Standard Companion Guide

Refers to the Implementation Guide Based on X12 Version 005010X223A2 Health Care Claim: Institutional

(837) Companion Guide Version

Number: 1.2

September 17
2020

Change Log

Version	Date	Changes
1.0	11/9/2015	Initial Draft
1.1	9/17/2019	EBP Codes - 2300 Loop Segment NTE (Claim Note)
1.2	9/17/2020	TPL/COB - Loops 2320, 2330A, 2330B, & 2430 Unique Patient Control Number Required - Loop 2300 Segment CLM01

HIPAA 837 Institutional Claims Companion Guide

Preface

This companion guide (CG) to the Technical Report Type 3 (TR3) adopted under HIPAA clarifies and specifies the data content when exchanging transactions electronically with Optum. Transactions based on this companion guide, used in tandem with the TR3, also called Health Care Claim: Institutional (837) ASC X12N/005010X223A2, are compliant with both X12 syntax and those guides. This companion guide is intended to convey information that is within the framework of the TR3 adopted for use under HIPAA. The companion guide is not intended to convey information that in any way exceeds the requirements or usages of data expressed in the TR3.

Table of Contents

HIPAA 837 Institutional Claims Companion Guide

1. INTRODUCTION

This Companion Guide is intended to be used in conjunction with the "837 Institutional Claim Companion Guide Specifications for Public Sector Behavioral Health" for the version "Consolidated Documents: May 2006 005010x223 and June 2010 005010X223A2."

The information contained in this Companion Guide are specific to Utah Medicaid and other locally funded Behavioral Health encounters and claims being filed to OptumHealth. Utah Health Information Network (UHIN) will act as the clearinghouse for all transactions between facilities and providers to OptumHealth. Please contact UHIN at www.uhin.org or call 801-466-7705 x200. UHIN will assign a Trading Partner Number (TPN) for EDI.

The purpose of this guide is to support the successful submission of all HIPAA compliant 837 Institutional Claims transactions to OptumHealth.

PLEASE NOTE: The submission of all values required within this companion guide does not guarantee payment. All claims are subject to claim/encounter edits and audit processing.

1.1. SCOPE

This document is to be used for the implementation of the Technical Report Type 3 (TR3) HIPAA 5010 Health Care Claim: Institutional (837) (referred to Institutional Claim in the rest of this document) for the purpose of submitting Institutional Claim(s) electronically. This companion guide (CG) is not intended to replace the TR3.

1.2. OVERVIEW

This CG will replace, in total, the previous Optum CG versions for Health Care Institutional Claim and must be used in conjunction with the TR3 instructions. The CG is intended to assist you in implementing electronic Institutional Claim that meet Optum processing standards, by identifying pertinent structural and data related requirements and recommendations.

1.3. REFERENCE

For more information regarding the ASC X12 Standards for Electronic Data Interchange Health Care Claim: Institutional (837) ASC X12N/005010X223A2 and to purchase copies of the TR3 documents, consult the Washington Publishing Company web site at http://www.wpc-edi.com/.

1.4. ADDITIONAL INFORMATION

The American National Standards Institute (ANSI) is the coordinator for information on national and international standards. In 1979 ANSI chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards for electronic interchange of business transactions and eliminate the problem of non-standard electronic data communication. The objective of the ASC X12 committee is to develop standards to facilitate electronic interchange relating to all types of business transactions. The ANSI X12 standards is recognized by the United States as the standard for North America. Electronic Data Interchange (EDI) adoption has been proved to reduce the administrative burden on providers.

- We can accept up to 999 claims per transaction. However, there is a limit of 50 lines per claim.

- The NPI and Tax ID (or SSN) must match to a single Medicaid contract see Loops 2010A, 2310B, 2310C). If a provider affiliates their NPI to more than one Medicaid Contract, a unique Taxonomy Code or unique address must be affiliated to their Contract. Update Taxonomy contract information with OptumHealth at 877-370-8953.

- All submissions must use Trading Partner Number (TPN) HT006885-001 see ISA08 and GS03). Only one claim transaction type (837I) is allowed per transmission. Multiple 837I can be filed however Optum cannot accept a transmission containing multiple transaction types.
- Claims may be submitted 24 hours a day, 7 days a week. Claims are adjudicated for acceptance into the processing system at multiple times per day Monday through Friday.

- A 999 Acknowledgment For Health Care Insurance will be available for download within 2 business day of transmission for all 837 transactions.

- All outpatient services must be registered through ProviderConnectTM in order for claims to be accepted into the Claims Processing System. Failure to register services will result in claims being rejected from processing.

- OptumHealth will send a 277CA which will list any claim(s) that were rejected prior to claim system load and any claim(s) that were accepted and pending in the claim system.

2. GETTING STARTED

2.1. WORKING WITH Optum

There is one method to connect with Optum for submitting and receiving EDI transactions; clearinghouse connection.

Clearinghouse Connection:

Physicians and Healthcare Institutions should contact their current clearinghouse vendor to discuss their ability to support the Institutional Claim transaction, as well as associated timeframe, costs, etc.

Physicians and Healthcare Institutions also have an opportunity to submit and receive a suite of EDI transactions via UHIN. For more information, please contact your UHIN Account Manager. If you do not have an UHIN Account Manager, please contact UHIN at www.uhin.org or call 801-466-7705 for more information.

2.2. TRADING PARTNER REGISTRATION

Clearinghouse Connection:

Physicians and Healthcare Institutions should contact their current clearinghouse vendor to discuss their ability to support the Institutional Claim transaction.

2.3. CERTIFICATION AND TESTING OVERVIEW

Optum does not certify Providers or Clearinghouses.

2.4. TESTING WITH Optum

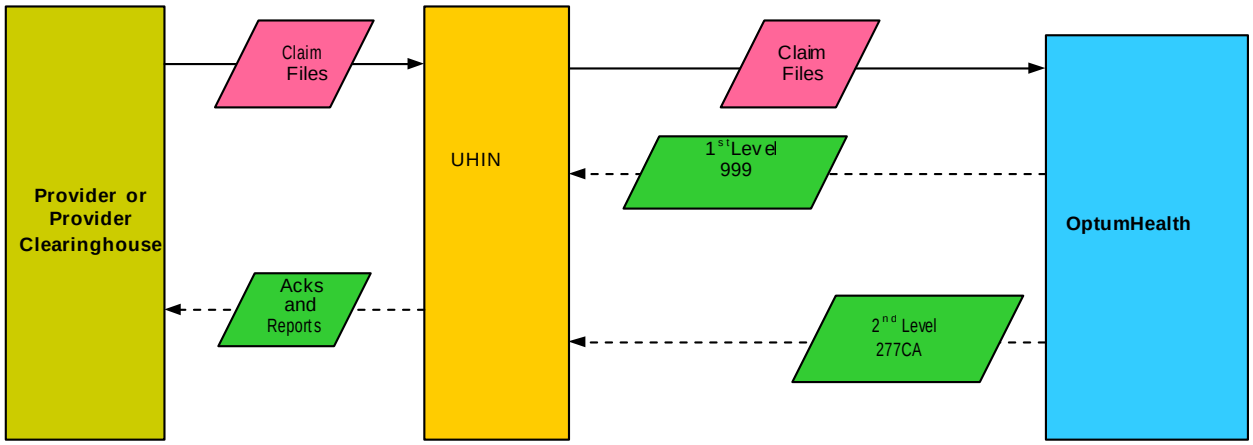
Clearinghouse Connection:

Physicians and Healthcare Institutions should contact their current clearinghouse vendor to discuss testing.

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

3.1. PROCESS FLOWS

Batch Institutional Claim:



3.2. TRANSMISSION ADMINISTRATIVE PROCEDURES

UHIN can be used in only batch mode.

3.3. RE-TRANSMISSION PROCEDURE

For sections 3.2 – 3.5, Physicians and Healthcare Institutions should contact their current clearinghouse vendor for information on the most current process.

3.4. COMMUNICATION PROTOCOL SPECIFICATIONS

Clearinghouse Connection:

Physicians and Healthcare Institutions should contact their current clearinghouse vendor to discuss communication protocol specifications.

3.5. PASSWORDS

Clearinghouse Connection:

Physicians and Healthcare Institutions should contact their current clearinghouse vendor to discuss testing.

