837 Health Care Claim Companion Guides

5010

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INTRODUCTION

In an effort to reduce the administrative costs of health care across the nation, the Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996. This legislation requires that health insurance payers in the United States comply with the electronic data interchange (EDI) standards for health care, established by the Secretary of Health and Human Services (HHS). For the health care industry to achieve the potential administrative cost savings with EDI, standard transactions and code sets have been developed and need to be implemented consistently by all organizations involved in the electronic exchange of data. The ANSI X12N 837 Health Care Claims transaction implementation guides provide the standardized data requirements to be implemented for all health care claim electronic submissions.

PURPOSE

The purpose of this document is to provide the information necessary to submit claims/encounters electronically to Beacon Health Options, Inc. This companion guide is to be used in conjunction with the ANSI X12N implementation guides. The information describes specific requirements for processing data within the payer's system. The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at http://www.wpcedi.com/hipaa/. Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org
United States Department of Health and Human Services (DHHS) – http://aspe.hhs.gov/
Centers for Medicare and Medicaid Services (CMS) – http://www.cms.gov
National Council of Prescription Drug Programs (NCPDP) – http://www.ncpdp.org/
National Uniform Billing Committee (NUBC) – http://www.nubc.org/
Accredited Standards Committee (ASC X12) – http://www.x12.org/

SPECIAL CONSIDERATIONS

Inbound Transactions Supported

This section is intended to identify the type and version of the ASC X12 837 Health Care Claim transactions that the health plans will accept.

837 Professional Health Care Claim - **ASC X12N 837 (005010X222A1)** ☒
837 Institutional Health Care Claim - **ASC X12N 837 (005010X223A2)** ☒

Response Transactions Supported

This section is intended to identify the response transactions supported by the health plan.

Beacon Health Options system issued email response Acknowledgement ☒
999 Functional Acknowledgement ☒
835 Health Care Claim Payment Advice - **ASC X12N 835 (005010X221A1)** ☒
227CA Claims Acknowledgment **(005010X214A1)** *(Can only be used if unique patient control numbers are utilized per claim.)* ☒

Delimiters Supported

A delimiter is a character used to separate two data elements or sub-elements, or to terminate a segment. Delimiters are specified in the interchange header segment, ISA. The ISA segment is a 105 byte fixed length record. The data element separator is byte number 4; the component element separator is byte number 105; and the segment terminator is the byte that immediately follows the component element separator. Once specified in the interchange header, delimiters are not to be used in a data element value elsewhere in the transaction.

Description	Default Delimiter
Data element separator	* Asterisk
Sub-element separator	: Colon
Segment Terminator	~ Tilde
Repetition Separator	^ Carat

Beacon Health Options will support these default delimiters or any delimiter specified by the trading partner in the ISA/IEA envelope structure.

Maximum Limitations

The 837 transaction is designed to transmit one or more claims for each billing provider. The hierarchy of the looping structure is billing provider, subscriber, patient, claim level, and claim service line level. Each transaction set contains groups of logically related data in units called segments. The number of times a loop or segment may repeat in the transaction set structure is defined in the implementation guide. Some of these limitations are explicit, such as:

The Claim Information loop (2300) is limited to 100 claims per patient.

The system allows a maximum of 1 ISA/IEA envelope per 837 file.

The Service Line loop (2400) is limited to 50 service lines per professional claim or 50 service lines per institutional claim.

The ST/SE envelope can be a maximum of 5000 claims per transaction as long as the file does not exceed the maximum file size of 8MB.

If submitting both encounter and claim transactions, the files must be sent in separate Interchange Control structures (ISA/IEA envelopes).

Validation Specifications

Initial validation is conducted at a batch level. If the batch file is not syntactically valid, the submitter will need to resubmit the corrected batch in its entirety.

Secondary validation is conducted at a claim level. If claims are rejected on the claim level validation, the submitter will need to rebuild the corrected claims in a new batch and submit the new batch for validation.

Do not resubmit the same batch after making the claim level corrections as this will cause any claims that have passed validation from the previous submission to duplicate in the system.

Telecommunication Specifications

Trading partners wishing to submit electronic Health Care Claims (837 transactions) to Beacon Health Options must have a valid Beacon Health Options Submitter ID/Password. If you do not have a Submitter ID you may obtain one by completing the Account Request form available on the Beacon Health Options website at http://www.valueoptions.com/providers/Adminforms.htm.

Beacon Health Options can accommodate multiple submission methods for the 837 Health Care Claim transactions. Please refer to the ETS (Electronic Transport System) Electronic Data Exchange Overview document on the Beacon Health Options website at http://www.valueoptions.com/providers/ProCompliance.htm for further details.

