITY TYPE QUALIFIER	M ID 1/1
		Code qualifying the type of entity.	
>		Required	
		2 Non-Person Entity	
NM103	1035	NAME LAST OR ORGANIZATION NAME	O AN 1/35
		Individual last name or organizational name	
>		Required	
>		Provider Organization Name	
>		The name of the organization submitting a claim for payment.	
>		PROVIDER NAME.	
>		10-12	
NM104	1036	NAME FIRST	O AN 1/25
		Individual first name.	
>		Not Used	
NM105	1037	NAME MIDDLE	O AN 1/25
		Individual middle name or initial.	
>		Not Used	
NM106	1038	NAME PREFIX	O AN 1/10
		Prefix to individual name.	
>		Not Used	
NM107	1039	NAME SUFFIX	O AN 1/10
		Suffix to individual name.	
>		Not Used	
NM108	66	IDENTIFICATION CODE QUALIFIER	C ID 1/2
		Code designating the system/method of code structure used for Identification Code (67).	
		FI Federal Taxpayer's Identification Number	
NM109	67	IDENTIFICATION CODE	C AN 2/20
		Code identifying a party or other code.	
>		Billing Provider Federal Tax Number	
>		This field references the Tax ID or EIN and the Federal Tax	
>		Sub ID.	
>		10-04 ; 10-05	

=====

SEGMENT: N2 Additional Name Information
 >WEDI NME: BILLING PROVIDER ADDITIONAL NAME
 POSITION: 020
 LEVEL: Detail
 LOOP: 2010
 USAGE: Optional

MAX USE: 2
 PURPOSE: To specify additional names or those longer than 35 characters
 in length
 > NOTES: 1. This segment should be utilized only if NM103 is
 > insufficient in size.
 > EXAMPLE: N2*EXTREMELY LONG NAME~

DATA ELEMENT SUMMARY -----

N201 93 NAME M AN 1/35
 Free-form name.
 > Required
 > Billing provider Additional Name
 N202 93 NAME O AN 1/35
 Free-form name.
 > Billing provider Additional Name

=====

SEGMENT: N3 Address Information
 >WEDI NME: BILLING PROVIDER ADDRESS
 POSITION: 025
 LEVEL: Detail
 LOOP: 2010
 USAGE: Optional
 MAX USE: 2
 PURPOSE: To specify the location of the named party
 > EXAMPLE: N3*35 W ELM ST SUITE 101~

DATA ELEMENT SUMMARY -----

N301 166 ADDRESS INFORMATION M AN 1/35
 Address information
 > Required
 > The street address of the Provider.
 > 10-13
 N302 166 ADDRESS INFORMATION O AN 1/35
 Address information
 > Not Used

=====

SEGMENT: N4 Geographic Location
 >WEDI NME: BILLING PROVIDER CITY, STATE, ZIP
 POSITION: 030
 LEVEL: Detail
 LOOP: 2010
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To specify the geographic place of the named party
 SYNTAX: 1. C0605--If N406 is present, then N405 is required.
 COMMENTS: A. A combination of either N401 through N404 (or N405 and
 N406) may be adequate to specify a location.
 B. N402 is required only if city name (N401) is in the USA or
 Canada.
 > EXAMPLE: N4*ANY TOWN*TX*75124~

DATA ELEMENT SUMMARY -----

N401 19 CITY NAME O AN 2/30
 Free-form text for city name.

> Provider City
> The city name of the Provider.
> 10-14
N402 156 STATE OR PROVINCE CODE O ID 2/2
Code (Standard State/Province) as defined by appropriate
government agency.
> Provider State
> See Section B for State Abbreviation Codes.
> 10-15
N403 116 POSTAL CODE O ID 3/11
Code defining international postal zone code excluding
punctuation and blanks (zip code for United States).
> Provider ZIP
> The ZIP code of the Provider.
> 10-16
N404 26 COUNTRY CODE O ID 2/3
Code identifying the country.
> 10-18
N405 309 LOCATION QUALIFIER C ID 1/2
Code identifying type of location.
> Not Used
N406 310 LOCATION IDENTIFIER O AN 1/30
Code which identifies a specific location.
> Not Used

=====

SEGMENT: PER Administrative Communications Contact
>WEDI NME: BILLING PROVIDER TELEPHONE NUMBER
POSITION: 040
LEVEL: Detail
LOOP: 2010
USAGE: Optional
MAX USE: 2
PURPOSE: To identify a person or office to whom administrative
communications should be directed
SYNTAX: 1. P0304--If either PER03 or PER04 is present, then the other
is required.
2. P0506--If either PER05 or PER06 is present, then the other
is required.
3. P0708--If either PER07 or PER08 is present, then the other
is required.
> EXAMPLE: PER*PH*MARIA DOE*TE*8175551212~

DATA ELEMENT SUMMARY -----

PER01 366 CONTACT FUNCTION CODE M ID 2/2
Code identifying the major duty or responsibility of the person
or group named.
> Required
PH Provider
> Entity providing health care services.
PER02 93 NAME O AN 1/35
Free-form name.
> Not used
PER03 365 COMMUNICATION NUMBER QUALIFIER C ID 2/2
Code identifying the type of communication number.
TE Telephone
PER04 364 COMMUNICATION NUMBER C AN 1/80
Complete communications number including country or area code
when applicable.
> Billing Provider Telephone Number
> The telephone number, including area code at which the

> provider can be contacted.
 > 10-11
 PER05 365 COMMUNICATION NUMBER QUALIFIER C ID 2/2
 Code identifying the type of communication number.
 FX Facsimile
 PER06 364 COMMUNICATION NUMBER C AN 1/80
 Complete communications number including country or area code
 when applicable.
 > Billing Provider Fax Number
 > The Telefax number, including area code at which the provider
 > can be contacted.
 > 10-17
 PER07 365 COMMUNICATION NUMBER QUALIFIER X ID 2/2
 Code identifying the type of communication number.
 > Not Used
 PER08 364 COMMUNICATION NUMBER X AN 1/80
 Complete communications number including country or area code
 when applicable.
 > Not Used
 PER09 443 CONTACT INQUIRY REFERENCE O AN 1/20
 Additional reference number or description to clarify a contact
 number.
 > Not Used

=====

SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: PROVIDER CHAIN INFORMATION
 POSITION: 015
 LEVEL: Detail
 LOOP: 2010 Repeat: 2
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational
 entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
 is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > EXAMPLE: NM1*2D*2*GOOD SAMARITAN HEATLH
 CENTER*****FI*05933311150001~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
 Code identifying an organizational entity, a physical location,
 or an individual
 2D Miscellaneous Health Care Facility
 NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
 Code qualifying the type of entity.
 2 Non-Person Entity
 NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
 Individual last name or organizational name
 > Provider Chain Name
 > 02-05
 NM104 1036 NAME FIRST O AN 1/25
 Individual first name.
 > Not Used
 NM105 1037 NAME MIDDLE O AN 1/25
 Individual middle name or initial.
 > Not Used
 NM106 1038 NAME PREFIX O AN 1/10
 Prefix to individual name.
 > Not Used

NM107 1039 NAME SUFFIX O AN 1/10
 Suffix to individual name.
 > Not Used
 NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
 Code designating the system/method of code structure used for
 Identification Code (67).
 FI Federal Taxpayer's Identification Number
 NM109 67 IDENTIFICATION CODE C AN 2/20
 Code identifying a party or other code.
 > Provider Chain Id & Sub-Id
 > 02-02 & 02-03

=====

SEGMENT: N3 Address Information
 >WEDI NME: PROVIDER CHAIN ADDRESS
 POSITION: 025
 LEVEL: Detail
 LOOP: 2010
 USAGE: Optional
 MAX USE: 2
 PURPOSE: To specify the location of the named party
 > EXAMPLE: N3*35 W ELM STREET SUITE 100~

DATA ELEMENT SUMMARY -----

N301 166 ADDRESS INFORMATION M AN 1/35
 Address information
 > 02-06
 > Provider Chain Address
 N302 166 ADDRESS INFORMATION O AN 1/35
 Address information
 > Not Used

=====

SEGMENT: N4 Geographic Location
 >WEDI NME: PROVIDER CHAIN CITY & STATE
 POSITION: 030
 LEVEL: Detail
 LOOP: 2010
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To specify the geographic place of the named party
 SYNTAX: 1. C0605--If N406 is present, then N405 is required.
 COMMENTS: A. A combination of either N401 through N404 (or N405 and
 N406) may be adequate to specify a location.
 B. N402 is required only if city name (N401) is in the USA or
 Canada.
 > EXAMPLE: N4*ANY TOWN*TX*75124~

DATA ELEMENT SUMMARY -----

N401 19 CITY NAME O AN 2/30
 Free-form text for city name.
 > 02-07
 > Provider Chain City
 N402 156 STATE OR PROVINCE CODE O ID 2/2
 Code (Standard State/Province) as defined by appropriate
 government agency.
 > 02-08

Number Qualifier.
> Not Used
SBR04 93 NAME O AN 1/35
Free-form name.
> Not Used
SBR05 1336 INSURANCE TYPE CODE O ID 1/3
Code identifying the type of insurance policy within a specific
insurance program
> Not Used
SBR06 1143 COORDINATION OF BENEFITS CODE O ID 1/1
Code identifying whether there is a coordination of benefits
> Not Used
SBR07 1073 YES/NO CONDITION OR RESPONSE CODE O ID 1/1
Code indicating a Yes or No condition or response.
> Not Used
SBR08 584 EMPLOYMENT STATUS CODE O ID 2/2
Code showing the general employment status of an
employee/claimant.
> Not Used
SBR09 1032 CLAIM FILING INDICATOR CODE O ID 1/2
Code identifying type of claim
30-09 (Not all codes map)
> BL Blue Cross/Blue Shield
> UB92 code "G"
> CH Champus
> UB92 code "H"
> CI Commercial Insurance Co.
> UB92 code "F"
> FI Federal Employees Program
> UB92 code "E"
> HM Health Maintenance Organization
> MA Medicare Part A
> UB92 code "C"
> MC Medicaid
> UB92 code "D"
> MH Managed Care Non-HMO
> OF Other Federal Program
> UB92 code "E"
> SA Self-administered Group
> UB92 code "A"
> TV Title V
> VA Veteran Administration Plan
> WC Workers' Compensation Health Claim
> UB92 code "B"

=====

SEGMENT: PAT Patient Information
POSITION: 090
LEVEL: Detail
LOOP: 2200 Repeat: >1
> USAGE: Mandatory NOTE: Required
MAX USE: 1
PURPOSE: To supply patient information
SYNTAX: 1. P0506--If either PAT05 or PAT06 is present, then the other
is required.
2. P0708--If either PAT07 or PAT08 is present, then the other
is required.
SEMANTIC: 1. PAT06 is the date of death.
2. PAT08 is the patient's weight.
> NOTES: 1. *NOTE: For fields from record type 30, use the destination
> payer's sequence of the record.
> EXAMPLE: PAT*18**RT~

DATA ELEMENT SUMMARY -----

PAT01 1069 INDIVIDUAL RELATIONSHIP CODE O ID 2/2
Code indicating the relationship between two individuals or entities.

- > Required
- > Patient's Relationship to Insured
- > 30-18
 - 01 Spouse
 - > UB92 code "02"
 - 18 Self
 - > UB92 code "01"
 - 19 Child
 - > UB92 code "03"
 - 21 Unknown
 - > UB92 code "09"

PAT02 1384 PATIENT LOCATION CODE O ID 1/1
Code identifying the location where patient is receiving medical treatment

- > Not Used

PAT03 584 EMPLOYMENT STATUS CODE O ID 2/2
Code showing the general employment status of an employee/claimant.

- > Patient Employment Status Code
- > A code indicating employment status of the patient. EMPLOYMENT STATUS CODE. If a UB92 value of '6' and it is not known if USA or Overseas; default to 'AU'.
- > 30-19 (Not all codes map)
 - AO Active Military - Overseas
 - AU Active Military - USA
 - FT Full-time
 - > UB92 Code "1"
 - NE Not Employed
 - > UB92 Code "3"
 - PT Part-time
 - > UB92 Code "2"
 - RT Retired
 - > UB92 Code "5"
 - SE Self-Employed
 - > UB92 Code "4"
 - UK Unknown
 - > UB92 Code "9"

PAT04 1220 STUDENT STATUS CODE O ID 1/1
Code indicating the student status of the patient if 19 years of age or older, not handicapped and not the insured

- > Not Used

PAT05 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or date and time format.

- > Not Used

PAT06 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates, times or dates and times.

- > Not Used

PAT07 355 UNIT OR BASIS FOR MEASUREMENT CODE C ID 2/2
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken

- > Not Used

PAT08 81 WEIGHT C R 1/10
Numeric value of weight.

- > Not Used

SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: PATIENT NAME AND HICNO
 POSITION: 095
 LEVEL: Detail
 LOOP: 2210 Repeat: 10
 > USAGE: Optional NOTE: Required
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > NOTES: 1. *NOTE: For fields from record type 30, use the destination payer's sequence of the record.
 > EXAMPLE: NM1*QC*1*JOE*JOHN****HN*123234567A~

DATA ELEMENT SUMMARY -----

NM101	98	ENTITY IDENTIFIER CODE	M ID 2/2
		Code identifying an organizational entity, a physical location, or an individual	
>		Required	
		QC Patient	
>		Individual receiving medical care	
NM102	1065	ENTITY TYPE QUALIFIER	M ID 1/1
		Code qualifying the type of entity.	
>		Required	
		1 Person	
NM103	1035	NAME LAST OR ORGANIZATION NAME	O AN 1/35
		Individual last name or organizational name	
>		Required	
>		Patient Last Name	
>		The last name of the individual to whom the services were provided.	
>		20-04	
NM104	1036	NAME FIRST	O AN 1/25
		Individual first name.	
>		Required	
>		Patient First Name	
>		The first name of the individual to whom the services were provided.	
>		20-05	
NM105	1037	NAME MIDDLE	O AN 1/25
		Individual middle name or initial.	
>		Patient Middle Initial	
>		The middle initial of the individual to whom the services were provided.	
>		Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set.	
>		20-06	
NM106	1038	NAME PREFIX	O AN 1/10
		Prefix to individual name.	
>		Not Used	
NM107	1039	NAME SUFFIX	O AN 1/10
		Suffix to individual name.	
>		Not Used	
NM108	66	IDENTIFICATION CODE QUALIFIER	C ID 1/2
		Code designating the system/method of code structure used for Identification Code (67).	
>		Required	
		HN Health Insurance Claim (HIC) Number	
>		Unique number assigned to individual for submitting claims covered by Medicare benefits.	
>			
NM109	67	IDENTIFICATION CODE	C AN 2/20

Code identifying a party or other code.
 > Required
 > Health Insurance Claim Number
 > Patient's Medicare ID number, including suffix or prefix. Do
 > NOT use hyphens.
 > 30-07

```
=====
  SEGMENT: N3 Address Information
>WEDI NME: PATIENT ADDRESS
  POSITION: 105
    LEVEL: Detail
    LOOP: 2210
>  USAGE: Optional NOTE: Required
    MAX USE: 2
    PURPOSE: To specify the location of the named party
> EXAMPLE: N3*44 W 1500 SOUTH ST~
```

DATA ELEMENT SUMMARY -----

```
N301  166  ADDRESS INFORMATION                      M AN 1/35
        Address information
        > Required
        > Patient Address 1
        > The mailing address of the patient.
        > 20-12
N302  166  ADDRESS INFORMATION                      O AN 1/35
        Address information
        > Patient Address 2
        > Additional mailing address of the patient.
        > 20-13
=====
```

```
  SEGMENT: N4 Geographic Location
>WEDI NME: PATIENT CITY, STATE, ZIP
  POSITION: 110
    LEVEL: Detail
    LOOP: 2210
>  USAGE: Optional NOTE: Required
    MAX USE: 1
    PURPOSE: To specify the geographic place of the named party
    SYNTAX:  1. C0605--If N406 is present, then N405 is required.
  COMMENTS:  A. A combination of either N401 through N404 (or N405 and
              N406) may be adequate to specify a location.
              B. N402 is required only if city name (N401) is in the USA or
              Canada.
> EXAMPLE: N4*ANY TOWN*TX*75122~
```

DATA ELEMENT SUMMARY -----

```
N401  19   CITY NAME                              O AN 2/30
        Free-form text for city name.
        > Required
        > Patient City
        > The City Name of the patient.
        > 20-14
N402  156  STATE OR PROVINCE CODE                 O ID 2/2
        Code (Standard State/Province) as defined by appropriate
        government agency.
        > Required
        > Patient State
        > 20-15
        > *See Appendix B for list of valid state codes.
N403  116  POSTAL CODE                            O ID 3/11
        Code defining international postal zone code excluding
        punctuation and blanks (zip code for United States).
```

```

> Required
> Patient ZIP Code
> The ZIP Code of the patient.
> 20-16
N404 26 COUNTRY CODE O ID 2/3
Code identifying the country.
> Not Used
N405 309 LOCATION QUALIFIER C ID 1/2
Code identifying type of location.
> Not Used
N406 310 LOCATION IDENTIFIER O AN 1/30
Code which identifies a specific location.
> Not Used

```

```

=====
SEGMENT: DMG Demographic Information
>WEDI NME: PATIENT DEMOGRAPHIC INFORMATION
POSITION: 115
LEVEL: Detail
LOOP: 2210
> USAGE: Optional NOTE: Required
MAX USE: 1
PURPOSE: To supply demographic information
SYNTAX: 1. P0102--If either DMG01 or DMG02 is present, then the other
is required.
SEMANTIC: 1. DMG02 is the date of birth.
2. DMG07 is the country of citizenship.
3. DMG09 is the age in years.
> EXAMPLE: DMG*D8*19321105*M*M~

```

DATA ELEMENT SUMMARY -----

```

DMG01 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or date and time
format.
> Required
D8 Date Expressed in Format CCYYMMDD
DMG02 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates, times or dates
and times.
> Required
> Patient Date of Birth
> The date the patient was born. DATE OF BIRTH.
> 20-08 UB-92 Format CCYYMMDD
DMG03 1068 GENDER CODE O ID 1/1
Code indicating the sex of the individual.
> Required
> Patient Sex Code
> Code indicating the sex of the patient.
> 20-07
F Female
M Male
U Unknown
DMG04 1067 MARITAL STATUS CODE O ID 1/1
Code defining the marital status of a person.
> Patient Marital Status
> 20-09
D Divorced
UB-92 Code "D"
I Single
UB-92 Code "S"
K Unknown

```


SEGMENT: CLM Health Claim
 POSITION: 130
 LEVEL: Detail
 LOOP: 2300 Repeat: 100
 > USAGE: Mandatory NOTE: Required
 MAX USE: 1
 PURPOSE: To specify basic data about the claim
 SEMANTIC: 1. CLM02 is the total amount of all submitted charges of service segments for this claim.
 2. CLM06 is provider signature on file indicator. A ``Y'' value indicates the provider signature is on file. An ``N'' value indicates the provider signature is not on file.
 3. CLM08 is assignment of benefits indicator. A ``Y'' value indicates insured or authorized person authorizes benefits to be assigned to the provider. An ``N'' value indicates benefits have not been assigned to the provider.
 4. CLM13 is CHAMPUS non-availability indicator. A ``Y'' value indicates a statement of non-availability is on file. An ``N'' value indicates statement of non-availability is not on file or not necessary.
 5. CLM15 is charges itemized by service indicator. A ``Y'' value indicates charges are itemized by service. An ``N'' value indicates charges are summarized by service.
 6. CLM18 is explanation of benefit (EOB) indicator. A ``Y'' value indicates that a paper EOB is requested. An ``N'' value indicates that no paper EOB is requested.
 > NOTES: 1. *NOTE: For fields from record type 30, use the destination payer's sequence of the record.
 > EXAMPLE: CLM*DARJ00002S001*2500.25*MA**11:A:1***Y*Y~

DATA ELEMENT SUMMARY -----

CLM01 1028 CLAIM SUBMITTER'S IDENTIFIER M AN 1/38
 Identifier used to track a claim from creation by the health care provider through payment.
 > Required
 > Patient Control Number
 > A unique value assigned by the provider to identify the patient.
 > 20-03 through 91-03
 CLM02 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Required
 > Total Claim Charges
 > This is the total of the SV2 segments with the exception of revenue code 001. Non-covered accommodations and non-covered ancillaries are not reflected in this element.
 > Total of 90-13 and 90-15
 >
 CLM03 1032 CLAIM FILING INDICATOR CODE O ID 1/2
 Code identifying type of claim
 > Required
 > Claim Editing Indicator
 > A code assigned by the receiver to determine the adjudication program.
 > 30-04 (Not all codes map)
 > BL Blue Cross/Blue Shield
 > UB92 code "G"
 > CH Champus
 > UB92 code "H"
 > CI Commercial Insurance Co.
 > UB92 code "F"
 > FI Federal Employees Program
 > UB92 code "E"

HM Health Maintenance Organization
 MA Medicare Part A
 > UB-92 Code "C"
 MC Medicaid
 > UB92 code "D"
 MH Managed Care Non-HMO
 OF Other Federal Program
 > UB92 code "E"
 SA Self-administered Group
 > UB92 code "A"
 TV Title V
 VA Veteran Administration Plan
 WC Workers' Compensation Health Claim
 > UB92 code "B"
 CLM04 1343 NON-INSTITUTIONAL CLAIM TYPE CODE O ID 1/2
 Code identifying the type of provider or claim
 > Not Used
 CLM05 C023 HEALTH CARE SERVICE LOCATION INFORMATION O
 To provide information that identifies the place of service or
 the type of bill related to the location at which a health
 care service was rendered
 > Type of Bill
 CLM05-1 1331 FACILITY CODE VALUE M AN 1/2
 Code identifying the type of facility where
 services were performed; the first and second
 positions of the Uniform Bill Type code or the
 Place of Service code from the Electronic Media
 Claims National Standard Format
 > Required
 > Type of Bill Positions 1-2
 > 40-04
 > FIRST 2 POSITIONS OF 3 POSITION FIELD
 > The first and second positions of the Uniform
 > Bill Type code or the Place of Service code from
 > the Electronic Media Claims National Standard
 > Format.
 CLM05-2 1332 FACILITY CODE QUALIFIER O ID 1/2
 Code identifying the type of facility referenced
 > See UB-92 Bill Types
 A Uniform Billing Claim Form Bill Type
 CLM05-3 1325 CLAIM FREQUENCY TYPE CODE O ID 1/1
 Code specifying the frequency of the claim; this
 is the third position of the Uniform Billing
 Claim Form Bill Type
 > Type of Bill Position 3
 > 40-04
 > THIRD POSITION OF 3 POSITION FIELD
 CLM06 1073 YES/NO CONDITION OR RESPONSE CODE O ID 1/1
 Code indicating a Yes or No condition or response.
 > Not Used
 CLM07 1359 PROVIDER ACCEPT ASSIGNMENT CODE O ID 1/1
 Code indicating whether the provider accepts assignment
 > Not Used
 CLM08 1073 YES/NO CONDITION OR RESPONSE CODE O ID 1/1
 Code indicating a Yes or No condition or response.
 > Required
 > Assignment of Benefits Indicator
 > A "Y" value indicates benefits are assigned to the provider.
 > A "N" indicates benefits are not assigned to the provider.
 > 30-17
 N No
 Y Yes
 CLM09 1363 RELEASE OF INFORMATION CODE O ID 1/1
 Code indicating whether the provider has on file a signed
 statement by the patient authorizing the release of medical

```

data to other organizations
> Release of Information Code
> A code indicating whether the provider has on file a signed
> statement permitting the release of medical data to other
> organizations in order to adjudicate the claim.
> 30-16
      M The Provider has Limited or Restricted Ability to
        Release Data Related to a Claim
>      UB-92 CODE R=M
      N No, Provider is Not Allowed to Release Data
>      UB-92 CODE N=N
      Y Yes, Provider has a Signed Statement Permitting Release
        of Medical Billing Data Related to a Claim
>      UB-92 CODE Y=Y
CLM10 1351 PATIENT SIGNATURE SOURCE CODE                0 ID 1/1
Code indicating how the patient or subscriber authorization
signatures were obtained and how they are being retained by the
provider
> Not Used
CLM11 C024 RELATED CAUSES INFORMATION                    0
To identify one or more related causes and associated state or
country information
> Not Used
CLM12 1366 SPECIAL PROGRAM CODE                        0 ID 2/3
Code indicating the Special Program under which the services
rendered to the patient were performed
> Not Used
CLM13 1073 YES/NO CONDITION OR RESPONSE CODE           0 ID 1/1
Code indicating a Yes or No condition or response.
> Not Used
CLM14 1338 LEVEL OF SERVICE CODE                      0 ID 1/3
Code specifying the level of service rendered
> Not Used
CLM15 1073 YES/NO CONDITION OR RESPONSE CODE           0 ID 1/1
Code indicating a Yes or No condition or response.
> Not Used
CLM16 1360 PROVIDER AGREEMENT CODE                    0 ID 1/1
Code indicating the type of agreement under which the provider
is submitting this claim
> Not Used
CLM17 1029 CLAIM STATUS CODE                          0 ID 1/2
Code identifying the status of an entire claim as assigned by
the payor, claim review organization or repricing organization
> NOTE: Use the Medicare payer sequence of the 92 record.
> 92-19
> Medicare Claim Status Code
CLM18 1073 YES/NO CONDITION OR RESPONSE CODE           0 ID 1/1
Code indicating a Yes or No condition or response.
> Not Used
CLM19 1383 CLAIM SUBMISSION REASON CODE                0 ID 2/2
Code identifying reason for claim submission
> Not Used
CLM20 1514 DELAY REASON CODE                          0 ID 1/2
Code indicating the reason why a request was delayed
> Not Used

