

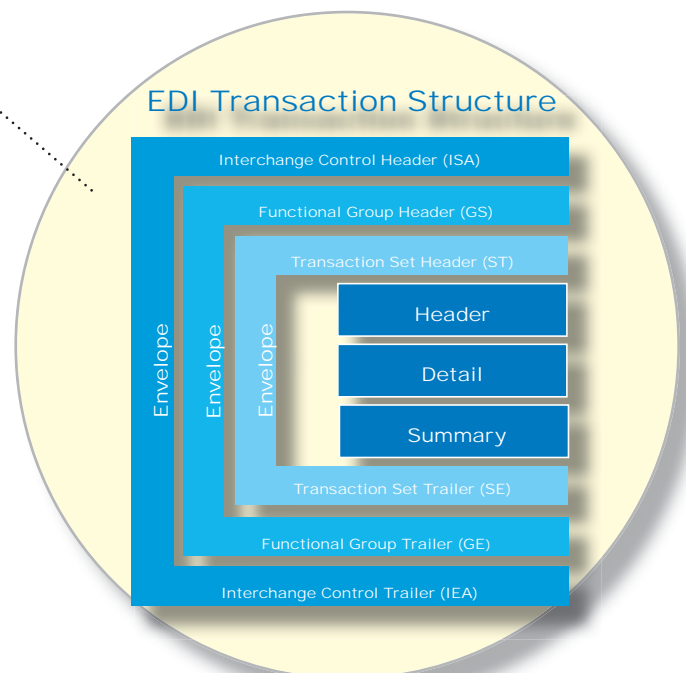
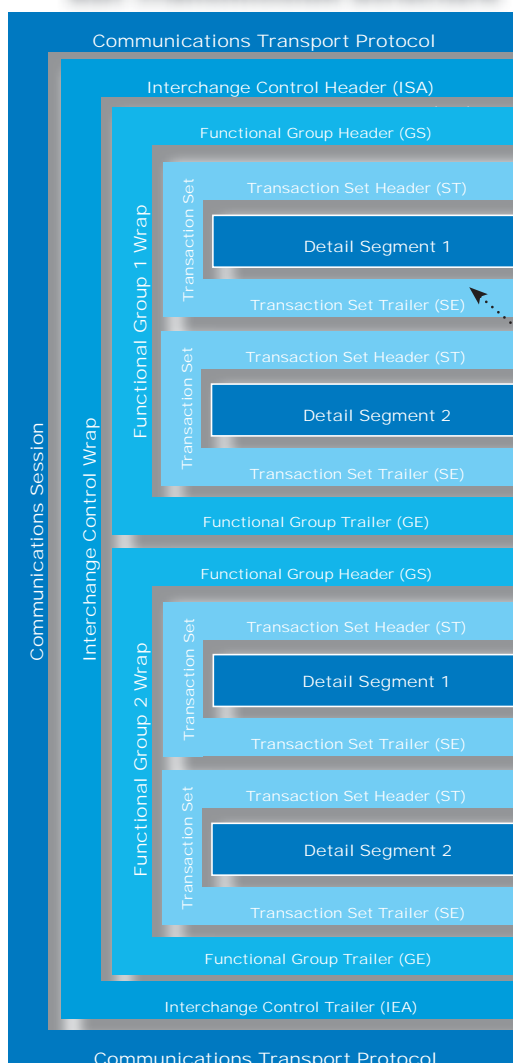
## 837 Professional Health Care Claim

### Basic Instructions

This section provides information to help you prepare for the ANSI ASC X12N 837 Health Care transaction for professional claims. The tables in this document provide information about 837 Claim segments and data elements that require specific instructions to efficiently process through Anthem Blue Cross and Blue Shield, Indiana, Kentucky, Ohio, Missouri, and Wisconsin (Central Region) systems.

Use this companion document in conjunction with both the Transaction Set Implementation Guide "Health Care Claim: Professional, 837, ASC X12N 837 (004010X098)," May 2000, and the subsequent Addenda (004010X098A1), October 2002, published by the Washington Publishing Co.

#### EDI Transmission Structure



## 1 Central Region Products (as indicated on member's ID card)

### **HMO/EPO/POS/PPO/TRAD:**

Refers to the following products in Indiana, Kentucky, Ohio, Missouri and Wisconsin: Blue Preferred Primary/Blue Priority (HMO), Blue Preferred Primary ASO (Ohio EPO), Blue Preferred Primary Blue (POS); Blue Access (PPO), and Blue Traditional (TRAD).

### **Federal Employees Program (FEP):**

Refers to product Government-Wide Service Benefit Plan.

**BlueCard® Program:** Enables members who obtain health care services while traveling or living in another Plan's service area to receive the same benefits of their contracting Blue Cross and Blue Shield Plan and access to BlueCard providers and savings. It also links participating providers and the independent Blue Cross and Blue Shield plans across the country through a single electronic network for claims processing and reimbursement.

**National Accounts (NASCO):** Refers to products BlueCard PPO, BlueCard Traditional, BlueCard POS, BlueCard HMO (Including Away from Home Care and Guest Membership), Bluecard Worldwide

## 2 X12 and HIPAA Compliance Checking, and Business Edits

### **Level 1.**

X12 Compliance: Central Region returns a 997 Functional Acknowledgment to the submitter for every inbound 837 transaction received. Each transaction passes through edits to ensure that it is X12 compliant. If it successfully passes X12 syntax edits, a 997 Functional Acknowledgement is returned indicating acceptance of the transaction. If the transaction fails X12 syntax compliance, the 997 Functional Acknowledgement will also report the Level 1 errors in the AK segments and, depending on where the error occurred, will indicate that the entire interchange, functional group or transaction set has been rejected.

### **Level 2.**

HIPAA IG Compliance - Code Sets: HIPAA Implementation Guide edits are strictly enforced. The Central Region will return a Level 2 Status Report to the submitter indicating if a transaction set has been accepted or rejected. If the transaction set has been rejected, this report will indicate the Level 2 HIPAA compliance error(s) that occurred.

## 3 HIPAA Compliant Codes

Follow the 837 Institutional IG precisely. Use HIPAA-Compliant codes from current versions of the sources listed in the 837 Institutional IG, Appendix C: External Code Sources.