If you have any questions please contact the Beacon Health Options EDI Helpdesk:

Email: e-supportservices@beaconhealthoptions.com
Telephone: 888.247.9311 (8 a.m. – 6 p.m. ET, Monday – Friday)
Fax: 866.698.6032

Compliance Testing Specifications

The Workgroup for Electronic Data Interchange (WEDI) and the Strategic National Implementation Process (SNIP) have recommended seven types HIPAA compliance testing, these are:

1. Integrity Testing – This is testing the basic syntax and integrity of the EDI transmission to include: valid segments, segment order, element attributes, numeric values in numeric data elements, X12 syntax and compliance with X12 rules.
2. Requirement Testing – This is testing for HIPAA Implementation Guide specific syntax such as repeat counts, qualifiers, codes, elements and segments. Also testing for required or intra-segment situational data elements and non-medical code sets whose values are noted in the guide via a code list or table.

3. Balance Testing – This is testing the transaction for balanced totals, financial balancing of claims or remittance advice and balancing of summary fields.
4. Situational Testing – This is testing of inter-segment situations and validation of situational fields based on rules in the Implementation Guide.
5. External Code Set Testing – This is testing of external code sets and tables specified within the Implementation Guide. This testing not only validates the code value but also verifies that the usage is appropriate for the particular transaction.
6. Product Type or Line of Service Testing – This is testing that the segments and elements required for certain health care services are present and formatted correctly. This type of testing only applies to a trading partner candidate that conducts the specific line of business or product type.
7. Implementation Guide-Specific Trading Partners Testing – This is testing of HIPAA requirements that pertain to specific trading partners such as Medicare, Medicaid and Indian Health. Compliance testing with these payer specific requirements is not required from all trading partners. If the trading partner intends to exchange transactions with one of these special payers, this type of testing is required.

Trading Partner Acceptance Testing Specifications

Trading partners are encouraged to submit a test file prior to submitting claims electronically to Beacon Health Options.

To submit claims electronically, trading partners must obtain an ID & Password from the Beacon Health Options EDI Helpdesk. Based on the types of services provided, a trading partner may receive multiple submitter IDs. Test files will need to be submitted under all assigned submitter IDs.

Trading partners who upgrade or change software are also encouraged to submit a test submission.

Submitters will be notified via e-mail as to the results of the file validation. If the file failed validation, the e-mail message will provide explanations for the failure. Any error message that is not understood can be explained thoroughly by a Beacon Health Options EDI Coordinator.

After receiving notification that your test batch has passed validation, you can begin to submit files to the “production” directories.

Test Submission Requirements:

Current Provider and Member data (claim data that has successfully processed within the last 3 months)

Minimum 5 test claims/Maximum 15 test claims per batch

Submit with dates of service within the past month

National Provider Identifier Specifications

Beacon Health Options, in accordance with the HIPAA mandate will require covered entities to submit electronic claims with the NPI and taxonomy codes in the appropriate locations. The NPI is a standard provider identifier that will replace the provider numbers used in standard electronic transactions today and was adopted as a provision of HIPAA. The NPI Final Rule was published on January 23, 2004 and applies to all health care providers.

Beacon Health Options requires that all covered entities report their NPI prior to submitting electronic transactions containing an NPI. To provide your NPI please contact our National Provider Line at 800.397.1630.

All electronic transactions for covered entities should contain the provider NPI, taxonomy code, employee identification number and zip code + the 4 digit postal code in the appropriate loops. The NPI should be sent in the NM109, where NM108 equals XX. The taxonomy code should be sent in the PRV03, employee identification number will be sent in the REF02 and the zip code + the 4 digit postal code should be sent in the N403 and N404.

Additional information on NPI including how to apply for a NPI can be found on the Centers for Medicare and Medicaid Services (CMS) website at:
http://www.cms.hhs.gov/NationalProvIdentStand/.

Provider Billing Requirements

The 837 Health Care Claim transaction provides a large amount of provider data at both the claim level and the service line level. Beacon Health Options claim adjudication system only utilizes the provider data present at the claim level. Much of the provider data is situational and must be provided if the condition is met. Such as, the referring provider is required when a referral has been made, or the attending provider (institutional claim) is required when the claim is for an inpatient stay.

The Billing/Pay-To loop (2000A) is a required loop. At a minimum the transaction must have a billing provider. The pay-to, rendering (professional claim), attending (institutional claims) loops are dependent upon what is entered in the billing loop.