3.6. SYSTEM AVAILABILITY

OptumHealth will accept 837 claim transaction submissions at any time, 24 hours per day/7 days a week. Claims are adjudicated for acceptance into the processing system at multiple times per day Monday through Friday. No changes to current system availability are expected. Any scheduled or unplanned outages will be communicated via email.

3.7. COSTS TO CONNECT

Clearinghouse Connection:

Physicians and Healthcare Institutions should contact their current clearinghouse vendor to discuss costs.

4. CONTACT INFORMATION

4.1. EDI CUSTOMER SERVICE

Should you have additional questions regarding the use of this Companion Guide,

please contact OptumHealth at 877-370-8953.

4.2. EDI TECHNICAL ASSISTANCE

Clearinghouse

- Please contact UHIN at www.uhin.org or call 801-466-7705 x200.

Optum EDI Issue Reporting

- Should you have additional questions regarding the use of this Companion Guide, please contact OptumHealth at 877-370-8953.

4.3. PROVIDER SERVICE NUMBER

Provider Services should be contacted at 877-370-8953 if you have questions regarding the details claim status. Provider Services is available Monday - Friday MT.

4.4. APPLICABLE WEBSITES / E-MAIL

Optum EDI help desk – 877-370-8953

Washington Publishing Company - http://www.wpc-edi.com/hipaa/

5. CONTROL SEGMENTS / ENVELOPES

5.1. ISA-IEA

Transactions transmitted during a session or as a batch are identified by an interchange header segment (ISA) and trailer segment (IEA) which form the envelope enclosing the transmission. Each ISA marks the beginning of the transmission (batch) and provides sender and receiver identification.

The table below represents only those fields that OptumHealth requires insertion of a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

Segment ID	Element ID	Segment or Element Name	(R)equired (S)ituational	OH Salt Lake County Instructions
ISA		**INTERCHANGE CONTROL HEADER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
ISA	01	Authorization Information Qualifier	R	Valid Value: "00" – No Authorization Information Present
ISA	02	Authorization Information	R	Valid Value: Pad to 10 characters
ISA	03	Security Information Qualifier	R	Valid Value: "00" – No Security Information Present
ISA	04	Security Information	R	Valid Value: Pad to 10 characters
ISA	05	Interchange (Sender) ID Qualifier	R	Valid Value: "ZZ" – Mutually Defined
ISA	06	Interchange Sender ID	R	Valid Value: UHIN Trading Partner ID (right padded to 15 characters. For example, AA000000-000)
ISA	07	Interchange (Receiver) ID	R	Valid Value: "ZZ" – Mutually Defined
ISA	08	Interchange Receiver ID	R	Valid Value: HT006885-001 (right padded to 15 characters)
ISA	09	Interchange Date	R	Valid Value: Date Interchange Sent (YYMMDD)
ISA	10	Interchange Time	R	HHMM
ISA	11	Repetition Separator	R	This field provides the 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 separator, and the segment terminator.
ISA	12	Interchange Control Version Number	R	Valid Value: "00501"
ISA	13	Interchange Control Number	R	Must be 9 characters and must be the same value as that sent in the associated IEA02.
ISA	14	Acknowledgment Requested	R	Valid Value: "0" – No Interchange Acknowledgment Requested
ISA	15	Interchange Usage Indicator	R	Valid Values: "P" – Production Data "T" – Test Data
ISA	16	Component Element Separator	R	":" – Colon is recommended

5.2. GS-GE

EDI transactions of a similar nature and destined for one trading partner may be gathered into a functional group, identified by a functional group header segment (GS) and a functional group trailer segment (GE). Each GS segment marks the beginning of a functional group. There can be many functional groups within an interchange envelope. The number of GS/GE functional groups that exist in the transmission.

Segment ID	Element ID	Segment or Element Name	(R)equired (S)ituational	OH Salt Lake County Instructions
GS		**FUNCTIONAL GROUP HEADER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
GS	01	Functional Identifier Code	R	Valid Value: "HC" – Health Care Claim
GS	02	Application Sender's Code	R	Valid Value: Please send your organization's UHIN ID
GS	03	Application Receiver's Code	R	Valid Value: HT006885-001
GS	04	Date (Functional Group Create Date)	R	CCYYMMDD
GS	05	Time (Functional Group Create Time)	R	HHMM
GS	06	Group Control Number	R	It is recommended that you send a sequential number or identifier that will help you to reconcile your filings.
GS	07	Responsible Agency Code	R	Valid Value: "X" – Accredited Standards Committee X12
GS	08	Version / Release /	R	Valid Value:
		Industry Identifier Code		"005010X222A1" – Standards Approved for Publication by ASC X12 Procedures Review Board
GE		**FUNCTIONAL GROUP TRAILER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
GE	01	Number of Transaction Sets Included	R	Total number of transaction sets included in this functional group.
GE	02	Group Control Number	R	Valid Value: Must = the value sent in the associated GS06.

5.3. ST-SE

The beginning of each individual transaction is identified using a transaction set header segment (ST). The end of every transaction is marked by a transaction set trailer segment (SE). For real time transactions, there will always be one ST and SE combination. An 837 file can only contain 837 transactions.

The table below represents only those fields that OptumHealth requires insertion of a specific value or has additional guidance on what the value should be. The table does not represent all of the fields necessary for a successful transaction; the TR3 should be reviewed for that information.

Loop ID	Segment ID	Element ID	Segment or Element Name	(R)equired (S)ituational	OH Salt Lake County Instructions
	ST		**TRANSACTION SET HEADER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
	ST	01	Transfer Set Identifier Qualifier	R	Valid Value: "837" – Health Care Claim
	ST	02	Transaction Set Control Number	R	A unique control number assigned by the Sender for this functional group for this transaction.
	ST	03	Implementation Convention Reference	R	Valid Value: "005010X222A1"
	SE		**TRANSACTION SET TRAILER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**

5.4. CONTROL SEGMENT HIERARCHY

ISA - Interchange Control Header segment
GS - Functional Group Header segment
ST - Transaction Set Header segment
First 837 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Second 837 Transaction
SE - Transaction Set Trailer segment
ST - Transaction Set Header segment
Third 837 Transaction
SE - Transaction Set Trailer segment
GE - Functional Group Trailer segment
IEA - Interchange Control Trailer segment

5.5. CONTROL SEGMENT NOTES

The ISA data segment is a fixed length record and all fields must be supplied. Fields that are not populated with actual data must be filled with space.

- The first element separator (byte 4) in the ISA segment defines the element separator to be used through the entire interchange.
- The ISA segment terminator (byte 106) defines the segment terminator used throughout the entire interchange.
- ISA16 defines the component element

5.6. FILE DELIMITERS

OptumHealth requests that you use the following delimiters on your 837 file. If used as delimiters, these characters (* : ~ ^) must not be submitted within the data content of the transaction sets.

Data Segment: The recommended data segment delimiter is a tilde (~).

Data Element: The recommended data element delimiter is an asterisk (*).

Component-Element: ISA16 defines the component element delimiter is to be used throughout the entire transaction. The recommended component-element delimiter is a colon (:).

Repetition Separator: ISA11 defines the repetition separator to be used throughout the entire transactions. The recommended repetition separator is a carrot (^).

6. PAYER SPECIFIC BUSINESS RULES AND LIMITATIONS

6.1 Electronic Claim Submission Guidelines

Please reference the OptumHealth Administrative Guide which can be found at OptumHealthOnline.com under the Quick Links section of the main page.

6.2 Validation of Claims at OptumHealth:

United applies 2-levels of editing to inbound HIPAA 837 **files** and **claims**:

1. **Level-1 HIPAA Compliance**:

   Full levels 1-4.
   Claims passing are assigned an OptumHealth Payer Claim Control Number and our "accepted" for **front-end** processing.

2. **Level-2 Front-End Validation:**

   a. Member match
   b. Provider match

3. Claims passing **front-end** validation are accepted into the **Adjudication** system for processing.

4. Institutional Claim that is received before the service date (prior to 10/1/2015) with ICD-10 codes qualifiers will be rejected by OptumHealth. Note: Mandate date for accepting the ICD -10 is set as 10/1/2015.