Acceptance of HIPAA standard codes or modifiers will not alter the Central Region's covered benefits or current payment policies, guidelines or processes.

## 4 Taxonomy Codes (PRV)

The Healthcare Provider Taxonomy code set divides health care providers into hierarchical groupings by type, classification, and specialization, and assigns a code to each grouping. The Taxonomy consists of two parts: individuals (e.g., physicians) and non-individuals (e.g., ambulatory health care facilities). All codes are alphanumeric and are 10 positions in length. These codes are not "assigned" to health care providers; rather, health care providers select the taxonomy code(s) that most closely represents their education, license, or certification. If a health care provider has more than one taxonomy code associated with it, a health plan may prefer that the health care provider use one over another when submitting claims for certain services.

It is strongly recommended that the taxonomy be populated in Loops 2000A, 2310A, 2310B, 2420A, 2420F PRV segment for all applicable claims that you are filing. Refer to the CMS website for a listing of codes, [www.wpc-edi.com/taxonomy](http://www.wpc-edi.com/taxonomy).

## 5 Uppercase Letters

All alpha characters must be submitted in UPPERCASE letters only.

## 6 Delimiters

The Central Region accepts any of the standard delimiters as defined by the ANSI standards.

The more commonly used delimiters include the following:

- Data Element Separator, Asterisk, (\*)
- Sub-Element Separator, Vertical Bar, (|)
- Segment Terminator, Tilde, (~)

These delimiters are for illustration purposes only and are not specific recommendations or requirements.

## 7 Coordination of Benefits

Specific 837 data elements work together to coordinate benefits between the Central Region and Medicare or other carriers. The tables in the section that follow (Loop 2320, 2330A, 2330B, and/or 2430), identify the data elements that pertain to Coordination of Benefits (COB) with Medicare (Provider-to-Payer-to-Payer COB model) and with other carriers (Payer-to-Provider-to-Payer COB model).

The Central Region recognizes submission of an 837 transaction to a sequential payer populated with data from the previous payer's 835 (Health Care Claim Payment/Advice). Based on the information provided and the level of policy, the claim will be adjudicated without the paper copy of the Explanation of Benefits from Medicare or the primary carrier.

When more than one payer is involved on a claim, payer sequencing is as follows:

- If a secondary payer is indicated, then all the data elements from the primary payer must also be present.
- If a tertiary payer is involved, then all the data elements from the primary and secondary payers must also be present.


If these data elements are omitted, the Central Region will fail the particular claim.

## 8 Sending Attachments to Support a Claim

Loop 2300 PWK segment is required when paper documentation (attachments) supports a claim.

To expedite processing of a claim:

- Mail the attachment the same day the claim is submitted
- Do not send a copy of the claim with the attachment.
- Send the completed PWK Attachment Face Sheet with the attachment.



**Anthem Mid-West  
(IN, KY, OH, MO, WI)  
Attachment Face Sheet  
Claim Supplemental Information**

PWK; Loop 2300 Original Service Line Number  
 PWK; Loop 2400 Line Supplemental Information

**The paper documentation included in this mailing supports the electronically submitted claim.**

Date Claim Transmitted	
Line of Business	<input type="checkbox"/> Professional <input type="checkbox"/> Institutional
Member's Contract Number (Prefix Included)	
Name of Patient	
Date of Service	
Name of Provider	
State Services Were Rendered	
Identification Code (Attachment Control #)	

(If the correspondence is not received in 14 calendar days and is necessary to adjudicate the claim, Anthem will fail the claim. After 14 calendar days, the claim will be reviewed on an inquiry basis only.)

**Please mail to: Anthem BCBS  
PO Box 37850  
Louisville, KY 40233-7850**

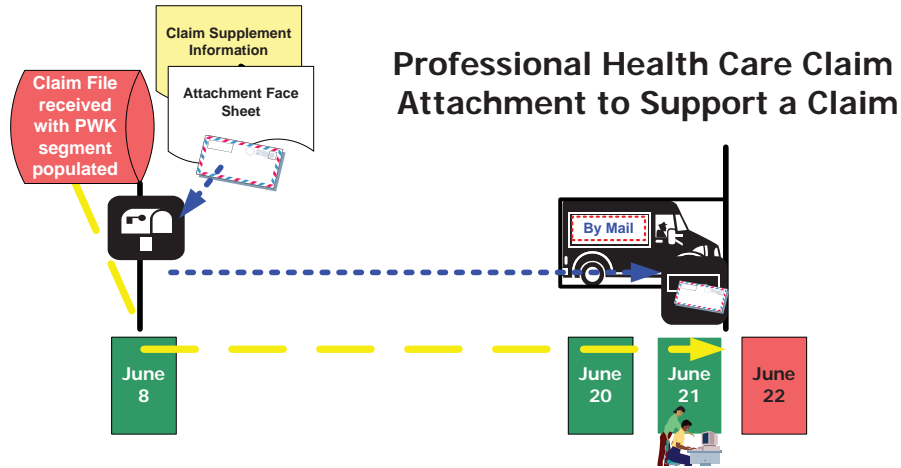
An independent licensee of the Blue Cross and Blue Shield Association.  
© Registered marks of the Blue Cross and Blue Shield Association.

The PWK Attachment Face Sheet is located in the appendices on [www.anthem.com/edi](http://www.anthem.com/edi) (IN, KY, OH, MO, WI) and includes the following fields:

- 1) Date Claim Transmitted
- 2) Line of Business  
(Professional, Institutional, Dental\*)
- \*Refer to 837D Companion Document for appropriate Attachment Face Sheet**
- 3) Member's Contract (Subscriber) Number
- 4) Patient Name
- 5) Date of Service
- 6) Provider Name
- 7) State Where Services Were Rendered
- 8) Identification Code. This is the Attachment Control Number, an alphanumeric code created by the provider for his records.

Mail the Attachment Face Sheet and supporting documentation to:

Anthem BCBS  
PO BOX 37850  
Louisville, KY 40233-7850



All documentation must be received within 14 calendar days of the electronic submission. If supporting documentation is not received but is required to process the claim, the Central Region will deny the claim.