Billing Provider Name loop (2010AA) - is a required loop used to identify the original entity that submitted the electronic claim/encounter. The billing provider entity may be a health care provider, a billing service or some other representative of the provider.

Pay-To Provider Name loop (2010AB) - is a situational loop, required if the pay-to provider is a **different entity** from the billing provider.

Rendering Provider Name loop (2310B) – PROFESSIONAL ONLY is a situational loop, required if the rendering provider information is different than that carried in either the billing provider or pay-to provider (2010AA/AB) loops.

Attending Provider Name loop (2310A) – INSTITUTIONAL ONLY is a situational loop, required if the attending provider information is different than that carried in either the billing provider or pay-to provider (2010AA/AB) loops.

Service Facility Location (2310C on Professional claims. 2310E on Institutional Claims) – is a required loop used in correlation with 2010AA to identify the provider record. This must be the physical street address of where the services took place.

Depending on the scenario one or more of the previously mentioned loops might be present in the 837 Health Care Claim transaction. Refer to the scenarios below to determine the loops to be included in your transaction.

Billing Agent Scenario: (Professional or Institutional Claims)

In this scenario the provider, provider group or facility (institutional claims) contracts with a billing agent to perform their billing and reconciliation functions. In this case the following information should be provided:

Billing Provider Name loop (2010AA) – this loop will contain the billing agent information.
Pay-To Provider Name (2010AB) – this loop will contain the provider, provider group or facility (institutional claims) information. The entity receiving payment for the claim.
Rendering Provider Name loop (2310B) – PROFESSIONAL CLAIMS. This loop will only be included if the rendering provider is different from the pay-to provider.
Attending Provider Name loop (2310A) – INSTITUTIONAL CLAIMS. This loop will only be included if the rendering provider is different from the pay-to-provider.
Service Location loop (2310C on Professional claims. 2310E on Institutional Claims) – Required on all claims.

Provider Group Scenario: (Professional Claims)

In this scenario the provider, who performed the services, is a member of a group. In this case the following information should be provided:

Billing Provider Name loop (2010AA) – this loop will contain the provider group information.
Pay-To Provider Name loop (2010AB) – this loop will be included if payment is being made to an entity other than the group in 2010AA.
Rendering Provider Name loop (2310B) – this loop will only be included if the provider group is being paid for the claim (the pay-to provider loop (2010AB) is not included in the transaction). The rendering provider information will be provided in this loop.
Service Location loop (2310C) – Required on all claims.

Individual Provider Scenario: (Professional Claims)

In this scenario the provider is submitting the claim for payment. In this case the following information should be provided:

Billing Provider Name loop (2010AA) – this loop will contain the billing provider information.
Pay-To Provider Name loop (2010AB) – this loop will not be included.
Rendering Provider Name loop (2310B) – this loop will not be included.
Service Location loop (2310C) – Required on all claims.

Service Facility Scenario: (Institutional Claims)

In this scenario the facility is submitting the claim for payment. In this case the following information should be provided:

Billing Provider Name loop (2010AA) – this loop will contain the facility information.
Pay-To Provider Name loop (2010AB) – this loop will be included if payment is being made to an entity other than the group in 2010AA.
Service Location loop (2310E) – Required on all claims

Note: If a clearinghouse is employed to format and transmit the 837 transaction, the clearinghouse information should be sent in the Submitter Name loop (1000A).

INTERCHANGE CONTROL HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
ISA		**Interchange Control Header**	**R**		
	ISA01	Authorization Information Qualifier	R	Valid values: '03' Additional Data Identification	Use '03' Additional Data Identification to indicate that a login ID will be present in ISA02.
	ISA02	Authorization Information	R	Information used for authorization.	Use the Beacon Health Options submitter ID as the login ID. Maximum 10 characters.
	ISA03	Security Information Qualifier	R	Valid values: '00' No Security Information Present '01' Password	Use '01' value to indicate that a password will be present in ISA04. Use '00' value to indicate that no password will be present in ISA04.
	ISA04	Security Information	R	Additional security information identifying the sender.	Use the Beacon Health Options submitter ID password. Maximum 10 characters.
	ISA05	Interchange ID Qualifier	R		Use 'ZZ' or Refer to the implementation guide for a list of valid qualifiers.
	ISA06	Interchange Sender ID	R		Usually Submitter ID out to 15 characters. Refer to the implementation guide specifications.
	ISA07	Interchange ID Qualifier	R		Use 'ZZ' Mutually Defined.
	ISA08	Interchange Receiver ID	R		Use 'FHC &Affiliates'.
	ISA09	Interchange Date	R	Date format YYMMDD.	The date (ISA09) is expected to be no more than seven days before the file is received. Any date that does not meet this criterion may cause the file to be rejected.