```

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=====
SEGMENT: DTP Date or Time or Period
>WEDI NME: STATEMENT COVERS PERIOD   DTP.A
POSITION: 135
LEVEL: Detail
LOOP: 2300

```

> USAGE: Optional NOTE: Recommended
 MAX USE: 2
 PURPOSE: To specify any or all of a date, a time, or a time period
 SEMANTIC: 1. DTP02 is the date or time or period format that will appear
 in DTP03.
 >
 > EXAMPLE: DTP*232*D8*19930120~

DATA ELEMENT SUMMARY -----

DTP01 374 DATE/TIME QUALIFIER M ID 3/3
 Code specifying type of date or time, or both date and time.
 > Required
 > Date on which the Billing Document was created.
 232 Claim Statement Period Start
 233 Claim Statement Period End
 DTP02 1250 DATE TIME PERIOD FORMAT QUALIFIER M ID 2/3
 Code indicating the date format, time format, or date and time
 format.
 > Required
 D8 Range of Dates Expressed in Format CCYYMMDD
 DTP03 1251 DATE TIME PERIOD M AN 1/35
 Expression of a date, a time, or range of dates, times or dates
 and times.
 > Required
 > Statement Covers Period
 > 20-19; 20-20 UB92 Format CCYYMMDD

=====

SEGMENT: DTP Date or Time or Period
 >WEDI NME: ADMISSION DATE (Inpatient) DTP.B
 POSITION: 135
 LEVEL: Detail
 LOOP: 2300
 > USAGE: Optional NOTE: Recommended
 MAX USE: 2
 PURPOSE: To specify any or all of a date, a time, or a time period
 SEMANTIC: 1. DTP02 is the date or time or period format that will appear
 in DTP03.
 > NOTES: 1. This segment may repeat twice, once for each date or time
 > to convey.
 > EXAMPLE: DTP*435*D8*19941020~

DATA ELEMENT SUMMARY -----

DTP01 374 DATE/TIME QUALIFIER M ID 3/3
 Code specifying type of date or time, or both date and time.
 > Required
 > Date of entrance to a healthcare establishment.
 435 Admission
 DTP02 1250 DATE TIME PERIOD FORMAT QUALIFIER M ID 2/3
 Code indicating the date format, time format, or date and time
 format.
 > Required
 D8 Date Expressed in Format CCYYMMDD
 TM Time Expressed in Format HHMM
 > Time expressed in the format HHMM where HH is the
 > numerical expression of hours in the day based on a
 > twenty-four hour clock and MM is the numerical
 > expression of minutes within an hour.
 DTP03 1251 DATE TIME PERIOD M AN 1/35
 Expression of a date, a time, or range of dates, times or dates

and times.
 > Required
 > Admission Date/Admission Hour
 > Admission Hour is not used for Medicare but is carried for
 > secondary insurance purposes.
 > 20-17; 20-18 UB-92 FORMAT CCYYMMDD

=====

X12 Segment Name: DTP Date or Time or Period

Name: Start of Care (SOC) Date DTP.C
 Loop: 2300
 Max. Use: 1

X12 Purpose: To specify any or all of a date, a time, or a time period.
 Usage: Situational (Required for Home Health claims)
 Examples: DTP*454*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
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DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time.	
------------------------	--	--

Code:

454 Initial Treatment - Date medical
treatment first began

DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format.	
------------------------	--	--

Codes:

D8 Date expressed in format
CCYYMMDD

DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	71-05 CCYYMMDD
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=====

X12 Segment Name: DTP Date or Time or Period

Name: Date of Onset or Exacerbation of PrincipleDiagnosis DTP.D
 Loop: 2300
 Max. Use: 1

X12 Purpose: To specify any or all of a date, a time, or a time period.
 Usage: Situational (Required for Home Health claims)
 Examples: DTP*431*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
--------------------	--------------------	--------------------------

DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time.	
------------------------	--	--

Code:

431 Onset of Current Symptoms or
Illness - Date first symptoms
appeared

DTP02 1250
ID 2 3 M

Date Time Period Format Qualifier
Code indicating the date format, time
format, or date and time format.
Codes:

D8 Date expressed in format
CCYYMMDD

DTP03 1251
AN 1 35 M

Date Time Period
Expression of a date or time

71-08, CCYYMMDD

=====
X12 Segment Name: DTP Date or Time or Period

Name: Date of Surgery DTP.E

Loop: 2300

Max. Use: 1

X12 Purpose: To specify any or all of a date, a time, or a time period.

Usage: Situational (Required for Home Health claims)

Examples: DTP*456*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element

Attributes

Data Element Usage

UB92 EMC VER.5.0 Mapping

DTP01 0374
ID 3 3 M

Date/Time Qualifier
Code specifying type of date or time,
or both date and time.

Code:

456 Surgery - Date on which
operation was performed

DTP02 1250
ID 2 3 M

Date Time Period Format Qualifier
Code indicating the date format, time
format, or date and time format.
Codes:

D8 Date expressed in format
CCYYMMDD

DTP03 1251
AN 1 35 M

Date Time Period
Expression of a date or time

71-10 CCYYMMDD

=====
X12 Segment Name: DTP Date or Time or Period

Name: Last Seen Date DTP.F

Loop: 2300

Max. Use: 1

X12 Purpose: To specify any or all of a date, a time, or a time period.

Usage: Situational (Required for Home Health claims)

Examples: DTP*304*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: 304 Latest Visit or Consultation - Date Subscriber or dependent last visited or consulted with a physician	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: D8 Date expressed in format CCYYMMDD	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	71-23 CCYYMMDD

=====
X12 Segment Name: DTP Date or Time or Period
Name: Verbal Start of Care (SOC) Date DTP.G
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: Situational (Required for Home Health claims)
Examples: DTP*150*D8*19970217~
=====

Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: 150 Service Period Start	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: D8 Date expressed in format CCYYMMDD	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	71-17 CCYYMMDD

X12 Segment Name: DTP Date or Time or Period
 Name: Date of Secondary Diagnosis - 1 DTP.H
 Loop: 2300
 Max. Use: 1
 X12 Purpose: To specify any or all of a date, a time, or a time period.
 Usage: Situational (Required for Home Health claims)
 Examples: DTP*438*D8*19970217~

 Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element Mapping	Data Element Usage	UB92 EMC VER.5.0 Mapping
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DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: 438 Onset of Similiar Symptoms or Illness - Date symptoms related to current illness first appeared	
------------------------	--	--

DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: D8 Date expressed in format CCYYMMDD	
------------------------	---	--

DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	71-11 CCYYMMDD
-------------------------	--	----------------

=====

X12 Segment Name: DTP Date or Time or Period
 Name: Date of Secondary Diagnosis - 2 DTP.I
 Loop: 2300
 Max. Use: 1
 X12 Purpose: To specify any or all of a date, a time, or a time period.
 Usage: Situational (Required for Home Health claims)
 Examples: DTP*447*D8*19970217~

 Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03. -----

Element	Data Element Usage	UB92 EMC VER.5.0 Mapping
---------	--------------------	--------------------------

DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: 447 Occurrence - Date on which an event happened	
------------------------	--	--

DTP02 1250	Date Time Period Format Qualifier	
------------	-----------------------------------	--

ID 2 3 M Code indicating the date format, time format, or date and time format.
Codes:

D8 Date expressed in format
CCYYMMDD

DTP03 1251 Date Time Period
AN 1 35 M Expression of a date or time 71-12 CCYYMMDD

=====

X12 Segment Name: DTP Date or Time or Period
Name: Date Last Contacted Physician DTP.J
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: Situational (Required for Home Health claims)
Examples: DTP*911*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
--------------------	--------------------	--------------------------

DTP01 0374 Date/Time Qualifier
ID 3 3 M Code specifying type of date or time, or both date and time.

Code:

911 Last Activity

DTP02 1250 Date Time Period Format Qualifier
ID 2 3 M Code indicating the date format, time format, or date and time format.
Codes:

D8 Date expressed in format
CCYYMMDD

DTP03 1251 Date Time Period
AN 1 35 M Expression of a date or time 71-24 CCYYMMDD

=====

SEGMENT: DTP Date or Time or Period
>WEDI NME: DISCHARGE DATE/HOUR DTP.K
POSITION: 135
LEVEL: Detail
LOOP: 2300
> USAGE: Optional NOTE: Recommended
MAX USE: 150
PURPOSE: To specify any or all of a date, a time, or a time period
SEMANTIC: 1. DTP02 is the date or time or period format that will appear in DTP03.
> NOTES: 1. This segment may repeat twice, once for each date or time to convey.
> EXAMPLE: DTP*096*TM*10~

DATA ELEMENT SUMMARY -----

DTP01 374 DATE/TIME QUALIFIER M ID 3/3

> only.
> 2. The authorization number will only be an IDE number if the
> corresponding authorization revenue code is equal to 0624.
> If the authorization number is not an IDE number, then it
> should not be mapped

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
LX Qualified Products List
REF02 127 REFERENCE NUMBER C AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> IDE Code
> 34-5 ; 34-10; 34-11
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

=====

SEGMENT: REF Reference Numbers
>WEDI NME: ORIGINAL ICN/DCN NUMBER
POSITION: 180
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 30
PURPOSE: To specify identifying numbers.
SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
> NOTES: 1. *NOTE: Use the 31 record corresponding to the destination
> payer.
> EXAMPLE: REF*F8*931278760100~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
> Required
F8 Original Reference Number
REF02 127 REFERENCE NUMBER M AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Original ICN/DCN Number
> 31-14
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

=====

SEGMENT: REF Reference Numbers
>WEDI NME: DATA ID
POSITION: 180
LEVEL: Detail
LOOP: 2300

USAGE: Optional
MAX USE: 30
PURPOSE: To specify identifying numbers.
SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
> EXAMPLE: REF*DD*9~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
> Required
DD Document Identification Code
REF02 127 REFERENCE NUMBER M AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Data ID
> 71-04
> Identifies the submission of 485 and 486 data or 486 data
> only.
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

=====

SEGMENT: REF Reference Numbers
>WEDI NME: MEDICARE PAYEOR'S CURRENT ICN/DCN
POSITION: 180
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 30
PURPOSE: To specify identifying numbers.
SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
> NOTES: 1. * NOTE: Use the Medicare occurrence of the 92 record.
> EXAMPLE: REF*1K*19604245000301~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
1K Payor's Claim Number
REF02 127 REFERENCE NUMBER C AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Current ICN/DCN
> 92-04
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

=====

SEGMENT: REF Reference Numbers
>WEDI NME: DIAGNOSIS RELATED GROUP CODE
POSITION: 180
LEVEL: Detail

LOOP: 2300
 USAGE: Optional
 MAX USE: 30
 PURPOSE: To specify identifying numbers.
 SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
 > NOTES: 1. * NOTE: Use the Medicare occurrence of the 92 record.
 > EXAMPLE: REF*1N*426~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
 Code qualifying the Reference Number.
 1N Diagnosis Related Group (DRG) Number
 REF02 127 REFERENCE NUMBER C AN 1/30
 Reference number or identification number as defined for a
 particular Transaction Set, or as specified by the Reference
 Number Qualifier.
 > Diagnosis Related Group Code (DRG)
 > 92-13
 REF03 352 DESCRIPTION C AN 1/80
 A free-form description to clarify the related data elements
 and their content.
 > Not Used

=====

SEGMENT: NTE Note/Special Instruction
 >WEDI NME: BILLING REMARKS
 POSITION: 190
 LEVEL: Detail
 LOOP: 2300
 USAGE: Optional
 MAX USE: 20
 PURPOSE: To transmit information in a free-form format, if necessary,
 for comment or special instruction
 COMMENTS: A. The NTE segment permits free-form information/data
 which, under ANSI X12 standard implementations, is not
 machine processable. The use of the ``NTE'' segment should
 therefore be avoided, if at all possible, in an automated
 environment.
 > NOTES: 1. Medical attachment information, such as ambulance, therapy
 > codes, or other additional information.
 > 2. *NOTE: Because element NTE02 is only 80 positions in
 > length, the input data must be split into two fields. Each
 > field will be mapped independently of the other.
 > EXAMPLE: NTE*ADD*No liability, patient fell at home~

DATA ELEMENT SUMMARY -----

NTE01 363 NOTE REFERENCE CODE O ID 3/3
 Code identifying the functional area or purpose for which the
 note applies.
 ADD Additional Information
 NTE02 352 DESCRIPTION M AN 1/80
 A free-form description to clarify the related data elements
 and their content.
 > Required
 > Billing Remarks
 > When translating from 837 to UB-92, generating RT 91 Remarks,
 > generate a "1" in the 90-12 field.
 > 90-17 (positions 1-80); 90-17 (positions 81-110); 91-04
 > (positions 1-80); 91-04 (positions 81-82)

```

=====
SEGMENT: NTE Note/Special Instruction
>WEDI NME: HOME HEALTH CORRESPONDING DATA
POSITION: 190
  LEVEL: Detail
  LOOP: 2300
  USAGE: Optional
MAX USE: 20
PURPOSE: To transmit information in a free-form format, if necessary,
for comment or special instruction
COMMENTS: A. The NTE segment permits free-form information/data
which, under ANSI X12 standard implementations, is not
machine processable. The use of the ``NTE'' segment should
therefore be avoided, if at all possible, in an automated
environment.
> NOTES: 1. Medical attachment information, such as home health update
> narrative.
> 2. *NOTE: Because element NTE02 is only 80 positions in
> length, the input field must be split into 3 fields. Due
> to the X12 standard's limitations on the number of NTE
> segments, only five occurrences of record 73 can be mapped.
> EXAMPLE: NTE*NTR*PATIENT REQUIRES TUBE FEEDING~

```

DATA ELEMENT SUMMARY -----

```

NTE01 363 NOTE REFERENCE CODE O ID 3/3
Code identifying the functional area or purpose for which the
note applies.
> 73-5 Use UB-92 Codes.

NTE02 352 DESCRIPTION M AN 1/80
A free-form description to clarify the related data elements
and their content.
> Required
> Corresponding Data
> Generate only when generating home health medical update
> narrative attachment. If more than one code applies, repeat
> the segment.
> 73-6 (position 1-80); 73-6 (position 81-160); 73-6 (position
> 161)

```

=====

X12 Segment Name: **CR6 Home Health Care Certification**

```

Loop: 2300
Max. Use: 1
X12 Purpose: To supply information related to the certification of a home health care patient
Usage: Situational (Required for Home Health claims)
Example: CR6*1*980413*RD8*19980301-19980331**N*Y*R~

```

Syntax Note: P0304 - If either CR603 or CR604 is present, then the other must be present.
Syntax Note: P091011 - If any of CR609, CR610 or CR611 is present, then all of them must be present.
Syntax Note: P151617 - If any of CR615, CR616 or CR617 is present, then all of them must be present.

Semantic Note: CR604 is the certification period covered by this plan of treatment.
Semantic Note: A "Y" value indicates patient is receiving care in a 1861J1 (skilled nursing) facility. An "N" value indicates patient is not receiving care in a 1861J1 facility. A "U" value indicates it is unknown whether or not the patient is receiving care in a 1861J1 facility.
Semantic Note: A "Y" value indicates the patient is covered by Medicare. An "N" - not covered by Medicare.
Semantic Note: CR610 qualifies CR611.

Semantic Note: CR611 is the surgical procedure most relevant to the care being rendered.

Semantic Note: CR616 is the date range of the most recent inpatient stay.

Semantic Note: CR617 indicates the type of facility from which the patient was most recently discharged.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
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CR601 0923 ID 1 1 M	Prognosis Code Code indicating physician's prognosis for the patient	71-16
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Codes:

- 1 - Poor
- 2 - Guarded
- 3 - Fair
- 4 - Good
- 5 - Very Good
- 6 - Excellent
- 7 - Less than 6 Months to Live
- 8 - Terminal

CR602 0373 DT 6 6 M	Date Date (YYMMDD) SOC Date	71-5 CCYYMMDD
-------------------------------	-----------------------------------	----------------------

Medicare Note : This duplicates the SOC date in the DTP segment. Do NOT process CR602 data. Process the SOC in its corresponding DTP segment (to comply with millennium requirements). The 6 digit SOC date is duplicated here to comply with X12 standards.

CR603 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format.
-------------------------------	--

Codes:

R08 Range of Dates Expressed in Format
CCYYMMDD-CCYYMMDD

CR604 1251 AN 1 35 M	Date Time Period Certification Period Expression of a date or time	71-6,7 CCYYMMDD
--------------------------------	---	------------------------

CR605 0373	Date Not Used.
-------------------	--------------------------

CR606 1073 ID 1 1 O	Yes/No Condition or Response Code Patient Receiving Care in 1861(j)(1) Facility Code indicating a Yes or No condition or response.	71-25
-------------------------------	---	--------------

Codes:

- | | |
|-------------|-----------------|
| N - No | N - NO |
| U - Unknown | D - DO NOT KNOW |
| Y - Yes | Y - YES |

CR607 1073 ID 1 1 M	Yes/No Condition or Response Code Medicare Covered Code indicating a Yes or No condition or response.	71-22
-------------------------------	---	--------------

Codes:
N - No
Y - Yes

CR608 1322
ID 1 1 M

Certification Type Code
Cert/Recert/Mod **71-26**
Code indicating the type of certification

Codes:
I - Initial C - CERTIFICATION
R - Renewal R - RECERTIFICATION
S - Revised M - MODIFIED

CR609 0373
DT 6 6 C

Date
Date (YYMMDD) **71-10 CCYYMMDD**

Date Surgical Procedure Performed
Medicare Note: This duplicates the surgery date in the DTP segment. Do NOT process CR609 data. Process the surgery date in its corresponding DTP segment (to comply with millennium requirements). The 6 digit surgery date is duplicated here to comply with X12 standards.

CR610 0235
ID 2 2 C

Product/Service ID Qualifier
Code identifying the type/source of the descriptive number used in Product/Service ID (234).

Codes:
ID - International Classification of Diseases Clinical Modification (ICD-9-CM)

CR611 1137
AN 1 15 C

Medical Code Value
Surgical Procedure Code **71-9**
Code value for describing a medical condition or procedure

CR612 0373

Date
Not Used.

CR613 0373

Date
Not Used.

CR614 0373

Date
Not Used.

CR615 1250
ID 2 3 C

Date Time Period Format Qualifier
Code indicating the date format, time format, or date and time format.

Codes:
RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

CR616 1251
AN 1 35 C

Date Time Period
Date Patient Discharged from Care **71-27,28**
Expression of a date, a time, or range of dates, times or dates and times. **CCYYMMDD**

For Medicare this is the date the patient was admitted to the provider for start of care, inpatient care, or outpatient services.

CR617 1384
ID 1 1 C

Patient Location Code
Type of Facility **71-29**
Code identifying the location where patient is receiving medical treatment
For Medicare, type of facility from which patient was most recently discharged.

Codes:

A - Acute Care Facility	A - ACUTE
D - Intermediate Care Facility	I - ICF
L - Other Location	L - OTHER
M - Rehabilitation Facility	R - REHAB FACILITY
S - Skilled Nursing Home (SNF)	S - SNF

CR618 0373

Date
Not Used.

CR619 0373

Date
Not Used.

CR620 0373

Date
Not Used.

CR621 0373

Date
Not Used.

=====

SEGMENT: CRC Conditions Indicator
>WEDI NME: HOME HEALTH FUNCTIONAL LIMITATIONS
POSITION: 220
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 100
PURPOSE: To supply information on conditions
SEMANTIC: 1. CRC01 qualifies CRC03 thru CRC07.
2. CRC02 is a Certification Condition Code applies indicator.
A `Y' value indicates the condition codes in CRC03 thru CRC07 apply. A `N' value indicates the condition codes in CRC03 thru CRC07 do not apply.
> NOTES: 1. Use only if creating the UB-92 Record 71 attachment.
> EXAMPLE: CRC*75*Y*AL~

DATA ELEMENT SUMMARY -----

CRC01 1136 CODE CATEGORY M ID 2/2
Specifies the situation or category the code applies to
> Required
75 Functional Limitations
CRC02 1073 YES/NO CONDITION OR RESPONSE CODE M ID 1/1
Code indicating a Yes or No condition or response.
> Required
> Conditions Apply / Do Not Apply
N No

Y Yes

CRC03 1321 CONDITION INDICATOR M ID 2/2
Code indicating a condition
> Required
> Codes reported in CRC04-07
> 71-13
AA Amputation
> UB-92 Code 1
AL Ambulation Limitations
> UB-92 Code 7
BL Bowel Limitations, Bladder Limitations, or both
(Incontinence)
> UB-92 Code 2
CO Contracture
> UB-92 Code 3
DY Dyspnea with Minimal Exertion
> UB-92 Code A
EL Endurance Limitations
> UB-92 Code 6
HL Hearing Limitations
> UB-92 Code 4
LB Legally Blind
> UB-92 Code 9
OL Other Limitation
> UB-92 Code B
PA Paralysis
> UB-92 Code 5
SL Speech Limitations
> UB-92 Code 8

CRC04 1321 CONDITION INDICATOR O ID 2/2
Code indicating a condition
> Required
> SEE CRC03 FOR VALID CODES

CRC05 1321 CONDITION INDICATOR O ID 2/2
Code indicating a condition
> Required
> SEE CRC03 FOR VALID CODES

CRC06 1321 CONDITION INDICATOR O ID 2/2
Code indicating a condition
> Required
> SEE CRC03 FOR VALID CODES

CRC07 1321 CONDITION INDICATOR O ID 2/2
Code indicating a condition
> Required
> SEE CRC03 FOR VALID CODES

=====

SEGMENT: CRC Conditions Indicator
POSITION: 220
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 100
PURPOSE: To supply information on conditions
SEMANTIC: 1. CRC01 qualifies CRC03 thru CRC07.
2. CRC02 is a Certification Condition Code applies indicator.
A `Y' value indicates the condition codes in CRC03 thru
CRC07 apply. A `N' value indicates the condition codes in
CRC03 thru CRC07 do not apply.

> NOTES: 1. Use only if creating the UB-92 Record 71 attachment.
> 2. Activities Permitted.

> EXAMPLE: CRC*76*Y*CB~

DATA ELEMENT SUMMARY -----

```

CRC01 1136 CODE CATEGORY M ID 2/2
        Specifies the situation or category the code applies to
>        Required
            76 Activities Permitted
CRC02 1073 YES/NO CONDITION OR RESPONSE CODE M ID 1/1
        Code indicating a Yes or No condition or response.
>        Required
>        Conditions Apply / Do Not Apply
            N No
            Y Yes
CRC03 1321 CONDITION INDICATOR M ID 2/2
        Code indicating a condition
>        Required
>        Codes reported in CRC04-07
>        71-14
            BR Bedrest BRP (Bathroom Privileges)
>            UB-92 Code 2
            CA Cane Required
>            UB-92 Code 9
            CB Complete Bedrest
>            UB-92 Code 1
            CR Crutches Required
>            UB-92 Code 8
            EP Exercises Prescribed
>            UB-92 Code 5
            IH Independent at Home
>            UB-92 Code 7
            NR No Restrictions
>            UB-92 Code C
            OR Other Restrictions
>            UB-92 Code D
            PW Partial Weight Bearing
>            UB-92 Code 6
            TR Transfer to Bed, or Chair, or Both
>            UB-92 Code 4
            UT Up as Tolerated
>            UB-92 Code 3
            WA Walker Required
>            UB-92 Code B
            WR Wheelchair Required
>            UB-92 Code A
CRC04 1321 CONDITION INDICATOR O ID 2/2
        Code indicating a condition
>        Required
>        SEE CRC03 FOR VALID CODES
CRC05 1321 CONDITION INDICATOR O ID 2/2
        Code indicating a condition
>        Required
>        SEE CRC03 FOR VALID CODES
CRC06 1321 CONDITION INDICATOR O ID 2/2
        Code indicating a condition
>        Required
>        SEE CRC03 FOR VALID CODES
CRC07 1321 CONDITION INDICATOR O ID 2/2
        Code indicating a condition
>        Required
>        SEE CRC03 FOR VALID CODES

```

=====

SEGMENT: CRC Conditions Indicator

>WEDI NME: HOME HEALTH MENTAL STATUS
 POSITION: 220
 LEVEL: Detail
 LOOP: 2300
 USAGE: Optional
 MAX USE: 100
 PURPOSE: To supply information on conditions
 SEMANTIC: 1. CRC01 qualifies CRC03 thru CRC07.
 2. CRC02 is a Certification Condition Code applies indicator.
 A `Y' value indicates the condition codes in CRC03 thru
 CRC07 apply. A `N' value indicates the condition codes in
 CRC03 thru CRC07 do not apply.
 > NOTES: 1. Use only if creating the UB-92 Record 71 attachment.
 > EXAMPLE: CRC*77*Y*DI~

DATA ELEMENT SUMMARY -----

CRC01 1136 CODE CATEGORY M ID 2/2
 Specifies the situation or category the code applies to
 > Required
 77 Mental Status

CRC02 1073 YES/NO CONDITION OR RESPONSE CODE M ID 1/1
 Code indicating a Yes or No condition or response.
 > Required
 > Conditions Apply / Do Not Apply
 N No
 Y Yes

CRC03 1321 CONDITION INDICATOR M ID 2/2
 Code indicating a condition
 > Required
 > Codes reported in CRC04-07
 > 71-15
 AG Agitated
 > UB-92 Code 7
 CM Comatose
 > UB-92 Code 2
 DI Disoriented
 > UB-92 Code 5
 DP Depressed
 > UB-92 Code 4
 FO Forgetful
 > UB-92 Code 3
 LE Lethargic
 > UB-92 Code 6
 MC Other Mental Condition
 > UB-92 Code 8
 OT Oriented
 > UB-92 Code 1

CRC04 1321 CONDITION INDICATOR O ID 2/2
 Code indicating a condition
 > Required
 > SEE CRC03 FOR VALID CODES

CRC05 1321 CONDITION INDICATOR O ID 2/2
 Code indicating a condition
 > Required
 > SEE CRC03 FOR VALID CODES

CRC06 1321 CONDITION INDICATOR O ID 2/2
 Code indicating a condition
 > Required
 > SEE CRC03 FOR VALID CODES

CRC07 1321 CONDITION INDICATOR O ID 2/2
 Code indicating a condition
 > Required
 > SEE CRC03 FOR VALID CODES

```

=====
SEGMENT: HI Health Care Information Codes
>WEDI NME: DIAGNOSIS CODES
POSITION: 231
    LEVEL: Detail
    LOOP: 2300
    USAGE: Optional
MAX USE: 25
PURPOSE: To supply information related to the delivery of health care
> EXAMPLE: HI*BJ:3420*BK:436*BF:25000*BF:12345~

```

DATA ELEMENT SUMMARY -----

```

HI01  C022 HEALTH CARE CODE INFORMATION                      M
      To send health care codes and their associated dates, amounts
      and quantities
>      Required
>      Health Care Code Information
      HI01 -1  1270 CODE LIST QUALIFIER CODE                M ID 1/3
      Code identifying a specific industry code list
>      Required
>      Health Care Codes
      BJ      Admitting Diagnosis
      HI01 -2  1271 INDUSTRY CODE                            M AN 1/30
      Code indicating a code from a specific industry
      code list
>      Required
>      Admitting Diagnosis Code
>      An ICD-9-CM Diagnosis Code identifying the
>      admitting diagnosis. Do not include the period.
>      70-25
      HI01 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER       C ID 2/3
      Code indicating the date format, time format, or
      date and time format.
>      Not Used
      HI01 -4  1251 DATE TIME PERIOD                        C AN 1/35
      Expression of a date, a time, or range of dates,
      times or dates and times.
>      Not Used
      HI01 -5  782  MONETARY AMOUNT                        O R 1/15
      Monetary amount.
>      Not Used
      HI01 -6  380  QUANTITY                               O R 1/15
      Numeric value of quantity.
>      Not Used
HI02  C022 HEALTH CARE CODE INFORMATION                      O
      To send health care codes and their associated dates, amounts
      and quantities
>      Health Care Code Information
      HI02 -1  1270 CODE LIST QUALIFIER CODE                M ID 1/3
      Code identifying a specific industry code list
>      Health Care Codes
      BK      Principal Diagnosis
      HI02 -2  1271 INDUSTRY CODE                            M AN 1/30
      Code indicating a code from a specific industry
      code list
>      Principle Diagnosis Code
>      An ICD-9-CM Diagnosis Code identifying the
>      principal diagnosis.
>      70-04
      HI02 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER       C ID 2/3
      Code indicating the date format, time format, or
      date and time format.

```

```

>
>         Not Used
HI02 -4  1251 DATE TIME PERIOD                C AN 1/35
>         Expression of a date, a time, or range of dates,
>         times or dates and times.
>         Not Used
HI02 -5  782 MONETARY AMOUNT                O R 1/15
>         Monetary amount.
>         Not Used
HI02 -6  380 QUANTITY                      O R 1/15
>         Numeric value of quantity.
>         Not Used
HI03 C022 HEALTH CARE CODE INFORMATION        O
>         To send health care codes and their associated dates, amounts
>         and quantities
>         Health Care Code Information
HI03 -1  1270 CODE LIST QUALIFIER CODE        M ID 1/3
>         Code identifying a specific industry code list
>         Required
>         Health Care Codes
>         BF      Diagnosis
HI03 -2  1271 INDUSTRY CODE                  M AN 1/30
>         Code indicating a code from a specific industry
>         code list
>         Required
>         Other Diagnosis Code-1
>         An ICD-9-CM Diagnosis Code identifying the
>         diagnosis.
>         70-05
HI03 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
>         Code indicating the date format, time format, or
>         date and time format.
>         Not Used
HI03 -4  1251 DATE TIME PERIOD                C AN 1/35
>         Expression of a date, a time, or range of dates,
>         times or dates and times.
>         Not Used
HI03 -5  782 MONETARY AMOUNT                O R 1/15
>         Monetary amount.
>         Not Used
HI03 -6  380 QUANTITY                      O R 1/15
>         Numeric value of quantity.
>         Not Used
HI04 C022 HEALTH CARE CODE INFORMATION        O
>         To send health care codes and their associated dates, amounts
>         and quantities
>         Health Care Code Information
HI04 -1  1270 CODE LIST QUALIFIER CODE        M ID 1/3
>         Code identifying a specific industry code list
>         Required
>         Health Care Codes
>         BF      Diagnosis
HI04 -2  1271 INDUSTRY CODE                  M AN 1/30
>         Code indicating a code from a specific industry
>         code list
>         Other Diagnosis Code-2
>         An ICD-9-CM Diagnosis Code identifying the
>         diagnosis.
>         70-06
HI04 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
>         Code indicating the date format, time format, or
>         date and time format.
>         Not Used
HI04 -4  1251 DATE TIME PERIOD                C AN 1/35
>         Expression of a date, a time, or range of dates,
>         times or dates and times.

```

```

>
>         HI04 -5  782  Not Used
>         MONETARY AMOUNT                                O R 1/15
>         Monetary amount.
>         Not Used
>         HI04 -6  380  QUANTITY                            O R 1/15
>         Numeric value of quantity.
>         Not Used
HI05  C022 HEALTH CARE CODE INFORMATION                    O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
> HI05 -1  1270 CODE LIST QUALIFIER CODE                  M ID 1/3
>         Code identifying a specific industry code list
>         Required
>         Health Care Code Information
>         BF      Diagnosis
>         HI05 -2  1271 INDUSTRY CODE                      M AN 1/30
>         Code indicating a code from a specific industry
>         code list
>         Required
>         Other Diagnosis Code-3
>         An ICD-9-CM Diagnosis Code identifying the
>         diagnosis.
>         70-07
>         HI05 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER  C ID 2/3
>         Code indicating the date format, time format, or
>         date and time format.
>         Not Used
>         HI05 -4  1251 DATE TIME PERIOD                    C AN 1/35
>         Expression of a date, a time, or range of dates,
>         times or dates and times.
>         Not Used
>         HI05 -5  782  MONETARY AMOUNT                    O R 1/15
>         Monetary amount.
>         Not Used
>         HI05 -6  380  QUANTITY                            O R 1/15
>         Numeric value of quantity.
>         Not Used
HI06  C022 HEALTH CARE CODE INFORMATION                    O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
> HI06 -1  1270 CODE LIST QUALIFIER CODE                  M ID 1/3
>         Code identifying a specific industry code list
>         Required
>         Health Care Codes
>         BF      Diagnosis
>         HI06 -2  1271 INDUSTRY CODE                      M AN 1/30
>         Code indicating a code from a specific industry
>         code list
>         Required
>         Other Diagnosis Code-4
>         An ICD-9-CM Diagnosis Code identifying the
>         diagnosis.
>         70-08
>         HI06 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER  C ID 2/3
>         Code indicating the date format, time format, or
>         date and time format.
>         Not Used
>         HI06 -4  1251 DATE TIME PERIOD                    C AN 1/35
>         Expression of a date, a time, or range of dates,
>         times or dates and times.
>         Not Used
>         HI06 -5  782  MONETARY AMOUNT                    O R 1/15
>         Monetary amount.

```