For example (as shown above):

- On June 8, a claim is received with the PWK segment populated.
- On June 22, the 14 day time period expires. The claim will be denied if the attachment has not been received and is required for adjudication.

## 9 Numeric Values, Monetary Amounts and Unit Amounts

- The Central Region pays all claims in US dollars and, therefore, accepts monetary amounts only in US dollars. If codes related to foreign currencies are used, then the claim will be denied.
- The Central Region recognizes unit amounts in whole numbers only.
- The claim will also be denied for negative values submitted in any of the two data elements in Loop 2400 SV1 Professional Service (See 837P IG, P.383):

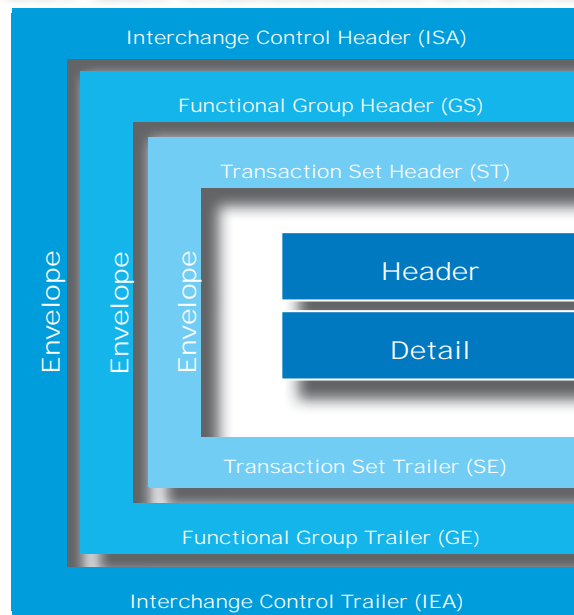
**SV102 Monetary Amount** – Line Item Charge Amount  
**SV104 Quantity** – Service Unit Count

## Enveloping

Electronic envelopes control and track communications between you and Anthem. One envelope may contain many transaction sets grouped into functional groups. The envelope includes the following components:

- Interchange Control Header (ISA)
- Functional Group Header (GS)
- Functional Group Trailer (GE)
- Interchange Control Trailer (IEA)

### 837 EDI Transaction Structure



## 837 Envelope Control Segments – Inbound

### 1 837 Health Care Claim Interchange Control Header (ISA)

The ISA segment is the beginning, outermost envelope of the interchange control structure. Containing authorization and security information, it clearly identifies the sender, receiver, date, time, and interchange control number. Anthem requests all data in the ISA-IEA segment to be entered in UPPER CASE.

837 Professional Health Care Claim Interchange Control Header (ISA)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
ISA Interchange Control Header	ISA01 Auth Info Qualifier	00	00 - No Authorization Information Present
	ISA02 Authorization Info	(10 Spaces)	Enter 10 positions.
	ISA03 Security Info Qualifier	00	00 - No Security Information Present
	ISA04 Security Information	(10 Spaces)	Enter 10 positions.
	ISA05 Interchange ID Qualifier	ZZ	ZZ - Mutually Defined
	ISA06 Interchange Sender ID	(Submitter ID)	<ul style="list-style-type: none"> <li>▪ Format - Fixed length of 15 positions, alphanumeric.</li> <li>▪ Left-justified followed by spaces.</li> <li>▪ Identical to GS02.</li> </ul>
	ISA07 Interchange ID Qualifier	ZZ	ZZ - Mutually Defined
	ISA08 Interchange Rec ID	ANTHEM	<ul style="list-style-type: none"> <li>▪ ANTHEM - Anthem Plans</li> <li>▪ Left-justified followed by spaces.</li> </ul>
	ISA09 Interchange Date	(YYMMDD)	Value must be a valid date in YYMMDD format.
	ISA10 Interchange Time	(HHMM)	Value must be a valid time in HHMM format.
	ISA11 Interchange Control Standards Identifier	U	U - U.S. EDI Community of ASC X12, TDCC, and UCS
	ISA12 Interchange Control Version Number	00401	00401 - Draft Standards for Trial Used Approved for Publication by ASC X12 Procedures Review Board through October 1997
	ISA13 Interchange Cntrl No.	(Assigned by Sender)	<ul style="list-style-type: none"> <li>▪ Format - Fixed length 9 positions, numeric.</li> <li>▪ Unique value greater than zero and not used in any HIPAA transmission within last 365 calendar days.</li> <li>▪ Right-justified, filled with leading zeroes.</li> <li>▪ Identical to IEA02.</li> </ul>
	ISA14 Ack Requested	0, 1	0 - No Acknowledgment Requested 1 - Interchange Acknowledgment Requested
	ISA15 Usage Indicator	P, T	Submitter ID must be approved to submit production data (P - Production Data; T - Test Data).
	ISA16 Component Element Separator	(X)	<ul style="list-style-type: none"> <li>▪ X - 1 character contained in Basic or Extended Character set.</li> <li>▪ Value must not equal A-Z, a-z, 0-9, "space", and special characters which may appear in text data (i.e., hyphen, comma, period, apostrophe).</li> </ul>

## 2 837 Health Care Claim Functional Group Header (GS)

The GS segment identifies the collection of transaction sets that are included within the functional group. More specifically, the GS segment identifies the functional control group, sender, receiver, date, time, group control number and version/release/industry code for the transaction sets. Anthem requests that all data in the GS-GE segment be entered in UPPERCASE.

837 Professional Health Care Claim Functional Group Header (GS)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
GS Functional Group Header	GS01 Functional Identifier Code	HC	HC - Health Care Claim (837)
	GS02 Application Sender's Code	(Submitter ID)	<ul style="list-style-type: none"> <li>Format - 2-15 positions, alphanumeric.</li> <li>Left-justified with no trailing zeroes or spaces.</li> <li>Identical to ISA06.</li> </ul>
	GS03 Application Receiver's Code	ANTHEMIN ANTHEMKY ANTHEMOH ANTHEMMO ANTHEMWI	Routing of batched transactions to: ANTHEMIN - IN BCBS Plan ANTHEMKY - KY BCBS Plan ANTHEMOH - OH BCBS Plan ANTHEMMO - MO BCBS Plan ANTHEMWI - WI BCBS Plan
	GS04 Date	(CCYYMMDD)	Value must be a valid date in CCYYMMDD format.
	GS05 Time	(HHMM)	Value must be a valid time in HHMM format.
	GS06 Group Control Number	(Assigned by Sender)	<ul style="list-style-type: none"> <li>Format - 1-9 positions, numeric.</li> <li>Unique value greater than zero and not used in any HIPAA transmission within last 365 calendar days.</li> <li>Left-justified with no trailing zeroes or spaces.</li> <li>Identical to GE02.</li> </ul>
	GS07 Responsible Agency Code	X	X - Accredited Standards Committee X12
	GS08 Version / Release / Industry Identifier Code	004010X098A1	Operationally used to identify the transaction: 004010X098A1 - 837 Professional Claim

NOTE. Critical Batching and Editing Information.