Seg	Data Element	Name	Usage	Comments	Expected Value
	ISA10	Interchange Time	R	Time format HHMM.	Refer to the implementation guide specifications.
	ISA11	Interchange Control Standards Identifier	R	Delimiter used to separate repeated occurrences of a simple data element or a composite data structure. This value must be different than the data element separator, component element, and the segment terminator. Valid value: '^' Repetition Separator	Use the value specified in the implementation guide. '^'
	ISA12	Interchange Control Version Number	R	Use the current standard approved for the ISA/IEA envelope.	'00501'
	ISA13	Interchange Control Number	R	The interchange control number in ISA13 must be identical to the associated interchange trailer IEA02.	This value is defined by the sender's system. If the sender does not wish to define a unique identifier zero fill this element. Out to 9 Characters.
	ISA14	Acknowledgement Requested	R	This pertains to the TA1 acknowledgement. Valid values: '0' No Acknowledgement Requested '1' Interchange Acknowledgement Requested	Use '0' No Acknowledgement Requested. Beacon Health Options will not be generating the TA1 Interchange Acknowledgement or the 997 Functional Acknowledgement.
	ISA15	Usage Indicator	R	Valid values: 'P' Production 'T' Test	The Usage Indicator should be set appropriately. Either can be used.
	ISA16	Component Element Separator	R	The delimiter must be a unique character not found in any of the data included in the transaction set. This element contains the delimiter that will be used to separate component data elements within a composite data structure. This value must be different from the data element separator and the segment terminator.	Beacon Health Options will accept any delimiter specified by the sender. The uniqueness of each delimiter will be verified. ':' (colon) usually

INTERCHANGE CONTROL TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
IEA		**Interchange Control Trailer**	**R**		
	IEA01	Number of Included Functional Groups		Count the number of functional groups in the interchange	Multiple functional groups may be sent in one ISA/IEA envelope. This is the count of the GS/GE functional groups included in the interchange structure. Limit the ISA/IEA envelope to one type of functional group i.e. functional identifier code 'HC' Health Care Claim (837). Segregate professional and institutional functional groups into separate ISA/IEA envelopes.
	IEA02	Interchange Control Number		The interchange control number in IEA02 must be identical to the associated interchange header value sent in ISA13.	The interchange control number in IEA02 will be compared to the number sent in ISA13. If the numbers do not match the file will be rejected.

FUNCTIONAL GROUP HEADER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
GS		**Functional Group Header**	**R**		
	GS01	Functional Identifier Code	R	Code identifying a group of application related transaction sets. Valid value: 'HC' Health Care Claim (837)	Use the value specified in the implementation guide.
	GS02	Application Sender's Code	R		The sender defines this value. Beacon Health Options will not be validating this value.
	GS03	Application Receiver's Code	R		This field will identify how the file is received by Beacon Health Options. Use 'EDI' for Electronic Data Interchange
	GS04	Date	R	Date format CCYYMMDD	Refer to the implementation guide for specifics.
	GS05	Time	R	Time format HHMM	Refer to the implementation guide for specifics.
	GS06	Group Control Number	R	The group control number in GS06, must be identical to the associated group trailer GE02.	This value is defined by the sender's system. If Beacon Health Options eventually implements the 997, this number will be used to identify the functional group being acknowledged.
	GS07	Responsible Agency Code	R	Code identifying the issuer of the standard. Valid value: 'X' Accredited Standards Committee X12	Use the value specified in the implementation guide.

Seg	Data Element	Name	Usage	Comments	Expected Value
	GS08	Version/Release Industry ID Code	R	Professional Addenda Approved for Publication by ASC X12: 005010X222A1 Institutional Addenda Approved for Publication by ASCX12: 005010X223A2	Use 005010X222A1 or 0051010X223A2 Other standards will not be accepted

FUNCTIONAL GROUP TRAILER SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
TRAILER					
GE		**Functional Group Trailer**	**R**		
	GE01	Number of Transaction Sets Included	R	Count of the number of transaction sets in the functional group.	Multiple transaction sets may be sent in one GS/GE functional group. Only similar transaction sets may be included in the functional group.
	GE02	Group Control Number	R	The group control number in GE02 must be identical to the associated functional group header value sent in GS06.	The group control number in GE02 will be compared to the number sent in GS06. If the numbers do not match the entire file will be rejected.