```

>
>           Not Used
HI06 -6  380  QUANTITY                               O R 1/15
>           Numeric value of quantity.
>           Not Used
HI07  C022 HEALTH CARE CODE INFORMATION              O
>           To send health care codes and their associated dates, amounts
>           and quantities
>           Health Care Code Information
HI07 -1  1270 CODE LIST QUALIFIER CODE              M ID 1/3
>           Code identifying a specific industry code list
>           Required
>           Health Care Codes
>           BF      Diagnosis
HI07 -2  1271 INDUSTRY CODE                          M AN 1/30
>           Code indicating a code from a specific industry
>           code list
>           Required
>           Other Diagnosis Code-5
>           An ICD-9-CM Diagnosis Code identifying the
>           diagnosis.
>           70-09
HI07 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER     C ID 2/3
>           Code indicating the date format, time format, or
>           date and time format.
>           Not Used
HI07 -4  1251 DATE TIME PERIOD                      C AN 1/35
>           Expression of a date, a time, or range of dates,
>           times or dates and times.
>           Not Used
HI07 -5  782  MONETARY AMOUNT                       O R 1/15
>           Monetary amount.
>           Not Used
HI07 -6  380  QUANTITY                               O R 1/15
>           Numeric value of quantity.
>           Not Used
HI08  C022 HEALTH CARE CODE INFORMATION              O
>           To send health care codes and their associated dates, amounts
>           and quantities
>           Health Care Code Information
HI08 -1  1270 CODE LIST QUALIFIER CODE              M ID 1/3
>           Code identifying a specific industry code list
>           Required
>           Health Care Codes
>           BF      Diagnosis
HI08 -2  1271 INDUSTRY CODE                          M AN 1/30
>           Code indicating a code from a specific industry
>           code list
>           Required
>           Other Diagnosis Code-6
>           An ICD-9-CM Diagnosis Code identifying the
>           diagnosis.
>           70-10
HI08 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER     C ID 2/3
>           Code indicating the date format, time format, or
>           date and time format.
>           Not Used
HI08 -4  1251 DATE TIME PERIOD                      C AN 1/35
>           Expression of a date, a time, or range of dates,
>           times or dates and times.
>           Not Used
HI08 -5  782  MONETARY AMOUNT                       O R 1/15
>           Monetary amount.
>           Not Used
HI08 -6  380  QUANTITY                               O R 1/15
>           Numeric value of quantity.

```

```

>                                     Not Used
HI09  C022 HEALTH CARE CODE INFORMATION                                O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI09 -1  1270 CODE LIST QUALIFIER CODE                               M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BF      Diagnosis
HI09 -2  1271 INDUSTRY CODE                                           M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Other Diagnosis Code-7
> An ICD-9-CM Diagnosis Code identifying the
> diagnosis.
> 70-11
HI09 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER                       C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI09 -4  1251 DATE TIME PERIOD                                       C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI09 -5  782  MONETARY AMOUNT                                         O R 1/15
Monetary amount.
> Not Used
HI09 -6  380  QUANTITY                                               O R 1/15
Numeric value of quantity.
> Not Used
HI10  C022 HEALTH CARE CODE INFORMATION                                O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI10 -1  1270 CODE LIST QUALIFIER CODE                               M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BF      Diagnosis
HI10 -2  1271 INDUSTRY CODE                                           M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Other Diagnosis Code-8
> An ICD-9-CM Diagnosis Code identifying the
> diagnosis.
> 70-12
HI10 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER                       C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI10 -4  1251 DATE TIME PERIOD                                       C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI10 -5  782  MONETARY AMOUNT                                         O R 1/15
Monetary amount.
> Not Used
HI10 -6  380  QUANTITY                                               O R 1/15
Numeric value of quantity.
> Not Used
HI11  C022 HEALTH CARE CODE INFORMATION                                O
To send health care codes and their associated dates, amounts

```

```

and quantities
> Health Care Code Information
HI11 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
BN United States Department of Health and
Human Services, Office of Vital
Statistics E-code
HI11 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
E-Code
> United States Department of Vital Statistics
> E-Code used to identify conditions related to
> the spell.
> 70-26
HI11 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
Not Used
> HI11 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
Not Used
> HI11 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
Not Used
> HI11 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
Not Used
HI12 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Not Used
> Health Care Code Information

```

=====

```

SEGMENT: HI Health Care Information Codes
>WEDI NME: PROCEDURE CODES
POSITION: 231
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 25
PURPOSE: To supply information related to the delivery of health care
> EXAMPLE: HI*BR:3420:D8:19941204*BQ:3410:D8:19941206~

```

DATA ELEMENT SUMMARY -----

```

HI01 C022 HEALTH CARE CODE INFORMATION M
To send health care codes and their associated dates, amounts
and quantities
> Required
> Health Care Code Information
HI01 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Required
> Health Care Codes
> 70-27
BR International Classification of Diseases
Clinical Modification (ICD-9-CM)
Principal Procedure

```



```

                                Procedure
HI03 -2  1271 INDUSTRY CODE                                M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Other Procedure Code - 2
> 70-17
HI03 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER          C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8      Date Expressed in Format CCYYMMDD
HI03 -4  1251 DATE TIME PERIOD                            C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Procedure Date
> 70-18                                UB-92 FORMAT CCYYMMDD
HI03 -5  782 MONETARY AMOUNT                              O R 1/15
Monetary amount.
> Not Used
HI03 -6  380 QUANTITY                                    O R 1/15
Numeric value of quantity.
> Not Used
HI04  C022 HEALTH CARE CODE INFORMATION                    O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI04 -1  1270 CODE LIST QUALIFIER CODE                    M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
BQ      International Classification of Diseases
Clinical Modification (ICD-9-CM)
Procedure
HI04 -2  1271 INDUSTRY CODE                                M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Other Procedure Code - 3
> 70-19
HI04 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER          C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8      Date Expressed in Format CCYYMMDD
HI04 -4  1251 DATE TIME PERIOD                            C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Procedure Date
> 70-20                                UB-92 FORMAT CCYYMMDD
HI04 -5  782 MONETARY AMOUNT                              O R 1/15
Monetary amount.
> Not Used
HI04 -6  380 QUANTITY                                    O R 1/15
Numeric value of quantity.
> Not Used
HI05  C022 HEALTH CARE CODE INFORMATION                    O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI05 -1  1270 CODE LIST QUALIFIER CODE                    M ID 1/3
Code identifying a specific industry code list
> Health Care Codes
BQ      International Classification of Diseases
Clinical Modification (ICD-9-CM)
Procedure
HI05 -2  1271 INDUSTRY CODE                                M AN 1/30

```

```

Code indicating a code from a specific industry
code list
>
> Other Procedure Code - 4
> 70-21
HI05 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8 Date Expressed in Format CCYYMMDD
HI05 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Procedure Date
> 70-22 UB-92 FORMAT CCYYMMDD
HI05 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI05 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI06 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI06 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
BQ International Classification of Diseases
Clinical Modification (ICD-9-CM)
Procedure
HI06 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Other Procedure Code - 5
> 70-23
HI06 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> D8 Date Expressed - format CCYYMMDD
HI06 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Procedure Date
> 70-24 UB-92 FORMAT CCYYMMDD
HI06 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI06 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI07 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Not Used
HI08 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Not Used
HI09 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Not Used
HI10 C022 HEALTH CARE CODE INFORMATION O

```



```

> Health Care Code Information
HI02 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
BH Occurrence
HI02 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
Occurrence Code 2
40-10
HI02 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8 Date Expressed in Format CCYYMMDD
HI02 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
Occurrence Date
40-11 UB-92 FORMAT CCYYMMDD
HI02 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
Not Used
HI02 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
Not Used
HI03 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
Health Care Code Information
HI03 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Required
Health Care Codes
BH Occurrence
HI03 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
Required
Occurrence Code 3
40-12
HI03 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8 Date Expressed in Format CCYYMMDD
HI03 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
Occurrence Date
40-13 UB-92 FORMAT CCYYMMDD
HI03 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
Not Used
HI03 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
Not Used
HI04 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
Health Care Code Information
HI04 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Required
Health Care Codes
BH Occurrence
HI04 -2 1271 INDUSTRY CODE M AN 1/30

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Code indicating a code from a specific industry
code list
> Required
> Occurrence Code 4
> 40-14
HI04 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8 Date Expressed in Format CCYYMMDD
HI04 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Occurrence Date
> 40-15 UB-92 FORMAT CCYYMMDD
HI04 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI04 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI05 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI05 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BH Occurrence
HI05 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Occurrence Code 5
> 40-16
HI05 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
D8 Date Expressed in Format CCYYMMDD
HI05 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Occurrence Date
> 40-17 UB-92 FORMAT CCYYMMDD
HI05 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI05 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI06 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI06 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BH Occurrence
HI06 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Occurrence Code 6
> 40-18

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HI06 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
           Code indicating the date format, time format, or
           date and time format.
           D8      Date Expressed in Format CCYYMMDD
HI06 -4 1251 DATE TIME PERIOD                        C AN 1/35
           Expression of a date, a time, or range of dates,
           times or dates and times.
>           Occurrence Date
>           40-19      UB-92 FORMAT CCYYMMDD
HI06 -5 782  MONETARY AMOUNT                          O R 1/15
           Monetary amount.
>           Not Used
HI06 -6 380  QUANTITY                                  O R 1/15
           Numeric value of quantity.
>           Not Used
HI07  C022 HEALTH CARE CODE INFORMATION                O
           To send health care codes and their associated dates, amounts
           and quantities
>           Health Care Code Information
HI07 -1 1270 CODE LIST QUALIFIER CODE                  M ID 1/3
           Code identifying a specific industry code list
>           Health Care Codes
           BH      Occurrence
HI07 -2 1271 INDUSTRY CODE                            M AN 1/30
           Code indicating a code from a specific industry
           code list
>           Occurrence Code 7
>           40-20
HI07 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
           Code indicating the date format, time format, or
           date and time format.
           D8      Date Expressed in Format CCYYMMDD
HI07 -4 1251 DATE TIME PERIOD                        C AN 1/35
           Expression of a date, a time, or range of dates,
           times or dates and times.
>           Occurrence Date
>           40-21      UB-92 FORMAT CCYYMMDD
HI07 -5 782  MONETARY AMOUNT                          O R 1/15
           Monetary amount.
>           Not Used
HI07 -6 380  QUANTITY                                  O R 1/15
           Numeric value of quantity.
>           Not Used

```

HI08 C022 Health Care Code Information
Not Used.

HI09 C022 Health Care Code Information
Not Used.

HI10 C022 Health Care Code Information
Not Used.

HI11 C022 Health Care Code Information
Not Used.

HI12 C022 Health Care Code Information
Not Used.

=====

SEGMENT: HI Health Care Information Codes
>WEDI NME: OCCURRENCE SPAN CODES

POSITION: 231
 LEVEL: Detail
 LOOP: 2300
 USAGE: Optional
 MAX USE: 25
 PURPOSE: To supply information related to the delivery of health care
 > NOTES: 1. * NOTE: Due to the X12 standard's limitation on the number
 > of HI segments allowed, only three occurrences of record
 > type 40 can be mapped to the HI segment.
 > EXAMPLE: HI*BI:01:RD8:19950701-19950715~

DATA ELEMENT SUMMARY -----

HI01 C022 HEALTH CARE CODE INFORMATION M
 To send health care codes and their associated dates, amounts
 and quantities
 > Required
 > Health Care Code Information
 HI01 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
 Code identifying a specific industry code list
 > Required
 > Health Care Codes
 BI Occurrence Span
 HI01 -2 1271 INDUSTRY CODE M AN 1/30
 Code indicating a code from a specific industry
 code list
 > Required
 > Occurrence Span Code 1
 > 40-22
 HI01 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
 Code indicating the date format, time format, or
 date and time format.
 RD8 Range of Dates Expressed in Format
 CCYYMMDD-CCYYMMDD
 HI01 -4 1251 DATE TIME PERIOD C AN 1/35
 Expression of a date, a time, or range of dates,
 times or dates and times.
 > Occurrence Span Date
 > 40-23; 40-24 UB-92 FORMAT CCYYMMDD
 HI01 -5 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 HI01 -6 380 QUANTITY O R 1/15
 Numeric value of quantity.
 > Not Used

 HI02 C022 HEALTH CARE CODE INFORMATION O
 To send health care codes and their associated dates, amounts
 and quantities
 > Health Care Code Information
 HI02 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
 Code identifying a specific industry code list
 > Health Care Codes
 BI Occurrence Span
 HI02 -2 1271 INDUSTRY CODE M AN 1/30
 Code indicating a code from a specific industry
 code list
 > Occurrence Span Code 2
 > 40-25
 HI02 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
 Code indicating the date format, time format, or
 date and time format.
 RD8 Range of Dates Expressed in Format
 CCYYMMDD-CCYYMMDD
 HI02 -4 1251 DATE TIME PERIOD C AN 1/35

```

Expression of a date, a time, or range of dates,
times or dates and times.
> Occurrence Span Date
> 40-26; 40-27          UB-92 FORMAT CCYYMMDD

HI02 -5 782 MONETARY AMOUNT          O R 1/15
      Monetary amount.
>      Not Used
HI02 -6 380 QUANTITY                O R 1/15
      Numeric value of quantity.
>      Not Used
HI03 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI04 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI05 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI06 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI07 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI08 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI09 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI10 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI11 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used
HI12 C022 HEALTH CARE CODE INFORMATION          0
      To send health care codes and their associated dates, amounts
      and quantities
>      Not Used

```

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=====
SEGMENT: HI Health Care Information Codes
>WEDI NME: CONDITION CODES
POSITION: 231
  LEVEL: Detail
  LOOP: 2300
  USAGE: Optional
  MAX USE: 25
  PURPOSE: To supply information related to the delivery of health care
>  NOTES: 1. * NOTE: Due to the X12 standard's limitation on the number

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> of HI segments allowed, only three occurrences of record
 > type 41 should be mapped to the HI segment.
 > EXAMPLE: HI*BG:01~

DATA ELEMENT SUMMARY -----

```

HI01  C022 HEALTH CARE CODE INFORMATION                M
      To send health care codes and their associated dates, amounts
      and quantities
>      Required
>      Health Care Code Information
      HI01 -1  1270 CODE LIST QUALIFIER CODE            M ID 1/3
      Code identifying a specific industry code list
>      Required
>      Health Care Codes
      BG      Condition
      HI01 -2  1271 INDUSTRY CODE                        M AN 1/30
      Code indicating a code from a specific industry
      code list
>      Required
>      Condition Code 1
>      41-04
>      Codes used to identify conditions that may
>      affect payor processing.
      HI01 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER    C ID 2/3
      Code indicating the date format, time format, or
      date and time format.
>      Not Used
      HI01 -4  1251 DATE TIME PERIOD                    C AN 1/35
      Expression of a date, a time, or range of dates,
      times or dates and times.
>      Not Used
      HI01 -5  782  MONETARY AMOUNT                      O R 1/15
      Monetary amount.
>      Not Used
      HI01 -6  380  QUANTITY                             O R 1/15
      Numeric value of quantity.
>      Not Used
HI02  C022 HEALTH CARE CODE INFORMATION                O
      To send health care codes and their associated dates, amounts
      and quantities
>      Health Care Code Information
      HI02 -1  1270 CODE LIST QUALIFIER CODE            M ID 1/3
      Code identifying a specific industry code list
>      Health Care Codes
      BG      Condition
      HI02 -2  1271 INDUSTRY CODE                        M AN 1/30
      Code indicating a code from a specific industry
      code list
>      Condition Code 2
>      41-05
>      Codes used to identify conditions that may
>      affect payor processing.
      HI02 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER    C ID 2/3
      Code indicating the date format, time format, or
      date and time format.
>      Not Used
      HI02 -4  1251 DATE TIME PERIOD                    C AN 1/35
      Expression of a date, a time, or range of dates,
      times or dates and times.
>      Not Used
      HI02 -5  782  MONETARY AMOUNT                      O R 1/15
      Monetary amount.
>      Not Used
      HI02 -6  380  QUANTITY                             O R 1/15
  
```

```

Numeric value of quantity.
>
Not Used
HI03  C022 HEALTH CARE CODE INFORMATION 0
To send health care codes and their associated dates, amounts
and quantities
>
Health Care Code Information
HI03 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
>
Required
>
Health Care Codes
BG Condition
HI03 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
Required
>
Codes used to identify conditions that may
>
affect payor processing.
>
Condition Code 3
>
41-06
HI03 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
Not Used
HI03 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
Not Used
HI03 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
Not Used
HI03 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
Not Used
HI04  C022 HEALTH CARE CODE INFORMATION 0
To send health care codes and their associated dates, amounts
and quantities
>
Health Care Code Information
HI04 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
>
Required
>
Health Care Codes
BG Condition
HI04 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
Required
>
Condition Code 4
>
Codes used to identify conditions that may
>
affect payor processing.
>
41-07
HI04 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
Not Used
HI04 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
Not Used
HI04 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
Not Used
HI04 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
Not Used
HI05  C022 HEALTH CARE CODE INFORMATION 0

```

```

To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI05 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Health Care Codes
BG Condition
HI05 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Condition Code 5
> Codes used to identify conditions that may
> affect payor processing.
> 41-08
HI05 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI05 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI05 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI05 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI06 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI06 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
BG Condition
HI06 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Condition Code 6
> Codes used to identify conditions that may
> affect payor processing.
> 41-09
HI06 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI06 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI06 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI06 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI07 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI07 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Health Care Codes

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```

BG      Condition
HI07 -2  1271 INDUSTRY CODE                      M AN 1/30
Code indicating a code from a specific industry
code list
Condition Code 7
Codes used to identify conditions that may
affect payor processing.
41-10
>
HI07 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER  C ID 2/3
Code indicating the date format, time format, or
date and time format.
Not Used
>
HI07 -4  1251 DATE TIME PERIOD                      C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
Not Used
>
HI07 -5  782  MONETARY AMOUNT                      O R 1/15
Monetary amount.
Not Used
>
HI07 -6  380  QUANTITY                              O R 1/15
Numeric value of quantity.
Not Used
>
HI08  C022 HEALTH CARE CODE INFORMATION          O
To send health care codes and their associated dates, amounts
and quantities
Health Care Code Information
>
HI08 -1  1270 CODE LIST QUALIFIER CODE          M ID 1/3
Code identifying a specific industry code list
Health Care Codes
BG      Condition
HI08 -2  1271 INDUSTRY CODE                      M AN 1/30
Code indicating a code from a specific industry
code list
Condition Code 8
Codes used to identify conditions that may
affect payor processing.
41-11
>
HI08 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER  C ID 2/3
Code indicating the date format, time format, or
date and time format.
Not Used
>
HI08 -4  1251 DATE TIME PERIOD                      C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
Not Used
>
HI08 -5  782  MONETARY AMOUNT                      O R 1/15
Monetary amount.
Not Used
>
HI08 -6  380  QUANTITY                              O R 1/15
Numeric value of quantity.
Not Used
>
HI09  C022 HEALTH CARE CODE INFORMATION          O
To send health care codes and their associated dates, amounts
and quantities
Health Care Code Information
>
HI09 -1  1270 CODE LIST QUALIFIER CODE          M ID 1/3
Code identifying a specific industry code list
Health Care Codes
BG      Condition
HI09 -2  1271 INDUSTRY CODE                      M AN 1/30
Code indicating a code from a specific industry
code list
Condition Code 9
Codes used to identify conditions that may
affect payor processing.

```

```

>
> 41-12
HI09 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
> Not Used
HI09 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
> Not Used
HI09 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
> Not Used
HI09 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
> Not Used
HI10 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
> Health Care Code Information
HI10 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
>
> BG Condition
HI10 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
> Condition Code 10
>
> Codes used to identify conditions that may
>
> affect payor processing.
>
> 41-13
HI10 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
> Not Used
HI10 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
> Not Used
HI10 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
> Not Used
HI10 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
> Not Used
HI11 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
> Not Used
HI12 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
> Not Used

```

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=====
SEGMENT: HI Health Care Information Codes
>WEDI NME: VALUE CODES
POSITION: 231
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 25
PURPOSE: To supply information related to the delivery of health care

```

> NOTES: 1. * NOTE: Due to the X12 standard's limitation on the number
 > of HI segments allowed, only three occurrences of record
 > type 41 should be mapped to the HI segment.
 > EXAMPLE: HI*BE:01:::200.5*BE:02:::125~

DATA ELEMENT SUMMARY -----

HI01 C022 HEALTH CARE CODE INFORMATION M
 To send health care codes and their associated dates, amounts
 and quantities
 > Required
 > Health Care Code Information
 HI01 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
 Code identifying a specific industry code list
 > Required
 > Health Care Codes
 BE Value
 HI01 -2 1271 INDUSTRY CODE M AN 1/30
 Code indicating a code from a specific industry
 code list
 > Required
 > Value Code 1
 > 41-16
 HI01 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
 Code indicating the date format, time format, or
 date and time format.
 > Not Used
 HI01 -4 1251 DATE TIME PERIOD C AN 1/35
 Expression of a date, a time, or range of dates,
 times or dates and times.
 > Not Used
 HI01 -5 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Value Amount
 > 41-17
 HI01 -6 380 QUANTITY O R 1/15
 Numeric value of quantity.
 > Not Used
 HI02 C022 HEALTH CARE CODE INFORMATION O
 To send health care codes and their associated dates, amounts
 and quantities
 > Health Care Code Information
 HI02 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
 Code identifying a specific industry code list
 > Health Care Codes
 BE Value
 HI02 -2 1271 INDUSTRY CODE M AN 1/30
 Code indicating a code from a specific industry
 code list
 > Value Code 2
 > 41-18
 HI02 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
 Code indicating the date format, time format, or
 date and time format.
 > Not Used
 HI02 -4 1251 DATE TIME PERIOD C AN 1/35
 Expression of a date, a time, or range of dates,
 times or dates and times.
 > Not Used
 HI02 -5 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Value Amount
 > 41-19
 HI02 -6 380 QUANTITY O R 1/15
 Numeric value of quantity.

```

>                                     Not Used
HI03  C022 HEALTH CARE CODE INFORMATION                                O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI03 -1  1270 CODE LIST QUALIFIER CODE                               M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BE      Value
HI03 -2  1271 INDUSTRY CODE                                           M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Value Code 3
> 41-20
HI03 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER                       C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI03 -4  1251 DATE TIME PERIOD                                       C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI03 -5  782 MONETARY AMOUNT                                         O R 1/15
Monetary amount.
> Value Amount
> 41-21
HI03 -6  380 QUANTITY                                               O R 1/15
Numeric value of quantity.
> Not Used
HI04  C022 HEALTH CARE CODE INFORMATION                                O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI04 -1  1270 CODE LIST QUALIFIER CODE                               M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BE      Value
HI04 -2  1271 INDUSTRY CODE                                           M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Value Code 4
> 41-22
HI04 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER                       C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI04 -4  1251 DATE TIME PERIOD                                       C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI04 -5  782 MONETARY AMOUNT                                         O R 1/15
Monetary amount.
> Value Amount
> 41-23
HI04 -6  380 QUANTITY                                               O R 1/15
Numeric value of quantity.
> Not Used
HI05  C022 HEALTH CARE CODE INFORMATION                                O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information

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```

HI05 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
> BE Value
HI05 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Value Code 5
> 41-24
HI05 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI05 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI05 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Value Amount
> 41-25
HI05 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI06 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI06 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> BE Value
HI06 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Value Code 6
> 41-26
HI06 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI06 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI06 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Value Amount
> 41-27
HI06 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI07 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI07 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Health Care Codes
> BE Value
HI07 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Value Code 7

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>
>         41-28
HI07 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
>         Not Used
HI07 -4  1251 DATE TIME PERIOD                        C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
>         Not Used
HI07 -5  782  MONETARY AMOUNT                          O R 1/15
Monetary amount.
>
>         Value Amount
>         41-29
HI07 -6  380  QUANTITY                                O R 1/15
Numeric value of quantity.
>
>         Not Used
HI08  C022 HEALTH CARE CODE INFORMATION                O
To send health care codes and their associated dates, amounts
and quantities
>
>         Health Care Code Information
HI08 -1  1270 CODE LIST QUALIFIER CODE                M ID 1/3
Code identifying a specific industry code list
Health Care Codes
>
>         BE      Value
HI08 -2  1271 INDUSTRY CODE                          M AN 1/30
Code indicating a code from a specific industry
code list
>
>         Value Code 8
>         41-30
HI08 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
>         Not Used
HI08 -4  1251 DATE TIME PERIOD                        C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
>         Not Used
HI08 -5  782  MONETARY AMOUNT                          O R 1/15
Monetary amount.
>
>         Value Amount
>         41-31
HI08 -6  380  QUANTITY                                O R 1/15
Numeric value of quantity.
>
>         Not Used
HI09  C022 HEALTH CARE CODE INFORMATION                O
To send health care codes and their associated dates, amounts
and quantities
>
>         Health Care Code Information
HI09 -1  1270 CODE LIST QUALIFIER CODE                M ID 1/3
Code identifying a specific industry code list
Health Care Codes
>
>         BE      Value
HI09 -2  1271 INDUSTRY CODE                          M AN 1/30
Code indicating a code from a specific industry
code list
>
>         Value Code 9
>         41-32
HI09 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
>         Not Used
HI09 -4  1251 DATE TIME PERIOD                        C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
>         Not Used

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HI09 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Value Amount
> 41-33
HI09 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI10 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI10 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Health Care Codes
> BE Value
HI10 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Value Code 10
> 41-34
HI10 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI10 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI10 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Value Amount
> 41-35
HI10 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI11 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI11 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Health Care Codes
> BE Value
HI11 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Value Code 11
> 41-36
HI11 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI11 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI11 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Value Amount
> 41-37
HI11 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI12 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts

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and quantities
> Health Care Code Information
HI12 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
BE Value
HI12 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Value Code 12
> 41-38
HI12 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI12 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI12 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Value Amount
> 41-39
HI12 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used

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=====
SEGMENT: HI Health Care Information Codes
>WEDI NME: TREATMENT CODES
POSITION: 231
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 25
PURPOSE: To supply information related to the delivery of health care
> NOTES: 1. Use only if generating the RT 72 UB-92 home health
> attachment.
> 2. * NOTE: Due to the X12 standard's limitation on the number
> of HI segments allowed, only three occurrences of the 72
> record should be mapped to the HI segment.
> EXAMPLE: HI*TC:01~

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DATA ELEMENT SUMMARY -----
HI01 C022 HEALTH CARE CODE INFORMATION M
To send health care codes and their associated dates, amounts
and quantities
> Required
> Health Care Code Information
HI01 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
TC Treatment Codes
HI01 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Treatment Code - 1 or 13 or 25

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```

>
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-18 ; 72-30 ; 72-42
> HI01 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
> Code indicating the date format, time format, or
> date and time format.
> Not Used
> HI01 -4 1251 DATE TIME PERIOD C AN 1/35
> Expression of a date, a time, or range of dates,
> times or dates and times.
> Not Used
> HI01 -5 782 MONETARY AMOUNT O R 1/15
> Monetary amount.
> Not Used
> HI01 -6 380 QUANTITY O R 1/15
> Numeric value of quantity.
> Not Used
HI02 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
> HI02 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
> Code identifying a specific industry code list
> Health Care Codes
> TC Treatment Codes
> HI02 -2 1271 INDUSTRY CODE M AN 1/30
> Code indicating a code from a specific industry
> code list
> Treatment Code - 2 or 14
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-19 ; 72-31
> HI02 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
> Code indicating the date format, time format, or
> date and time format.
> Not Used
> HI02 -4 1251 DATE TIME PERIOD C AN 1/35
> Expression of a date, a time, or range of dates,
> times or dates and times.
> Not Used
> HI02 -5 782 MONETARY AMOUNT O R 1/15
> Monetary amount.
> Not Used
> HI02 -6 380 QUANTITY O R 1/15
> Numeric value of quantity.
> Not Used
HI03 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
> HI03 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
> Code identifying a specific industry code list
> Required

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```

>
> Health Care Codes
> TC Treatment Codes
HI03 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Treatment Code - 3 or 15
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-20 ; 72-32
HI03 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI03 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI03 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI03 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI04 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI04 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
> TC Treatment Codes
HI04 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Required
> Treatment Code - 4 or 16
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-21 ; 72-33
HI04 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI04 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI04 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI04 -6 380 QUANTITY O R 1/15

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Numeric value of quantity.
> Not Used
HI05 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI05 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Health Care Codes
TC Treatment Codes
HI05 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Treatment Code - 5 or 17
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-22 ; 72-34
HI05 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI05 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
> Not Used
HI05 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Not Used
HI05 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
HI06 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
> Health Care Code Information
HI06 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
> Required
> Health Care Codes
TC Treatment Codes
HI06 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
> Treatment Code - 6 or 18
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-23 ; 72-35
HI06 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
> Not Used
HI06 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,

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times or dates and times.
>
HI06 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
HI06 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
Not Used
HI07 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
Health Care Code Information
HI07 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
TC Treatment Codes
HI07 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
Treatment Code - 7 or 19
>
Use only if generating RT 72 home health
>
attachment. Codes describing the treatment
>
ordered by the physician. Show in ascending
>
order. Valid codes are: A01-A30= Skilled
>
nursing, B01-B15= Physical Therapy, C01-C09=
>
Speech Therapy, D01-D11= Occupational Therapy,
>
E01-E06= Medical School Services, F01-F15= Home
>
Health Aide.
>
72-24 ; 72-36
HI07 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
Not Used
HI07 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
Not Used
HI07 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
Not Used
HI07 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
Not Used
HI08 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
Health Care Code Information
HI08 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
TC Treatment Codes
HI08 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
Treatment Code - 8 or 20
>
Use only if generating RT 72 home health
>
attachment. Codes describing the treatment
>
ordered by the physician. Show in ascending
>
order. Valid codes are: A01-A30= Skilled
>
nursing, B01-B15= Physical Therapy, C01-C09=
>
Speech Therapy, D01-D11= Occupational Therapy,
>
E01-E06= Medical School Services, F01-F15= Home
>
Health Aide.
>
72-25 ; 72-37
HI08 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3

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Code indicating the date format, time format, or
date and time format.
>
Not Used
HI08 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
Not Used
HI08 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
Not Used
HI08 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
Not Used
HI09 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
Health Care Code Information
HI09 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
>
TC Treatment Codes
HI09 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
Treatment Code - 9 or 21
>
Use only if generating RT 72 home health
>
attachment. Codes describing the treatment
>
ordered by the physician. Show in ascending
>
order. Valid codes are: A01-A30= Skilled
>
nursing, B01-B15= Physiscal Therapy, C01-C09=
>
Speech Therapy, D01-D11= Occupational Therapy,
>
E01-E06= Medical School Services, F01-F15= Home
>
Health Aide.
>
72-26 ; 72-38
HI09 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
Code indicating the date format, time format, or
date and time format.
>
Not Used
HI09 -4 1251 DATE TIME PERIOD C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>
Not Used
HI09 -5 782 MONETARY AMOUNT O R 1/15
Monetary amount.
>
Not Used
HI09 -6 380 QUANTITY O R 1/15
Numeric value of quantity.
>
Not Used
HI10 C022 HEALTH CARE CODE INFORMATION O
To send health care codes and their associated dates, amounts
and quantities
>
Health Care Code Information
HI10 -1 1270 CODE LIST QUALIFIER CODE M ID 1/3
Code identifying a specific industry code list
Health Care Codes
>
TC Treatment Codes
HI10 -2 1271 INDUSTRY CODE M AN 1/30
Code indicating a code from a specific industry
code list
>
Treatment Code - 10 or 22
>
Use only if generating RT 72 home health
>
attachment. Codes describing the treatment
>
ordered by the physician. Show in ascending
>
order. Valid codes are: A01-A30= Skilled
>
nursing, B01-B15= Physiscal Therapy, C01-C09=

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>         Speech Therapy, D01-D11= Occupational Therapy,
>         E01-E06= Medical School Services, F01-F15= Home
>         Health Aide.
>         72-27          ; 72-39
HI10 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
Code indicating the date format, time format, or
date and time format.
>         Not Used
HI10 -4  1251 DATE TIME PERIOD                          C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>         Not Used
HI10 -5  782  MONETARY AMOUNT                          O R 1/15
Monetary amount.
>         Not Used
HI10 -6  380  QUANTITY                                  O R 1/15
Numeric value of quantity.
>         Not Used
HI11  C022 HEALTH CARE CODE INFORMATION                  O
To send health care codes and their associated dates, amounts
and quantities
>         Health Care Code Information
HI11 -1  1270 CODE LIST QUALIFIER CODE                  M ID 1/3
Code identifying a specific industry code list
Health Care Codes
TC      Treatment Codes
HI11 -2  1271 INDUSTRY CODE                            M AN 1/30
Code indicating a code from a specific industry
code list
>         Treatment Code - 11 or 23
>         Use only if generating RT 72 home health
>         attachment. Codes describing the treatment
>         ordered by the physician. Show in ascending
>         order. Valid codes are: A01-A30= Skilled
>         nursing, B01-B15= Physical Therapy, C01-C09=
>         Speech Therapy, D01-D11= Occupational Therapy,
>         E01-E06= Medical School Services, F01-F15= Home
>         Health Aide.
>         72-28          ; 72-40
HI11 -3  1250 DATE TIME PERIOD FORMAT QUALIFIER      C ID 2/3
Code indicating the date format, time format, or
date and time format.
>         Not Used
HI11 -4  1251 DATE TIME PERIOD                          C AN 1/35
Expression of a date, a time, or range of dates,
times or dates and times.
>         Not Used
HI11 -5  782  MONETARY AMOUNT                          O R 1/15
Monetary amount.
>         Not Used
HI11 -6  380  QUANTITY                                  O R 1/15
Numeric value of quantity.
>         Not Used
HI12  C022 HEALTH CARE CODE INFORMATION                  O
To send health care codes and their associated dates, amounts
and quantities
>         Health Care Code Information
HI12 -1  1270 CODE LIST QUALIFIER CODE                  M ID 1/3
Code identifying a specific industry code list
Required
Health Care Codes
TC      Treatment Codes
HI12 -2  1271 INDUSTRY CODE                            M AN 1/30
Code indicating a code from a specific industry
code list