5. Institutional Claim with the value 'll' (Standard Unique Health Identifier) in Subscriber Name, field NM108 will be rejected by OptumHealth.

7. ACKNOWLEDGEMENTS AND OR REPORTS

7.1. REPORT INVENTORY

999 - This file informs submitter that the transaction arrived and provides information about the syntactical quality of each of the 837 claims submitted. Level 1 validation.

277CA – This file informs the submitter of the disposition of their claims through Level 2 Front End Validation, it reports both accepted and rejected claims.

8. TRADING PARTNER AGREEMENTS

8.1. TRADING PARTNERS

An EDI Trading Partner is defined as any OptumHealth customer (provider, billing service, software vendor, employer group, financial institution, etc.) that transmits to, or receives electronic data from UnitedHealth Group.

Payers have EDI Trading Partner Agreements that accompany the standard implementation guide to ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

For example, a Trading Partner Agreement may specify among other things, the roles and responsibilities of each party to the agreement in conducting standard transactions.

9. TRANSACTION SPECIFIC INFORMATION

This section describes how TR3's adopted under HIPAA will be detailed with the use of a table. The tables contain a row for each segment that UnitedHealth Group has something additional, over and above, the information in the TR3's. That information can:

1. Limit the repeat of loops, or segments
2. Limit the length of a simple data element
3. Specify a sub-set of the TR3's internal code listings
4. Clarify the use of loops, segments, composite and simple data elements
5. Any other information tied directly to a loop, segment, and composite or simple data element pertinent to trading electronically with OptumHealth

In addition to the row for each segment, one or more additional rows are used to describe OptumHealth's usage for composite and simple data elements and for any other information. Notes and comments should be placed at the deepest level of detail. For example, a note about a code value should be placed on a row specifically for that code value, not in a general note about the segment.

The following table specifies the columns and suggested use of the rows for the detailed description of the transaction set companion guides. The table contains a row for each segment that OptumHealth has something additional, over and above, the information in the TR3's. The following is just an example of the type of information that would be spelled out or elaborated on in: Section 9 – Transaction Specific Information.

The below table provides any OptumHealth specific requirements for claim construct and data values.

Page #	Loop ID	Segment ID	Element ID	Segment or Element Name	(R)equired (S)ituational	OH Instructions
67		**ST**		**TRANSACTION SET HEADER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
67		ST	01	Transfer Set Identifier Qualifier	R	Valid Value: "837" – Health Care Claim
67		ST	02	Transaction Set Control Number	R	A unique control number assigned by the Sender for this functional group for this transaction.
67		ST	03	Implementation Convention Reference	R	Valid Value: 005010X223
68		**BHT**		**BEGINNING OF HIERARCHICAL TRANSACTION**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
68		BHT	01	Hierarchical Structure Code	R	Valid Value: "0019" – Information Source, Subscriber, Dependent
68		BHT	02	Transaction Set Purpose Code	R	Valid Values: "00" – Original "18" – Reissue
69		BHT	03	Originator Application Transaction Identifier	R	This is an inventory file number of the transmission assigned by the Submitter and operates as the Submitter's batch number. Can be up to 30 characters.
69		BHT	04	Transaction Set Creation Date	R	CCYYMMDD
69		BHT	05	Transaction Set Creation Time	R	HHMM
69		BHT	06	Transaction Type Code	R	Valid Values: "CH" – Chargeable (used by fee for service providers) "RP" – To be used by providers who are not fee for service but do report encounters
71	**1000A**			**SUBMITTER NAME LOOP**	**R**	
72	***1000A***	***NM1***		***SUBMITTER NAME***	***R***	
72	1000A	NM1	01	Entity Identifier Code	R	Valid Value: "41" – Submitter
72	1000A	NM1	02	Entity Type Qualifier	R	Valid Values: "1" – Person "2" – Non-Person Entity
72	1000A	NM1	03	Submitter Last or Organization Name	R	Follow Implementation Guide for this data element.
72	1000A	NM1	04	Submitter First Name	S	Follow Implementation Guide for this data element.
72	1000A	NM1	05	Submitter Middle Name	S	Follow Implementation Guide for this data element.
72	1000A	NM1	08	Identification Code Qualifier	R	Valid Value: "46" – Trading Partner Number

72	1000A	NM1	09	Submitter Identifier	R	Submitter's Trading Partner Number (TPN) supplied by UHIN.
73	***1000A***	***PER***		***SUBMITTER EDI CONTACT INFORMATION***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
74	1000A	PER	01	Contact Function Code	R	Valid Value: "IC" – Information Contact
74	1000A	PER	02	Name	S	Required when the contact name is different t than the name contained in the Submitter Name segment of this loop AND it is the first iteration of this Segment.
74	1000A	PER	03	Communication Number Qualifier	R	Valid Values: "EM" – Electronic Mail "FX" – Facsimile - "TE" – Telephone
74	1000A	PER	04	Communication Number	R	Contact communication number/address
74	1000A	PER	05	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone "EX" – Telephone Extension
74	1000A	PER	06	Communication Number	S	Contact communication number/address
75	1000A	PER	07	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone "EX" – Telephone Extension
75	1000A	PER	08	Communication Number	S	Contact communication number/address
76	**1000B**	**NM1**		**RECEIVER NAME LOOP**	**R**	
76	***1000B***	***NM1***		***RECIEVER INDIVIDUAL OR ORGANIZATIONAL NAME***	***R***	
76	1000B	NM1	01	Entity Identification Code	R	Valid Value: "40" - Receiver
76	1000B	NM1	02	Entity Type Qualifier	R	Valid Value: "2" – Non-Person Entity
77	1000B	NM1	03	Receiver Name	R	"OptumHealth PS"
77	1000B	NM1	08	Information Receiver Identification Number Qualifier	R	Valid Value: "46" – Electronic Transmitter Identification Number
77	1000B	NM1	09	Receiver Primary Identifier	R	HT006885-001
78	**2000A**			**BILLING/PAY-TO PROVIDER LOOP**	**R**	
78	***2000A***	***HL***		***BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
78	2000A	HL	01	Hierarchical ID Number	R	Follow Implementation Guide for this data element.

78	2000A	HL	03	Hierarchical Level Code	R	Valid Value: "20" – Information Source
79	2000A	HL	04	Hierarchical Child Code	R	Valid Value: "1" – Additional Subordinate HL Data Segments
80	***2000A***	***PRV***		***BILLING/PAY-TO PROVIDER SPECIALTY INFORMATION***	***S***	***Required when the Rendering Provider is the same entity as the Billing and/or Pay-to Provider.***
80	2000A	PRV	01	Provider Code	R	Valid Value: "BI" – Billing Provider
80	2000A	PRV	02	Reference Identification Qualifier	R	Valid Value: "PXC" – Taxonomy Code
80	2000A	PRV	03	Provider Taxonomy Code	R	Provider Taxonomy Code
81	***2000A***	***CUR***		***FOREIGN CURRENCY INFORMATION***	***S***	***Allowed but not used for processing***
84	**2010AA**			**BILLING PROVIDER NAME LOOP**	**R**	
85	2010AA	NM1	01	Entity Identification Code	R	Valid Value: "85" – Billing Provider
85	2010AA	NM1	02	Entity Type Qualifier	R	Valid Values: "2" – Non-Person
85	2010AA	NM1	03	Billing Provider Last Name	R	Follow Implementation Guide for this data element.
85	2010AA	NM1	07	Billing Provider Name Suffix	S	Not used
86	2010AA	NM1	08	Identification Code Qualifier	R	"XX" – NPI
86	2010AA	NM1	09	Billing Provider Identifier	R	Billing Provider NPI
87	***2010AA***	***N3***		***BILLING PROVIDER ADDRESS***	***R***	
87	2010AA	N3	01	Billing Provider Address Line	R	Address that coordinates with OptumHealth contract Service Location
87	2010AA	N3	02	Billing Provider Address Line	S	Address that coordinates with OptumHealth contract Service Location
88	***2010AA***	***N4***		***BILLING PROVIDER CITY/STATE/ZIP CODE***	***R***	
88	2010AA	N4	01	Billing Provider City Name	R	City that coordinates with OptumHealth contract Service Location
89	2010AA	N4	02	Billing Provider State	R	State that coordinates with OptumHealth contract Service Location
89	2010AA	N4	03	Billing Provider's Zip Code	R	Zip Code that coordinates with OptumHealth contract Service Location
89	2010AA	N4	04	Billing Provider's Country Code	S	Not Used
89	2010AA	N4	07	Billing Provider's Country Subdivision Code	S	Not Used