\*\*Transactions must be batched in separate functional group by Application Receiver's Code (GS03).

\*\*\*Group Control Number (GS06) may not be duplicated by submitter. Files containing duplicate or previously received group control numbers will be rejected.

### 3 837 Health Care Claim Functional Group Trailer (GE)

The GE segment indicates the end of the functional group and provides control information.

837 Professional Health Care Claim Functional Group Trailer (GE)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
GE Functional Group Trailer	GE01 Number of Transaction Sets Included	<i>(Total Number of Transaction Sets in Functional Group or Transmission)</i>	<ul style="list-style-type: none"> <li>Format - 1-6 positions, numeric.</li> <li>Left-justified with no trailing zeroes or spaces.</li> </ul>
	GE02 Group Control Number	<i>(Control Number)</i>	<ul style="list-style-type: none"> <li>Format - 1-9 positions, numeric.</li> <li>Left-justified with no trailing zeroes or spaces.</li> <li>Identical to GS06.</li> </ul>

### 4 837 Health Care Claim Interchange Control Trailer (IEA)

The IEA segment is the ending, outermost level of the interchange control structure. It indicates and verifies the number of functional groups included within the interchange and the interchange control number (the same number indicated in the ISA segment).

837 Professional Health Care Claim Interchange Control Trailer (IEA)			
Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Anthem
IEA Interchange Control Trailer	IEA01 Number of Included Functional Groups	<i>(Number of Functional Groups GS/GE Pairs in Interchange)</i>	<ul style="list-style-type: none"> <li>Format - 1-5 positions, numeric.</li> <li>Left-justified with no trailing zeroes.</li> </ul>
	IEA02 Interchange Control Number	<i>(Control Number)</i>	<ul style="list-style-type: none"> <li>Format - Fixed length 9 positions, numeric.</li> <li>Unique value greater than zero.</li> <li>Identical to ISA13.</li> </ul>

## 837 Professional Claim Header

The 837 Claim Header identifies the start of a transaction, the specific transaction set, and its business purpose. Also, when a transaction set uses a hierarchical data structure, a data element in the header, BHT01 (Hierarchical Structure Code) relates the type of business data expected within each level. The following table indicates the specific values of the required header segments and data elements for Central Region processing.

837 Professional Health Care Claim—Header				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Beginning of Hierarchical Transaction</b>				
P.63	<b>BHT</b> Beginning of Hierarchical Transaction	<b>BHT06</b> Transaction Type Code	<b>CH</b>	All submissions recognized as chargeable.
P.66	<b>REF</b> Transmission Type Identification	<b>REF02</b> Transmission Type Code	<b>004010X098A1</b>	Will not be used to distinguish between test and production. Anthem will determine based on the value in ISA15 only.
<b>Loop ID 1000A—Submitter Name</b>				
P.67	<b>NM1</b> Submitter Name	<b>NM109</b> Identification Code	<b>(Submitter Identifier) UPPERCASE</b>	<ul style="list-style-type: none"> <li>EDI assigned Sender ID.</li> <li>Equals the value entered in ISA06 and GS02.</li> </ul>
P.71	<b>PER</b> Administrative Communications Contact	<b>PER03</b> Communication Qualifier	<b>TE</b>	TE - Telephone For support purposes, the Central Region requests the telephone number of the submitter be identified.
<b>Loop ID 1000B—Receiver Name</b>				
P.74	<b>NM1</b> Receiver Name	<b>NM103</b> Last Name or Organization Name	<b>ANTHEM BLUE CROSS AND BLUE SHIELD</b>	Receiver Name
		<b>NM109</b> Identification Code	<b>00630 00660 00834 00241 00950</b>	00630 - Represents Indiana 00660 - Represents Kentucky 00834 - Represents Ohio 00241 - Represents Missouri 00950 - Represents Wisconsin

## 837 Professional Claim Detail

The 837 Detail level has a hierarchical level (HL) structure based on the participants involved in the transaction. The three levels for the participant levels include:

- 1) **Information Source** (Billing/Pay-to Provider)
- 2) **Subscriber** (Can be the Patient when the Patient is the Subscriber)
- 3) **Dependent** (Patient when the Patient is not the Subscriber)

### 1 837 Claim Detail: Billing/Pay-to Provider Hierarchical Level

The first hierarchical level (HL) of the 837 Claim Detail, Billing/Pay-to Provider HL, identifies the original entity who submitted the electronic claim to the destination payer.