```

> Required
> Treatment Code - 12
> Use only if generating RT 72 home health
> attachment. Codes describing the treatment
> ordered by the physician. Show in ascending
> order. Valid codes are: A01-A30= Skilled
> nursing, B01-B15= Physical Therapy, C01-C09=
> Speech Therapy, D01-D11= Occupational Therapy,
> E01-E06= Medical School Services, F01-F15= Home
> Health Aide.
> 72-29 ; 72-41
> HI12 -3 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
> Code indicating the date format, time format, or
> date and time format.
> Not Used
> HI12 -4 1251 DATE TIME PERIOD C AN 1/35
> Expression of a date, a time, or range of dates,
> times or dates and times.
> Not Used
> HI12 -5 782 MONETARY AMOUNT O R 1/15
> Monetary amount.
> Not Used
> HI12 -6 380 QUANTITY O R 1/15
> Numeric value of quantity.
> Not Used

=====

SEGMENT: QTY Quantity
>WEDI NME: NON-COVERED DAYS ACTUAL (MEDICARE)
POSITION: 240
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 10
PURPOSE: To specify quantity information.
> NOTES: 1. **NOTE: Use the Medicare sequence of the 30 record.
> EXAMPLE: QTY*NA*2*DA~

DATA ELEMENT SUMMARY -----

QTY01 673 QUANTITY QUALIFIER M ID 2/2
Code specifying the type of quantity.
> Required
NA Number of Non-covered Days
QTY02 380 QUANTITY M R 1/15
Numeric value of quantity.
> Required
> Non-Covered Days Actual (Medicare)
> 30-21
QTY03 355 UNIT OR BASIS FOR MEASUREMENT CODE O ID 2/2
Code specifying the units in which a value is being expressed,
or manner in which a measurement has been taken
DA Days

=====

SEGMENT: QTY Quantity
>WEDI NME: CO-INSURANCE DAYS ACTUAL (MEDICARE)
POSITION: 240
LEVEL: Detail

LOOP: 2300
USAGE: Optional
MAX USE: 10
PURPOSE: To specify quantity information.
> NOTES: 1. *NOTE: Use the Medicare sequence of the 30 record.
> EXAMPLE: QTY*CD*2*DA~

DATA ELEMENT SUMMARY -----

QTY01 673 QUANTITY QUALIFIER M ID 2/2
Code specifying the type of quantity.
> Required
CD Co-insured - Actual
QTY02 380 QUANTITY M R 1/15
Numeric value of quantity.
> Required
> Co-Insurance Days Actual
> 30-22
QTY03 355 UNIT OR BASIS FOR MEASUREMENT CODE O ID 2/2
Code specifying the units in which a value is being expressed,
or manner in which a measurement has been taken
DA Days

=====

SEGMENT: CR7 Home Health Treatment Plan Certification
POSITION: 242
LEVEL: Detail
LOOP: 2305 Repeat: 6
USAGE: Optional
MAX USE: 1
PURPOSE: To supply information related to the home health care plan of
treatment and services
SEMANTIC: 1. CR702 is the total visits on this bill rendered prior to
the recertification ``to'' date.
2. CR703 is the total visits projected during this
certification period.
> NOTES: 1. This segment should only be generated when generating the
> UB-92 RT 72 home health attachment.
> EXAMPLE: CR7*SN*12*15~

DATA ELEMENT SUMMARY -----

CR701 921 DISCIPLINE TYPE CODE M ID 2/2
Code indicating disciplines ordered by a physician
> Required
> Discipline
> 72-4
AI Home Health Aide
MS Medical Social Worker
OT Occupational Therapy
PT Physical Therapy
SN Skilled Nursing
ST Speech Therapy
CR702 1470 NUMBER M NO 1/9
A generic number
> Required
> Visits (this bill) Related to Prior Certification
> Total visits on this bill rendered prior to recertification
> "to" date.
> 72-5
CR703 1470 NUMBER M NO 1/9
A generic number

> Required
 > Total Visits Projected During this Certification Period
 > Total covered visits to be rendered by each discipline during
 > the period covered by the POT. Include PRN visits.
 > 72-43

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=====
SEGMENT: HSD Health Care Services Delivery
POSITION: 243
LEVEL: Detail
LOOP: 2305
USAGE: Optional
MAX USE: 12
PURPOSE: To specify the delivery pattern of health care services
SYNTAX: 1. P0102--If either HSD01 or HSD02 is present, then the other
         is required.
         2. C0605--If HSD06 is present, then HSD05 is required.
> NOTES: 1. Create this segment for each Frequency & Duration received.
> EXAMPLE: HSD*VS*2*WK**35*090~
  
```

DATA ELEMENT SUMMARY -----

```

HSD01 673 QUANTITY QUALIFIER C ID 2/2
Code specifying the type of quantity.
VS Visits
HSD02 380 QUANTITY C R 1/15
Numeric value of quantity.
> Frequency Number - 1
> 72-6 (position 1) 9; 72-7 thru 72-17 (position 1) 9
HSD03 355 UNIT OR BASIS FOR MEASUREMENT CODE O ID 2/2
Code specifying the units in which a value is being expressed,
or manner in which a measurement has been taken
> Frequency Period - 1
> Q_ = every n days where n = number in positions 4-6.
> 72-6 (positions 2-3) XX; 72-7 thru 72-17 (positions 2-3) XX.
DA Days
MO Months
Q1 Quarter (Time)
WK Week
HSD04 1167 SAMPLE SELECTION MODULUS O R 1/6
To specify the sampling frequency in terms of a modulus of the
Unit of Measure, e.g., every fifth bag, every 1.5 minutes
> Not Used
HSD05 615 TIME PERIOD QUALIFIER C ID 1/2
Code defining periods.
35 Week
HSD06 616 NUMBER OF PERIODS O NO 1/3
Total number of periods.
> Duration - 1
> Duration of days 001-999
> 72-6 (positions 4-6) ; 72-7 thru 72-17 (positions 4-6)
>
HSD07 678 SHIP/DELIVERY OR CALENDAR PATTERN CODE O ID 1/2
Code which specifies the routine shipments, deliveries, or
calendar pattern.
> Not Used
HSD08 679 SHIP/DELIVERY PATTERN TIME CODE O ID 1/1
Code which specifies the time for routine shipments or
deliveries.
> Not Used
  
```

=====

SEGMENT: LS Loop Header
 POSITION: 245
 LEVEL: Detail
 LOOP: 2300
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To indicate that the next segment begins a loop
 SEMANTIC: 1. One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as ``mandatory'', this segment in combination with ``LE'', must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

> NOTES: 1. This segment MUST be used once, and only once, if NM1 at
 > position 250 is used, regardless of the number of
 > repetitions of loop 2310.
 > EXAMPLE: LS*2310~

DATA ELEMENT SUMMARY -----

LS01 447 LOOP IDENTIFIER CODE M AN 1/4
 The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE
 > Required
 > Use 2310

=====

SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: ATTENDING PHYSICIAN NAME
 POSITION: 250
 LEVEL: Detail
 LOOP: 2310 Repeat: 9
 > USAGE: Optional NOTE: Required
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > NOTES: 1. The Physician must be identified by name (NM103) and by
 > Identification Number (NM108 and NM109) according to
 > Billing Instructions.
 > 2. Only the first occurrence of record type 80 should be
 > mapped.
 > EXAMPLE: NM1*71*1*ZUBELDIA*KEPA****UP*A01234~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
 Code identifying an organizational entity, a physical location, or an individual
 > Required
 > 71 Attending Physician
 > Physician present when medical services are performed
 NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1

Code qualifying the type of entity.
 > Required
 1 Person

NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
 Individual last name or organizational name
 > Attending Physician Last Name
 > 80-09 positions 91-106; Also maps to 71-18 if you are
 > creating this attachment.

NM104 1036 NAME FIRST O AN 1/25
 Individual first name.
 > Attending Physician First Name
 > 80-09 positions 107-114; Also maps to 71-19 of you are
 > creating this attachment
 > This is the first name of the attending physician.

NM105 1037 NAME MIDDLE O AN 1/25
 Individual middle name or initial.
 > Attending Physician Middle Name
 > This is the middle name or initial of the attending physician.
 > 80-09 position 115; Also maps to 71-20 if you are
 > creating this attachment.

NM106 1038 NAME PREFIX O AN 1/10
 Prefix to individual name.
 > Not Used

NM107 1039 NAME SUFFIX O AN 1/10
 Suffix to individual name.
 > Not Used

NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
 Code designating the system/method of code structure used for
 Identification Code (67).
 > 80-04
 UP Unique Physician Identification Number (UPIN)
 "Number assigned to the provider by the National
 Registry for Medicare Identification purposes."
 ZZ Mutually Defined
 "National Provider Identification Code"

NM109 67 IDENTIFICATION CODE C AN 2/20
 Code identifying a party or other code.
 > 80-05
 > Attending Physician Number

=====

SEGMENT: N4 Geographic Location
 >WEDI NME: ATTENDING PHYSICIAN ZIP
 POSITION: 270
 LEVEL: Detail
 LOOP: 2310
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To specify the geographic place of the named party
 SYNTAX: 1. C0605--If N406 is present, then N405 is required.
 COMMENTS: A. A combination of either N401 through N404 (or N405 and
 N406) may be adequate to specify a location.
 B. N402 is required only if city name (N401) is in the USA or
 Canada.
 > EXAMPLE: N4***101234~

DATA ELEMENT SUMMARY -----

N401 19 CITY NAME O AN 2/30
 Free-form text for city name.
 > Not Used

N402 156 STATE OR PROVINCE CODE O ID 2/2

Code (Standard State/Province) as defined by appropriate government agency.

> Not Used

N403 116 POSTAL CODE O ID 3/11
Code defining international postal zone code excluding punctuation and blanks (zip code for United States).

> Physician ZIP Code

> The ZIP Code of the attending physician. Use only if you are mapping from 71-21 for home health.

> 71-21

N404 26 COUNTRY CODE O ID 2/3
Code identifying the country.

> Not Used

N405 309 LOCATION QUALIFIER C ID 1/2
Code identifying type of location.

> Not Used

N406 310 LOCATION IDENTIFIER O AN 1/30
Code which identifies a specific location.

> Not Used

=====

SEGMENT: NM1 Individual or Organizational Name

>WEDI NME: OPERATING PHYSICIAN NAME

POSITION: 250

LEVEL: Detail

LOOP: 2310 Repeat: 9

USAGE: Optional

MAX USE: 1

PURPOSE: To supply the full name of an individual or organizational entity

SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other is required.

SEMANTIC: 1. NM102 qualifies NM103.

> NOTES: 1. The Physician must be identified by name (NM103) and/or by Identification Number (NM108 and NM109) according to Billing Instructions.

> EXAMPLE: NM1*72*1*ZUBELDIA*KEPA****UP*A01234~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
Code identifying an organizational entity, a physical location, or an individual

> Required

72 Operating Physician

> Doctor who performs a surgical procedure

NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
Code qualifying the type of entity.

> Required

1 Person

NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
Individual last name or organizational name

> Operating Physician Last Name

> 80-10

NM104 1036 NAME FIRST O AN 1/25
Individual first name.

> Operating Physician First Name

> 80-10 positions 132-139

NM105 1037 NAME MIDDLE O AN 1/25
Individual middle name or initial.

> Operating Physician Middle Name

> 80-10 position 140

NM106 1038 NAME PREFIX O AN 1/10
 Prefix to individual name.
 > Not Used

NM107 1039 NAME SUFFIX O AN 1/10
 Suffix to individual name.
 > Not Used

NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
 Code designating the system/method of code structure used for
 Identification Code (67).
 > 80-04
 UP Unique Physician Identification Number (UPIN)
 > "Number assigned to the provider by the National
 > Registry for Medicare Identification purposes".
 ZZ Mutually Defined
 > "National Provider Identification Code"

NM109 67 IDENTIFICATION CODE C AN 2/20
 Code identifying a party or other code.
 > Other Physician UPIN
 > 80-06

=====

SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: OTHER PHYSICIAN NAME
 POSITION: 250
 LEVEL: Detail
 LOOP: 2310 Repeat: 9
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational
 entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
 is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > NOTES: 1. The Physician must be identified by name (NM103) and/or by
 > Identification Number (NM108 and NM109) according to
 > Billing Instructions.
 > 2. This segment should be repeated if information is present
 > for more than one 'other' physician.
 > EXAMPLE: NM1*73*1*SMITH*JOHN*I***UP*B12365~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
 Code identifying an organizational entity, a physical location,
 or an individual
 > Required
 73 Other Physician
 > Physician not one of the other specified choices

NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
 Code qualifying the type of entity.
 > Required
 1 Person

NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
 Individual last name or organizational name
 > Other Physician Last Name
 > 80-11 (position 141-156), 80-12 (position 166-181)

NM104 1036 NAME FIRST O AN 1/25
 Individual first name.
 > Other Physician First Name
 > 80-11 (position 157-164); 80-12 (position 182-189)

NM105 1037 NAME MIDDLE O AN 1/25
 Individual middle name or initial.

```

> Other Physician Middle Name
> 80-11 (position 165); 80-12 (position 190)
NM106 1038 NAME PREFIX O AN 1/10
Prefix to individual name.
Not Used
>
NM107 1039 NAME SUFFIX O AN 1/10
Suffix to individual name.
Not Used
>
NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
Code designating the system/method of code structure used for
Identification Code (67).
>
80-04
UP Unique Physician Identification Number (UPIN)
> "Number assigned to the provider by the National
> Registry for Medicare Identification purposes."
ZZ Mutually Defined
> "National Provider Identification Code"
NM109 67 IDENTIFICATION CODE C AN 2/20
Code identifying a party or other code.
> Other Physician UPIN
> 80-07; 80-08

```

```

=====
SEGMENT: LE Loop Trailer
POSITION: 280
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 1
PURPOSE: To indicate that the loop immediately preceding this segment is
complete
SEMANTIC: 1. One loop may be nested contained within another loop,
provided the inner nested loop terminates before the other
loop. When specified by the standards setting body as
`mandatory`, this segment in combination with `LS`,
must be used. It is not to be used if not specifically set
forth for use. The loop identifier in the loop header and
trailer must be identical. The value for the identifier is
the loop ID of the required loop beginning segment. The
loop ID number is given on the transaction set diagram in
the appropriate ASC X12 version/release.

> NOTES: 1. This segment MUST be used once, and only once, if NM1 at
> position 250 is used, regardless of the number of
> repetitions of loop 2310.
> EXAMPLE: LE*2310~

```

DATA ELEMENT SUMMARY -----

```

LE01 447 LOOP IDENTIFIER CODE M AN 1/4
The loop ID number given on the transaction set diagram is the
value for this data element in segments LS and LE
> Required
> Use 2310

```

```

=====
SEGMENT: LS Loop Header
POSITION: 285
LEVEL: Detail
LOOP: 2300
USAGE: Optional
MAX USE: 1
PURPOSE: To indicate that the next segment begins a loop

```

SEMANTIC: 1. One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as ``mandatory'', this segment in combination with ``LE'', must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

> NOTES: 1. This loop MUST be used once if additional insurance other than Medicare. Medicare should only be sent in this loop if the claim is a COB (coordination of benefits) claim. Otherwise, Medicare should never be sent in this loop. In cases where Medicare is secondary, the primary would be reported in this loop 2320.
> EXAMPLE: LS*2320~

DATA ELEMENT SUMMARY -----

LS01 447 LOOP IDENTIFIER CODE M AN 1/4
The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE
> Required
> Use 2320

=====

SEGMENT: SBR Subscriber Information
>WEDI NME: ADDITIONAL PAYOR INFORMATION
POSITION: 290
LEVEL: Detail
LOOP: 2320 Repeat: 10
> USAGE: Optional NOTE: Required
MAX USE: 1
PURPOSE: To record information specific to the primary insured and the insurance carrier for that insured
SEMANTIC: 1. SBR02 specifies the relationship to the person insured.
2. SBR03 is policy or group number.
3. SBR04 is plan name.
4. SBR07 is destination payer code. A ``Y'' value indicates the payer is the destination payer. An ``N'' value indicates the payer is not the destination payer.
> NOTES: 1. Required when the Medicare patient has other insurance. If there is more than one additional insurance, repeat loops 2320 and 2330. When Medicare is not the primary payer, report primary payer in this loop and repeat if necessary for other insurance. Medicare should not be reported in this loop unless this is a COB (coordination of benefits) claim. For COB claims, all payers should be in this loop in addition to the destination payer being in the 2300 loop.
> *NOTE: If COB, the SBR05 element will contain 'MA' for the Medicare payer only.
> EXAMPLE: SBR*S*18*0001234*GOLDEN GAP~

DATA ELEMENT SUMMARY -----

SBR01 1138 PAYER RESPONSIBILITY SEQUENCE NUMBER CODE M ID 1/1
Code indentifying the insurance carrier's level of responsibility for a payment of a claim
> Required

> Supplementary Payor Responsibility Sequence Code
> Code identifying the supplementary payor's level of
> responsibility for payment of the claim.
> 30-02
> P Primary
> UB92 Code "1"
> S Secondary
> UB92 Code "2"
> T Tertiary
> UB92 Code "3"

SBR02 1069 INDIVIDUAL RELATIONSHIP CODE O ID 2/2
Code indicating the relationship between two individuals or
entities.
> Required
> Patient Relationship to Insured
> Code specifying the relationship of the Medicare patient to
> the insured.
> 30-18
> 01 Spouse
> UB-92 Code "02"
> 18 Self
> UB-92 Code "01"
> 19 Child
> UB-92 Code "03"
> 21 Unknown
> UB-92 Code "09"

SBR03 127 REFERENCE NUMBER O AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Recommended
> Supplementary Payor Group or Number
> Identification number of the insured's group or policy as
> assigned by the supplementary payor.
> 30-10

SBR04 93 NAME O AN 1/35
Free-form name.
> Supplementary Payor Group Name
> Name of the insured's group as known to the supplementary
> payor.
> 30-11

SBR05 1336 INSURANCE TYPE CODE O ID 1/3
Code identifying the type of insurance policy within a specific
insurance program
> **This field is only applicable for the Medicare payer
> segment.
> MA Medicare Part A

SBR06 1143 COORDINATION OF BENEFITS CODE O ID 1/1
Code identifying whether there is a coordination of benefits
> Not Used

SBR07 1073 YES/NO CONDITION OR RESPONSE CODE O ID 1/1
Code indicating a Yes or No condition or response.
> Not Used

SBR08 584 EMPLOYMENT STATUS CODE O ID 2/2
Code showing the general employment status of an
employee/claimant.
> Employment Status Code
> Note: If the UB92 code equal to "6" and it is not known if the
> value means Overseas or USA, default to "AU" for USA.
> 30-19 (Not all codes map)
> AO Active Military - Overseas
> AU Active Military - USA
> FT Full-time
> UB92 Code "1"
> NE Not Employed

```

>          UB92 Code "3"
          PT Part-time
>          UB92 Code "2"
          RT Retired
>          UB92 Code "5"
          SE Self-Employed
>          UB92 Code "4"
          UK Unknown
>          UB92 Code "9"
SBR09 1032 CLAIM FILING INDICATOR CODE          O ID 1/2
          Code identifying type of claim
>          Not Used

```

=====

```

SEGMENT: CAS Claims Adjustment
>WEDI NME: CAS - CLAIM LEVEL ADJUSTMENTS
POSITION: 295
  LEVEL: Detail
  LOOP: 2320
  USAGE: Optional
MAX USE: 1
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:  1. L050607--If CAS05 is present, then at least one of CAS06 or
CAS07 are required.
          2. C0605--If CAS06 is present, then CAS05 is required.
          3. C0705--If CAS07 is present, then CAS05 is required.
          4. L080910--If CAS08 is present, then at least one of CAS09 or
CAS10 are required.
          5. C0908--If CAS09 is present, then CAS08 is required.
          6. C1008--If CAS10 is present, then CAS08 is required.
          7. L111213--If CAS11 is present, then at least one of CAS12 or
CAS13 are required.
          8. C1211--If CAS12 is present, then CAS11 is required.
          9. C1311--If CAS13 is present, then CAS11 is required.
         10. L141516--If CAS14 is present, then at least one of CAS15 or
CAS16 are required.
         11. C1514--If CAS15 is present, then CAS14 is required.
         12. C1614--If CAS16 is present, then CAS14 is required.
         13. L171819--If CAS17 is present, then at least one of CAS18 or
CAS19 are required.
         14. C1817--If CAS18 is present, then CAS17 is required.
         15. C1917--If CAS19 is present, then CAS17 is required.
SEMANTIC: 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: A. 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.
          B. When the submitted charges are paid in full, the value for
CAS03 should be zero.

```

> NOTES: 1. Each claim adjustment amount and/or quantity relates to the
> immediately preceding adjustment reason code.
> 2. Use an applicable reason code from the National Standard
> adjustment reason code list.
> 3. If a group code is present then a reason code must be
> present. If a reason code is present then either an amount
> or quantity must be present.
> 4. Due to the X12 standard's limitation of one CAS segment at
> the claim level, only one 42 record should be mapped per
> payer for loop 2320.
> EXAMPLE: CAS*CO*96*555.52~

DATA ELEMENT SUMMARY -----

CAS01	1033	CLAIM ADJUSTMENT GROUP CODE	M ID 1/2
>		Code identifying the general category of payment adjustment.	
>	42-05		
		CO Contractual Obligations	
		CR Correction and Reversals	
		OA Other adjustments	
		PR Patient Responsibility	
CAS02	1034	CLAIM ADJUSTMENT REASON CODE	M ID 1/5
>		Code identifying the detailed reason the adjustment was made.	
>	42-6		
CAS03	782	MONETARY AMOUNT	M R 1/15
>		Monetary amount.	
>	42-07		
CAS04	380	QUANTITY	O R 1/15
>		Numeric value of quantity.	
>	42-08		
CAS05	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
>		Code identifying the detailed reason the adjustment was made.	
>	42-9		
CAS06	782	MONETARY AMOUNT	C R 1/15
>		Monetary amount.	
>	42-10		
CAS07	380	QUANTITY	C R 1/15
>		Numeric value of quantity.	
>	42-11		
CAS08	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
>		Code identifying the detailed reason the adjustment was made.	
>	42-12		
CAS09	782	MONETARY AMOUNT	C R 1/15
>		Monetary amount.	
>	42-13		
CAS10	380	QUANTITY	C R 1/15
>		Numeric value of quantity.	
>	42-14		
CAS11	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
>		Code identifying the detailed reason the adjustment was made.	
>	42-15		
CAS12	782	MONETARY AMOUNT	C R 1/15
>		Monetary amount.	
>	42-16		
CAS13	380	QUANTITY	C R 1/15
>		Numeric value of quantity.	
>	42-17		
CAS14	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
>		Code identifying the detailed reason the adjustment was made.	
>	42-18		
CAS15	782	MONETARY AMOUNT	C R 1/15
>		Monetary amount.	
>	42-19		
CAS16	380	QUANTITY	C R 1/15
>		Numeric value of quantity.	

> 42-20
CAS17 1034 CLAIM ADJUSTMENT REASON CODE C ID 1/5
Code identifying the detailed reason the adjustment was made.
> 42-21
CAS18 782 MONETARY AMOUNT C R 1/15
Monetary amount.
> 42-22
CAS19 380 QUANTITY C R 1/15
Numeric value of quantity.
> 42-23

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: PAYOR AMOUNT PAID
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> NOTES: 1. Payor amount paid for this claim.
> EXAMPLE: AMT*D*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> Required
D Payor Amount Paid
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Required
> 30-25
> Amount Payor Paid
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: ESTIMATED AMOUNT DUE
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*C5*575~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> Required
C5 Claim Amount Due - Estimated
> Approximate value rightfully belonging to the
> individual
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.

> Required
> 30-26
> Estimated Amount Due
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
> Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: TOTAL CHARGES ALLOWED
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*B6*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
B6 Allowed - Actual
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Total Charges Allowed (claim-level)
> 92-8
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
> Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: TOTAL SUBMITTED CHARGES
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*T3*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
T3 Total Submitted Charges
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Total Submitted Charges (claim-level)
> 92-6
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
> Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: DRG OUTLIER AMOUNT
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*ZZ*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> *NOTE: The qualifier will be used until a more suitable one is
> developed. At this time it will represent what it is being
> used for (see monetary amount description).
ZZ Mutually Defined
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> DRG Outlier Amount
> 92-15
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: MEDICARE PAID AMOUNT
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*N1*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> *NOTE: The qualifier will be used until a more suitable one is
> developed. At this time it will represent what it is being
> used for (see monetary amount description).
N1 Net Worth
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Total Medicare Reimbursement (claim-level)
> 92-09
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: ALLOWED CHARGES MEDICARE PAID AT 100%
POSITION: 300
LEVEL: Detail
LOOP: 2320

USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*KF*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> *NOTE: The qualifier will be used until a more suitable one is
> developed. At this time it will represent what it is being
> used for (see monetary amount description).
KF Net Paid Amount
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Allowed Charges Medicare Paid at 100% (claim-level)
> 93-4
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: ALLOWED CHARGES MEDICARE PAID AT 80%
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*PG*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> *NOTE: The qualifier will be used until a more suitable one is
> developed. At this time it will represent what it is being
> used for (see monetary amount description).
PG Payoff
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Allowed Charges Medicare Paid at 80% (claim-level)
> 93-05
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: PAID FROM MEDA TRUST FUND
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*AA*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> *NOTE: The qualifier will be used until a more suitable one is
> developed. At this time it will represent what it is being
> used for (see monetary amount description).
AA Allocated
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Paid From Medicare A Trust Fund
> 93-06
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: PAID FROM MEDB TRUST FUND
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*B1*150~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
> *NOTE: The qualifier will be used until a more suitable one is
> developed. At this time it will represent what it is being
> used for (see monetary amount description).
B1 Benefit Amount
AMT02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Paid From Medicare B Trust Fund
> 93-07
AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
Code indicating whether amount is a credit or debit
> Not Used

=====

SEGMENT: AMT Monetary Amount
>WEDI NME: TOTAL NON-COVERED CHARGES
POSITION: 300
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 15
PURPOSE: To indicate the total monetary amount.
> EXAMPLE: AMT*A8*25.25~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
Code to qualify amount
A8 Noncovered Charges - Actual

AMT02 782 MONETARY AMOUNT M R 1/15
 Monetary amount.
 > Total non-covered charges (claim level)
 > 92-07
 AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
 Code indicating whether amount is a credit or debit
 > Not Used

=====

SEGMENT: AMT Monetary Amount
 >WEDI NME: TOTAL DENIED CHARGES
 POSITION: 300
 LEVEL: Detail
 LOOP: 2320
 USAGE: Optional
 MAX USE: 15
 PURPOSE: To indicate the total monetary amount.
 > EXAMPLE: AMT*YT*51.5~

DATA ELEMENT SUMMARY -----

AMT01 522 AMOUNT QUALIFIER CODE M ID 1/2
 Code to qualify amount
 YT Denied
 AMT02 782 MONETARY AMOUNT M R 1/15
 Monetary amount.
 > Total Denied Charges (claim level)
 > 92-16
 AMT03 478 CREDIT/DEBIT FLAG CODE O ID 1/1
 Code indicating whether amount is a credit or debit
 > Not Used

=====

SEGMENT: DMG Demographic Information
 >WEDI NME: OTHER INSURED DATE OF BIRTH AND SEX
 POSITION: 305
 LEVEL: Detail
 LOOP: 2320
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To supply demographic information
 SYNTAX: 1. P0102--If either DMG01 or DMG02 is present, then the other
 is required.
 SEMANTIC: 1. DMG02 is the date of birth.
 2. DMG07 is the country of citizenship.
 3. DMG09 is the age in years.
 > NOTES: 1. Do not create this segment for the destination payer's SBR
 > loop.
 > EXAMPLE: DMG***F~

DATA ELEMENT SUMMARY -----

DMG01 1250 DATE TIME PERIOD FORMAT QUALIFIER C ID 2/3
 Code indicating the date format, time format, or date and time
 format.
 > Not Used
 DMG02 1251 DATE TIME PERIOD C AN 1/35
 Expression of a date, a time, or range of dates, times or dates
 and times.