90	***2010AA***	***REF***		***BILLING PROVIDER SECONDARY IDENTIFICATION***	***R***	***Each submission must contain a minimum of 1-2010AA REF segments.***
90	2010AA	REF	01	Reference Identification Qualifier	R	Valid Values: "EI" – Tax Identification Number
90	2010AA	REF	02	Reference Identification	R	Tax Identification Number
91	***2010AA***	***PER***		***BILLING PROVIDER CONTACT INFORMATION***	***S***	***Follow Implementation Guide for this Segment and all data elements. Used only when the Billing and Submitter contact information is different.***
92	2010AA	PER	01	Contact Function Code	R	Valid Value: "IC" – Information Contact
92	2010AA	PER	02	Name	S	Required when the contact name is different than the name contained in the Submitter and/or Billing Name segments.
92	2010AA	PER	03	Communication Number Qualifier	R	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone "EX" – Telephone Extension
92	2010AA	PER	04	Communication Number	R	Contact communication number/address
92	2010AA	PER	05	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone "EX" – Telephone Extension
93	2010AA	PER	06	Communication Number	S	Contact communication number/address
93	2010AA	PER	07	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone "EX" – Telephone Extension
93	2010AA	PER	08	Communication Number	S	Contact communication number/address
94	**2010AB**			**PAY-TO ADDRESS NAME LOOP**	**S**	**Required when the Pay-To Provider Address is different than the Billing Provider Address.**
94	***2010AB***	***NM1***		***PAY-TO PROVIDER NAME***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
95	2010AB	NM1	01	Entity Identification Code	R	Valid Value: "87" – Pay-to Provider
95	2010AB	NM1	02	Entity Type Qualifier	R	Valid Values: "2" – Non-Person
96	***2010AB***	***N3***		***PAY-TO PROVIDER ADDRESS***	***S***	***Required when the Pay-To Provider Address is different than the Billing Provider Address.***
96	2010AB	N3	01	Pay-To Provider Address Line	R	Line 1 of Pay-To Address
96	2010AB	N3	02	Pay-To Provider Address Line	S	Line 2 of Pay-To Address

97	***2010AB***	***N4***		***PAY-TO PROVIDER CITY/STATE/ZIP CODE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
97	2010AB	N4	01	Pay-To Provider City Name	R	
98	2010AB	N4	02	Pay-To Provider State	R	
98	2010AB	N4	03	Pay-To Provider's Zip Code	R	
98	2010AB	N4	04	Pay-To Provider's Country Code	S	Not Used
98	2010AB	N4	07	Pay-To Provider's Country Subdivision Code	S	Not Used
99	**2010AC**			**PAY-TO PLAN NAME LOOP**	**S**	***Allowed but not used for processing***
99	***2010AC***	***NM1***		***PAY-TO PLAN NAME***	***S***	***Allowed but not used for processing***
101	***2010AC***	***N3***		***PAY-TO PLAN ADDRESS***	***S***	***Allowed but not used for processing***
102	***2010AC***	***N4***		***PAY-TO PLAN CITY,STATE,ZIP***	***S***	***Allowed but not used for processing***
104	***2010AC***	***REF***		***PAY-TO PLAN SECONDARY INDENTIFICATION***	***S***	***Allowed but not used for processing***
106	***2010AC***	***REF***		***PAY-TO PLAN TAX INDENTIFICATION NUMBER***	***S***	***Allowed but not used for processing***
107	**2000B**			**SUBSCRIBER HIERARCHICAL LOOP**	**R**	**For Public Sector Behavioral Health, the subscriber is always the patient. Therefore, all patient data is included in this loop.**
107	***2000B***	***HL***		***SUBSCRIBER HIERARCHICAL LEVEL***	***R***	
107	2000B	HL	01	Hierarchical ID Number	R	Must be numeric and incremental from preceding HL Segments within the transaction set.
108	2000B	HL	02	Hierarchical Parent ID Number	R	Follow Implementation Guide for this data element.
108	2000B	HL	03	Hierarchical Child Code	R	Valid Value: "22" – Subscriber
108	2000B	HL	04	Hierarchical Child Code	R	Valid Value: "0" – No Subordinate HL Segments
109	***2000B***	***SBR***		***SUBSCRIBER INFORMATION***	***R***	
109	2000B	SBR	01	Payer Responsibility Sequence Number Code	R	Valid Values: "P" – Primary "S" – Secondary "T" – Tertiary
110	2000B	SBR	02	Patients Relationship to Insured	R	Valid Value: "18" – Self
110	2000B	SBR	03	Insured Group or Policy Number	S	Not Used The PACMIS or other unique Identifier is reported at Loop 2010BA – NM109

110	2000B	SBR	04	Insured Group Name	S	Not Used
110	2000B	SBR	09	Claim Filing Indicator Code	R	Valid Values: "11" – Other Non-Federal Programs (Non-Medicaid) "MC" – Medicaid
111	***2000B***	***PAT***		***PATIENT INFORMATION***	***S***	***Allowed but not used for processing***
112	**2010BA**			**SUBSCRIBER NAME LOOP**	**R**	
112	***2010BA***	***NM1***		***SUBSCRIBER NAME***	***R***	
112	2010BA	NM1	01	Entity Identifier Code	R	Valid Value: "IL" – Subscriber
113	2010BA	NM1	02	Entity Type Qualifier	R	Valid Value: "1" - Person
113	2010BA	NM1	03	Subscriber Last Name	R	Patient's Last Name
113	2010BA	NM1	04	Subscriber First Name	R	Patient's First Name
113	2010BA	NM1	05	Subscriber Middle Name	S	Patient's Middle Name (if available)
113	2010BA	NM1	06	Not Used	S	Not Used
113	2010BA	NM1	07	Name Suffix	s	Not Used
113	2010BA	NM1	08	Identification Code Qualifier	R	Valid Value: "MI" – Member Identification Number
114	2010BA	NM1	09	Subscriber Primary Identifier	R	Medicaid PACMIS # when Medicaid OptumHealth assigned ID for Non-Medicaid
115	***2010BA***	***N3***		***SUBSCRIBER ADDRESS***	***S***	***Follow Implementation Guide for this Segment and all data elements.*** ***Please complete with available information.***
116	***2010BA***	***N4***		***SUBSCRIBER CITY/STATE/ZIP CODE***	***S***	***Follow Implementation Guide for this Segment and all data elements.*** ***Please complete with available information.***
118	***2010BA***	***DMG***		***SUBSCRIBER DEMOGRAPHIC INFORMATION***	***S***	***This segment is required for a claim to be accepted into the OptumHealth system.***
118	2010BA	DMG	01	Date Time Period Format Qualifier	R	"D8"
118	2010BA	DMG	02	Date of Birth - Patient	R	CCYYMMDD
119	2010BA	DMG	03	Gender - Patient	R	Valid Values: "F" – Female "M" – Male "U" – Unknown
120	***2010BA***	***REF***		***SUBSCRIBER SECONDARY IDENTIFICATION***	***S***	
120	2010BA	REF	01	Reference Identification Qualifier	R	"SY" Social Security Number
120	2010BA	REF	02	Subscriber Supplemental Identifier	R	Patient's Social Security Number