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS

837 PROFESSIONAL CLAIM TRANSACTION SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
BHT		**Beginning of Hierarchical Transaction**	**R**		
	BHT02	Transaction Set Purpose Code	R	Valid values: '00' Original '18' Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original
	BHT06	Transaction Type Code	R	Separate claim and encounter data into two separate ISA/IEA envelopes (files).	'CH' is used for Claims 'RP' is used for Encounters
LOOP 1000A – SUBMITTER NAME					
NM1		**Submitter Name**	**R**		
	NM109	Submitter Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the Beacon Health Options assigned submitter ID Maximum 10 characters.
Loop 1000B					
NM1		**Receiver Name**	**R**		
	NM103	Receiver Name	R		Use 'Beacon Health Options, Inc.'
	NM109	Receiver Primary Identifier	R	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'FHC &Affiliates'

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2010AA – BILLING PROVIDER NAME					
NM1		**Billing Provider Name**	**R**		
	NM108	Billing Provider Identification Code Qualifier	**R**	Required for ALL NPI submitters. See Implementation Guide for additional information.	Valid Value- 'XX'
	NM109	Billing Provider Identifier	**R**		Covered entities send the National Provider
REF		**Billing Provider Secondary Identification**	**S**	When NPI is submitted in the NM108/09 of this loop, the either the EIN or SSN of the provider must be carried in this REF segment. The number sent is the one which be used on the 1099.	
	REF01	Reference Identification Qualifier	R		Place **EI** in REF01 if the Provider ID is EIN and place **SY** in REF01 if Provider ID is SSN
	REF02	Billing Provider Additional Identifier	R		**EIN** or **SSN** of the billing provider.
LOOP 2010BA – SUBSCRIBER NAME					
NM1		**Subscriber Name**	**R**		
	NM108	Identification Code Qualifier	R	An identifier must be present in the subscriber loop.	Valid value: 'MI' Member Identification Number. Refer to Implementation Guide for further details.
	NM109	Subscriber Primary Identifier	R	Use the Beacon Health Options Subscriber ID.	*Note: Medical Assistance Number can be used if applicable.

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2010BB – PAYER NAME					
NM1		**Payer Name**	**R**		
	NM103	Payer Name	R	Destination payer name	Use 'Beacon Health Options, Inc'
	NM108	Identification Code Qualifier	R	Valid values: 'PI' Payer Identification 'XV' HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier' until the National Plan ID is mandated.
	NM109	Payer Identifier	R	Destination payer identifier	Use 'FHC &Affiliates'
LOOP 2300 – CLAIM INFORMATION					
CLM		**Claim Information**	**R**		
	CLM05-3	Claim Frequency Type Code	R	1 = Original 7 = Replacement 8 = Void	Record Action
PWK		**Claim Supplemental Information**	**S**		
	PWK02	Attachment Transmission Code	R	Valid values: 'AA' Available on Request at Provider Site	Use 'AA' Available on Request at Provider Site
REF		**Original Reference Number (ICN/DCN)**	**S**	**Required if Claim Frequency Type Code is 7, or 8**	
	REF01	Reference Identification Qualifier	R		'F8' Original Reference Number
	REF02	Original Reference Number (ICN/DCN)	R		If this is a correction to a previously submitted claim use the Beacon Health Options claim number prefixed by 'RC'. Enter the whole claim number without spaces or dashes.

Seg	Data Element	Name	Usage	Comments	Expected Value
HI		Health Care Diagnosis Code	R	Do not include a decimal point.	Diagnoses submitted must include all characters out to the furthest position as defined by the diagnosis coding system.
	HI01	Health Care Code Information	R		Principal Diagnosis
	HI01-1	Code List Qualifier Code	R		BK - Principal Diagnosis – ICD-9 ABK- Principal Diagnosis- ICD10
	HI01-2	Industry Code	R	Use ABK for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BK for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	HI02	Health Care Code Information	S		Additional Diagnosis
	HI02-1	Code List Qualifier Code	R		BF- Diagnosis – ICD-9 ABF- Diagnosis- ICD10
	HI02-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	HI03	Code List Qualifier Code	S		Additional Diagnosis
	HI03-1	Code List Qualifier Code	R		BF- Diagnosis – ICD-9 ABF- Diagnosis- ICD10
	HI03-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
	HI04	Code List Qualifier Code	S		Additional Diagnosis
	HI04-1	Code List Qualifier Code	R		BF- Diagnosis – ICD-9 ABF- Diagnosis- ICD10
	HI04-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2310A – REFERRING PROVIDER NAME					
NM1		**Referring Provider Name**	**S**		
	NM108	Identification Code Qualifier	S	National Provider Identifier	Valid Value- 'XX'
	NM109	Identification Code	S	This element contains the NPI for the referring provider.	Use the NPI of the referring provider.
LOOP 2310B – RENDERING PROVIDER NAME					
NM1		**Rendering Provider Name**	**S**		
	NM108	Rendering Provider Identification Code Qualifier	S	The rendering provider loop is only required if Beacon Health Options contracts with the rendering provider directly.	Valid Value- 'XX'
	NM109	Rendering Provider Identifier	S	This element contains the NPI for the rendering provider.	Use the NPI of the rendering provider.
LOOP 2310C – SERVICE FACILITY LOCATION					
NM1		**Professional Service**	**R**		
	NM101	Entity Identifier Code	R		77= Service Location or FA= Facility
	NM102	Entity Type Qualifier	R		2= non-person entity
	NM103	Last Name or Organization Name	R		Last Name or Organization Name
	NM108	Identification Code Qualifier	S		Valid Value- 'XX'