837 Professional Health Care Claim—Detail Billing/Pay-to Provider Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2000A—Billing/Pay-to Provider Hierarchical Level</b>				
P.79	PRV Billing/Pay-to Provider Specialty Information	PRV01 Provider Code	<b>BI</b>	BI - Billing
		PRV03 Reference Identification	<b>(Provider Taxonomy Code)</b>	When using NPI, enter the taxonomy code that applies to the service on the claim that you are filing ( <b>NOTE</b> to Clearinghouses - DO NOT DEFAULT).
P.81	CUR Foreign Currency	CUR02 Currency Code	<b>USD</b>	USD - US dollars Monetary amounts recognized in US dollars only.
<b>Loop ID 2010AA—Billing Provider Name</b>				
P.84	NM1 Billing Provider Name	NM108 ID Code Qualifier	<b>XX</b> <b>24</b>	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	<b>(Billing Provider Primary ID No.)</b>	<ul style="list-style-type: none"> <li>• NPI ('XX') for Non-Exempt providers</li> <li>• Tax ID ('24') for Exempt providers</li> </ul>
P.91	REF Billing Provider Secondary Identification	<b>Segment required to accurately identify the Billing Provider.</b>		
		REF01 Reference ID Qualifier	<b>1B</b> <b>EI</b> <b>SY</b>	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	<b>(Billing Provider Additional Identifier)</b>	<ul style="list-style-type: none"> <li>• Provider's Tax ID ('EI')</li> <li>• Provider's Social Security No. ('SY')</li> <li>• Assigned Provider No. ('1B') - for Exempt Providers</li> </ul>
<b>Loop ID 2010AB—Pay-to Provider Name</b>				
P.99	NM1 Pay-to Provider Name	NM108 ID Code Qualifier	<b>XX</b> <b>24</b>	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	<b>(Pay-to Provider Primary ID No.)</b>	<ul style="list-style-type: none"> <li>• NPI ('XX') for Non-Exempt providers</li> <li>• Tax ID ('24') for Exempt providers</li> </ul>
P.106	REF Pay-to Provider Secondary	<b>Segment required to accurately identify the Pay-to Provider.</b>		
		REF01 Reference ID Qualifier	<b>1B</b> <b>EI</b> <b>SY</b>	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	<b>(Billing Provider Additional Identifier)</b>	<ul style="list-style-type: none"> <li>• Provider's Tax ID ('EI')</li> <li>• Provider's Social Security No. ('SY')</li> <li>• Assigned Provider No. ('1B') - for Exempt Providers</li> </ul>

## 2 837 Claim Detail Subscriber Hierarchical Level

The second hierarchical level (HL) of the 837 Detail is the Subscriber HL. It is strongly recommended that each interchange (ISA-IEA envelope) be limited to 3000 claims for processing efficiency.

837 Professional Health Care Claim—Detail Subscriber Hierarchical Level					
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region	
<b>Loop ID 2000B—Subscriber Hierarchical Level</b>					
P.108	<b>SBR</b> Subscriber Information	<b>SBR01</b> Payer Responsibility Sequence Number Code	<i>P, S, T</i>	Usage of 'S' or 'T' must be accompanied by information populated in Loop 2320.	
<b>Loop ID 2010BA—Subscriber Name</b>					
P.117	<b>NM1</b> Subscriber Name	<b>NM109</b> Identification Code	<i>(Subscriber Primary Identifier)</i>	<i>Enter one of the following formats:</i>	Format Explanation
				<b>***ALL ALPHA CHARACTERS MUST BE IN UPPERCASE LETTERS.</b>	
				<i>Enter the ID Number exactly as it appears on the front of the ID card, including ANY PREFIX.</i>	
				<i>(XXX999999999)</i> e.g. YTA123456789	3-4 - character alpha prefix (uppercase) followed by 9-character alphanumeric subscriber ID code.
				<i>(R999999999)</i> e.g. R12345678	R (uppercase) followed by 8-position numeric subscriber ID code.
			<i>(999999999)</i> e.g. 012345678	9-position numeric subscriber ID code.	
<b>Loop ID 2010BB—Payer Name</b>					
P.130	<b>NM1</b> Payer Name	<b>NM108</b> ID Code	<i>PI</i>	PI - Payer Identification	
		<b>NM109</b> Identification Code	<i>(Payer Primary Identifier)</i>	00630 - represents Indiana 00660 - represents Kentucky 00834 - represents Ohio 00241 - represents Missouri 00950 - represents Wisconsin	

**3 837 Claim Detail Patient Hierarchical Level**

The third hierarchical level (HL) of the 837 Claim Detail is the Patient HL. It is strongly recommended that each interchange (ISA-IEA envelope) be limited to 3000 claims for processing efficiency.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2300—Claim Information</b>				
P.170	CLM Claim Information	CLM01 Claim Submitter's Identifier	<i>(Patient Account Number)</i>	<ul style="list-style-type: none"> <li>Maximum of 20 alphanumeric characters.</li> <li>Value is returned on outbound 835 and other transactions.</li> </ul>
		CLM02 Monetary Amount	<i>(Total Claim Charge Amount)</i>	Value must equal the total amount of submitted charges for service lines in Loop 2400 SV102.
		CLM05-3 Claim Frequency Type Code	<i>7, 8</i>	If '7' (replacement) or '8' (void/cancel) then the Original Reference Number (ICN/DCN) data segment (Loop 2300 REF02) is required and must contain Anthem's originally assigned claim number.
P.214	PWK Claim Supplemental Information	PWK02 Report Transmission Code	<i>BM</i>	Supporting documentation accepted by mail (BM) only. Illegible information will delay processing. All documentation and Attachment Face Sheet must be received within 14 calendar days of the electronic transmission otherwise the claim will be denied. Refer to Basic Instructions for mailing details.
		PWK06 Identification Code	<i>(Attachment Control Number)</i>	Field reserved for self-assigned attachment control number (10 alphanumeric characters) on the Attachment Face Sheet. Digits will be drawn beginning from the left to match the Attachment with the appropriate electronically submitted claim.
P.229	REF Original Reference Number (ICN/DCN)	REF01 Reference ID Qualifier	<i>F8</i>	F8 - Original Reference Number
		REF02 Reference Identification	<i>(Claim Original Reference Number)</i>	Represents the claim number assigned by the Central Region. This value will be returned on 835 and should be submitted when Loop 2300 CLM05-3 Claim Frequency Type Code is populated with values of '7' or '8'.
P.265	HI Health Care Diagnosis Code	HI01-2 -- HI08-2 Industry Code	<i>(Diagnosis Code)</i>	<ul style="list-style-type: none"> <li>Include diagnosis information to promote more efficient adjudication and processing of bill type 4XX, 5XX, and 14 transactions.</li> <li>ICD-9-CM Guide requires diagnosis codes to the highest level of specificity. A 3-digit code cannot be used if a 4-digit exists, no 4-digit if a 5-digit code exists, etc. A code is invalid if it has not been coded to the full number of digits required for that code.</li> </ul>