```

> Not Used
DMG03 1068 GENDER CODE O ID 1/1
Code indicating the sex of the individual.
> Other Insured's Sex
> 30-15
F Female
M Male
U Unknown
DMG04 1067 MARITAL STATUS CODE O ID 1/1
Code defining the marital status of a person.
> Not Used
DMG05 1109 RACE OR ETHNICITY CODE O ID 1/1
Code indicating the racial or ethnic background of a person; it
is normally self-reported. Under certain circumstances this
information is collected for United States Government
statistical purposes.
> Not Used
DMG06 1066 CITIZENSHIP STATUS CODE O ID 1/2
Code indicating citizenship status.
> Not Used
DMG07 26 COUNTRY CODE O ID 2/3
Code identifying the country.
> Not Used
DMG08 659 BASIS OF VERIFICATION CODE O ID 1/2
Code indicating the basis of verification
> Not Used
DMG09 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used

```

=====

```

SEGMENT: OI Other Health Insurance Information
>WEDI NME: SUPPLEMENTARY PAYOR TYPE OF INSURANCE
POSITION: 310
LEVEL: Detail
LOOP: 2320
USAGE: Optional
MAX USE: 1
PURPOSE: To specify information associated with other health insurance
coverage
SEMANTIC: 1. OI03 is assignment of benefits indicator. A ``Y'' value
indicates insured or authorized person authorizes benefits
to be assigned to the provider. An ``N'' value indicates
benefits have not been assigned to the provider.
> NOTES: 1. Do not create this segment for the destination payer's SBR
> loop.
> EXAMPLE: OI*CI**Y***Y~

```

DATA ELEMENT SUMMARY -----

```

OI01 1032 CLAIM FILING INDICATOR CODE O ID 1/2
Code identifying type of claim
> Supplementary payor type of insurance
> 30-04 (Not all codes map)
BL Blue Cross/Blue Shield
UB92 code = "G"
CH Champus
UB92 code = "H"
CI Commercial Insurance Co.
UB92 code = "F"
FI Federal Employees Program
UB92 code = "E"

```

```

HM Health Maintenance Organization
MA Medicare Part A
> UB92 code = "C"
MC Medicaid
> UB92 code = "D"
MH Managed Care Non-HMO
OF Other Federal Program
> UB92 code = "E"
SA Self-administered Group
> UB92 code = "A"
TV Title V
VA Veteran Administration Plan
WC Workers' Compensation Health Claim
> UB92 code = "B"
OI02 1383 CLAIM SUBMISSION REASON CODE O ID 2/2
Code identifying reason for claim submission
> Not Used
OI03 1073 YES/NO CONDITION OR RESPONSE CODE O ID 1/1
Code indicating a Yes or No condition or response.
> Assignments of Benefits Indicator
> 30-17
> A "Y" value indicates insured or authorized person authorizes
> benefits to be assigned to the provider.
> A "N" value indicates benefits have not been assigned to the
> provider.
N No
U Unknown
Y Yes
OI04 1351 PATIENT SIGNATURE SOURCE CODE O ID 1/1
Code indicating how the patient or subscriber authorization
signatures were obtained and how they are being retained by the
provider
> Not Used
OI05 1360 PROVIDER AGREEMENT CODE O ID 1/1
Code indicating the type of agreement under which the provider
is submitting this claim
> Not Used
OI06 1363 RELEASE OF INFORMATION CODE O ID 1/1
Code indicating whether the provider has on file a signed
statement by the patient authorizing the release of medical
data to other organizations
> Release of information indicator
> 30-16
M The Provider has Limited or Restricted Ability to
Release Data Related to a Claim
> UB92 code = 'R'
N No, Provider is Not Allowed to Release Data
> UB92 code = 'N'
Y Yes, Provider has a Signed Statement Permitting Release
of Medical Billing Data Related to a Claim
> UB92 code = 'Y'

```

```

=====
SEGMENT: MIA Medicare Inpatient Adjudication
POSITION: 315
LEVEL: Detail
LOOP: 2320
> USAGE: Optional NOTE: Recommended
MAX USE: 1
PURPOSE: To provide claim-level data related to the adjudication of
Medicare inpatient claims
SEMANTIC: 1. MIA01 is covered days.

```

2. MIA02 is lifetime reserve days.
3. MIA03 is lifetime psychiatric days.
4. MIA04 is Diagnosis Related Group (DRG) amount.
5. MIA05 is the Health Care Financing Administration 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 Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
21. MIA21 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
22. MIA22 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
23. MIA23 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.
24. MIA24 is the capital exception amount.

> NOTES: 1. Create for Inpatient claims only.
 > EXAMPLE: MIA*****3568.98*MAO*****21*****MA25~

DATA ELEMENT SUMMARY -----

MIA01	380	QUANTITY	M R 1/15
>		Numeric value of quantity.	
>		Covered Days - Actual	
>		30-20	
MIA02	380	QUANTITY	O R 1/15
>		Numeric value of quantity.	
>		Lifetime Reserve Days - Actual	
>		30-23	
MIA03	380	QUANTITY	O R 1/15
>		Numeric value of quantity.	
>		Lifetime Psychiatric Days	
>		92-18	
MIA04	782	MONETARY AMOUNT	O R 1/15
>		Monetary amount.	
>		DRG Amount	
>		92-14	
MIA05	127	REFERENCE NUMBER	O AN 1/30
>		Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference	

Number Qualifier.
 > Message Code
 > Medicare message code pertaining to this claim. Use standard
 > X12 code list.
 > 42-24
 MIA06 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA07 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA08 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA09 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA10 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA11 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA12 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA13 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA14 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA15 380 QUANTITY O R 1/15
 Numeric value of quantity.
 > Cost Report Days
 > 92-17
 MIA16 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA17 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA18 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA19 782 MONETARY AMOUNT O R 1/15
 Monetary amount.
 > Not Used
 MIA20 127 REFERENCE NUMBER O AN 1/30
 Reference number or identification number as defined for a
 particular Transaction Set, or as specified by the Reference
 Number Qualifier.
 > Message Code
 > Medicare message code pertaining to this claim. Use standard
 > X12 code list.
 > 42-25
 MIA21 127 REFERENCE NUMBER O AN 1/30
 Reference number or identification number as defined for a
 particular Transaction Set, or as specified by the Reference
 Number Qualifier.
 > Message Code
 > Medicare message code pertaining to this claim. Use standard
 > X12 code list.
 > 42-26
 MIA22 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X12 code list.

> 42-27

MIA23 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X12 code list.

> 42-28

MIA24 782 MONETARY AMOUNT O R 1/15

Monetary amount.

> Not Used

=====

SEGMENT: MOA Medicare Outpatient Adjudication

POSITION: 320

LEVEL: Detail

LOOP: 2320

> USAGE: Optional NOTE: Recommended

MAX USE: 1

PURPOSE: To convey claim-level data related to the adjudication of Medicare claims not related to an inpatient setting

SEMANTIC: 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 Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

4. MOA04 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

5. MOA05 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

6. MOA06 is the Health Care Financing Administration Claim Payment Remark code. See Code Source 411.

7. MOA07 is the Health Care Financing Administration Payment Remark code. See Source 411.

8. MOA08 is the End Stage Renal Disease (ESRD) payment amount.

9. MOA09 is the professional component amount billed but not payable.

> NOTES: 1. Inpatient or Outpatient Claims. The reason codes should

> not be populated for inpatient claims. For outpatient

> claims, use the standardized Medicare reason codes for

> acceptable MOA codes. Always include an appeal message

> when a service has been denied or reduced.

> EXAMPLE: MOA*12.5**MA01~

DATA ELEMENT SUMMARY -----

MOA01 954 PERCENT O R 1/10

Percentage expressed as a decimal

> Reimbursement Rate

> 92-20

MOA02 782 MONETARY AMOUNT O R 1/15

Monetary amount.

> Not Used

MOA03 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a

particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X-12 code list

> 42-24

MOA04 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X-12 code list

> 42-25

MOA05 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X-12 code list

> 42-26

MOA06 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X-12 code list

> 42-27

MOA07 127 REFERENCE NUMBER O AN 1/30

Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.

> Message Code

> Medicare message code pertaining to this claim. Use standard

> X-12 code list

> 42-28

MOA08 782 MONETARY AMOUNT O R 1/15

Monetary amount.

> Not Used

MOA09 782 MONETARY AMOUNT O R 1/15

Monetary amount.

> Not Used

=====

SEGMENT: NM1 Individual or Organizational Name

>WEDI NME: SUPPLEMENTARY PAYOR NAME

POSITION: 325

LEVEL: Detail

LOOP: 2330 Repeat: 10

> USAGE: Optional NOTE: Required

MAX USE: 1

PURPOSE: To supply the full name of an individual or organizational entity

SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other is required.

SEMANTIC: 1. NM102 qualifies NM103.

> EXAMPLE: NM1*PR*2*NATIONAL RETIREMENT*****PI*NR002~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
Code identifying an organizational entity, a physical location,
or an individual
> Required
PR Payer

NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
Code qualifying the type of entity.
> Required
2 Non-Person Entity

NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
Individual last name or organizational name
> Supplementary Payor Name
> Payor Name required if NM109 is not a Intermediary assigned
> code.|
> 30-8b

NM104 1036 NAME FIRST O AN 1/25
Individual first name.
> Not Used

NM105 1037 NAME MIDDLE O AN 1/25
Individual middle name or initial.
> Not Used

NM106 1038 NAME PREFIX O AN 1/10
Prefix to individual name.
> Not Used

NM107 1039 NAME SUFFIX O AN 1/10
Suffix to individual name.
> Not Used

NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
Code designating the system/method of code structure used for
Identification Code (67).
> 30-8a
> Payer Identification Indicator
PI Payor Identification
ZZ Mutually Defined
> (National Payer ID)

NM109 67 IDENTIFICATION CODE C AN 2/20
Code identifying a party or other code.
> Supplementary Payor Identification
> 30-05 , 30-06

=====

SEGMENT: DTP Date or Time or Period
>WEDI NME: CLAIM PAID DATE
POSITION: 350
LEVEL: Detail
LOOP: 2330
USAGE: Optional
MAX USE: 9
PURPOSE: To specify any or all of a date, a time, or a time period
SEMANTIC: 1. DTP02 is the date or time or period format that will appear
in DTP03.
> EXAMPLE: DTP*666*D8*19930120~

DATA ELEMENT SUMMARY -----

DTP01 374 DATE/TIME QUALIFIER M ID 3/3
Code specifying type of date or time, or both date and time.
666 Date Paid

DTP02 1250 DATE TIME PERIOD FORMAT QUALIFIER M ID 2/3
Code indicating the date format, time format, or date and time
format.
D8 Date Expressed in Format CCYYMMDD

DTP03 1251 DATE TIME PERIOD M AN 1/35
Expression of a date, a time, or range of dates, times or dates
and times.
> Claim Paid Date

```

=====
SEGMENT: REF Reference Numbers
>WEDI NME: TREATMENT AUTHORIZATION NUMBER
POSITION: 355
  LEVEL: Detail
  LOOP: 2330
  USAGE: Optional
  MAX USE: 3
  PURPOSE: To specify identifying numbers.
  SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
> EXAMPLE: REF*BB*9300007891~

```

DATA ELEMENT SUMMARY -----

```

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
  BB Authorization Number
> Proves that permission was obtained to provide a
> service
REF02 127 REFERENCE NUMBER C AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Treatment Authorization Number
> 40-05 WHEN SBR01=P; 40-06 WHEN SBR01=S; 40-07 WHEN SBR01=T
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

```

```

=====
SEGMENT: REF Reference Numbers
>WEDI NME: PROVIDER IDENTIFICATION NUMBER
POSITION: 355
  LEVEL: Detail
  LOOP: 2330
  USAGE: Optional
  MAX USE: 3
  PURPOSE: To specify identifying numbers.
  SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
> EXAMPLE: REF*G2*731234567~

```

DATA ELEMENT SUMMARY -----

```

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
  G2 Provider Commercial Number
> A unique number assigned to a provider by a commercial
> insurer
REF02 127 REFERENCE NUMBER C AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Provider Identification Number
> 30-24
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

```

```

=====
SEGMENT: REF Reference Numbers
>WEDI NME: ORIGINAL ICN/DCN NUMBER
POSITION: 355
  LEVEL: Detail
  LOOP: 2330

```

USAGE: Optional
 MAX USE: 3
 PURPOSE: To specify identifying numbers.
 SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
 > NOTES: 1. This segment is required when reporting additional
 > insurance.
 > 2. * NOTE: Do not create this REF segment for the Medicare SBR
 > loop.
 > EXAMPLE: REF*F8*931278760100~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
 Code qualifying the Reference Number.
 F8 Original Reference Number
 REF02 127 REFERENCE NUMBER C AN 1/30
 Reference number or identification number as defined for a
 particular Transaction Set, or as specified by the Reference
 Number Qualifier.
 > Original ICN/DCN Number
 > 31-14
 REF03 352 DESCRIPTION C AN 1/80
 A free-form description to clarify the related data elements
 and their content.
 > Not Used

=====
 SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: SUPPLEMENTARY PAYOR NAME (CONTRACT NUMBER)
 POSITION: 325
 LEVEL: Detail
 LOOP: 2330 Repeat: 10
 > USAGE: Optional NOTE: Required
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational
 entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
 is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > EXAMPLE: NM1*PR*2*****ZY*NR002~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
 Code identifying an organizational entity, a physical location,
 or an individual
 > Required
 PR Payer
 NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
 Code qualifying the type of entity.
 > Required
 2 Non-Person Entity
 NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
 Individual last name or organizational name
 > Not Used
 NM104 1036 NAME FIRST O AN 1/25
 Individual first name.
 > Not Used
 NM105 1037 NAME MIDDLE O AN 1/25
 Individual middle name or initial.
 > Not Used
 NM106 1038 NAME PREFIX O AN 1/10
 Prefix to individual name.
 > Not Used
 NM107 1039 NAME SUFFIX O AN 1/10

Suffix to individual name.
 > Not Used
 NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
 Code designating the system/method of code structure used for
 Identification Code (67).
 > Payer Identification Indicator
 ZY Temporary Identification Number (Contract Number)
 NM109 67 IDENTIFICATION CODE C AN 2/20
 Code identifying a party or other code.
 > Supplementary Payor Identification
 > 31-15

=====

SEGMENT: NM1 Individual or Organizational Name
 >WEDI NME: OTHER INSURED NAME
 POSITION: 325
 LEVEL: Detail
 LOOP: 2330 Repeat: 10
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To supply the full name of an individual or organizational
 entity
 SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
 is required.
 SEMANTIC: 1. NM102 qualifies NM103.
 > NOTES: 1. For COB, this segment is not required for the destination
 > payer's SBP loop.
 > EXAMPLE: NM1*IL*1*ZUBELDIA*LESLIE*B**C1*464675489~

DATA ELEMENT SUMMARY -----

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
 Code identifying an organizational entity, a physical location,
 or an individual
 > Required
 IL Insured or Subscriber
 NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
 Code qualifying the type of entity.
 > Required
 1 Person
 NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
 Individual last name or organizational name
 > Other Insured Last Name
 > 30-12
 NM104 1036 NAME FIRST O AN 1/25
 Individual first name.
 > Other Insured First Name
 > 30-13
 NM105 1037 NAME MIDDLE O AN 1/25
 Individual middle name or initial.
 > Other Insured Middle Initial
 > 30-14
 NM106 1038 NAME PREFIX O AN 1/10
 Prefix to individual name.
 > Not Used
 NM107 1039 NAME SUFFIX O AN 1/10
 Suffix to individual name.
 > Not Used
 NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
 Code designating the system/method of code structure used for
 Identification Code (67).
 C1 Insured or Subscriber
 NM109 67 IDENTIFICATION CODE C AN 2/20
 Code identifying a party or other code.
 > Other Insured Identification Number
 > Other insured's unique identification number.

> 30-07

```
=====
SEGMENT: N3 Address Information
>WEDI NME: OTHER INSURED ADDRESS
POSITION: 332
  LEVEL: Detail
  LOOP: 2330
  USAGE: Optional
  MAX USE: 2
  PURPOSE: To specify the location of the named party
> NOTES: 1. *NOTE: Do not create this segment for the destination
>         payer's SBR loop.
> EXAMPLE: N3*44 W1500 SOUTH ST~
```

DATA ELEMENT SUMMARY -----

```
N301 166 ADDRESS INFORMATION M AN 1/35
      Address information
>      Required
>      Other Insured Address Line 1
>      31-04
N302 166 ADDRESS INFORMATION O AN 1/35
      Address information
>      Other Insured Address Line 2
>      31-05
```

```
=====
SEGMENT: N4 Geographic Location
>WEDI NME: OTHER INSURED CITY, STATE, ZIP
POSITION: 340
  LEVEL: Detail
  LOOP: 2330
  USAGE: Optional
  MAX USE: 1
  PURPOSE: To specify the geographic place of the named party
  SYNTAX: 1. C0605--If N406 is present, then N405 is required.
  COMMENTS: A. A combination of either N401 through N404 (or N405 and
            N406) may be adequate to specify a location.
            B. N402 is required only if city name (N401) is in the USA or
            Canada.
> NOTES: 1. *NOTE: Do not create this segment for the destination
>         payer's SBR loop.
> EXAMPLE: N4*ANYTOWN*TX*75122~
```

DATA ELEMENT SUMMARY -----

```
N401 19 CITY NAME O AN 2/30
      Free-form text for city name.
>      Other Insured City
>      31-06
N402 156 STATE OR PROVINCE CODE O ID 2/2
      Code (Standard State/Province) as defined by appropriate
      government agency.
>      Other Insured State
>      31-07
N403 116 POSTAL CODE O ID 3/11
      Code defining international postal zone code excluding
      punctuation and blanks (zip code for United States).
>      Other Insured ZIP
>      31-08
N404 26 COUNTRY CODE O ID 2/3
      Code identifying the country.
```

```

> Not Used
N405 309 LOCATION QUALIFIER C ID 1/2
Code identifying type of location.
> Not Used
N406 310 LOCATION IDENTIFIER O AN 1/30
Code which identifies a specific location.
> Not Used

```

=====

```

SEGMENT: NM1 Individual or Organizational Name
>WEDI NME: SUBSCRIBER'S EMPLOYER NAME
POSITION: 325
LEVEL: Detail
LOOP: 2330 Repeat: 10
USAGE: Optional
MAX USE: 1
PURPOSE: To supply the full name of an individual or organizational
entity
SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
is required.
SEMANTIC: 1. NM102 qualifies NM103.
> NOTES: 1. Required when the payor is the subscriber's employer group
> insurance.
> EXAMPLE: NM1*84*2*ACME BRICK~

```

DATA ELEMENT SUMMARY -----

```

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
Code identifying an organizational entity, a physical location,
or an individual
> Required
84 Subscriber's Employer
NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
Code qualifying the type of entity.
> Required
2 Non-Person Entity
NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
Individual last name or organizational name
> Subscriber's Employer Name
> 31-09
NM104 1036 NAME FIRST O AN 1/25
Individual first name.
> Not Used
NM105 1037 NAME MIDDLE O AN 1/25
Individual middle name or initial.
> Not Used
NM106 1038 NAME PREFIX O AN 1/10
Prefix to individual name.
> Not Used
NM107 1039 NAME SUFFIX O AN 1/10
Suffix to individual name.
> Not Used
NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
Code designating the system/method of code structure used for
Identification Code (67).
> Not Used
NM109 67 IDENTIFICATION CODE C AN 2/20
Code identifying a party or other code.
> Not Used

```

```

=====
SEGMENT: N3 Address Information
>WEDI NME: SUBSCRIBER'S EMPLOYER ADDRESS
POSITION: 332
    LEVEL: Detail
    LOOP: 2330
    USAGE: Optional
    MAX USE: 2
    PURPOSE: To specify the location of the named party
> EXAMPLE: N3*Industrial Drive~

```

DATA ELEMENT SUMMARY -----

```

N301 166 ADDRESS INFORMATION M AN 1/35
      Address information
>      Required
>      Employer Address Line 1
>      31-10
N302 166 ADDRESS INFORMATION O AN 1/35
      Address information
>      Not Used

```

```

=====
SEGMENT: N4 Geographic Location
>WEDI NME: SUBSCRIBER'S EMPLOYER CITY, STATE, ZIP
POSITION: 340
    LEVEL: Detail
    LOOP: 2330
    USAGE: Optional
    MAX USE: 1
    PURPOSE: To specify the geographic place of the named party
    SYNTAX: 1. C0605--If N406 is present, then N405 is required.
    COMMENTS: A. A combination of either N401 through N404 (or N405 and
              N406) may be adequate to specify a location.
              B. N402 is required only if city name (N401) is in the USA or
              Canada.
> EXAMPLE: N4*Somewhere*TX*75122~

```

DATA ELEMENT SUMMARY -----

```

N401 19 CITY NAME O AN 2/30
      Free-form text for city name.
>      Subscriber's Employer City
>      31-11
N402 156 STATE OR PROVINCE CODE O ID 2/2
      Code (Standard State/Province) as defined by appropriate
      government agency.
>      Subscriber's Employer State
>      31-12
N403 116 POSTAL CODE O ID 3/11
      Code defining international postal zone code excluding
      punctuation and blanks (zip code for United States).
>      Subscriber's Employer ZIP
>      31-13
N404 26 COUNTRY CODE O ID 2/3
      Code identifying the country.
>      Not Used
N405 309 LOCATION QUALIFIER C ID 1/2
      Code identifying type of location.
>      Not Used
N406 310 LOCATION IDENTIFIER O AN 1/30
      Code which identifies a specific location.
>      Not Used

```