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM109	Identification Code	S	Entities send the National Provider ID	Use the NPI of the Service Facility Location.
N3		**Address Information**	**R**		
	N301	Address Line 1	R		Address Line 1
	N302	Address Line 2	S		Address Line 2
N4		**Consumer City/State/Zip Code**	R		
	N401	City Name	R		City Name
	N402	State	S		State
	N403	Postal Code	S		Zip Code
LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION					
SBR		**Subscriber Information**	**S**		
	SBR01	Payer responsibility	R	**This loop is for OTHER PAYER ONLY; If there is another payer whose liability precedes Beacon Health Options coverage, do not submit claim until you have received payment or denial from the other payer.**	P (Primary) S (Secondary) T (Tertiary) See Implementation Guide for additional Values
	SBR02	Individual Relationship Code	R	See Implementation Guide for other values	18 = Self
	SBR03	Reference Identification	S		Group or Policy Number
	SBR04	Name	S	Free-form name	Other Insured Group Name
	SBR05	Insurance Type Code	S		See Implementation Guide for valid values
	SBR09	Claim Filing Indicator	S		See Implementation Guide for valid values

Seg	Data Element	Name	Usage	Comments	Expected Value
AMT		**COB Payer Paid Amount**	**R**		
	AMT01	Amount Qualifier	R		D
	AMT02	Monetary Amount	R		Amount Paid by the Other Payer
AMT		**COB NON Covered Amount**			
	AMT01	Amount Qualifier Code	R		A8
	AMT02	Monetary Amount	R	Non-covered charge amount	
OI		**Other Insurance Coverage Information**	**R**		
	OI03	Benefits Assignment	R		'N'- NO 'W'- not applicable 'Y'-YES
	OI04	Patient Signature Source	S	See Implementation Guide for valid values	
	OI06	Release of Information Code	R	See Implementation Guide for valid values	
LOOP 2330A – SUBSCRIBER INFORMATION					
NM1			**S**	Required if Loop 2320 is present	
	NM101	Entity ID	R	Insured or Subscriber	IL
	NM102	Entity Type	R		1 = Person
	NM103	Last Name	R		
	NM104	First Name	S		
	NM105	Middle Name	S		
	NM107	Suffix	S		

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM108	Identification Code	R		MI = Member Identification Number
	NM109	Identification Number	R	Member Identification Number	
N3		**Address**	**S**		
N4		**City*State*ZIP**	**R**		
LOOP 2330B – PAYER INFORMATION					
NM1		**Other Payer Name**	**R**		
	NM101	Entity Identifier	R		PR = Payer
	NM102	Entity Type	R		2 = Non-Person Entity
	NM103	Organization Name	R	Name of Payer (Other Insurance Company)	
	NM108	ID Code Qualifier	R		PI = Payer Identification
	NM109	Identification Code	R	Payer ID	
N3		Address	S		
N4		City*State*ZIP	R		
DTP		Claim Adjudication Date	R		
	DTP01	Date/Time Qualifier	R	Date Claim Paid	573
	DTP02	Format Qualifier	R		D8
	DTP03	Adjudication Date	R	YYYYMMDD	
LOOP 2400 – SERVICE LINE					
SV1		**Professional Service**	**R**		
	SV101	Composite Medical Procedure Identifier	R		
				Use ‘HC’ Health Care Financing Administration	