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2310A—Referring Provider Name</b>				
P.282	NM1 Rendering Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Referring Provider Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.285	PRV Referring Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	When using NPI, enter the taxonomy code that applies to the service on the claim that you are filing ( <b>NOTE</b> to Clearinghouses - DO NOT DEFAULT).
P.288	REF Referring Provider Secondary Identification	<b>Segment required to accurately identify the Referring Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Referring Provider Additional ID)	• Provider's Tax ID ('EI') • Provider's Social Security No. ('SY') • Assigned Provider No. ('1B') - for Exempt Providers
<b>Loop ID 2310B—Rendering Provider Name</b>				
P.290	NM1 Rendering Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Rendering Primary Identifier)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.293	PRV Referring Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	When using NPI, enter the taxonomy code that applies to the service on the claim that you are filing ( <b>NOTE</b> to Clearinghouses - DO NOT DEFAULT).
P.296	REF Rendering Provider Secondary Identification	<b>Segment required to accurately identify the Rendering Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Rendering Provider Additional ID)	• Provider's Tax ID ('EI') • Provider's Social Security No. ('SY') • Assigned Provider No. ('1B') - for Exempt Providers

837 Professional Health Care Claim—Detail				
Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2310C—Purchased Service Provider Name</b>				
P.298	NM1 Purchased Service Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Purchased Service Provider Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.301	REF	<b>Segment required to accurately identify the Purchased Service Provider.</b>		
	Purchased Service Provider	REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		Secondary Identification	REF02 Reference Identification	(Purchased Service Provider Additional ID)
<b>Loop ID 2310D—Service Facility Location</b>				
P.303	NM1 Service Facility Location Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Service Facility Location Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.310	REF	<b>Segment required to accurately identify the Service Facility Location.</b>		
	Service Facility Location	REF01 Reference ID Qualifier	1B TJ	1B - Blue Shield Provider Number TJ - Tax ID
		Secondary Identification	REF02 Reference Identification	(Laboratory or Facility Secondary ID)
<b>Loop ID 2310E—Supervising Provider Name</b>				
P.312	NM1 Supervising Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Supervising Provider Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.316	REF	<b>Segment required to accurately identify the Supervising Provider Name.</b>		
	Supervising Provider	REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		Secondary Identification	REF02 Reference Identification	(Supervising Provider Additional ID)

837 Professional Health Care Claim—Detail				
Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>For COB claims, enter data elements as noted for Loops 2320, 2330A, 2330B, and/or 2430.</b>				
<b>Loop ID 2320—Other Subscriber Information</b>				
P.318	<b>SBR</b> Other Subscriber Information	<b>SBR01</b> Payer Responsibility Sequence Number Code	<b>P</b> <b>S</b> <b>T</b>	P - Primary; S - Secondary; T - Tertiary  Represents the other payers level of responsibility for payment of this claim.
P.332	<b>AMT</b> COB Payer Paid Amount	<b>AMT01</b> Amount Qualifier Code	<b>D</b>	D - Payor Amount Paid
		<b>AMT02</b> Monetary Amount	<b>(Payer Paid Amount)</b>	Represents total amount paid by Other Payer (835, Loop 1000B CLP04).
P.333	<b>AMT</b> COB Approved Amount	<b>AMT01</b> Amount Qualifier Code	<b>AAE</b>	AAE - Approved Amount
		<b>AMT02</b> Monetary Amount	<b>(Approved Amount)</b>	Represents approved amount by Other Payer. Provide amount, if available.
P.334	<b>AMT</b> COB Allowed Amount	<b>AMT01</b> Amount Qualifier Code	<b>B6</b>	B6 - Allowed-Actual
		<b>AMT02</b> Monetary Amount	<b>(Allowed Amount)</b>	Represents allowed amount by Other Payer. Provide amount, if available.
P.335	<b>AMT</b> COB Patient Responsibility Amount	<b>AMT01</b> Amount Qualifier Code	<b>F2</b>	F2 - Patient Responsibility - Actual
		<b>AMT02</b> Monetary Amount	<b>(Other Payer Pat. Resp. Amount)</b>	Represents Other Payer patient responsibility. Provide amount, if available (835, Loop 1000B CLP05).
P.337	<b>AMT</b> COB Discount Amount	<b>AMT01</b> Amount Qualifier Code	<b>D8</b>	D8 - Discount Amount
		<b>AMT02</b> Monetary Amount	<b>(Other Payer Discount Amount)</b>	Represents Other Payer discount amount. Provide amount, if available (835, AMT).
P.342	<b>DMG</b> Other Subscriber Demog. Information	<b>DMG01</b> Date Time Period Format Qualifier	<b>D8</b>	D8 - Date expressed in format CCYYMMDD
		<b>DMG02</b> Date Time Period	<b>(Other Insured Birth Date)</b>	Represents other insured's date of birth.
		<b>DMG03</b> Other Insured Gender Code	<b>F</b> <b>M</b> <b>U</b>	F - Female; M - Male; U - Unknown
P.344	<b>OI</b> Other Insurance Coverage Information	<b>OI03</b> Yes/No Condition or Response Indicator	<b>N</b> <b>Y</b>	N - No; Y - Yes Indicates authorization of assignment of benefits (Loop 2300 CLM08).
		<b>OI04</b> Patient Signature Source Code	<b>(Patient Signature Source Code)</b>	Required except when OI06 = N. Indicates Source of Patient's signature (Loop 2300 CLM10).
		<b>OI06</b> Release of Information Code	<b>(Release of Information Code)</b>	Indicates authorization of release on file. If value does not equal 'N', OI04 must be populated (Loop 2300 CLM09).