```

=====
SEGMENT: NM1 Individual or Organizational Name

```


DATA ELEMENT SUMMARY -----

N301 166 ADDRESS INFORMATION M AN 1/35
 Address information
 > Required
 > 21-05; 21-12
 > Other Employer Address
 N302 166 ADDRESS INFORMATION O AN 1/35
 Address information
 > Not Used

=====

SEGMENT: N4 Geographic Location
 >WEDI NME: OTHER EMPLOYER CITY, STATE, ZIP
 POSITION: 340
 LEVEL: Detail
 LOOP: 2330
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To specify the geographic place of the named party
 SYNTAX: 1. C0605--If N406 is present, then N405 is required.
 COMMENTS: A. A combination of either N401 through N404 (or N405 and
 N406) may be adequate to specify a location.
 B. N402 is required only if city name (N401) is in the USA or
 Canada.
 > NOTES: 1. This segment may be repeated four times for other
 > employers.
 > 2. * NOTE: This segment should only be created for the
 > "Primary Payer" SBR loop.
 > EXAMPLE: N4*Somewhere*TX*75122~

DATA ELEMENT SUMMARY -----

N401 19 CITY NAME O AN 2/30
 Free-form text for city name.
 > Other Employer City
 > 21-06; 21-13
 N402 156 STATE OR PROVINCE CODE O ID 2/2
 Code (Standard State/Province) as defined by appropriate
 government agency.
 > Other Employer State
 > 21-07; 21-14
 N403 116 POSTAL CODE O ID 3/11
 Code defining international postal zone code excluding
 punctuation and blanks (zip code for United States).
 > Other Employer ZIP
 > 21-08; 21-15
 N404 26 COUNTRY CODE O ID 2/3
 Code identifying the country.
 > Not Used
 N405 309 LOCATION QUALIFIER C ID 1/2
 Code identifying type of location.
 > Not Used
 N406 310 LOCATION IDENTIFIER O AN 1/30
 Code which identifies a specific location.
 > Not Used

=====

SEGMENT: REF Reference Numbers

>WEDI NME: EMPLOYMENT STATUS CODE
 POSITION: 355
 LEVEL: Detail
 LOOP: 2330
 USAGE: Optional
 MAX USE: 3
 PURPOSE: To specify identifying numbers.
 SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
 > NOTES: 1. This segment is required when reporting additional
 > insurance.
 > 2. * NOTE: This segment should only be created for the
 > "Primary Payer" SBR loop.
 > EXAMPLE: REF*ZZ*FT~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
 Code qualifying the Reference Number.
 ZZ Mutually Defined

REF02 127 REFERENCE NUMBER C AN 1/30
 Reference number or identification number as defined for a
 particular Transaction Set, or as specified by the Reference
 Number Qualifier.
 > FT Full Time
 > UB-92 CODE "1"
 > NE Not Employed
 > UB-92 CODE "3"
 > PT Part Time
 > UB-92 CODE "2"
 > RT Retired
 > UB-92 CODE "5"
 > SE Self-Employed
 > UB-92 CODE "4"
 > UK Unknown
 > UB-92 CODE "9"
 > AO Active Military - Oversees
 > AU Active Military - USA
 > 21-09 ; 21-16 (Not all codes map)

REF03 352 DESCRIPTION C AN 1/80
 A free-form description to clarify the related data elements
 and their content.
 > Not Used

=====

SEGMENT: LE Loop Trailer
 POSITION: 360
 LEVEL: Detail
 LOOP: 2300
 USAGE: Optional
 MAX USE: 1
 PURPOSE: To indicate that the loop immediately preceding this segment is
 complete

SEMANTIC: 1. One loop may be nested contained within another loop,
 provided the inner nested loop terminates before the other
 loop. When specified by the standards setting body as
 ``mandatory'', this segment in combination with ``LS'',
 must be used. It is not to be used if not specifically set
 forth for use. The loop identifier in the loop header and
 trailer must be identical. The value for the identifier is
 the loop ID of the required loop beginning segment. The
 loop ID number is given on the transaction set diagram in
 the appropriate ASC X12 version/release.

> NOTES: 1. This segment MUST be used once, and only once, if SBR at
 > position 290 is used, regardless of the number of
 > repetitions of loop 2500.

> EXAMPLE: LE*2320~

DATA ELEMENT SUMMARY -----

LE01 447 LOOP IDENTIFIER CODE M AN 1/4
The loop ID number given on the transaction set diagram is the
value for this data element in segments LS and LE
> Required
> Use 2320

=====

SEGMENT: LX Assigned Number
>WEDI NME: SERVICE LINE NUMBER
POSITION: 365
LEVEL: Detail
LOOP: 2400 Repeat: >1
> USAGE: Optional NOTE: Required
MAX USE: 1
PURPOSE: To reference a line number in a transaction set.
> NOTES: 1. The LX loop should be created for each service line.
> Within the LX loop all records pertaining to that service
> revenue code will be mapped. For IP Accommodations the
> mapping would be for record types
> 50, 51, and 52. For IP Ancillaries, the mapping would be
> for record types 60, 62, and 63. For Outpatient
> procedures the mapping would be for record types 61, 62,
> and 63.
> EXAMPLE: LX*1~

DATA ELEMENT SUMMARY -----

LX01 554 ASSIGNED NUMBER M NO 1/6
Number assigned for differentiation within a transaction set.
> Required
> Service line number, beginning with 1, incremented by 1 for
> each service line. The maximum number of service lines per
> claim is determined by the Intermediary receiving the claim.

=====

SEGMENT: SV2 Institutional Service
POSITION: 375
LEVEL: Detail
LOOP: 2400
> USAGE: Optional NOTE: Required
MAX USE: 1
PURPOSE: To specify the claim service detail for a Health Care
institution
SYNTAX: 1. P0405--If either SV204 or SV205 is present, then the other
is required.
SEMANTIC: 1. SV201 is revenue code.
2. SV203 is submitted charge amount.
3. SV207 is non-covered charge amount.
4. SV208 is detail service line indicator. A ``Y'' value
indicates a detail service line. An ``N'' value indicates
a summary service line.
> EXAMPLE: SV2*0305*HC:99211*70.5*UN*5~

DATA ELEMENT SUMMARY -----

SV201 234 PRODUCT/SERVICE ID M AN 1/40
Identifying number for a product or service.
> Revenue Center Code
> 50-04, 50-11, 50-12, 50-13, 60-04, 60-13, 60-14,
61-04, 61-14, 60-15
SV202 C003 COMPOSITE MEDICAL PROCEDURE IDENTIFIER C
To identify a medical procedure by its standardized codes and
applicable modifiers

> This composite element should only be created if record types
> 60 thru 63 are being mapped and contain a HCPCS code.

SV202-1 235 PRODUCT/SERVICE ID QUALIFIER M ID 2/2
Code identifying the type/source of the
descriptive number used in Product/Service ID
(234).

CJ Current Procedural Terminology (CPT)
Codes
Published by the AMA. It is a listing of
descriptive terms and identifying codes
for reporting medical services and
procedures performed by physicians. The
uniform language accurately designates
medical, surgical, and diagnostic
services, and thereby provides reliable
communications among physicians,
patients, and payers

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

SV202-2 234 PRODUCT/SERVICE ID M AN 1/40
Identifying number for a product or service.
HCPCS Procedure Code
60-05, 13, 14; 61-05, 14, 15

SV202-3 1339 PROCEDURE MODIFIER O AN 2/2
This identifies special circumstances related to
the performance of the service, as defined by
trading partners
Modifier 1
A code to identify special circumstances related
to the performance of the service. Enter the
first Procedure modifier, if applicable.
60-06, 13, 14; 61-06, 14, 15

SV202-4 1339 PROCEDURE MODIFIER O AN 2/2
This identifies special circumstances related to
the performance of the service, as defined by
trading partners
Modifier 2
A code to identify special circumstances related
to the performance of the service. Enter the
first Procedure modifier, if applicable.
60-07, 13, 14; 61-07, 14, 15

SV202-5 1339 PROCEDURE MODIFIER O AN 2/2
This identifies special circumstances related to
the performance of the service, as defined by
trading partners
Not Used

SV202-6 1339 PROCEDURE MODIFIER O AN 2/2
This identifies special circumstances related to
the performance of the service, as defined by
trading partners
Not Used

SV202-7 352 DESCRIPTION O AN 1/80
A free-form description to clarify the related
data elements and their content.
Not Used

SV203 782 MONETARY AMOUNT O R 1/15
Monetary amount.
Total Charges
Submitted charge amount. The charge related to the service.

> Submitted charge amount in dollars. Optionally may include
> cents. The decimal point is only required when sending cents.
> Leading and trailing zeros should not be used. Use "25"
> instead of "25.00" or "25.1" instead of "25.10"
> 50-07, 11, 12, 13; 60-09, 13, 14; 61-10, 14, 15
SV204 355 UNIT OR BASIS FOR MEASUREMENT CODE C ID 2/2
Code specifying the units in which a value is being expressed,
or manner in which a measurement has been taken
> For IP Accommodations, the units would represent days. For IP
> Ancillaries and Outpatient services, the units would represent
> units of service.
DA Days
UN Unit
SV205 380 QUANTITY C R 1/15
Numeric value of quantity.
> The number of services rendered in the units described in
> SV204.
> 50-06, 11, 12, 13; 60-08, 13, 14; 61-08, 14, 15
SV206 1371 UNIT RATE O R 1/10
The rate per unit of associate revenue for hospital
accommodation
> Accommodations Rate
> 50-05; 50-11; 50-12; 50-13
SV207 782 MONETARY AMOUNT O R 1/15
Monetary amount.
> Non-Covered Charges
> Actual charge amount in dollars. Optionally may include cents.
> The decimal point is ONLY required when sending cents. Leading
> and trailing zeroes should not be used. Use "25" instead of
> "25.00" or "25.1" instead of "25.10"
> 50-08, 11, 12, 13; 60-10, 13, 14; 61-11, 14, 15
SV208 1073 YES/NO CONDITION OR RESPONSE CODE O ID 1/1
Code indicating a Yes or No condition or response.
> Not Used
SV209 1345 NURSING HOME RESIDENTIAL STATUS CODE O ID 1/1
Code specifying the status of a nursing home resident at the
time of service
> Not Used
SV210 1337 LEVEL OF CARE CODE O ID 1/1
Code specifying the level of care provided by a nursing home
facility
> Not Used

=====
X12 Segment Name: **DTP Date or Time or Period**
Name: **Outpatient Service Date or Inpatient Health Insurance Prospective Payment System (HIPPS) Assessment Date**
Loop: 2400
POSITION: 455
Max. Use: 3
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Conditional (Required for Skilled Nursing Facility (SNF) claims. When the revenue code is 002X, the HIPPS assessment date will be placed in this segment.)**
Examples: DTP*472*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time.	

Code:

472 Service

DTP02 1250
ID 2 3 M

Date Time Period Format Qualifier
Code indicating the date format, time
format, or date and time format.
Codes:

**D8 Date expressed in format
CCYYMMDD**

DTP03 1251
AN 1 35 M

Date Time Period
Expression of a date or time

Outpatient
61-12, 61-14, 61-15
HIPPS
60-12 ,13,14

```

=====
SEGMENT: NM1 Individual or Organizational Name
>WEDI NME: PAYER NAME
POSITION: 500
  LEVEL: Detail
  LOOP: 2420 Repeat: 10
  USAGE: Optional
  MAX USE: 1
  PURPOSE: To supply the full name of an individual or organizational
           entity
  SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other
           is required.
  SEMANTIC: 1. NM102 qualifies NM103.
> EXAMPLE: NM1*PR*2*Medicare~

```

DATA ELEMENT SUMMARY -----