121	***2010BA***	***REF***		***PROPERTY AND CASUALTY CLAIM NUMBER***	***S***	***Allowed but not used for processing***
122	**2010BB**			**PAYER NAME LOOP**	**R**	
122	2010BB	NM1		**PAYER NAME**	R	
122	2010BB	NM1	01	Entity Identifier Code	R	Valid Value: "PR" – Payer
123	2010BB	NM1	02	Entity Type Qualifier	R	Valid Value: "2" - Non-Person Entity
123	2010BB	NM1	03	Payer Name	R	Valid Value: "OptumHealth"
123	2010BB	NM1	08	Identification Code Qualifier	R	Valid Value: "PI" – Payer Identification
123	2010BB	NM1	09	Payer Identification	R	HT006885-001
124	***2010BB***	***N3***		***PAYER ADDRESS***	***S***	***Allowed but not used for processing***
125	***2010BB***	***N4***		***PAYER CITY, STATE, ZIP CODE***	***S***	***Allowed but not used for processing***
127	***2010BB***	***REF***		***PAYER SECONDARY IDENTIFICATION***	***S***	***Allowed but not used for processing***
127	***2010BB***	***REF***		***BILLING PROVIDER SECONDARY IDENTIFICATION***	***S***	***Allowed but not used for processing***
131	**2000C**			**PATIENT HIERARCHICAL LOOP**	**S**	**DO NOT USE THIS LOOP; The patient is always the subscriber for Medicaid and other funded Behavioral Health Services.**
131	***2000C***	***HL***		***PATIENT HIERARCHICAL LEVEL***	***S***	***Allowed but not used for processing***
133	***2000C***	***PAT***		***PATIENT INFORMATION***	***S***	***Allowed but not used for processing***
135	**2010CA**			**PATIENT NAME LOOP**	**S**	**DO NOT USE THIS LOOP; The patient is always the subscriber for Medicaid and other funded Behavioral Health Services.**
135	***2010CA***	***NM1***		***PATIENT NAME***	***S***	***Allowed but not used for processing***
137	***2010CA***	***N3***		***PATIENT ADDRESS***	***S***	***Allowed but not used for processing***
138	***2010CA***	***N4***		***PATIENT CITY, STATE, ZIP CODE***	***S***	***Allowed but not used for processing***
140	***2010CA***	***DMG***		***PATIENT DEMOGRAPHIC INFORMATION***	***S***	***Allowed but not used for processing***
142	***2010CA***	***REF***		***PROPERTY AND CASUALTY CLAIM NUMBER***	***S***	***Allowed but not used for processing***
143	***2010CA***	***REF***		***PROPERTY AND CASUALTY PATIENT IDENTIFIER***	***S***	***Allowed but not used for processing***

145	2300			CLAIM INFORMATION LOOP	R	
145	***2300***	***CLM***		***CLAIM INFORMATION***	***R***	
146	2300	CLM	01	Claim Submitter's Identifier	R	Patient Control Number Must Be Unique
147	2300	CLM	02	Total Claim Charge Amount	R	Follow Implementation Guide for this data element.
147	***2300***	***CLM***	***05***	***Health Care ServiceLocation Information (Composite Data Element)***	***R***	
147	2300	CLM	05-1	Facility Type Code	R	Valid Value: First and Second positions of the Uniform Billing Type Code for Institutional Services
147	2300	CLM	05-2	Facility Code Qualifier	R	Valid Value: "A" – Uniform Billing Claim Form Bill Type
147	2300	CLM	05-3	Claim Frequency Code	R	For original submissions (or re-submission of denied claims) use value: "1" – Original OptumHealth will allow for submission of electronic corrections or voids to a previously paid claim. Acceptable Values: "6" - Corrections "7" – Replacement "8" – Void The OptumHealth Claim Number assigned to the claim that is being voided ("8") or replaced ("7") must be reported in the associated 2300 ORIGINAL REFERENCE NUMBER REF02.
148	2300	CLM	07	Provider Accept Assignment Code	R	Follow Implementation Guide for this data element.
148	2300	CLM	08	Assignment of Benefits Indicator	R	Follow Implementation Guide for this data element.
149	2300	CLM	09	Release of Information Code	R	Follow Implementation Guide for this data element.
149	2300	CLM	20	Delay Reason Code	S	Follow Implementation Guide for this data element.
151	***2300***	***DTP***		***DATE – DISCHARGE HOUR***	***S***	***Required for final inpatient claims.***
151	2300	DTP	01	Date Time Qualifier	R	Valid Value: "096" – Discharge
151	2300	DTP	02	Date Time Period Format Qualifier	R	Valid Value: "TM" – Time Expressed in Format HHMM
151	2300	DTP	03	Discharge Time	R	
152	***2300***	***DTP***		***DATE – STATEMENT DATES***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
152	2300	DTP	01	Date Time Qualifier	R	Valid Value: "434" – Statement
152	2300	DTP	02	Date Time Period Format Qualifier	R	Valid Value: "RD8" – Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
152	2300	DTP	03	Statement From and To Dates	R	

153	***2300***	***DTP***		***DATE – ADMISSION DATE/HOUR***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
154	***2300***	***DTP***		***DATE – REPRICER RECEIVED DATE***	***S***	***Not used***
155	***2300***	***CL1***		***INSTITUTIONAL CLAIM CODE***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
155	2300	CL1	01	Admission Type Code	S	Required when the patient is being admitted for inpatient services.
155	2300	CL1	02	Admission Source Code	S	Required when the patient is being admitted for inpatient services.
155	2300	CL1	03	Patient Status Code	R	
156	***2300***	***PWK***		***CLAIM SUPPLEMENTAL INFORMATION***	***S***	***Allowed but not used for processing***
160	***2300***	***CN1***		***CONTRACT INFORMATION***	***S***	***Allowed but not used for processing***
162	***2300***	***AMT***		***PATIENT ESTIMATED AMOUNT DUE***	***S***	***This segment is Required when the patient is responsible for any copayment amount. Follow Implementation Guide for this Segment and all data elements.***
162	2300	AMT	01	Amount Qualifier Code	R	Valid Value: "F3" – Patient Responsibility – Estimated
162	2300	AMT	02	Patient Amount Paid	R	Patient Responsibility Amount
163	***2300***	***REF***		***SERVICE AUTHORIZATION EXCEPTION CODE***	***S***	***Allowed but not used for processing***
165	***2300***	***REF***		***REFERRAL NUMBER***	***S***	***Allowed but not used for processing***
166	***2300***	***REF***		***PRIOR AUTHORIZATION***	***S***	***Required for all claims to be accepted into the Optum's claims system.***
166	2300	REF	01	Reference Identification Qualifier	R	Accepted Value: "G1" – Prior Authorization Number
167	2300	REF	02	Prior Authorization Number	R	The authorization number provided for this patient to the provider for the claim Date(s) of Service. This number is obtained from OptumHealth and is available through Provider Connect. For more information please connect to our web site at : http://www.optumhealthOptumHealth.com/providers.htm
168	***23 00***	***REF***		***PAYER CLAIM CONTROL NUMBER***	***S***	***This segment is required when codes "6", "7", or "8" are submitted in Loop 2300 CLM05-3.***
168	2300	REF	01	Reference Identification Qualifier	R	Must = "F8" – Original Reference Number
168	2300	REF	02	Claim Original Reference Number	R	Do not submit hyphens or spaces. Do not submit replacement/void claims until the original claim processes
169	***2300***	***REF***		***REPRICED CLAIM NUMBER***	***S***	***Allowed but not used for processing***

170	***2300***	***REF***		***ADJUSTED REPRICED CLAIM NUMBER***	***S***	***Allowed but not used for processing***
171	***2300***	***REF***		***INVESTIGATIONAL DEVICE EXEMPTION NUMBER***	***S***	***Allowed but not used for processing***
172	***2300***	***REF***		***CLAIM INDENTIFICATION NUMBER FOR TRANSMISSION INTERMEDIARIES***	***S***	***Allowed but not used for processing***
174	***2300***	***REF***		***AUTO ACCIDENT STATE***	***S***	***Allowed but not used for processing***
175	***2300***	***REF***		***MEDICAL RECORD NUMBER***	***S***	***Recommended. Follow Implementation Guide for this Segment and all data elements.***
175	2300	REF	01	Reference Identification Qualifier	R	Valid Value: "EA" – Medical Record Identification Number
175	2300	REF	02	Medical Record Number	R	
176	***2300***	***REF***		***DEMONSTRATION PROJECT IDENTIFIER***	***S***	***Allowed but not used for processing***
177	***2300***	***REF***		***PEER REVIEW ORGANIZATION APPROVAL NUMBER***	***S***	***Allowed but not used for processing***
178	***2300***	***K3***		***FILE INFORMATION***	***S***	***Allowed but not used for processing***
180	***2300***	***NTE***		***CLAIM NOTE***	***S***	***Valid Values: NTE01 = "DCP"; NTE02 = "EBP-[code]-...-[code]"***
182	***2300***	***NTE***		***BILLING NOTE***	***S***	***Allowed but not used for processing***
183	***2300***	***CRC***		***EPSDT REFERRAL***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
186	***2300***	***HI***		***PRINCIPAL DIAGNOSIS***	***R***	***This segment is Required for all claims submitted for services provided to Consumers who are covered under Behavioral Health Services.*** ***Follow Implementation Guide for this Segment and all data elements.***
186	2300	HI	01-1	Code List Qualifier	R	Valid Value: "BK" – Principal Diagnosis "ABK" – Principal Diagnosis
187	2300	HI	01-2	Diagnosis Code	R	DSM-5, ICD-9 or ICD-10
187	2300	HI	01-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
189	***2300***	***HI***		***ADMITTING DIAGNOSIS***	***S***	***This segment is Required for all Inpatient Admissions.*** ***Follow Implementation Guide for this Segment and all data elements.***