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>For COB claims, enter data elements as noted for Loops 2320, 2330A, 2330B, and/or 2430.</b>				
<b>Loop ID 2330A—Other Subscriber Name</b>				
P.350	NM1 Other Subscriber Name	NM101 Entity Identifier Code	<i>IL</i>	IL - Insured or Subscriber
		NM102 Entity Type Qualifier	<i>1</i>	1 - Person
		NM103, NM104 Name Last/Org. Name, Name First	<i>(Other Subscriber Last &amp; First Name)</i>	Represents the Other Subscriber's First and Last name.
		NM108 ID Code Qualifier	<i>MI</i>	MI - Member Identification Number
		NM109 Identification Code	<i>(Other Sub. Primary Member ID No.)</i>	Represents the Other Subscriber's ID No. as assigned by the Other Payer
<b>Loop ID 2330B—Other Payer Name</b>				
P.359	NM1 Other Payer Name	NM101 Entity Identifier Code	<i>PR</i>	PR - Payer (Other)
		NM102 Entity Type Qualifier	<i>2</i>	2 - Non-Person Entity
		NM103 Name Last/Org. Name	<i>(Other Payer Org. Name)</i>	Represents the Other Payer Last or Organization Name
		NM108 ID Code Qualifier	<i>PI</i>	PI - Payer Identification
		NM109 Identification Code	<i>(Other Payer Primary ID No.)</i>	If Other Payer is a BCBS Plan, indicate Plan Code assigned by BCBS Association.
P.366	DTP Claim Adjudication Date	<b>Required when Loop 2430 is not used &amp; Other Payer has adjudicated the claim.</b>		
		DTP01 Date/Time Qualifier	<i>573</i>	573 - Date Claim Paid
		DTP02 Date Time Period Format Qualifier	<i>D8</i>	D8 - Date expressed in format CCYYMMDD
		DTP03 Date Time Period	<i>(Other Payer Adjud. or Payment Date)</i>	Represents date the primary payer adjudicated the claim

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2400—Service Line</b>				
P.398	LX Service Line	LX01 Assigned Number	Accept up to 50 service lines per claim.	
P.400	SV1 Professional Service	SV101-2 Procedure Code	<i>(Procedure Code)</i>	When billing unlisted HCPCS (NOC codes), include the drug and dosage at the service line in Loop 2400 NTE02 (Description). Report the corresponding NDC# in Loop 2410 LIN03.
		SV101-3—6 Procedure Modifier	<i>(Procedure Modifier 1-4)</i>	<ul style="list-style-type: none"> <li>Modifiers listed in the CPT and HCPCS manuals are considered to be compliant.</li> <li><b>Certified Registered Nurse Anesthetists (CRNAs):</b> If the anesthesiologist employs the CRNA, DO NOT use modifier QX (CRNA service: with medical direction by a physician) for the service rendered. The claim should be filed under the CRNAs PIN number using the appropriate CPT anesthesia code. Refer to the current CPT manual for proper codes.</li> <li>Additional information - contact your provider representative for billing guidelines.</li> </ul>
		SV102 Monetary Amount	<i>(Line Item Charge Amount)</i>	<ul style="list-style-type: none"> <li>Sum of service line charges must equal the Total Claim Charge Amount in Loop 2300 CLM02.</li> <li>Value cannot be less than zero, or greater than \$999,999.99.</li> </ul>
		SV103 Unit or Measurement Code	<i>MJ</i>	MJ - Minutes <ul style="list-style-type: none"> <li>Report total anesthesia time in minutes. (EXCEPTION: Anthem Senior Advantage (ASA), follow HCFA guidelines for billing of anesthesia services.)</li> </ul>
		SV104 Quantity	<i>(Service Unit Count)</i>	<ul style="list-style-type: none"> <li>Accept values greater than or equal to zero, and up to 9999.</li> <li>When SV103=MJ, value is divided by 15 minutes to determine number of anesthesia units.</li> <li>When SV103=UN, round the value to the nearest whole integer during processing.</li> </ul>
P.485	AMT Approved Amount	AMT02 Monetary Amount	<i>(Approved Amount)</i>	When Central Region is secondary, enter the amount allowed by Medicare or primary carrier.
P.488	NTE Line Note	NTE02 Description	<i>(Line Note Text)</i>	When billing unlisted HCPCS (NOC codes) in Loop 2400 SV101-2 (Procedure Code), include the drug and dosage.  For Medicare Private Fee for Service claims, submit the dates when the provider assumed/relinquished patient to/from post-operative care.
<b>Loop ID 2410—Drug Identification</b>				
P.494	LIN Drug Identification	LIN03 Product/Service ID	<i>(National Drug Code)</i>	NDC# (without hyphens) corresponds to unlisted HCPCS (NOC codes) in Loop 2400 SV101-2, and the drug and dosage in Loop 2400 NTE02. Example: NDC# 12345-6789-10 is recognized as 12345678910.

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2420A—Rendering Provider Name</b>				
P.501	NM1 Rendering Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Rendering Provider Primary ID)	<ul style="list-style-type: none"> <li>NPI ('XX') for <u>Non-Exempt</u> providers</li> <li>Tax ID ('24') for <u>Exempt</u> providers</li> </ul>
P.504	PRV Rendering Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	When using NPI, enter the taxonomy code that applies to the service on the claim that you are filing ( <b>NOTE</b> to Clearinghouses - DO NOT DEFAULT).
P.507	REF Rendering Provider Secondary Identification	<b>Segment required to accurately identify the Rendering Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Rendering Provider Additional ID)	<ul style="list-style-type: none"> <li>Provider's Tax ID ('EI')</li> <li>Provider's Social Security No. ('SY')</li> <li>Assigned Provider No. ('1B') - for Exempt Providers</li> </ul>
<b>Loop ID 2420B—Purchased Service Provider Name</b>				
P.509	NM1 Purchased Service Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Purchased Service Provider Primary ID)	<ul style="list-style-type: none"> <li>NPI ('XX') for <u>Non-Exempt</u> providers</li> <li>Tax ID ('24') for <u>Exempt</u> providers</li> </ul>
P.512	REF Purchased Service Provider Secondary Identification	<b>Segment required to accurately identify the Purchased Service Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Purchased Service Provider Additional ID)	<ul style="list-style-type: none"> <li>Provider's Tax ID ('EI')</li> <li>Provider's Social Security No. ('SY')</li> <li>Assigned Provider No. ('1B') - for Exempt Providers</li> </ul>