Seg	Data Element	Name	Usage	Comments	Expected Value
	SV101-1	Product/Service ID Qualifier	R	Use 'HC' Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes	Use HC to identify health care financing administration. Use common procedural coding system (HCPCS) codes.
	SV101-3 SV101-4 SV101-5 SV101-6	Procedure Modifier	S	Modifiers must be billed in the order they appear on the benefit grid.	
	SV104	Quantity	R		Use whole number unit values.
DTP		**Date – Service Date**	**R**		
	DTP01	Date/Time Qualifier	R	Valid Value: '472' Service	Use '472' Service
	DTP02	Date Time Period Format Qualifier	R	Valid Values: 'D8' Date Expressed in Format CCYYMMDD 'RD8' Date Range Expressed in Format CCYYMMDD-CCYYMMDD	Use 'RD8' to specify a range of dates. The from and through service dates should be sent for each service line.
	DTP03	Date Time Period	R	Service Date	
LOOP - 2420C SERIVICE FACILITY LOCATION					
NM1		**Service Facility Location Name**	**S**		
	N3	Service Facility Location Address	R	If loop 2310C is left blank, Loop 2420C can have multiple service lines; however the addresses in each line must be identical. The line level service facility location address (2420C) should not be different from the claim level service facility location (2310C).	
	N4	Service Facility Location City, State, ZIP Code	R		

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2430 – LINE ADJUDICATION INFORMATION					
SVD		**Professional Service**	**R**		
	SVD01	Payer ID	R	Payer Identification Code/Number	
	SVD02	Monetary Amount	R	Paid Amount	
	SVD03-1	Procedure Code/ID Qualifier	R		HC = HCPCS
	SVD03-2	Procedure Code/ID	R		
	SVD03-3 through 6	Modifiers	S		
	SVD06	Bundled or Unbundled	R	Number of Units Paid for by Other Payer	(Whole Units Only)

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS

837 INSTITUTIONAL CLAIM TRANSACTION SPECIFICATIONS

Seg	Data Element	Name	Usage	Comments	Expected Value
HEADER					
BHT		**Beginning of Hierarchal Transaction**	**R**		
	BHT02	Transaction Set Purpose Code	**R**	Valid Values '00' Original '18' Reissue Case where the transmission was interrupted and the receiver requests that the batch be sent again.	Use '00' Original
	BHT06	Transaction Type Code	**R**	Separate claim and encounter data into separate ISA/IEA envelopes (files).	Use 'CH' for claims and 'RP' for encounters.
LOOP 1000A – SUBMITTER NAME					
NM1		**Submitter Name**	**R**		
	NM109	Submitter Primary Identifier	**R**	This element contains the Electronic Transaction Identifier Number (ETIN).	Use the Beacon Health Options assigned submitter ID. Maximum 10 characters.
LOOP 1000B – RECEIVER NAME					
NM1		**Receiver Name**	**R**		
	NM103	Receiver Name	**R**		Use 'Beacon Health Options, Inc.'
	NM109	Receiver Primary Identifier	**R**	This element contains the Electronic Transaction Identifier Number (ETIN).	Use 'FHC &Affiliates'
LOOP 2010AA – BILLING PROVIDER NAME					
NM1		**Billing Provider Name**	**R**		

Seg	Data Element	Name	Usage	Comments	Expected Value
	NM108	Billing Provider Identification	**R**	A business requirement by Beacon Health Options.	Use 'XX' Centers for Medicare and Medicaid Services National Provider Identifier
	NM109	Billing Provider Identifier	**R**	This element contains the NPI for the Billing Provider.	
REF		**Billing Provider Secondary Identification**	**S**		**The Billing Provider Secondary ID is required by Beacon Health Options only when the Billing Provider is the Pay-To Provider (Loop 2010AB is not sent).**
	REF01	Reference Identification Qualifier	R		Place EI in REF01.
	REF02	Billing Provider Additional Identifier	R		EIN or SSN of the billing provider.
LOOP 2010AB – PAY-TO ADRESS NAME					
NM1		**Pay-To-Provider Name**	**S**		**The Pay-To Provider loop is required if the pay-to provider is a *different entity* from the billing provider.**
LOOP 2010BA – SUBSCRIBER NAME					
NM1		**Subscriber Name**	**R**		
	NM109	Subscriber Primary Identifier	**R**		Use the contract holder's ID number in effect for the date of service that is being submitted for this claim.
LOOP 2010BB – PAYER NAME					
NM1		**Payer Name**	**R**		
	NM103	Payer Name	**R**	Destination payer name.	Use 'Beacon Health Options, Inc.'
	NM108	Identification Code Qualifier	**R**	Valid values: 'PI' Payer Identification 'XV' HCFA Plan ID (when mandated)	Use 'PI' Payer Identifier until the National Plan ID is mandated.
	NM109	Payer Identifier	**R**	Destination payer identifier	Use 'FHC &Affiliates'