190	2300	HI	01-1	Code List Qualifier	R	Valid Value: "BJ" – Admitting Diagnosis "ABJ" – Admitting Diagnosis
190	2300	HI	01-2	Admitting Diagnosis Code	R	DSM-5, ICD-9 or ICD-10
191	***2300***	***HI***		***PATIENT's REASON FOR VISIT***	***S***	***This segment is Required for all Outpatient visits. Follow Implementation Guide for this Segment and all data elements.***
192	2300	HI	01-1	Code List Qualifier	R	Valid Value: "PR" – Patient's Reason for Visit "APR" – Patient's Reason for Visit
192	2300	HI	01-2	Patient Reason for Visit	R	DSM-5, ICD-9 or ICD-10
192	2300	HI	02-1	Code List Qualifier	R	Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. Valid Value: "PR" – Patient's Reason for Visit "APR" – Patient's Reason for Visit
193	2300	HI	01-2	Patient Reason for Visit	R	DSM-5, ICD-9 or ICD-10
193	2300	HI	03-1	Code List Qualifier	R	Required when an additional Patient's Reason for Visit must be sent and the preceding HI data elements have been used to report other patient's reason for visit. Valid Value: "PR" – Patient's Reason for Visit "APR" – Patient's Reason for Visit
194	2300	HI	03-2	Patient Reason for Visit	R	DSM-5, ICD-9 or ICD-10
195	***2300***	***HI***		***EXTERNAL CAUSE OF INJURY***	***S***	***Allowed but not used for processing***
220	***2300***	***HI***		***DIAGNOSIS RELATED GROUP (DRG)***	***S***	***Allowed but not currently used for processing***
222	***2300***	***HI***		***OTHER DIAGNOSIS INFORMATION***	***S***	***Required when other condition(s) coexist or develop subsequently during a patient's treatment Follow Implementation Guide for this Segment and all data elements.***
223	2300	HI	01-1	Code List Qualifier	R	Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
223	2300	HI	01-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
223	2300	HI	01-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
224	2300	HI	02-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
224	2300	HI	02-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10

225	2300	HI	02-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
226	2300	HI	03-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
226	2300	HI	03-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
226	2300	HI	03-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
	2300	HI	04-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
227	2300	HI	04-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
228	2300	HI	04-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
229	2300	HI	05-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
229	2300	HI	05-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
229	2300	HI	05-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
230	2300	HI	06-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
230	2300	HI	06-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
231	2300	HI	06-9	Present On Admission	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable

232	2300	HI	07-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
232	2300	HI	07-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
232	2300	HI	07-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
233	2300	HI	08-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
233	2300	HI	08-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
234	2300	HI	08-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
235	2300	HI	09-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
235	2300	HI	09-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
235	2300	HI	09-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
236	2300	HI	10-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
236	2300	HI	10-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
237	2300	HI	10-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable

238	2300	HI	11-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
238	2300	HI	11-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
238	2300	HI	11-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
239	2300	HI	12-1	Code List Qualifier	R	Required when it is necessary to report an additional Diagnosis and the preceding HI data elements have been used to report other diagnosis Valid Value: "BF" – Other Diagnosis "ABF" – Other Diagnosis
239	2300	HI	12-2	Other Diagnosis	R	DSM-5, ICD-9 or ICD-10
240	2300	HI	12-9	Present On Admission Indicator	S	Valid Value: "Y" – Yes "N" – No "U" – Unknown "W" – Not Applicable
241	***2300***	***HI***		***PRINCIPAL PROCEDURE INFORMATION***	***S***	***Required on Inpatient Claims when a Procedure was performed*** ***Follow Implementation Guide for this Segment and all data elements.***
242	2300	HI	01-1	Code List Qualifier	R	Valid Value: "BR" – Principal Procedure Code "BBR" – Principal Procedure Code
242	2300	HI	01-2	Principal Procedure Code	R	DSM-5, ICD-9 or ICD-10
242	2300	HI	01-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
242	2300	HI	01-4	Principal Procedure Date	R	CCYYMMDD
244	***2300***	***HI***		***OTHER PROCEDURE INFORMATION***	***S***	***Required on Inpatient Claims when additional Procedures must be reported*** ***Follow Implementation Guide for this Segment and all data elements.***
244	***2300***	***HI***	***01***	***Health Care Code Information***	***R***	
245	2300	HI	01-1	Code List Qualifier	R	Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
245	2300	HI	01-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
245	2300	HI	01-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
245	2300	HI	01-4	Principal Procedure Date	R	CCYYMMDD

246	***2300***	***HI***	***02***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
246	2300	HI	02-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
246	2300	HI	02-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
246	2300	HI	02-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
247	2300	HI	02-4	Principal Procedure Date	R	CCYYMMDD
247	***2300***	***HI***	***03***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
247	2300	HI	03-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
247	2300	HI	03-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
248	2300	HI	03-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
248	2300	HI	03-4	Principal Procedure Date	R	CCYYMMDD
248	***2300***	***HI***	***04***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
248	2300	HI	04-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
249	2300	HI	04-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
249	2300	HI	04-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
249	2300	HI	04-4	Principal Procedure Date	R	CCYYMMDD
249	***2300***	***HI***	***05***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
250	2300	HI	05-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
250	2300	HI	05-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
250	2300	HI	05-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
250	2300	HI	05-4	Principal Procedure Date	R	CCYYMMDD

251	***2300***	***HI***	***06***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
251	2300	HI	06-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
251	2300	HI	06-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
251	2300	HI	06-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
252	2300	HI	06-4	Principal Procedure Date	R	CCYYMMDD
252	***2300***	***HI***	***07***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
252	2300	HI	07-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
252	2300	HI	07-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
253	2300	HI	07-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
253	2300	HI	07-4	Principal Procedure Date	R	CCYYMMDD
253	***2300***	***HI***	***08***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
253	2300	HI	08-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
254	2300	HI	08-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
254	2300	HI	08-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
254	2300	HI	08-4	Principal Procedure Date	R	CCYYMMDD
254	***2300***	***HI***	***09***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
255	2300	HI	09-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
255	2300	HI	09-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
255	2300	HI	09-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
255	2300	HI	09-4	Principal Procedure Date	R	CCYYMMDD

256	***2300***	***HI***	***10***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
256	2300	HI	10-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
256	2300	HI	10-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
256	2300	HI	10-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
257	2300	HI	10-4	Principal Procedure Date	R	CCYYMMDD
257	***2300***	***HI***	***11***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
257	2300	HI	11-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
257	2300	HI	11-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
258	2300	HI	11-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
258	2300	HI	11-4	Principal Procedure Date	R	CCYYMMDD
258	***2300***	***HI***	***12***	***Health Care Code Information***	***S***	***Required when necessary to report an additional procedure.***
258	2300	HI	12-1	Code List Qualifier	R	Required when it is necessary to report an additional procedure and the preceding HI elements gave been used Valid Value: "BQ" – Principal Procedure Code "BBQ" – Principal Procedure Code
259	2300	HI	12-2	Procedure Code	R	DSM-5, ICD-9 or ICD-10
259	2300	HI	12-3	Date Time Period Format Qualifier	R	Valid Value: "D8"
259	2300	HI	12-4	Principal Procedure Date	R	CCYYMMDD
260	***2300***	***HI***		***OCCURRENCE SPAN INFORMATION***	***S***	***Allowed but not used for processing***
273	***2300***	***HI***		***OCCURRENCE INFORMATION***	***S***	***Allowed but not used for processing***
286	***2300***	***HI***		***VALUE INFORMATION***	***S***	***Allowed but not used for processing***
296	***2300***	***HI***		***CONDITION INFORMATION***	***S***	***Allowed but not used for processing***
306	***2300***	***HI***		***TREATMENT CODE INFORMATION***	***S***	***Allowed but not used for processing***
315	***2300***	***HCP***		***CLAIM PRICING/REPRICING INFORMATION***	***S***	***Allowed but not used for processing***