```

NM101 98 ENTITY IDENTIFIER CODE M ID 2/2
Code identifying an organizational entity, a physical location,
or an individual
PR Payer
NM102 1065 ENTITY TYPE QUALIFIER M ID 1/1
Code qualifying the type of entity.
2 Non-Person Entity
NM103 1035 NAME LAST OR ORGANIZATION NAME O AN 1/35
Individual last name or organizational name
> The payer name from the 30 record which corresponds to the
> payer sequence within the service line record.
> 30-08b
> Payer Name
NM104 1036 NAME FIRST O AN 1/25
Individual first name.
> Not Used
NM105 1037 NAME MIDDLE O AN 1/25
Individual middle name or initial.
> Not Used
NM106 1038 NAME PREFIX O AN 1/10
Prefix to individual name.
> Not Used
NM107 1039 NAME SUFFIX O AN 1/10
Suffix to individual name.
> Not Used
NM108 66 IDENTIFICATION CODE QUALIFIER C ID 1/2
Code designating the system/method of code structure used for
Identification Code (67).

```

> Not Used
NM109 67 IDENTIFICATION CODE C AN 2/20
Code identifying a party or other code.
> Not Used

=====

SEGMENT: REF Reference Numbers
>WEDI NME: REF ATTACHMENT CODES
POSITION: 525
LEVEL: Detail
LOOP: 2420
USAGE: Optional
MAX USE: 20
PURPOSE: To specify identifying numbers.
SYNTAX: 1. R0203--At least one of REF02 or REF03 is required.
> NOTES: 1. REF remarks codes assigned for each adjudicated service
> line-item as indicated by the payer. A REF segment should
> be created for each REF remarks code.
> EXAMPLE: REF*E9*A12~

DATA ELEMENT SUMMARY -----

REF01 128 REFERENCE NUMBER QUALIFIER M ID 2/3
Code qualifying the Reference Number.
E9 Attachment Code
REF02 127 REFERENCE NUMBER C AN 1/30
Reference number or identification number as defined for a
particular Transaction Set, or as specified by the Reference
Number Qualifier.
> Reference Code as assigned by the Payer
> 51-06; 51-07; 51-08; 51-09; 51-10; 51-11; 51-12; 51-13; 51-14;
> 51-15; 62-06; 62-07; 62-08; 62-09; 62-10; 62-11; 62-12; 62-13;
> 62-14; 62-15
REF03 352 DESCRIPTION C AN 1/80
A free-form description to clarify the related data elements
and their content.
> Not Used

=====

SEGMENT: SVD Service Line Adjudication
>WEDI NME: SERVICE LINE ADJUDICATION FROM THE 52 RECORD "INPATIENT
ACCOMMODATIONS REASON CODES".
POSITION: 540
LEVEL: Detail
LOOP: 2430 Repeat: >1
USAGE: Optional
MAX USE: 1
PURPOSE: To convey service line adjudication information for
coordination of benefits between the initial payers of a
health care claim and all subsequent payers
SEMANTIC: 1. SVD01 is the payer identification code.
2. SVD02 is the amount paid for this service line.
3. SVD04 is the revenue code.
4. SVD05 is the paid units of service.
COMMENTS: A. SVD03 represents the medical procedure code upon which
adjudication of this service line was based. This may be
different than the submitted medical procedure code.
B. SVD06 is only used for bundling of service lines. It
references the LX Assigned Number of the service line into
which this service line was bundled.
> EXAMPLE: SVD*NR002*50.5**0305~

DATA ELEMENT SUMMARY -----

SVD01 67 IDENTIFICATION CODE M AN 2/20
Code identifying a party or other code.
> This is the payer identification from the 30 record. Use the

> 30 record with the same sequence number as the payer sequence
> on the service line record.
> ie. record 30 sequence number pairs
> with the payer sequence on records 50, 51, 52, 60, 61, 62, and
> 63
> 30-5 & 30-6
SVD02 782 MONETARY AMOUNT M R 1/15
Monetary amount.
> Total Charges
> 50-07; 50-11; 50-12; 50-13
SVD03 C003 COMPOSITE MEDICAL PROCEDURE IDENTIFIER O
To identify a medical procedure by its standardized codes and
applicable modifiers
> Not Used
SVD04 234 PRODUCT/SERVICE ID O AN 1/40
Identifying number for a product or service.
> Revenue Code
> 52-05, 51-05, 62-05, 63-05
SVD05 380 QUANTITY O R 1/15
Numeric value of quantity.
> Not Used
SVD06 554 ASSIGNED NUMBER O NO 1/6
Number assigned for differentiation within a transaction set.
> Not Used

=====

SEGMENT: CAS Claims Adjustment
>WEDI NME: SERVICE LINE ADJUSTMENT REASON CODES
POSITION: 545
LEVEL: Detail
LOOP: 2430
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: 1. L050607--If CAS05 is present, then at least one of CAS06 or
CAS07 are required.
2. C0605--If CAS06 is present, then CAS05 is required.
3. C0705--If CAS07 is present, then CAS05 is required.
4. L080910--If CAS08 is present, then at least one of CAS09 or
CAS10 are required.
5. C0908--If CAS09 is present, then CAS08 is required.
6. C1008--If CAS10 is present, then CAS08 is required.
7. L111213--If CAS11 is present, then at least one of CAS12 or
CAS13 are required.
8. C1211--If CAS12 is present, then CAS11 is required.
9. C1311--If CAS13 is present, then CAS11 is required.
10. L141516--If CAS14 is present, then at least one of CAS15 or
CAS16 are required.
11. C1514--If CAS15 is present, then CAS14 is required.
12. C1614--If CAS16 is present, then CAS14 is required.
13. L171819--If CAS17 is present, then at least one of CAS18 or
CAS19 are required.
14. C1817--If CAS18 is present, then CAS17 is required.
15. C1917--If CAS19 is present, then CAS17 is required.

SEMANTIC: 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: A. 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.
 B. When the submitted charges are paid in full, the value for CAS03 should be zero.

> NOTES: 1. Line level reason codes as assigned by the payer's system.
 > EXAMPLE: CAS*CO*A1*25~

DATA ELEMENT SUMMARY -----

CAS01	1033	CLAIM ADJUSTMENT GROUP CODE	M ID 1/2
		Code identifying the general category of payment adjustment.	
>		52-06	
		CO Contractual Obligations	
		CR Correction and Reversals	
		OA Other adjustments	
		PR Patient Responsibility	
CAS02	1034	CLAIM ADJUSTMENT REASON CODE	M ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		52-07	
CAS03	782	MONETARY AMOUNT	M R 1/15
		Monetary amount.	
>		52-08	
>		Charges applied to preceding reason code.	
CAS04	380	QUANTITY	O R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		52-09	
CAS05	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		52-10	
CAS06	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		52-11	
CAS07	380	QUANTITY	C R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		52-12	
CAS08	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		52-13	
CAS09	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		52-14	
CAS10	380	QUANTITY	C R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		52-15	
CAS11	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		52-16	
CAS12	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		52-17	
CAS13	380	QUANTITY	C R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		52-18	
CAS14	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5

Code identifying the detailed reason the adjustment was made.

> 52-19

CAS15 782 MONETARY AMOUNT C R 1/15
 Monetary amount.

> Charges applied to preceeding reason code.

> 52-20

CAS16 380 QUANTITY C R 1/15
 Numeric value of quantity.

> Quantity applied to preceeding reason code.

> 52-21

CAS17 1034 CLAIM ADJUSTMENT REASON CODE C ID 1/5
 Code identifying the detailed reason the adjustment was made.

> 52-22

CAS18 782 MONETARY AMOUNT C R 1/15
 Monetary amount.

> Charges applied to preceeding reason code.

> 52-23

CAS19 380 QUANTITY C R 1/15
 Numeric value of quantity.

> Quantity applied to preceeding reason code.

> 52-24

=====

SEGMENT: SVD Service Line Adjudication

>WEDI NME: SERVICE LINE ADJUDICATION FROM RECORD 62 "ANCILLARY OR OP REASON CODES".

POSITION: 540

LEVEL: Detail

LOOP: 2430 Repeat: >1

USAGE: Optional

MAX USE: 1

PURPOSE: To convey service line adjudication information for coordination of benefits between the initial payers of a health care claim and all subsequent payers

SEMANTIC: 1. SVD01 is the payer identification code.
 2. SVD02 is the amount paid for this service line.
 3. SVD04 is the revenue code.
 4. SVD05 is the paid units of service.

COMMENTS: A. SVD03 represents the medical procedure code upon which adjudication of this service line was based. This may be different than the submitted medical procedure code.
 B. SVD06 is only used for bundling of service lines. It references the LX Assigned Number of the service line into which this service line was bundled.

> EXAMPLE: SVD*NR002*50.5**0305~

DATA ELEMENT SUMMARY -----

SVD01 67 IDENTIFICATION CODE M AN 2/20
 Code identifying a party or other code.

> This is the payer identification from the 30 record. Use the

> 30 record with the same sequence number as the payer sequence

> on the service line record.

> ie. record 30 sequence number pairs

> with the payer sequence on records 50, 51, 52, 60, 61, 62, and

> 63

> 30-5 & 30-6

SVD02 782 MONETARY AMOUNT M R 1/15
 Monetary amount.

> 61-10, 14, 15

> Total Charges

SVD03 C003 COMPOSITE MEDICAL PROCEDURE IDENTIFIER 0

To identify a medical procedure by its standardized codes and applicable modifiers

> Not Used

SVD04 234 PRODUCT/SERVICE ID O AN 1/40
 Identifying number for a product or service.

> Revenue Code
 > 63-05

SVD05 380 QUANTITY O R 1/15
 Numeric value of quantity.

> Not Used

SVD06 554 ASSIGNED NUMBER O NO 1/6
 Number assigned for differentiation within a transaction set.

> Not Used

=====

SEGMENT: CAS Claims Adjustment

>WEDI NME: IP ANCILLARY OR OUTPATIENT PROCEDURE - SERVICE LINE
 ADJUSTMENTS

POSITION: 545

LEVEL: Detail

LOOP: 2430

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: 1. L050607--If CAS05 is present, then at least one of CAS06 or CAS07 are required.
 2. C0605--If CAS06 is present, then CAS05 is required.
 3. C0705--If CAS07 is present, then CAS05 is required.
 4. L080910--If CAS08 is present, then at least one of CAS09 or CAS10 are required.
 5. C0908--If CAS09 is present, then CAS08 is required.
 6. C1008--If CAS10 is present, then CAS08 is required.
 7. L111213--If CAS11 is present, then at least one of CAS12 or CAS13 are required.
 8. C1211--If CAS12 is present, then CAS11 is required.
 9. C1311--If CAS13 is present, then CAS11 is required.
 10. L141516--If CAS14 is present, then at least one of CAS15 or CAS16 are required.
 11. C1514--If CAS15 is present, then CAS14 is required.
 12. C1614--If CAS16 is present, then CAS14 is required.
 13. L171819--If CAS17 is present, then at least one of CAS18 or CAS19 are required.
 14. C1817--If CAS18 is present, then CAS17 is required.
 15. C1917--If CAS19 is present, then CAS17 is required.

SEMANTIC: 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: A. 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.

B. When the submitted charges are paid in full, the value for CAS03 should be zero.

> NOTES: 1. Adjustment reason coding information as assigned by the
 > payer's system for a service or procedure. This
 > information applies to the preceding revenue code.

> EXAMPLE: CAS*CO*A1*25~

DATA ELEMENT SUMMARY -----

CAS01	1033	CLAIM ADJUSTMENT GROUP CODE	M ID 1/2
		Code identifying the general category of payment adjustment.	
>		63-06	
		CO Contractual Obligations	
		CR Correction and Reversals	
		OA Other adjustments	
		PR Patient Responsibility	
CAS02	1034	CLAIM ADJUSTMENT REASON CODE	M ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		63-07	
CAS03	782	MONETARY AMOUNT	M R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		63-08	
CAS04	380	QUANTITY	O R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		63-09	
CAS05	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		63-10	
CAS06	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		63-11	
CAS07	380	QUANTITY	C R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		63-12	
CAS08	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		63-13	
CAS09	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		63-14	
CAS10	380	QUANTITY	C R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		63-15	
CAS11	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		63-16	
CAS12	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	
>		Charges applied to preceding reason code.	
>		63-17	
CAS13	380	QUANTITY	C R 1/15
		Numeric value of quantity.	
>		Quantity applied to preceding reason code.	
>		63-18	
CAS14	1034	CLAIM ADJUSTMENT REASON CODE	C ID 1/5
		Code identifying the detailed reason the adjustment was made.	
>		63-19	
CAS15	782	MONETARY AMOUNT	C R 1/15
		Monetary amount.	

> Charges applied to preceeding reason code.
> 63-20
CAS16 380 QUANTITY C R 1/15
Numeric value of quantity.
> Quantity applied to preceeding reason code.
> 63-21
CAS17 1034 CLAIM ADJUSTMENT REASON CODE C ID 1/5
Code identifying the detailed reason the adjustment was made.
> 63-22
CAS18 782 MONETARY AMOUNT C R 1/15
Monetary amount.
> Charges applied to preceeding reason code.
> 63-23
CAS19 380 QUANTITY C R 1/15
Numeric value of quantity.
> Quantity applied to preceeding reason code.
> 63-24

=====

SEGMENT: SE Transaction Set Trailer
POSITION: 555
LEVEL: Detail
LOOP: _____
USAGE: Mandatory
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).
COMMENTS: A. SE is the last segment of each transaction set.
> EXAMPLE: SE*1230*112233~

DATA ELEMENT SUMMARY -----

SE01 96 NUMBER OF INCLUDED SEGMENTS M NO 1/10
Total number of segments included in a transaction set
including ST and SE segments.
SE02 329 TRANSACTION SET CONTROL NUMBER M AN 4/9
Identifying control number that must be unique within the
transaction set functional group assigned by the originator for
a transaction set

=====

X12 Segment Name: GE Functional Group Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of a functional group and to provide
control information
Usage: Mandatory
Example: GE*1*1~

Semantic Note: The data interchange control number GE02 in this trailer must be identical to the same data
element in the associated Functional Header GS06.

X12 Comment: The use of identical data interchange control numbers in
the associated functional group header and trailer is
designed to maximize functional group integrity. The
control number is the same as that used in the
corresponding header.

-----+-----+-----

Element
Attributes Data Element Usage

-----+-----+-----

GE01 0097 Number of Transaction Sets Included
 NO 1 6 M Total number of transaction sets
 included in the functional group or
 interchange (transmission) group
 terminated by the trailer containing
 this data element.

GE02 0028 Group Control Number
 NO 1 9 M Assigned number originated and
 maintained by the sender.
 The Group Control Number, GE02, must be
 identical to the one found in the
 associated functional header GS06.

=====

X12 Segment Name: IEA Interchange Control Trailer
 Loop: ----
 Max. Use: 1
 X12 Purpose: To define the end of an interchange of zero or more
 functional groups and interchange-related control segments
 Usage: Mandatory
 Example: IEA*1*000000905~

-----+-----+-----

Element Attributes	Data Element Usage
IEA01 I16 NO 1 5 M	Number of Included Functional Groups A count of the number of functional groups included in an interchange
IEA02 I12 NO 9 9 M	Interchange Control Number A control number assigned by the interchange sender The Interchange Control Number, IEA02, must be identical to the one found in the associated Interchange Header ISA13.

=====

COB "MEDA" DATA DICTIONARY
DATA ELEMENT

APPENDIX A

DESCRIPTION

Accommodation Days	A numeric count of accommodation days in accordance with the payer instructions. Includes UB-92 revenue codes 10X through 21X.
Accommodation Non-Covered Charges	Accommodation charges pertaining to the related UB-92 accommodation revenue code that are not covered by the primary payer as determined by the provider.
Accommodation Rate	Per diem rate for related UB-92 accommodation revenue codes.

Accommodation Revenue Code	UB-92 revenue code center for the accommodation provided. Includes codes 10X through 21X.
Accommodation Total Charges	Total charges for the related revenue code.
Activities Permitted	Codes describing the activities permitted by the physician or for which physician's orders are present. A minimum of one of the following values must be present for abbreviated POC. 1 = Complete Bedrest 2 = Bedrest BRP 3 = Up as Tolerated 4 = Transfer Bed/Chair 5 = Exercises Prescribed 6 = Partial Weight Bearing 7 = Independent at Home 8 = Crutches 9 = Cane A = Wheelchair B = Walker C = No Restrictions D = Other
Adjustment Amount	The adjustment amount for the associated reason code.
Adjustment Quantity	The numeric quantity associated with the related reason code.
Admission Date/Start of Care Date	The date the patient was admitted to the provider for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits. format: CCYYMMDD
Admission Hour	The hour during which the patient was admitted for inpatient care. ** military time is used
Admitting Diagnosis	The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Air Ambulance Justification	A code indicating the justification for the usage of an air ambulance instead of a conventional ambulance.
Allowed Charges Medicare Paid at 100%	The total of charges that Medicare paid at 100%.
Allowed Charges that Medicare Paid at 80%	The total of charges that Medicare only paid at 80%
Ancillary Charges Other	*not mapped at this time.
Application Version	Application version code for Medicare Intermediary applications system used to produce the file.
Assessment Date	HIPPS Assessment Date
Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y = Benefits assigned C = Benefits not assigned
Attending Physician Name	Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
Attending Physician Number	Number assigned to identify attending the physician. For Medicare this must be the UPIN.
Authorization From Date	Beginning date of a period being authorized for a stay extension, admission, or performance of a procedure.
Authorization HCPCS Number (PROCEDURE)	A reference that indicates the HCPCS being authorized by the PRO or payer.

Authorization Number	A number or other code issued to the provider by the payer or the PRO granting permission to the provider for a procedure, admission, or extension of stay.
Authorization Revenue Code	A reference that indicates the revenue code being authorized by the PRO or payer.
Authorization Thru Date	Ending date of a period being authorized a stay extension, admission, or performance of a procedure.
Authorization Type	A code that specifies the type of authorization contained in the particular iteration of the authorization for this payer.
Authorization	Any of 3 iterations of the authorization data used to provide detailed information regarding an authorization by a PRO or a payer.
Base Charge	*not mapped at this time
Batch Number	Number assigned to each new batch of claims as the file is created.
Billing Cycle Date	Date of submitter's billing cycle which created the file. Effective date of payment. Format: CCYYMMDD
Cert/Recert/Mod	One of the following applicable codes: C = Certification R = Recertification M = Modified
Certificate/Social Security Number/Health Insurance Claim Identification Number	Insured's unique identification number assigned by the payer organization. For Medicare purposes, this is the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Hospital Transfer Form, or as reported by the Social Security Office.

Certification Period	From and through dates of period to be covered by this plan of treatment. Format: CCYYMMDD
CHAMPUS Insurer Provider Number	The number assigned to the provider by CHAMPUS.
Claim Paid Date	Date the current payer paid the claim. Format: CCYYMMDD
Claim Status	A code specifying the status of a claim submitted by the provider to the payer for processing. 1 = Processed as Primary 2 = Processed as Secondary 3 = Processed as Tertiary 4 = Denied 5 = Pended 10 = Received, but not in process 19 = Processed as Primary and Crossed Over 20 = Processed as Secondary and Crossed Over 21 = Processed as Tertiary and Crossed Over 22 = Reversal of Previous Payment 23 = Not our Claim and Crossed Over 27 = Reviewed
COB Identification	Identifies file as a COB file for Medicare A claims. Value = 'COBA'
Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.
Condition Codes	Code(s) used to identify condition(s) relating to this bill that may affect payer processing. See addendum C of the UB-92 instructions for valid values.
Contract Number	Number identifying a contracted organization participating in the Medicare Choices Program.

Corresponding Data	Narrative data from the plan of treatment
Cost Per Mile Ancillary Charges	*not mapped at this time.
Cost Report Days	The number of days claimable as Medicare patient days on a cost report.
Country Code	Four position code indicating the geographic location of the submitter or provider.
Covered Charges	Amount covered by the payer for the associated service line.
Covered Days	The number of days covered by the primary payor, as qualified by the payor organization.
Current DCN/ICN	The payer's control number assigned to this claim. This is generated by the current payer.
Current Lab Value	*not mapped at this time
Data ID	Identifies submittal of HCFA-485 and HCFA-486 data or HCFA-486 data only. Required for abbreviated POC. 1 = HCFA-485 & HCFA-486 2 = HCFA-486 only
Data ID Number	Number corresponding to the data element narrative on plan of treatment.
Data Indicator	*not mapped at this time
Date (Agency) Last Contacted The Physician	Date of agency's most recent physician contact. Format: CCYYMMDD
Date Current Lab	*not mapped at this time
Date Current Test/SVC	*not mapped at this time
Date of Extra Session	*not mapped at this time
Date Physician Last Saw the Patient	Date (if known) that the patient was last seen by the physician. Format: CCYYMMDD
Date of Onset/Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the principal diagnosis. Format: CCYYMMDD

Date of Surgical Procedure	The date the surgery was performed. Format: CCYYMMDD
Dates of Onset/Exacerbation	The date of onset or exacerbation of the secondary diagnosis. The related dates are entered in the same order as the secondary diagnosis codes. Format: CCYYMMDD
Date of Previous Lab	*not mapped at this time
Date of Previous Test/SVC	*not mapped at this time
Denied Charges	Amount that the payer denied for the related service line.
Destination Address	Address to which the ambulance delivered the patient and the facility name. This field is broken into name, street address, city, state, and zip code.
Discharge Date	Date that the patient was discharged from inpatient care. Format: CCYYMMDD
Discharge Hour	Hour in which the patient was discharged from inpatient care. ** military time is used
Discipline	Code indicating discipline(s) ordered by the physician: SN = Skilled Nursing PT = Physical Therapy ST = Speech Therapy OT = Occupational Therapy MS = Medical Social Worker AI = Home Health Aide
DRG Amount Applied via Pricer	Dollar amount for DRG as calculated by Pricer.
DRG Assigned via Grouper	Diagnosis related group for this claim.
DRG Outlier Amount	Total PPS Outlier and Capital Outlier amounts for this claim.

Employer Location	The specific location for the employer of the individual covered by this insurance payer. This field is broken into address, city, state, and zip code fields.
Employer Name	Name of employer that may provide health care coverage for the individual covered by this insurance payer.
Employer Qualifier	*use UB-92 Relationship codes
Employment Status Code	A code used to define the employment status of the individual covered by this insurance payer.
Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer.
External Cause of Injury (E-Code)	The ICD-9-Cm code which describes the external cause of the injury, poisoning, or adverse effect. Use of this data element is voluntary in states where E-coding is not required.
Federal Tax Number (EIN)	The number assigned to the provider by the Federal government for tax reports purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
Federal Tax ID	Four position modifier to the Federal Tax number listed above.
File Sequence & Serial Number	Sequence and/or Serial number assigned to the file by the submitter. This will facilitate investigating problems if each file is assigned a unique number.
Form Locator	These are the item numbers on the UB-92 hardcopy forms. These fields vary in size.

<p>Frequency and Duration</p>	<p>Six position code indicating the frequency and duration of visits during the period covered by the plan of care. Position 1 is the number of visits. Positions 2-3 are an alpha expression of the period of time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. *A minimum of one group must be present for abbreviated POC.</p> <p style="padding-left: 40px;">position 1 codes = 1-9 position 2-3 codes = DA for day WK for week MO for month Qn for every n days* position 4-6 = duration in days 001-999</p> <p>*n would = the value that is in positions 4-6</p> <p>EXAMPLE: 1 daily visit for 10 days = 1DA010 2 visits every 9 days for 3 months = 2 Q090</p>
<p>Frequency of Administration</p>	<p>*not mapped at this time</p>

Functional Limitation Code	<p>Codes describing the patient's functional limitations as assessed by the physician. A minimum of one functional limitation code must be present on an abbreviated POC.</p> <ul style="list-style-type: none"> 1 = Amputation 2 = Bowel/Bladder (Incontinence) 3 = Contracture 4 = Hearing 5 = Paralysis 6 = Endurance 7 = Ambulation 8 = Speech 9 = Legally Blind A = Dyspnea with Minimal Exertion B = Other
Group Code	<p>This code is used to establish financial liability for the adjustment amount returned. Only one group code can be applied to a reason code and adjustment amount.</p>
HCPCS/Procedure Code	<p>A procedure code reported in record types identifying services so that appropriate payment can be made. HCFA Common Procedural Coding System (HCPCS) code is required for many specific types of outpatient services and a few inpatient services. May include up to two modifiers. (If necessary, refer to CPT-4 Manual for complete code list).</p>
HICN	<p>Health Insurance Claim Identification Number</p>
Injectable Drugs	<p>*not mapped at this time</p>
Inpatient Ancillary Non-Covered Charges	<p>Charges pertaining to the related UB-92 inpatient ancillary revenue center code that the primary payer will not cover.</p>

Inpatient Ancillary Revenue Code	UB-92 revenue center code for the inpatient ancillary services provided. Includes codes 22X through 99X.
Inpatient Ancillary Total Charges	Total charges pertaining to the related UB-92 inpatient ancillary revenue code.
Inpatient Ancillary Units of Service	A quantitative measure of services rendered by inpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, etc.
Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator which identifies the group under which the individual is covered.
Insured Address	Insured's current mailing address. This field is broken into Address Line 1, Address Line 2, City, State, and Zip Code.
Insured Group Name	Name of the group or plan that provides insurance to the insured.
Insured's Name	Name of the individual in whose name the insurance is carried. This field is broken into Last Name, First Name, and Middle Initial.
Insured's Sex	A code indicating the sex of the insured. M = Male F = Female
Intermediary Number	The Medicare payer identification number. This number indicates the payer who created the file.
IV Solutions	* not mapped at this time
Justification for Extra Session	* not mapped at this time
Lifetime Psychiatric Days	The number of lifetime psychiatric days used for this claim.

Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.
Medicaid Provider Number	The number assigned to the provider by Medicaid.
Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records.
Medical Surgical Supplies	* Not mapped at this time
Medicare Covered	The following are applicable codes: Y = Covered N = Noncovered
Medicare Provider Number	The number assigned to the provider by Medicare.
Mental Status Code	Codes describing the patient's mental condition. A minimum of one code must be present on an abbreviated POC. 1 = Oriented 2 = Comatose 3 = Forgetful 4 = Depressed 5 = Disoriented 6 = Lethargic 7 = Agitated 8 = Other
MIA/MOA Remarks Codes	These codes are used to return claim-specific information to a provider. They may be used to detail the adjustment codes returned for claim. Standard reason codes list for MIA/MOA remarks must be used.
Modifier	Two position codes serving as modifier to HCPCS procedure code.
Multiple Provider Billing File Indicator	*not mapped at this time

Non-Covered Accommodation Charges-Revenue Centers	Sum of accommodation charges not covered by the primary payer for this bill.
Non-Covered Ancillary Charges-Revenue Centers	Sum of ancillary charges not covered by the primary payer for this claim.
Non-Covered Days	Days of care not covered by the primary payer.
Number of Claims this File	Total number of claims on this file, same as total number of record type 20 records.
Number of Trips	Number of trips needed by ambulance for this claim.
Number of Records this File	Total number of records 01 thru 99 on this file.
Number of Miles	Total number of miles driven by ambulance.
Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. (See Addendum C of UB-92 Instructions manual). Occurrence code and date can repeat for a total of 10 iterations.
Occurrence Date	Date associated with the Occurrence Code in the preceding field. (See addendum C of the UB-92 instructions manual.) The occurrence code and date can repeat for a total of 10 iterations. Format: CCYYMMDD
Occurrence Span Code	A code that identifies an event that relates to the payment of the claim. (See addendum C of UB-92 instructions manual). The occurrence span code and date can repeat for a total of 2 iterations.

Occurrence Span Date	The dates related to the occurrence span code shown in the preceding field. The from and thru date are both shown. Format: CCYYMMDD - CCYYMMDD
Operating Physician Name	Name used by the provider to identify the operating physician in the provider records.
Operating Physician Number	Number used by the provider to identify the operating physician in the provider records. For Medicare, this must be the UPIN and it must be left justified in the field.
Other Diagnosis Codes	The ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or length of stay.
Other Insurer Provider Number	The number assigned to the provider by an insurer other than Medicare, Medicaid, or CHAMPUS.
Other Physician ID Name/Number	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization. For Medicare, the number must be UPIN and left justified.
Other Procedure Code	The code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.
Other Procedure Date	Date associated with the preceding procedure code. Format: CCYYMMDD
Outpatient Date of Service	The date that the associated service (indicated by the outpatient UB-92 revenue code center) was delivered.

Outpatient Non-covered Charges	Charges pertaining to the related outpatient UB-92 revenue code center that the primary payer will not cover.
Outpatient Revenue Center	UB-92 revenue center code for outpatient ancillary services provided.
Outpatient Total Charges	Total charges for the related outpatient revenue code center.
Outpatient Units of Service	A quantitative measure of services rendered by outpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, etc.
Oxygen/Oxygen Supplies	*not mapped at this time
Paid From Part A Medicare Trust Fund	Dollar amount paid for claim from the Part A Medicare Trust fund.
Paid From Part B Medicare Trust Fund	Dollar amount paid for claim from the Part B Medicare Trust fund.
Patient Address	The address of the patient as qualified by the payer organization. This field is broken into Address Line 1, Address Line 2, City, State, and Zip Code.
Patient Birthdate	The date of birth of the patient. This field includes the 4 position year. Format: CCYYMMDDYY
Patient Control Number	Patient's unique alpha-numeric identification number as assigned by the provider to facilitate retrieval of individual case records and posting payments. This field is used to link all claim record pertaining to a single claim.

Patient Marital Status	<p>The marital status of the patient at the date of admission, outpatient service, or start of care.</p> <p>S = Single M = Married X = Legally Separated D = Divorced W = Widowed U = Unknown</p>
Patient Name	<p>Last name, First name, and middle initial of the patient.</p>
Patient Receiving Care in 1861 (j) (1) Facility	<p>Y = YES N = NO D = Do not know</p>
Patient's Relationship to Insured	<p>Code indicating the patient's relationship to the identified insured.</p> <p>01 = Patient is Insured 02 = Spouse 03 = Natural Child/Insured Financially responsible 04 = Natural Child/Insured not Financially responsible 05 = Step Child 06 = Foster Child 07 = Ward of Court 08 = Employee 09 = Unknown 10 = Handicapped Dependent 11 = Organ Donor 12 = Cadaver Donor 13 = Grandchild 14 = Niece/Nephew 15 = Injured Plaintiff 16 = Sponsored Dependent 17 = Minor Dependent of a Minor Dependent 18 = Parent 19 = Grandparent 20-99 Reserved for National Assignment</p>

Patient Sex	The sex of the patient as recorded at the date of admission, outpatient service, or start of care. M = Male F = Female U = Unknown
Patient Status	A code indicating the patient's status as at the date of admission, outpatient service, or start of care. *See UB-92 manual for valid values
Payer Identification	Number identifying the payer A organization from which the provider might expect some payment for the bill.
Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.
Payer Sub-Identification	The identification of the specific office within the insurance carrier designated as responsible for this claim.
Payments Received	Amount patient has paid to the provider towards the bill.
Physical Record Count	The total number of physical records submitted for this bill, including all record types 20 through 8n, excludes records 9n.
Physician's Name	Last name, first name, and middle initial of attending physician. This is the physician ordering or administering the plan of treatment.
Physician Number Qualifying Code	The type of physician number being submitted. U = UPIN FI = Federal Taxpayer ID Number SL = State License ID Number SP = Specialty License Number

Physician's Zip code	Zip code of attending physician's address. This is the physician ordering or administering the plan of treatment.
Pickup Address	Address where patient was picked up by the ambulance. This field is broken into street address, city, state, and zip code.
Pickup Destination Code	*not mapped at this time
Previous Lab	*not mapped at this time
Place of Administration	*not mapped at this time
Primary Payer Code	Identifies reason that another payer is primary to Medicare. Z = Medicare A = Working Aged/EGHP B = ESRD/GHP C = Conditional D = Auto No-Fault/Liability E = Worker's Compensation F = PHS/Other Federal Agency G = Disabled/LGHP H = Black Lung Disease 1 = Medicaid 2 = Blue Cross 3 = Other Insurance
Principal Diagnosis Code	The ICD-9-CM diagnosis code describing the principal diagnosis (i.e. the condition established after study to be chiefly responsible for causing this hospitalization).
Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill.
Principal Procedure Date	The date on which the principal procedure described on the bill was performed. Format: CCYYMMDD

Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill. 1-2 = Reserved for State Assignment 3 = CPT-3 (Worker's Comp & No-Fault) 4 = CPT-4 5 = HCPCS (HCFA Common Procedure Coding) 6-8 = Reserved for National Assignment 9 = ICD-9-CM
Processing Date ("Date File was Created")	The date the submitter prepared the file. Format = CCYYMMDD
Process Date This File Covers	The from and thru dates from the remittance advice.
Production/Test Identifier	A code indicating whether the file is a 'PROD' or a 'TEST' file.
Prognosis	Code indicating physician's prognosis for the patient. 1 = Poor 2 = Guarded 3 = Fair 4 = Good 5 = Excellent
Provider Address	Complete mailing address to which the provider wishes payment sent. This field is broken into street address or box number, city, State, Zip code, and country.
Provider Chain Name & Address Information	Name and address assigned to the provider chain id.
Provider Chain ID, Tax, or EIN# and SUB-ID	Provider ID assigned by the intermediary and used as a network address. use anytime there are multiple provider numbers for a single electronic address and the data receiver requests one transmission for multiple numbers in place of one transmission for each number.
Provider Fax Number	Fax number for the provider.

Provider Identification Number	Six digit identification number as assigned by Medicare.
Provider Name	Name of provider responsible for the batch of claims.
Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.
Reason Code	Reason codes are for comments, changes, or denials reported for a claim. Only use codes from the Standard ASC reason code list.
Reason for Ambulance Transportation	Codes indicating the reason that ambulance transportation was necessary.
Reason for Bypassing the nearest Facility	A code indicating the nearest, facility was bypassed in order to deliver the patient to another facility.
Reason for Transfer	A code indicating why the patient needed to be transferred from one facility to another by ambulance.
Receiver Identification (NAIC)	Number identifying the organization designated to receive the file.
Receiver Sub-Identification	The identification of the specific location within the receiver organization designated to receive the file.

Receiver Type Code	<p>A code indicating the class of organization designated to received the file.</p> <p>A = Self pay B = Workers Compensation C = Medicare D = Medicaid E = Other Federal Program F = Insurance Company G = Blue Cross H = CHAMPUS I = Other local-coding table applies Z = Multiple principal sources of payment</p>