Seg	Data Element	Name	Usage	Comments	Expected Value
LOOP 2300 – CLAIM INFORMATION					
CLM		**Claim Information**	**R**		
	CLM05-3	Claim Frequency Type Code	R	1 = Original 7 = Replacement 8 = Void	Record Action
PWK		**Claim Supplemental Information**	**S**		
	PWK02	Attachment Transmission Code	**R**	'AA' Available on Request at	Use 'AA' Available on Request at Provider Site.
REF		**Payer Claim Control Number**	**S**	**Required if Claim Frequency Type Code is 7 or 8**	
	REF01	Reference Identification Qualifier	R		'F8' Original Reference Number
	REF02	Original Reference Number (ICN/DCN)	R		If this is a correction to a previously submitted claim use the Beacon Health Options claim number prefixed by an 'RC'. The **whole claim number without spaces or dashes.**
HI		**Principal Diagnosis**	**R**		
	HI01-1	Code List Qualifier Code	R		BK - Principal Diagnosis – ICD-9 ABK- Principal Diagnosis- ICD10
	HI01-2	Industry Code	R	Use ABK for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BK for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
HI		**Admitting Diagnosis**	**S**		
	HI01-1	Code List Qualifier Code	R		BJ - Admitting Diagnosis – ICD-9 ABJ- Admitting Diagnosis- ICD10

Seg	Data Element	Name	Usage	Comments	Expected Value
	HI01-2	Industry Code	R	Use ABJ for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BJ for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	
HI		**Patient's Reason for Visit**	**S**		
	HI01-1	Code List Qualifier Code	R		PR – Patient reason for visit – ICD-9 APR- Patient reason for visit - ICD10
	HI01-2	Industry Code	R	Use APR for ICD-10 when service date is 10/01/2015 and after. Use PR for ICD-9 when service date is 9/30/2015 and prior.	
HI		**External Cause of Injury**	**S**		
	HI01-1	Code List Qualifier Code	R		BN – External cause of injury – ICD-9 ABN- External cause of injury - ICD10
	HI01-2	Industry Code	R	Use ABN for ICD-10 when service date is 10/01/2015 and after. Use BN for ICD-9 when service date is 9/30/2015 and prior.	
HI		**Other Diagnosis Information**	**S**		
	HI01-1	Code List Qualifier Code	R		BF - Other Diagnosis – ICD-9 ABF- Other Diagnosis- ICD10
	HI01-2	Industry Code	R	Use ABF for ICD-10 Diagnosis when service date is 10/01/2015 and after. Use BF for ICD-9 Diagnosis when service date is 9/30/2015 and prior.	

Seg	Data Element	Name	Usage	Comments	Expected Value
HI		**Principal Procedure Information**	**S**		
	HI01-1	Code List Qualifier Code	R		BR - Principal Procedure – ICD-9 BBR- Principal Procedure- ICD10
	HI01-2	Industry Code	R	Use BBR when service date is 10/01/2015 and after. Use BR when service date is 9/30/2015 and prior.	
HI		**Other Procedure Information**	**S**		
	HI01-1	Code List Qualifier Code	R		BQ - Other Procedure – ICD-9 BBQ- Other Procedure- ICD10
	HI01-2	Industry Code	R	Use BBQ when service date is 10/01/2015 and after. Use BQ when service date is 9/30/2015 and prior.	
LOOP 2320 – COORDINATION OF BENEFITS (COB) OTHER PAYER INFORMATION					
AMT		**COB Payer Paid Amount**	**R**		
	AMT02	Monetary Amount	R	When submitting claims with multiple claim lines where not all claim lines have a COB relationship; send separate claims.	Amount Paid by the Other Payer.
LOOP 2400 – SERVICE LINE NUMBER					
DTP		**Service Line Number**	**R**		
	DTP01	Date/Time Qualifier	R	Valid Value: ‘472’ Service	Use ‘472’ Service
	DTP02	Date Time Period Format Qualifier	R	Valid Values: ‘D8’ Date Expressed in Format CCYYMMDD ‘RD8’ Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	Use ‘RD8’ to specify a range of dates. The from and through service dates should be sent for each service line.
	DTP03	Date Time Period	R	Service Date	

Seg	Data Element	Name	Usage	Comments	Expected Value
SV2		**Institutional Service Line**	**R**		
	SV205	Quantity	S		Use whole number unit values.
LOOP 2430 – LINE ADJUDICATION INFORMATION					
SVD		**Professional Service**	**R**		
	SVD06	Assigned Number	R	Number of Units Paid for by Other Payer	(Whole Units Only)