321	**2310A**			**ATTENDING PROVIDER NAME LOOP**	**S**	***Required if the claim contains any services other than non-scheduled transportation claims.***
321	2310A	NM1	01	Entity Identifier Code	R	Valid Value: "71" – Attending Physician
322	2310A	NM1	02	Entity Type Qualifier	R	Valid Value: "1" – Person
322	2310A	NM1	03	Attending Provider Last Name	R	
322	2310A	NM1	04	Attending Provider First Name	S	Required when the person has a First Name
322	2310A	NM1	05	Attending Provider Middle Name	S	
322	2310A	NM1	07	Attending Provider Name Suffix	S	Not used
323	2310A	NM1	08	Identification Code Qualifier	R	Valid Value: "XX" – NPI
323	2310A	NM1	09	Attending Provider NPI	R	NPI
324	***2310A***	***PRV***		***ATTENDING PROVIDER SPECIALTY INFORMATION***	***S***	***Allowed but not used for processing***
324	2310A	PRV	01	Provider Code	R	Valid Value: "AT" – Attending Provider
324	2310A	PRV	02	Reference Identification Qualifier	R	Valid Value: "PXC" – Taxonomy Code
324	2310A	PRV	03	Provider Taxonomy Code	R	Taxonomy Code
326	***2310A***	***REF***		***ATTENDING PROVIDER SECONDARY IDENTIFICATION***	***S***	***Allowed but not used for processing***
326	2310A	REF	01	Reference Identification Qualifier	R	Valid Value: "G2" – Provider Commercial Number
327	2310A	REF	02	Attending Provider Secondary Identifier	R	State Medicaid Provider ID
328	**2310B**			**OPERATING PHYSICIAN NAME LOOP**		***Allowed but not used for processing***
333	**2310C**			**OTHER OPERATING PHYSICIAN NAME LOOP**		***Allowed but not used for processing***
338	**2310D**			**RENDERING PROVIDER NAME**		**Required when the Rendering Provider is different than the Attending Provider.**
339	2310D	NM1	01	Entity Identifier Code	R	Valid Value: "82" – Rendering Physician
339	2310D	NM1	02	Entity Type Qualifier	R	Valid Value: "1" – Person
339	2310D	NM1	03	Rendering Provider Last Name	R	
339	2310D	NM1	04	Rendering Provider First Name	S	Required when the person has a First Name

339	2310D	NM1	05	Rendering Provider Middle Name	S	
339	2310D	NM1	07	Rendering Provider Name Suffix	S	Not used
340	2310D	NM1	08	Identification Code Qualifier	R	Valid Value: "XX" – NPI
340	2310D	NM1	09	Rendering Provider NPI	R	NPI
343	**2310E**			**SERVICE FACILITY LOCATION NAME LOOP**	**S**	
344	***2310E***	***NM1***		***SERVICE FACILITY LOCATION***	***S***	***Required when the location of the Service is different than that carried in Loop 2010AA (Billing Provider).***
344	2310E	NM1	01	Entity Identifier Code	R	Valid Value: "77" – Service Location
344	2310E	NM1	02	Entity Type Qualifier	R	Valid Value: "2" - Non-Person Entity
344	2310E	NM1	03	Last or Organization Name	R	Follow Implementation Guide for this data element.
344	2310E	NM1	08	Identification Code Qualifier	S	Accepted Values: "XX" – NPI
344	2310E	NM1	09	Rendering Provider Identifier	S	NPI
346	***2310E***	***N3***		***SERVICE FACILITY LOCATION ADDRESS***	***R***	***Required when this loop is present. Follow Implementation Guide for this Segment and all data elements.***
347	***2310E***	***N4***		***SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE***	***R***	***Required when this loop is present. Follow Implementation Guide for this Segment and all data elements.***
349	***2310E***	***REF***		***SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
351	**2310F**			**REFERRING PROVIDER NAME LOOP**		***Allowed but not used for processing***
356	**2320**			**OTHER SUBSCRIBER INFORMATION LOOP**		**Required when other payers are involved in paying on this claim.**
356	***2320***	***SBR***		***OTHER SUBSCRIBER INFORMATION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
357	2320	SBR	01	Payer Responsibility Sequence Number Code	R	Valid Values: Please see the Implementation Guide for values.

357	2320	SBR	02	Individual Relationship Code	R	Valid Value: "01" – Spouse "18" – Self "19" – Child "20" – Employee "21" – Unknown "39" – Organ Donor "40" – Cadaver Donor "53" – Life Partner "G8" – Other Relationship
358	2320	SBR	03	Insured Group or Policy Number	S	Other Insurer's ID for this person.
358	2320	SBR	04	Other Insured Group Name	S	Follow Implementation Guide for this data element.
358	2320	SBR	09	Claim Filing Indicator Code	S	Valid Values: "11" – Other Non-Federal Programs "12" – Preferred Provider Organization "13" – Point of Service "14" – Exclusive Provider Organization "15" – Indemnity Insurance "16" – Health Maintenance Organization Medicare Risk "17" – Dental Maintenance Organization "AM" – Automobile Medical "BL" – Blue Cross/Blue Shield "CH" – Champus "CI" – Commercial Insurance Company "DS" – Disability "FI" – Federal Employees Program "HM" – Health Maintenance Organization "LM" – Liability Medical "MA" – Medicare Part A "MB" – Medicare Part B "MC" - Medicaid "OF" – Other Federal Program (includes Medicare Part D) "TV" – Title V "VA" – Veteran Administration Plan "WC" – Workers' Compensation "ZZ" - Unknown
360	***2320***	***CAS***		***CLAIM LEVEL ADJUSTMENT***	***S***	***Required when the claim has been adjudicated by the payer identified in this loop and the claim has claim level adjustment information. Used to report prior payers' amount paid.***
362	2320	CAS	01	Claim Adjustment Group Code	R	Valid Values: "CO" – Contractual Obligations "CR" – Correction and Reversals "OA" – Other Adjustments "PI" – Payor Initiated Reductions "PR" – Patient Responsibility
362	2320	CAS	02	Claim Adjustment Reason Code	R	
362	2320	CAS	03	Adjustment Amount	R	
362	2320	CAS	04	Adjustment Quantity	S	Required when the number of service units has been adjusted.
362	2320	CAS	05	Claim Adjustment Group Code	S	Valid Values: "CO" – Contractual Obligations "CR" – Correction and Reversals "OA" – Other Adjustments "PI" – Payor Initiated Reductions "PR" – Patient Responsibility
362	2320	CAS	06	Adjustment Amount	S	Required when CAS05 is present
363	2320	CAS	07	Adjustment Quantity	S	