REF Code	<p>A code used to return service-specific information to the provider. This code is used to clarify reason codes.</p>
Reimbursement Rate	<p>Rate used when payment is based upon a percentage of applicable charges.</p>
Release of Information Certification Indicator	<p>A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim.</p> <p>Y = YES N = NO R = Restricted or Modified Release</p>
Remarks	<p>Notations relating to specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Also used for overflow data for any element for which there is not enough space.</p>
Remarks Codes	<p>Codes from the remittance advice generated for this claim.</p>
Revenue Code	<p>*See Inpatient revenue center or Outpatient revenue centers depending upon the bill type.</p>

Route of Administration	*not mapped at this time
SOC Date "start of care date"	Date covered home health service began. This date is required for abbreviated POC. Format: CCYYMMDD
Sequence Number	Sequential number from 01 to 99 assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 21-2n do not have a sequence number greater than 01. records 01, 10, 92, 91, 95, and 99 do not have sequence numbers. the sequence number for record type 30, 31, 34, and 80 are used for matching criteria to determine which type 30, type 31, type 34, and/or type 80 records are associated, like sequence numbers indicating the records are associated.
Source of Admission	A code indicating the source of this admission. * See UB-92 instructions manual for valid values.
Source of Payment Code	A code indicating source of payment associated with this payer record. A = Self Pay B = Workers compensation C = Medicare D = Medicaid E = Other Federal Program F = Insurance Company G = Blue Cross H = CHAMPUS I = Other to be designated by the Universal Data Set Specifications Task Force
State Code	Code that indicates state coding structure to which the form locators apply.

Statement Covers Period	The beginning and ending service dates of the period covering the bill. Format: CCYYMMDD & CCYYMMDD
Submitter Address	Mailing address of the submitter of this file. This field is broken into street address, city, state, and zip code.
Submitter EIN	This is the Medicare Contractor ID number of the submitter of this file. ** See Federal Tax Number
Submitter Fax Number	FAX number for the submitter of the file.
Submitter Name	Name of provider, third party billing service, or other organization to which the receiver/processor must direct inquiries regarding this file or transmittal.
Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim developments.
Surgical Procedure Code	The ICD-9-CM code describing the surgical procedure (if any) most relevant to the care being rendered.
Test/Production Indicator	Code to determine whether data enclosed by an interchange envelope is test or production.
Total Accommodations Charges Revenue Centers	Total accommodation charges for this bill.
Total Amount Medicare Paid Beneficiary	The total amount that Medicare paid to the beneficiary for this claim.
Total Amount Medicare Paid Provider	The total amount that Medicare paid to the provider for this claim.
Total Ancillary Charges-Revenue Centers	Total ancillary charges for this bill.

Total Charge Allowed	The maximum amount determined by the payer as being "allowed" under the provisions of the contract. This should be the total amount allowed for the claim.
Total Charges for this File	This is the sum of Accommodations Total charges and Ancillary Totals Charges for this file (record 99 fields 6 & 8 respectively).
Total Denied Charges	Total amount of charges that were denied for this claim.
Total Medicare Days Utilized	Equal to covered days.
Total Medicare Reimbursement	Total amount Medicare paid for this claim: this should be the sum of amount Medicare paid to the provider and the amount Medicare paid to the beneficiary.
Total Non-covered Charges	Total charges not covered for this claim. This should be the sum of all non-covered ancillary and non-covered accommodation charges.
Total Noncovered Charges for this File	This is the sum of Accommodation Non-covered charges and Ancillary Non-covered charges for this file (record 99 fields 6 & 8 respectively).
Total Submitted Charges	Total charges submitted for this claim. This should be the sum of all ancillary charges and accommodation charges.
Total Visits Projected This Cert.	Total covered visits to be rendered by each discipline during the period covered by the plan of treatment. Includes PRN visits. Required for abbreviated POC.

<p>Treatment Authorization</p>	<p>A number or other indicator that designates that the treatment covered by this bill has been authorized by the PRO or by the payer. Three iterations, one each for payer A, payer b, and/or payer C.</p>
<p>Treatment Codes</p>	<p>Codes describing the treatment ordered by the physician. Show in ascending order. One or more codes must be present for each discipline (e.g. SN, Pt, etc.) Required for abbreviated POC.</p> <p>A01-A30 = Skilled Nursing B01-B15 = Physical Therapy C01-C09 = Speech Therapy D01-D11 = Occupational Therapy E01-E06 = Medical School Services F01-F15 = Home Health Aide</p>
<p>Type of Facility</p>	<p>Code indicating type of facility from which the patient was most recently discharged.</p> <p>A = Acute S = SNF I = ICF R = Rehabilitation Facility O = Other</p>
<p>Type of Admission</p>	<p>A code indicating the priority of this admission.</p> <p>1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn (not used for Medicare) 5-8 = Reserved for National Assignment 9 = Information not available</p>
<p>Type of Batch</p>	<p>A code indicating the types of bills that occur in this batch. For COB, claims are batched by the first two positions of Type Of Bill if batching is used.</p>

Type of Bill	A code indicating the specific type of bill (hospital inpatient, SNF outpatient, adjustments, voids, etc.) *See UB-92 instructions manual.
Units of Service	Units associated with the outpatient revenue center.
Value Amount	Amount of money related to the associated value code. ** See UB-92 instructions manual for valid value codes.
Value Code	A code that identifies data of monetary nature that is necessary for processing this claim as require by the payer organization. ** See the UB-92 instructions manual for valid value codes.
Verbal SOC (Start of Care) Date	The date the agency received the verbal orders from the physician, if this is prior to the date care started. FORMAT: CCYYMMDD
Version Code	A code that indicates the version of the National Specifications submitted on this file, disk, etc. 001 = UB-82 data set as finally approved 08/17/82 003 = UB-82 data set as revised to handle 1,000,000 charges, bigger fields for units and UPINS. Effective 01/01/92 and 04/01/92. 004 = UB-92 data set as approved by NUBC 2/92. Effective 10/01/93.
Visits (This Bill) Rel. to Prior Certification	Total visits on this bill rendered prior to recertification "to" date. If applicable, required for abbreviated POC.
Weight in KG	*not mapped at this time

State Postal Abbreviation Codes

Alabama..... AL	New Hampshire..... NH
Alaska..... AK	New Jersey..... NJ
Arizona..... AZ	New Mexico..... NM
Arkansas..... AR	New York..... NY
California..... CA	North Carolina..... NC
Colorado..... CO	North Dakota..... ND
Connecticut..... CT	Ohio..... OH
Delaware..... DE	Oklahoma..... OK
District of Columbia. DC	Oregon..... OR
Florida..... FL	Pennsylvania..... PA
Georgia..... GA	Rhode Island..... RI
Hawaii..... HI	South Carolina..... SC
Idaho..... ID	South Dakota..... SD
Illinois..... IL	Tennessee..... TN
Indiana..... IN	Texas..... TX
Iowa..... IA	Utah..... UT
Kansas..... KS	Vermont..... VT
Kentucky..... KY	Virginia..... VA
Louisiana..... LA	Washington..... WA
Maine..... ME	West Virginia..... WV
Maryland..... MD	Wisconsin..... WI
Massachusetts..... MA	Wyoming..... WY
Michigan..... MI	Canal Zone..... CZ
Minnesota..... MN	Guam..... GU
Mississippi..... MS	Puerto Rico..... PR
Missouri..... MO	Virgin Islands..... VI
Montana..... MT	Canada..... CN
Nebraska..... NE	Mexico..... MX
Nevada..... NV	All Other..... FC

01-01 Record Type	NA	
01-02 Submitter EIN	1 020 NM109	
01-03 Multiple Provider Billing File Indicator	NA	
01-04 Filler (National Use)	NA	
01-05 Receiver Type Code	NA	
01-06 Receiver Identification	0 020 GS03	0 010 ISA08
01-07 Receiver Sub-Identification	0 020 GS03	0 010 ISA08
01-08 Filler	NA	
01-09 Submitter Name	1 020 NM103	
01-10 Submitter Address	1 030 N301	
01-11 Submitter City	1 035 N401	
01-12 Submitter State	1 035 N402	
01-13 Submitter ZIP Code	1 035 N403	
01-14 Submitter FAX Number	1 045 PER06	
01-15 Submitter Country Code	1 035 N404	
01-16 Submitter Telephone Number	1 045 PER04	
01-17 File Sequence & Serial Number	1 010 BGN02	
01-18 Test/Production Indicator	NA	
01-19 Date of Receipt (CCYYMMDD)	NA	
01-20 Processing Date ("Date Bill Submitted" on HCFA-1450)	1 010 BGN03	

01-21	Filler	NA
01-22	Version Code	NA
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02-01	Record type	NA
02-02	Provider Chain ID, TAX, or EIN#	2-015.A-NM109
02-03	Provider Chain Sub-ID	2-015.A-NM109
02-04	Filler (National Use)	NA
02-05	Provider Chain Name (sender)	2-015.A-NM103
02-06	Provider Chain Address	2-025.A-N301
02-07	Provider Chain City	2-030.A-N401
02-08	Provider Chain State	2-030.A-N402
02-09	Provider Chain Zip Code	2-030.A-N403
02-10	Billing Cycle Date (CCYYMMDD)	NA
02-11	Application Version	NA
02-12	Data Indicator	NA
02-13	Intermediary Number	ISA06 GS02
02-14	COB Identification	1-010-BGN07
02-15	Filler (National Use)	NA
02-16	Process Date this file covers (FROM CCYYMMDD)	NA
02-17	Process Date this file covers (THRU CCYYMMDD)	NA
02-18	Filler	NA
02-19	Filler	NA
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10-01	Record type	NA
10-02	Type of Batch	2 130 CLM05.01
10-03	Batch Number	NA
10-04	Federal Tax Number or EIN	2 015.B NM109
10-05	Federal Tax Sub ID	2 015.B NM109
10-06	National Provider Identifier	2 005 PRV03
10-07	Medicaid Provider Number	NA
10-08	CHAMPUS Insurer Provider Number	NA
10-09	Other Insurer Provider Number	NA
10-10	Other Insurer Provider Number	NA
10-11	Provider Telephone Number	2 040 PER04
10-12	Provider Name	2 015 NM103
10-13	Provider Address	2 025 N301
10-14	Provider City	2 030 N401
10-15	Provider State	2 030 N402
10-16	Provider ZIP Code	2 030 N403
10-17	Provider FAX Number	2 040 PER06
10-18	Provider Country Code	2 030 N404
10-19	Filler	NA
10-20	Filler	NA
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20-01	Record type	NA
20-02	Filler (National Use)	NA
20-03	Patient Control Number	2 130 CLM01
20-04	Patient Last Name	2 095 NM103
20-05	Patient First Name	2 095 NM104
20-06	Patient Middle Initial	2 095 NM105
20-07	Patient Sex	2 115 DMG03
20-08	Patient Birth Date (CCYYMMDD)	2 115 DMG02
20-09	Patient Marital Status	2 115 DMG04
20-10	Type of Admission	2 140 CL101
20-11	Source of Admission	2 140 CL102
20-12	Patient Address - Line 1	2 105 N301

20-13	Patient Address - Line 2	2 105 N302
20-14	Patient City	2 110 N401
20-15	Patient State	2 110 N402
20-16	Patient ZIP Code	2 110 N403
20-17	Admission/Start of Care Date (CCYYMMDD)	2 DTP.B DTP03
20-18	Admission Hour	2 DTP.B DTP03
20-19	Statement Covers From (CCYYMMDD)	2 DTP.A DTP03 DTP02 = 232
20-20	Statement Covers Thru (CCYYMMDD)	2 DTP.A DTP03 DTP02 = 233
20-21	Patient Status	2 140 CL103
20-22	Discharge Hour	2 DTP.K DTP03
20-23	Payments Received (Patient line)	2 175.A AMT02
20-24	Estimated Amount Due (Patient line)	2 175.B AMT02
20-25	Medical Record Number	1 125 REF02
20-26	Filler (National Use)	NA

21-01	Record type	NA
21-02	Sequence Number	NA
21-03	Patient Control Number	2 130 CLM01
21-04	Employer-1Name	2 325.D NM103
21-05	Employer-1 Address	2 335.D N301
21-06	Employer-1 City	2 340.D N401
21-07	Employer-1 State	2 340.D N402
21-08	Employer-1 ZIP Code	2 340.D N403
21-09	Employment-1 Status Code	2 355.D REF02
21-09a	Employer Qualifier	NA
21-10	Filler (National Use)	NA
21-11	Employer-2 Name	2 325.D NM103
21-12	Employer-2 Address	2 335.D N301
21-13	Employer-2 City	2 340.D N401
21-14	Employer-2 State	2 340.D N402
21-15	Employer-2 ZIP Code	2 340.D N403
21-16	Employment-2 Status Code	2 355.D REF02
21-16a	Employer Qualifier	NA
21-17	Filler (National Use)	NA

22-01	Record type	NA
22-02	Sequence Number	NA
22-03	Patient Control Number	2 130 CLM01
22-04	State Code	NA
22-05	Form Locator 2 (upper line)	NA
22-06	Form Locator 2 (lower line)	NA
22-07	Form Locator 11 (upper line)	NA
22-08	Form Locator 11 (lower line)	NA
22-09	Form Locator 56 (upper line)	NA
22-10	Form Locator 56 (2nd line)	NA
22-11	Form Locator 56 (3rd line)	NA
22-12	Form Locator 56 (4th line)	NA
22-13	Form Locator 56 (patient line)	NA
22-14	Form Locator 78 (upper line)	NA
22-15	Form Locator 78 (lower line)	NA
22-16	Filler	NA

30-01	Record type	NA	
30-02	Sequence Number	2 045 SBR01	
		2 290 SBR01	
30-03	Patient Control Number	2 130 CLM01	
30-04	Source of Payment Code	2 130 CLM03	
		2 310 OI01	
30-05	Payer Identification	2 325.A NM109	
		2 540 SVD01	
30-06	Payer Sub-Identification	2 325.A NM109	
		2 540 SVD01	
30-07	Certificate/SocSecNumber/Health Insurance Claim/ID	2 325.B NM109	
		2 095 NM109	
30-08a	Payer Identification Indicator	2 325 NM108	
		2 500 NM103	
30-08b	Payer Name	2 325.A NM103	
30-09	Primary Payer Code	2 045 SBR09	
30-10	Insurance Group Number	2 290 SBR03	
30-11	Insured Group Name	2 290 SBR04	
30-12	Insured's Last Name	2 325.B NM103	
30-13	Insured's First Name	2 325.B NM104	
30-14	Insured's Middle Initial	2 325.B NM105	
30-15	Insured's Sex	2 115 DMG03	
30-16	Release of Information Certification Indicator	2 130 CLM09	
		2 310 OI06	
30-17	Assignment of Benefits Certification Indicator	2 130 CLM08	
		2 310 OI03	
30-18	Patient's Relationship to Insured	2 090 PAT01	
		2 290 SBR02	
30-19	Employment Status Code	2 090 PAT03	2 290 SBR08
30-20	Covered Days	2 315 MIA01	
30-21	Noncovered Days	2 240 QTY02	
30-22	Coinsurance Days	2 240 QTY02	
30-23	Lifetime Reserve Days	2 315 MIA02	
30-24	Provider Identification Number	2 005 PRV03	2 355.AB REF02
30-25	Payments Received	2 300.A AMT02	
30-26	Estimated Amount Due	2 300.B AMT02	

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31-01	Record type	NA
31-02	Sequence Number	NA
31-03	Patient Control Number	2 130 CLM01
31-04	Insured's Address - Line 1	NA
31-05	Insured's Address - Line 2	NA
31-05a	Filler	NA
31-06	Insured's City	NA
31-07	Insured's State	NA
31-08	Insured's ZIP Code	NA
31-09	Employer Name	2 325.C NM103
31-10	Employer Address	2 332.C N301
31-11	Employer City	2 340.C N401
31-12	Employer State	2 340.C N402
31-13	Employer ZIP Code	2 340.C N403
31-14	Form Locator 37 (ICN/DCN)	2 355.AC REF02

31-15	Contract Number	2 325 NM109
31-16	Filler (National Use)	NA

32-01	Record type '32'	NA
32-02	Sequence Number	NA
32-03	Patient Control Number	NA
32-04	Payer Name	NA
32-05	Payer Address	NA
32-06	Payer Address	NA
32-07	Payer City	NA
32-08	Payer State	NA
32-09	Payer Zip Code	NA
32-10	Filler (National Use)	NA

34-01	Record type	NA
34-02	Sequence Number	NA
34-03	Patient Control Number	NA
34-04	Authorization Type 1	NA
34-05	Authorization Number IDE Number	2-180 REF02
34-06	Authorization From Date (CCYYMMDD)	NA
34-07	Authorization Thru Date (CCYYMMDD)	NA
34-08	Authorization Revenue Code	NA
34-09	Authorization HCPCS Procedure Code	NA
34-10	Authorization - 2	2-180 REF02
34-11	Authorization - 3	2-180 REF02
34-12	Filler (National Use)	NA

40-01	Record Type	NA
40-02	Sequence Number	NA
40-03	Patient Control Number	2 130 CLM01
40-04	Type of Bill	2 130 CLM05.01 2 130 CLM05.3
40-05	Treatment Authorization Code-A	2 355.AA REF02
40-06	Treatment Authorization Code-B	2 355.AA REF02
40-07	Treatment Authorization Code-C	2 355.AA REF02
40-08	Occurrence Code - 1	2 231.C HI01.02
40-09	Occurrence Date - 1 (CCYYMMDD)	2 231.C HI01.04
40-10	Occurrence Code - 2	2 231.C HI02.02
40-11	Occurrence Date - 2 (CCYYMMDD)	2 231.C HI02.04
40-12	Occurrence Code - 3	2 231.C HI03.02
40-13	Occurrence Date - 3 (CCYYMMDD)	2 231.C HI03.04
40-14	Occurrence Code - 4	2 231.C HI04.02
40-15	Occurrence Date - 4 (CCYYMMDD)	2 231.C HI04.04
40-16	Occurrence Code - 5	2 231.C HI05.02
40-17	Occurrence Date - 5 (CCYYMMDD)	2 231.C HI05.04
40-18	Occurrence Code - 6	2 231.C HI06.02
40-19	Occurrence Date - 6 (CCYYMMDD)	2 231.C HI06.04
40-20	Occurrence Code - 7	2 231.C HI07.02
40-21	Occurrence Date - 7 (CCYYMMDD)	2 231.C HI07.04
40-22	Occurrence Span Code - 1	2 231.D HI01.02
40-23	Occurrence Span FROM DATE - 1 (CCYYMMDD)	2 231.D HI01.04
40-24	Occurrence Span THRU DATE - 1 (CCYYMMDD)	2 231.D HI01.04
40-25	Occurrence Span Code - 2	2 231.D HI02.02

40-26	Occurrence Span FROM DATE - 2 (CCYYMMDD)	2 231.D HI02.04
40-27	Occurrence Span THRU DATE - 2	2 231.D HI02.04
40-28	Filler (National Use)	NA

41-01	Record Type	NA
41-02	Sequence Number	NA
41-03	Patient Control Number	2 130 CLM01
41-04	Condition Code - 1	2 231.E HI01.02
41-05	Condition Code - 2	2 231.E HI02.02
41-06	Condition Code - 3	2 231.E HI03.02
41-07	Condition Code - 4	2 231.E HI04.02
41-08	Condition Code - 5	2 231.E HI05.02
41-09	Condition Code - 6	2 231.E HI06.02
41-10	Condition Code - 7	2 231.E HI07.02
41-11	Condition Code - 8	2 231.E HI08.02
41-12	Condition Code - 9	2 231.E HI09.02
41-13	Condition Code - 10	2 231.E HI10.02
41-14	Form Locator 31 (upper)	NA
41-15	Form Locator 31 (lower)	NA
41-16	Value Code - 1	2 231.F HI01.02
41-17	Value Amount - 1	2 231.F HI01.05
41-18	Value Code - 2	2 231.F HI02.02
41-19	Value Amount - 2	2 231.F HI02.05
41-20	Value Code - 3	2 231.F HI03.02
41-21	Value Amount - 3	2 231.F HI03.05
41-22	Value Code - 4	2 231.F HI04.02
41-23	Value Amount - 4	2 231.F HI04.05
41-24	Value Code - 5	2 235.F HI05.02
41-25	Value Amount - 5	2 231.F HI05.05
41-26	Value Code - 6	2 231.F HI06.02
41-27	Value Amount - 6	2 231.F HI06.05
41-28	Value Code - 7	2 231.F HI07.02
41-29	Value Amount - 7	2 231.F HI07.05
41-30	Value Code - 8	2 231.F HI08.02
41-31	Value Amount - 8	2 231.F HI08.05
41-32	Value Code - 9	2 231.F HI09.02
41-33	Value Amount - 9	2 231.F HI09.05
41-34	Value Code - 10	2 231.F HI10.02
41-35	Value Amount - 10	2 231.F HI10.05
41-36	Value Code - 11	2 231.F HI11.02
41-37	Value Amount - 11	2 231.F HI11.05
41-38	Value Code - 12	2 231.F HI12.02
41-39	Value Amount - 12	2 231.F HI12.05
41-40	Filler (National Use)	NA

42-1	Record Type	NA
42-2	Sequence Number	NA
42-3	Payer Sequence	NA
42-4	Patient Control	2-130-CLM01
42-5	Group Code	2-295-CAS01
42-6	Reason Code-1	2-295-CAS02
42-7	Adjustment Amount-1	2-295-CAS03
42-8	Adjustment Quantity-1	2-295-CAS04
42-9	Reason Code-2	2-295-CAS05

51-14 REF Remarks Code 9	2-525-REF02
51-15 REF Remarks Code 10	2-525-REF02
51-16 Filler	NA

52-01 Record Type	NA
52-02 Sequence Number	NA
52-03 Payer Sequence Number	2-540-SVD01
52-04 Patient Control Number	2-130-CLM01
52-05 Revenue Code-1	2-540-SVD05
52-06 Group Code	2-545-CAS01
52-07 Reason Code 1	2-545-CAS02
52-08 Adjustment Amount 1	2-545-CAS03
52-09 Adjustment Quantity 1	2-545-CAS04
52-10 Reason Code 2	2-545-CAS05
52-11 Adjustment Amount 2	2-545-CAS06
52-12 Adjustment Quantity 2	2-545-CAS07
52-13 Reason Code 3	2-545-CAS08
52-14 Adjustment Amount 3	2-545-CAS09
52-15 Adjustment Quantity 3	2-545-CAS10
52-16 Reason Code 4	2-545-CAS11
52-17 Adjustment Amount 4	2-545-CAS12
52-18 Adjustment Quantity 4	2-545-CAS13
52-19 Reason Code 5	2-545-CAS14
52-20 Adjustment Amount 5	2-545-CAS15
52-21 Adjustment Quantity 5	2-545-CAS16
52-22 Reason Code 6	2-545-CAS17
52-23 Adjustment Amount 6	2-545-CAS18
52-24 Adjustment Quantity 6	2-545-CAS19
52-25 Filler	NA

60-01 Record type	NA
60-02 Sequence Number	NA
60-03 Patient Control Number	2 130 CLM01
60-04 Inpatient Ancillary Revenue Code	2 375 SV201
60-05 HCPCS Procedure Code/HIPPS code	2 375 SV202.02
60-06 Modifier 1 (HCPCS & CPT-4)	2 375 SV202.03
60-07 Modifier 2 (HCPCS & CPT-4)	2 375 SV202.04
60-08 Inpatient Ancillary Units of Service	2 375 SV205
60-09 Inpatient Ancillary Total Charges	2 375 SV203
60-10 Inpatient Ancillary Noncovered Charges	2 375 SV207
60-11 Form Locator 49	NA
60-12 HIPPS Assessment Date (CCYYMMDD)	2 475 DTP03
60-12a Filler (National Use)	NA
60-13 Inpatient Ancillaries - 2	2 375 SV201
60-14 Inpatient Ancillaries - 3	2 375 SV201

61-01 Record type	NA
61-02 Sequence Number	NA
61-03 Patient Control Number	2 130 CLM01
61-04 Revenue Code	2 375 SV201
61-05 HCPCS Procedure Code	2 375 SV202.02
61-06 Modifier 1 (HCPCS & CPT-4)	2 375 SV202.03
61-07 Modifier 2 (HCPCS & CPT-4)	2 375 SV202.04
61-08 Units of Service	2 375 SV205

61-09	Form Locator 49	NA
61-10	Outpatient Total Charges	2 375 SV203 2 540 SVD02
61-11	Outpatient Noncovered Charges	2 375 SV207
61-12	Date of Service (CCYYMMDD)	2 455 DTP03
61-13	Filler (National Use)	NA
61-14	Revenue Code - 2	2 375 SV201
61-15	Revenue Code - 3	2 375 2V201

62-01	Record Type	NA
62-02	Sequence Number	NA
62-03	Payer Sequence	2-540-SVD01
62-04	Patient Control Number	2-130-CLM01
62-05	Revenue Code	2-540-SVD04
62-06	Remarks Code 1	2-525-REF02
62-07	Remarks Code 2	2-525-REF02
62-08	Remarks Code 3	2-525-REF02
62-09	Remarks Code 4	2-525-REF02
62-10	Remarks Code 5	2-525-REF02
62-11	Remarks Code 6	2-525-REF02
62-12	Remarks Code 7	2-525-REF02
62-13	Remarks Code 8	2-525-REF02
62-14	Remarks Code 9	2-525-REF02
62-15	Remarks Code 10	2-525-REF02
62-16	Filler	NA

63-01	Record Type	NA
63-02	Sequence Number	NA
63-03	Payer Sequence	2-540-SVD01
63-04	Patient Control Number	2-130-CLM01
63-05	Revenue Code	2-540-SVD04
63-06	Group Code	2-545-CAS01
63-07	Reason Code 1	2-545-CAS02
63-08	Adjustment Amount 1	2-545-CAS03
63-09	Adjustment Quantity 1	2-545-CAS04
63-10	Reason Code 2	2-545-CAS05
63-11	Adjustment Amount 2	2-545-CAS06
63-12	Adjustment Quantity 2	2-545-CAS07
63-13	Reason Code 3	2-545-CAS08
63-14	Adjustment Amount 3	2-545-CAS09
63-15	Adjustment Quantity 3	2-545-CAS10
63-16	Reason Code 4	2-545-CAS11
63-17	Adjustment Amount 4	2-545-CAS12
63-18	Adjustment Quantity 4	2-545-CAS13
63-19	Reason Code 5	2-545-CAS14
63-20	Adjustment Amount 5	2-545-CAS15
63-21	Adjustment Quantity 5	2-545-CAS16
63-22	Reason Code 6	2-545-CAS17
63-23	Adjustment Amount 6	2-545-CAS18
63-24	Adjustment Quantity 6	2-545-CAS19
63-25	Filler	NA

70-01	Record Type	NA
70-02	Sequence "01"	NA

70-03 Patient Control Number	2 130 CLM01	
70-04 Principal Diagnosis Code	2 231.A HI02.02	HI02.01 BK
70-05 Other Diagnosis Code - 1	2 231.A HI03.02	HI03.01 BF
70-06 Other Diagnosis Code - 2	2 231.A HI04.02	HI04.01 BF
70-07 Other Diagnosis Code - 3	2 231.A HI05.02	HI05.01 BF
70-08 Other Diagnosis Code - 4	2 231.A HI06.02	
70-09 Other Diagnosis Code - 5	2 231.A HI07.02	
70-10 Other Diagnosis Code - 6	2 231.A HI08.02	
70-11 Other Diagnosis Code - 7	2 231.A HI09.02	
70-12 Other Diagnosis Code - 8	2 231.A HI10.02	
70-13 Principal Procedure Code	2 231.B HI01.02	
70-14 Principal Procedure Date (CCYYMMDD)	2 231.B HI01.04	
70-15 Other Procedure Code - 1	2 231.B HI02.02	HI02.01 BQ
70-16 Other Procedure Date - 1 (CCYYMMDD)	2 231.B HI02.04	
70-17 Other Procedure Code - 2	2 231.B HI03.02	
70-18 Other Procedure Date - 2 (CCYYMMDD)	2 231.B HI03.04	
70-19 Other Procedure Code - 3	2 231.B HI04.02	
70-20 Other Procedure Date - 3 (CCYYMMDD)	2 231.B HI04.04	
70-21 Other Procedure Code - 4	2 231.B HI05.02	
70-22 Other Procedure Date - 4 (CCYYMMDD)	2 231.B HI05.04	
70-23 Other Procedure Code - 5	2 231.B HI06.02	
70-24 Other Procedure Date - 5 (CCYYMMDD)	2 231.B HI06.04	
70-25 Admitting Diagnosis Code	2 231.A HI01.02	HI01.01 BJ
70-26 External Cause of Injury (E-Code)	2 231.A HI11.02	HI11.01 BN
70-27 Procedure Coding Method Used	2 231.B HI01.01	
70-28 Filler (National Use)	NA	
70-01 Record Type	NA	
70-02 Sequence "02"	NA	
70-03 Patient Control Number	2 130 CLM01	
70-04 Form Locator 57	NA	
70-05 Filler (National Use)	NA	

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NOTE: MAP ONLY ONCE FROM THE FIRST OCCURRENCE OF A UB-92 71 RECORD

71-01 Record Type	NA	
71-02 Sequence	NA	
71-03 Patient Control Number	2 130 CLM01	
71-04 Data ID	2 180.B REF02	
71-05 SOC Date (CCYYMMDD)	2 DTP.C DTP03	also CR602 required
71-06 Certification Period From (CCYYMMDD)	2 216 CR604	
71-07 Certification Period To (CCYYMMDD)	2 216 CR604	
71-08 Date of Onset or Exacerbation of Principal Diagnosis	2 DTP.D DTP03	
71-09 Surgical Procedure Code	2 216 CR611	
71-10 Date Surgical Procedure Performed (CCYYMMDD)	2 DTP.E DTP03	also CR609 required
71-11 Date Secondary Diagnosis-1 (CCYYMMDD)	2 DTP.H DTP03	
71-12 Date Secondary Diagnosis-2 (CCYYMMDD)	2 DTP.I DTP03	
71-13 Functional Limitation Code	2 220.A CRC03 thru CRC07	
71-14 Activities Permitted Code	2 220.B CRC03 thru CRC07	
71-15 Mental Status Code	2 220.C CRC03 thru CRC07	
71-16 Prognosis	2 216 CR601	
71-17 Verbal SOC Date (CCYYMMDD)	2 DTP.G DTP03	
71-18 Physician's Last Name	2 250.A NM103	
71-19 Physician's First Name	2 250.A NM104	
71-20 Physician's Initial	2 250.A NM105	
71-21 Physician's ZIP Code	2 270.A N403	

71-22 Medicare Covered	2 216 CR607
71-23 Date Physician Last Saw Patient (CCYYMMDD)	2 DTP.F DTP03
71-24 Date Last Contacted Physician (CCYYMMDD)	2 DTP.J DTP03
71-25 Patient Receiving Care in 1861(J)(1) Facility	2 216 CR606
71-26 Cert/Recert/Mod	2 216 CR608
71-27 Admission (CCYYMMDD)	2 216 CR616
71-28 Discharge (CCYYMMDD)	2 216 CR616
71-29 Type of Facility	2 216 CR617
=====	
72-01 Record Type	NA
72-02 Sequence Number	NA
72-03 Patient Control Number	2 130 CLM01
72-04 Discipline	2 242 CR701
72-05 Visits (This Bill) Related to Prior Certification	2 242 CR702
72-06 Frequency and Duration of Visits - 1	2 243 HSD02, HSD03, HSD06
72-07 Frequency and Duration of Visits - 2	2 243 HSD02, HSD03, HSD06
72-08 Frequency and Duration of Visits - 3	2 243 HSD02, HSD03, HSD06
72-09 Frequency and Duration of Visits - 4	2 243 HSD02, HSD03, HSD06
72-10 Frequency and Duration of Visits - 5	2 243 HSD02, HSD03, HSD06
72-11 Frequency and Duration of Visits - 6	2 243 HSD02, HSD03, HSD06
72-12 Frequency and Duration of Visits - 7	2 243 HSD02, HSD03, HSD06
72-13 Frequency and Duration of Visits - 8	2 243 HSD02, HSD03, HSD06
72-14 Frequency and Duration of Visits - 9	2 243 HSD02, HSD03, HSD06
72-15 Frequency and Duration of Visits -10	2 243 HSD02, HSD03, HSD06
72-16 Frequency and Duration of Visits -11	2 243 HSD02, HSD03, HSD06
72-17 Frequency and Duration of Visits -12	2 243 HSD02, HSD03, HSD06
72-18 Treatment Code - 1	2 231.G HI01.02 HI01.01 TC
72-19 Treatment Code - 2	2 231.G HI02.02
72-20 Treatment Code - 3	2 231.G HI03.02
72-21 Treatment Code - 4	2 231.G HI04.02
72-22 Treatment Code - 5	2 231.G HI05.02
72-23 Treatment Code - 6	2 231.G HI06.02
72-24 Treatment Code - 7	2 231.G HI07.02
72-25 Treatment Code - 8	2 231.G HI08.02
72-26 Treatment Code - 9	2 231.G HI09.02
72-27 Treatment Code -10	2 231.G HI10.02
72-28 Treatment Code -11	2 231.G HI11.02
72-29 Treatment Code -12	2 231.G HI12.02
72-30 Treatment Code -13 start 2 nd occurrence	2 231.G HI01.02
72-31 Treatment Code -14	2 231.G HI02.02
72-32 Treatment Code -15	2 231.G HI03.02
72-33 Treatment Code -16	2 231.G HI04.02
72-34 Treatment Code -17	2 231.G HI05.02
72-35 Treatment Code -18	2 231.G HI06.02
72-36 Treatment Code -19	2 231.G HI07.02
72-37 Treatment Code -20	2 231.G HI08.02
72-38 Treatment Code -21	2 231.G HI09.02
72-39 Treatment Code -22	2 231.G HI10.02
72-40 Treatment Code -23	2 231.G HI11.02
72-41 Treatment Code -24	2 231.G HI12.02
72-42 Treatment Code -25 start 3 rd occurrence	2 231.G HI01.02
72-43 Total Visits Projected This Cert.	2 242 CR703
72-44 Filler (National Use)	NA
72-45 Filler (Local Use)	NA

73-01	Record Type	NA
73-02	Sequence Number	NA
73-03	Patient Control Number	2 130 CLM01
73-04	Filler (National Use)	NA
73-05	Data ID Number	2 190.B NTE01
73-06	Corresponding Data	2 190.B NTE02

74-01	Record Type	NA
74-02	Filler (National Use)	NA
74-03	Patient Control Number	NA
74-04	Attachment Submission Status	NA
74-05	HICN	NA
74-06	Medical Record Number	NA
74-07	Patient Last Name	NA
74-08	Patient First Name	NA
74-09	Patient Middle Initial	NA
74-10	Patient Birth date (CCYYMMDD)	NA
74-11	Patient Sex	NA
74-12	Principal Diagnosis Code	NA
74-13	Other Diagnosis Code-1	NA
74-14	Other Diagnosis Code-2	NA
74-15	Other Diagnosis Code-3	NA
74-16	Other Diagnosis Code-4	NA
74-17	Start of Care (SOC) Date (CCYYMMDD)	NA
74-18	FROM Date (CCYYMMDD)	NA
74-19	THROUGH Date (CCYYMMDD)	NA
74-20	Provider Number	NA
74-21	Internal Control (ICN/DCN)	NA
74-22	Filler (National Use)	NA

75-01	Record Type '75'	NA
75-02	Sequence Number	NA
75-03	Patient Control Number	NA
	Reasons for Ambulance	NA
	Transportation (occurs 3 times)	NA
75-04	Reason 1	NA
75-05	Reason 2	NA
75-06	Reason 3	NA
75-07	Number of Trips	NA
	Pickup - Destination Code (occurs 2 times)	NA
75-08	Code-1	NA
75-09	Code-2	NA
75-10	Base Charge	NA
75-11	Number of Miles	NA
75-12	Cost Per Mile	NA
	Ancillary Charges	NA
75-13	Medical Surgical Supplies	NA
75-14	IV Solutions	NA
75-15	Oxygen/Oxygen Supplies	NA
75-16	Injectable Drugs	NA
	Pickup Address	NA
75-17	Place	NA
75-18	City	NA

75-19	State		NA
75-20	Zip Code	NA	
	Destination Address		NA
75-21	Name		NA
75-22	Place		NA
75-23	City		NA
75-24	State		NA
75-25	Zip Code		NA
75-26	Filler		NA
75-01	Record Type 75		NA
75-02	Sequence Number "02"		NA
75-03	Patient Control Number		NA
75-04	Reason for Transfer		NA
75-05	Reason for Bypass	NA	
	Nearest Facility		NA
75-06	Air Ambulance Justification	NA	
75-07	Ancillary Charge Other		NA
75-08	Remarks		NA

76-01	Record Type '76'		NA
76-02	Sequence No.		NA
76-03	Patient Control No.		NA
76-04	Record Format Type-L, Non-routine and Separately Billable Laboratory Tests(Occurs 1 to 4 times)	NA	
76-05	HCPCS Code		NA
76-06	Modifier 1		NA
76-07	Modifier 2		NA
76-08	Previous Lab Value		NA
76-09	Date Previous Lab (CCYYMMDD)		NA
76-10	Current Lab Value	NA	
76-11	Date Current Lab (CCYYMMDD)		NA
76-12	Lab Tests-Occurrence 2		NA
76-13	Lab Tests-Occurrence 3		NA
76-14	Lab Tests-Occurrence 4		NA
76-15	Filler (National Use)		NA

76-01	Record Type '76'		
76-02	Sequence No.		NA
76-03	Patient Control Number		NA
76-04	Record Format Type-M Medication Administration (occurs 1 to 3 times)		NA
76-05	National Drug Code		NA
76-06	Drug Units		NA
76-07	Place of Administration		NA
76-08	Route to Administration		NA
76-09	Frequency and Duration		NA
76-10	Medication-Occurrence 2		NA
76-11	Medication-Occurrence 3 Extra Dialysis Sessions (occurs 1 to 3 times)		NA
76-12	Date of Extra Session (CCYYMMDD)		NA
76-13	Justification for Extra Session		NA
76-14	Extra Dialysis-Occurrence 2		NA
76-15	Extra Dialysis-Occurrence 3 Other Services (occurs 1 to 3 times)		NA

76-16	HCPCS/CPT Code	NA
76-17	Date Previous Test/Service (CCYYMMDD)	NA
76-18	Date Current Test/Service (CCYYMMDD)	NA
76-19	Other Services-Occurrence 2	NA
76-20	Other Services-Occurrence 3	NA
76-21	Weight in Kg	NA
76-22	Filler (National Use)	NA
=====		
77-01	Record type '77'	NA
77-02	Sequence number	NA
77-03	Patient Control Number (PCN)	NA
77-04	Record Format - A	NA
77-05	Discipline Physician Information (Fields 6-9)	NA
77-06	Attending Physician Identifier	NA
77-07	Physician Referral Date (CCYYMMDD)	NA
77-08	Physician Signature Date on Plan of Treatment (CCYYMMDD)	NA
	Rehabilitation Professional Information (Fields 9-14)	NA
77-09	Rehabilitation Professional Identifier	NA
77-10	Rehabilitation Professional Name (Last)	NA
77-11	Rehabilitation Professional Name (First)	NA
77-12	Rehabilitation Professional Name (MI)	NA
77-13	Professional Designation of Rehabilitation Professional	NA
77-14	Rehabilitation Professional Signature Date on Plan of Treatment (CCYYMMDD)	NA
	Prior Hospitalization Dates (From-Through)(Fields 15-19)	NA
77-15	From Date (CCYYMMDD)	NA
77-16	Through Date (CCYYMMDD)	NA
77-17	Date of Onset/Exacerbation of Principal Diagnosis (CCYYMMDD)	NA
77-18	Admission Date/Start Care Date (CCYYMMDD)	NA
77-19	Total Visits From Start of Care	NA
77-20	Most Recent Event Requiring Cardiac Rehab Date (CCYYMMDD)	NA
77-21	Treatment Diagnosis Code (ICD-9)	NA
77-22	Treatment Diagnosis (Narrative)	NA
77-23	Filler (National Use)	NA
=====		
77-01	Record Type '77'	NA
77-02	Sequence Number	NA
77-03	Patient Control Number (PCN)	NA
77-04	Record Format - R	NA
77-05	Discipline Plan of Treatment (POT)(Fields 6-12)	NA
77-06	POT - Status (Initial/Update)	NA
77-07	POT - Date Established (CCYYMMDD)	NA
	POT - Period Covered (From-Through)	NA
77-08	From Date (CCYYMMDD)	NA
77-09	Through Date (CCYYMMDD)	NA
77-10	Frequency and Duration	NA
	Frequency Number	NA
	Frequency Period	NA
	Duration	NA
77-11	Estimated Date of Completion of Outpatient Rehab (CCYYMMDD)	NA
77-12	Service Status (Continue/Discontinue)	NA

77-13	Certification Status	NA
77-14	Date of Last Certification (CCYYMMDD)	NA
77-15	Route of Administration - IM	NA
77-16	Route of Administration - IV	NA
77-17	Route of Administration - PO	NA
77-18	Drug Administered (Narrative)	NA
77-19	Prognosis	NA
77-20	Filler (National Use)	NA
=====		
77-01	Record type '77'	NA
77-02	Sequence number	NA
77-03	Patient Control Number	NA
77-04	Record Format - N	NA
77-05	Discipline	NA
77-06	Narrative Type Indicator	NA
77-07	Free Form Narrative	NA
77-08	Filler (National Use)	NA
=====		
80-01	Record Type	NA
80-02	Sequence	NA
80-03	Patient Control Number	2 130 CLM01
80-04	Physician Number Qualifying Code	2 250.A NM108, 2 250.B NM108, 2 250.C NM108
80-05	Attending Physician Number	2 250.A NM109
80-06	Operating Physician Number	2 250.B NM109
80-07	Other Physician Number	2 250.C NM109
80-08	Other Physician Number	2 250.C NM109
80-09	Attending Physician Last Name	2 250.A NM103
80-09	Attending Physician First Name	2 250.A NM104
80-09	Attending Physician Middle Initial	2 250.A NM105
80-10	Operating Physician Last Name	2 250.B NM103
80-10	Operating Physician First Name	2 250.B NM104
80-10	Operating Physician Middle Initial	2 250.B NM105
80-11	Other Physician Last Name	2 250.C NM103
80-11	Other Physician First Name	2 250.C NM104
80-11	Other Physician Middle Initial	2 250.C NM105
80-12	Other Physician Last Name	2 250.C NM103
80-12	Other Physician First Name	2 250.C NM104
80-12	Other Physician Middle Initial	2 250.C NM105
80-13	Filler (National Use)	NA
=====		
90-01	Record Type	NA
90-02	Filler (National Use)	NA
90-03	Patient Control Number	2 130 CLM01
90-04	Physical Record Count	NA
90-05	Record Type 2n Count	NA
90-06	Record Type 3n Count	NA
90-07	Record Type 4n Count	NA
90-08	Record Type 5n Count	NA
90-09	Record Type 6n Count	NA
90-10	Record Type 7n Count	NA
90-11	Record Type 8n Count	NA
90-12	Record Type 91 Qualifier	NA
90-13	Total Accommodation Charges - Revenue Centers	2 130 CLM02

90-14	Noncovered Accommodation Charges - Revenue Centers	NA
90-15	Total Ancillary Charges - Revenue Centers	2 130 CLM02
90-16	Noncovered Ancillary Charges - Revenue Centers	NA
90-17	Remarks	2 190.A NTE02

91-01	Record Type	NA
91-02	Filler (National Use)	NA
91-03	Patient Control Number	2 130 CLM01
91-04	Remarks (Additional)	2 190.A NTE02
91-05	Filler (National Use)	NA

92-01	Record Type	NA
92-02	Sequence Number	NA
92-03	Patient Control Number	2-130-CLM01
92-04	Current DCN/ICN	2-180-REF02
92-05	Filler	NA
92-06	Total Submitted Charges	2-300-AMT02
92-07	Total Noncovered Charges	2-300-AMT02
92-08	Total Charge Allowed	2-300-AMT02
92-09	Total Medicare Reimbursement	2-300-AMT02
92-10	Total Amount Medicare Paid Provider	NA
92-11	Total Amount Medicare Paid Beneficiary	NA
92-12	Total Medicare Days Utilized	NA
92-13	DRG/APG Amount Assigned via Grouper	2-180-REF02
92-14	DRG/APG Amount Applied Via Pricer	2-315-MIA 04
92-15	DRG Outlier Amount	2-300-AMT02
92-16	Total Denied Charges	2-300-AMT02
92-17	Cost Report Days	2-315-MIA15
92-18	Lifetime Psychiatric Days	2-315-MIA03
92-19	Claim Status	2-130-CLM17
92-20	Reimbursement Rate	2-320-MOA01
92-21	Claim Paid Date (CCYYMMDD)	2-350-DTP03
92-22	Filler	NA

93-01	Record Type	NA
93-02	Sequence Number	NA
93-03	Patient Control Number	2-130-CLM01
93-04	Allowed charges Medicare (Paid at 100%)	2-300-AMT02
93-05	Allowed Charges Medicare (Paid at 80%)	2-300-AMT02
93-06	Paid from Part A Medicare Trust Fund	2-300-AMT02
93-07	Paid from Part B Medicare Trust Fund	2-300-AMT02
93-08	Filler	NA

95-01	Record Type	NA
95-02	Federal Tax Number (EIN)	NA
95-03	Receiver Identification	NA
95-04	Receiver Sub-Identification	NA
95-05	Type of Batch	NA
95-06	Number of Claims	NA
95-07	Number of 3M Batch Attachment Records	NA

95-08	Accommodations Total Charges for the Batch		NA
95-09	Accommodations Noncovered Charges for the Batch	NA	
95-10	Ancillary Total Charges for the Batch		NA
95-11	Ancillary Noncovered Charges for the Batch		NA
95-12	Total Charges for the Batch	NA	
95-13	Total Noncovered Charges for the Batch		NA
95-14	Reserved for Future Use		NA
95-15	Filler (National Use)		NA
95-16	Filler (Local Use)		NA

98-01	Record Type		NA
98-02	Filler		NA
98-03	Provider Chain Id		NA
98-04	Provider Chain Sub-Id		NA
98-05	Filler		NA
98-06	Total Number of Provider Chain Claims		NA
98-08	Accommodations Total Charges for the Provider Chain	NA	
98-09	Accommodations Noncovered Charges for the Provider Chain		NA
98-10	Ancillary Total Charges for the Provider Chain		NA
98-11	Ancillary Noncovered Charges for the Provider Chain		NA
98-12	Total Charges for the Provider		NA
98-13	Total Noncovered Charges for the Provider Chain		NA
98-14	Filler		NA
98-15	Filler		NA
98-16	Filler		NA

99-01	Record Type		NA
99-02	Submitter EIN		NA
99-03	Receiver Identification		NA
99-04	Receiver Sub-Identification		NA
99-05	Number of Batches Billed this File	NA	
99-06	Accommodations Total Charges for the File		NA
99-07	Accommodations Noncovered Charges for the File	NA	
99-08	Ancillary Total Charges for the File	NA	
99-09	Ancillary Noncovered Charges for the File		NA
99-10	Total Charges for the File		NA
99-11	Total Noncovered Charges for the File		NA
99-12	Number of Claims for the File		NA
99-11	Number of Records for the File	NA	
99-14	Filler (National Use)		NA
99-15	Filler (Local Use)		NA