837 Professional Health Care Claim—Detail				
Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2420C—Service Facility Location</b>				
P.514	NM1 Service Facility Location	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Service Facility Prov. Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.521	REF Service Facility Location Secondary Identification	<b>Segment required to accurately identify the Service Facility Location.</b>		
		REF01 Reference ID Qualifier	1B TJ	1B - Blue Shield Provider Number TJ - Tax ID
		REF02 Reference Identification	(Laboratory or Facility Secondary ID)	• Provider's Tax ID ('TJ') • Assigned Provider No. ('1B') - for Exempt Providers
<b>Loop ID 2420D—Supervising Provider Name</b>				
P.523	NM1 Supervising Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Supervising Provider Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.527	REF Supervising Provider Secondary Identification	<b>Segment required to accurately identify the Supervising Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Supervising Provider Additional ID)	• Provider's Tax ID ('EI') • Provider's Social Security No. ('SY') • Assigned Provider No. ('1B') - for Exempt Providers
<b>Loop ID 2420E—Ordering Provider Name</b>				
P.529	NM1 Ordering Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Ordering Provider Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.536	REF Ordering Provider Secondary Identification	<b>Segment required to accurately identify the Ordering Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Ordering Provider Additional ID)	• Provider's Tax ID ('EI') • Provider's Social Security No. ('SY') • Assigned Provider No. ('1B') - for Exempt Providers

837 Professional Health Care Claim—Detail Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<b>Loop ID 2420F—Referring Provider Name</b>				
P.541	NM1 Referring Provider Name	NM108 ID Code Qualifier	XX 24	XX - National Provider Identifier 24 - Employer's Identification Number
		NM109 Identification Code	(Referring Provider Primary ID)	• NPI ('XX') for <u>Non-Exempt</u> providers • Tax ID ('24') for <u>Exempt</u> providers
P.544	PRV Referring Provider Specialty Information	PRV03 Reference Identification	(Provider Taxonomy Code)	When using NPI, enter the taxonomy code that applies to the service on the claim that you are filing ( <b>NOTE</b> to Clearinghouses - DO NOT DEFAULT).
P.547	REF Referring Provider Secondary Identification	<b>Segment required to accurately identify the Referring Provider.</b>		
		REF01 Reference ID Qualifier	1B EI SY	1B - Blue Shield Provider Number EI - Employer's Identification SY - Social Security Number
		REF02 Reference Identification	(Referring Provider Additional ID)	• Provider's Tax ID ('EI') • Provider's Social Security No. ('SY') • Assigned Provider No. ('1B') - for Exempt Providers
<b>For COB claims, enter data elements as noted for Loops 2320, 2330A, 2330B, and/or 2430.</b>				
<b>Loop ID 2430—Line Adjudication Information</b>				
<b>Only use when service line adjustments reported. If not reported, enter claim adjud. date (Loop 2300).</b>				
P.554	SVD Service Line Adjudication	SVD01 Identification Code	(Other Payer Identification Code)	Matches Loop 2330B NM109 identifying Other Payer
		SVD02 Monetary Amount	(Service Line Paid Amount)	Represents paid amount by the Other Payer
		SVD03-1 Product/Service ID	HC	HC - HCPCS Code
		SVD03-2 Product/Service ID	(Procedure Code)	Represents procedure code
		SVD03-3, -4, -5, -6 Product/Service ID	(Procedure Modifier)	Represents procedure modifier, if applicable
		SVD05 Quantity	(Paid Service Unit Count)	Represents paid units of service by the Other Payer

837 Professional Health Care Claim—Detail				
Patient Hierarchical Level				
IG	Segment	Reference Designator(s)	Value	Definitions and Notes Specific to Central Region
<i>For COB claims, enter data elements as noted for Loops 2320, 2330A, 2330B, and/or 2430.</i>				
<b>Loop ID 2430—Line Adjudication Information (cont'd)</b>				
<i>Only use when service line adjustments reported. If not reported, enter claim adjud. date (Loop 2300).</i>				
P.558	CAS	<i>Use CAS segments to report Other Payer(s) service line level adjustments.</i>		
	Claim Level Adjustment	<b>DEDUCTIBLE</b>		
		CAS01 Claim Adjustment Group Code		<b>OA - Other Adjustments</b>
		CAS02,5,8,11,14,17 Claim Adjustment Reason Code	1	1 - Deductible Amount
		CAS03,6,9,12,15,18 Monetary Amount	(Adjustment Amount)	Represents the deductible as reported by the Other Payer.
		<b>COINSURANCE</b>		
		CAS01 Claim Adjustment Group Code		<b>OA - Other Adjustments</b>
		CAS02,5,8,11,14,17 Claim Adjustment Reason Code	2	2 - Coinsurance Amount
		CAS03,6,9,12,15,18 Monetary Amount	(Adjustment Amount)	Represents the coinsurance as reported by the Other Payer.
		<b>COPAYMENT</b>		
		CAS01 Claim Adjustment Group Code		<b>OA - Other Adjustments</b>
		CAS02,5,8,11,14,17 Claim Adjustment Reason Code	3	3 - Copayment Amount
		CAS03,6,9,12,15,18 Monetary Amount	(Adjustment Amount)	Represents the copayment amount as reported by the Other Payer.
		<b>NON-COVERED CHARGES</b>		
		CAS01 Claim Adjustment Group Code		<b>PR - Patient Responsibility</b>
		CAS02,5,8,11,14,17 Claim Adjustment Reason Code	(Adjustment Rsn Code)	Enter the adjustment reason based on the Other Payer(s) Explanation of Benefits.
		CAS03,6,9,12,15,18 Monetary Amount	(Adjustment Amount)	Represents the non-covered amount as reported by Other Payer.
		<b>CONTRACTUAL OBLIGATION</b>		
		CAS01 Claim Adjustment Group Code		<b>CO - Contractual Obligation</b>
		CAS02,5,8,11,14,17 Claim Adjustment Reason Code	(Adjustment Rsn Code)	Enter the adjustment reason based on the Other Payer(s) Explanation of Benefits.
		CAS03,6,9,12,15,18 Monetary Amount	(Adjustment Amount)	Represents the contractual obligation amount as reported by Other Payer.
P.566	DTP	<i>Enter the adjudication date at line level only if service line adjustments have been reported, otherwise report the adjudication date at claim level (Loop 2300).</i>		
	Line Adjudication Date	DTP01 Date Time Qualifier	573	573 - Claim Paid Date by Other Payer
		DTP02 Date Time Period Format Qualifier	D8	D8 - Date expressed in format CCYYMMDD
		DTP03 Date Time Period	(Adjud. or Payment Date)	Represents when Other Payer made payment and recognized for processing COB.