363	2320	CAS	08	Claim Adjustment Reason Code	S	Valid Values: "CO" – Contractual Obligations "CR" – Correction and Reversals "OA" – Other Adjustments "PI" – Payor Initiated Reductions "PR" – Patient Responsibility
363	2320	CAS	09	Adjustment Amount	S	Required when CAS08 is present
363	2320	CAS	10	Adjustment Quantity	S	
363	2320	CAS	11	Claim Adjustment Reason Code	S	Valid Values: "CO" – Contractual Obligations "CR" – Correction and Reversals "OA" – Other Adjustments "PI" – Payor Initiated Reductions "PR" – Patient Responsibility
364	2320	CAS	12	Adjustment Amount	S	Required when CAS11 is present
364	2320	CAS	13	Adjustment Quantity	S	
364	2320	CAS	14	Claim Adjustment Reason Code	S	Valid Values: "CO" – Contractual Obligations "CR" – Correction and Reversals "OA" – Other Adjustments "PI" – Payor Initiated Reductions "PR" – Patient Responsibility
364	2320	CAS	15	Adjustment Amount	S	Required when CAS14 is present
364	2320	CAS	16	Adjustment Quantity	S	
365	2320	CAS	17	Claim Adjustment Reason Code	S	Valid Values: "CO" – Contractual Obligations "CR" – Correction and Reversals "OA" – Other Adjustments "PI" – Payor Initiated Reductions "PR" – Patient Responsibility
365	2320	CAS	18	Adjustment Amount	S	Required when CAS17 is present
365	2320	CAS	19	Adjustment Quantity	S	
366	***2320***	***AMT***		***COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT***	***S***	***Required when the claim has been adjudicated by the payer identified in Loop 2330B of this loop OR when loop 2010AC is present.***
366	2320	AMT	01	Amount Qualifier Code	R	Valid Value: "D" – Payor Amount Paid
366	2320	AMT	02	Other Payer Paid Amount	R	Other Payor Paid Amount (Can = 0)
367	***2320***	***AMT***		***REMAINING PATIENT LIABILITY***	***S***	***Allowed but not used for processing***
368	***2320***	***AMT***		***COORDINATION OF BENEFITS (COB) TOTAL NON- COVERED AMOUNT***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
368	2320	AMT	01	Amount Qualifier Code	R	Valid Value: "A8" – Non-covered Charges - Actual
368	2320	AMT	02	Non-Covered Charge Amount	R	

369	***2320***	***OI***		***OTHER INSURANCE COVERAGE INFORMATION***	***R***	***Information in this segment applies only to the payer identified in Loop 2330B***
369	2320	OI	03	Benefits Assignment Certification Indicator	R	Valid Values: "N" – No "W" – Not Applicable (use when patient refuses to assign benefits) "Y" - Yes
370	2320	OI	06	Release of Information Code	R	Valid Values: "I" – Informed Consent "Y" – Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim
371	***2320***	***MIA***		***MEDICARE INPATIENT ADJUDICATION INFORMATION***	***S***	***Allowed but not used for processing***
376	***2320***	***MOA***		***MEDICARE OUTPATIENT ADJUDICATION INFORMATION***	***S***	***Allowed but not used for processing***
379	**2330A**			**OTHER SUBSCRIBER NAME LOOP**	**S**	**The 2330A Loop is required when Loop ID 2320 - Other Subscriber Information is present. Otherwise, this loop is not used.**
379	***2330A***	***NM1***		***OTHER SUBSCRIBER NAME***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
380	2330A	NM1	01	Entity Identifier Code	R	Valid Value: "IL" – Subscriber
380	2330A	NM1	02	Entity Type Qualifier	R	Valid Value: "1" – Person "2" – Non-Person Entity
380	2330A	NM1	03	Other Insured Last Name	R	Other Subscriber Last Name
380	2330A	NM1	04	Other Insured First Name	S	Other Subscriber First Name. Required when NM102=1
380	2330A	NM1	05	Other Insured Middle Name	S	Other Subscriber Middle Name (if available)
380	2330A	NM1	07	Other Insured Name Suffix	S	Not Used
381	2330A	NM1	08	Other Subscriber Identification Code Qualifier	R	Valid Value: "MI" – Member Identification Number
381	2330A	NM1	09	Other Subscriber Primary Identifier	R	Other Subscriber Primary Identifier
382	***2330A***	***N3***		***OTHER SUBSCRIBER ADDRESS***	***S***	***Allowed but not used for processing***

383	***2330A***	***N4***		***OTHER SUBSCRIBER CITY, STATE, ZIP CODE***	***S***	***Allowed but not used for processing***
385	***2330A***	***REF***		***OTHER SUBSCRIBER SECONDARY INFORMATION***	***S***	***Allowed but not used for processing***
386	**2330B**			**OTHER PAYER NAME LOOP**	**S**	**The 2330B Loop is required when Loop ID 2320 - Other Subscriber Information is used. Otherwise, this loop is not used.**
386	***2330B***	***NM1***		***OTHER PAYER NAME***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
386	2330B	NM1	01	Entity Identifier Code	R	Valid Value: "PR" – Payer
386	2330B	NM1	02	Entity Type Identifier	R	Valid Value: "2" – Non-Person
387	2330B	NM1	03	Other Payer Organization Name	R	Other Payer Organization Name
387	2330B	NM1	08	Identification Code Qualifier	R	Valid Value: "PI" – Payer Identification
387	2330B	NM1	09	Other Payer Identifier	R	Other Payer Identifier
388	***2330B***	***N3***		***OTHER PAYER ADDRESS***	***S***	***Allowed but not used for processing***
389	***2330B***	***N4***		***OTHER PAYER CITY, STATE, ZIP***	***S***	***Allowed but not used for processing***
391	***2330B***	***DTP***		***CLAIM CHECK OR REMITTANCE DATE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
392	***2330B***	***REF***		***OTHER PAYER SECONDARY IDENTIFIER***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
394	***2330B***	***REF***		***OTHER PAYER PRIOR AUTHORIZATION NUMBER***	***S***	***Allowed but not used for processing***
395	***2330B***	***REF***		***OTHER PAYER REFERRAL NUMBER***	***S***	***Allowed but not used for processing***
396	***2330B***	***REF***		***OTHER PAYER CLAIM ADJUSTMENT INDICATOR***	***S***	***Allowed but not used for processing***
397	***2330B***	***REF***		***OTHER PAYER CLAIM CONTRAL NUMBER***	***S***	***Allowed but not used for processing***
398	**2330C**			**OTHER PAYER ATTENDING PROVIDER LOOP**	**S**	***Allowed but not used for processing***

402	**2330D**			**OTHER PAYER OPERATING PHYSICIAN LOOP**	**S**	***Allowed but not used for processing***
406	**2330E**			**OTHER PAYER OTHER OPERATING PHYSICIAN LOOP**	**S**	***Allowed but not used for processing***
410	**2330F**			**OTHER PAYER SERVICE FACILITY LOCATION LOOP**	**S**	***Allowed but not used for processing***
414	**2330G**			**OTHER PAYER RENDERING PROVIDER NAME LOOP**	**S**	***Allowed but not used for processing***
418	**2330H**			**OTHER PAYER REFERRING PROVIDER LOOP**	**S**	***Allowed but not used for processing***
422	**2330I**			**OTHER PAYER BILLING PROVIDER LOOP**	**S**	***Allowed but not used for processing***
	2400			**SERVICE LINE LOOP**	**R**	
425	***2400***	***LX***		***SERVICE LINE NUMBER***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
425	2400	LX	01	Assigned Number	R	Claim Line Number
426	***2400***	***SV2***		***INSTITUTIONAL SERVICE LINE***	***R***	
426	2400	SV2	01	Service Line Revenue Code	R	
427	2400	SV2	02-1	Product or Service ID Qualifier	R	Valid Value: "HC" - HCPCS (and CPT) codes
428	2400	SV2	02-2	Procedure Code	R	Procedure code for this line item
428	2400	SV2	02-3	Procedure Modifier 1	S	Follow Implementation Guide for this data element.
428	2400	SV2	02-4	Procedure Modifier 2	S	Follow Implementation Guide for this data element.
429	2400	SV2	02-5	Procedure Modifier 3	S	Follow Implementation Guide for this data element.
429	2400	SV2	02-6	Procedure Modifier 4	S	Follow Implementation Guide for this data element.
429	2400	SV2	02-7	Description	S	Follow Implementation Guide for this data element.
429	2400	SV2	03	Line Item Charge Amount	R	Follow Implementation Guide for this data element. "0" is an acceptable value
430	2400	SV2	04	Unit or Basis for Measurement Code	R	Follow Implementation Guide for this data element.
430	2400	SV2	05	Service Unit Count	R	Follow Implementation Guide for this data element.
430	2400	SV1	05	Place of Service Code	S	Please provide for county/state reporting. Follow Implementation Guide for this data element.
430	2400	SV2	07	Line Item Denied Charge or Non-Covered Charge Amount	S	Follow Implementation Guide for this data element.

431	***2400***	***PWK***		***LINE SUPPLEMENTAL INFORMATION***	***S***	***Allowed but not used for processing***
435	***2400***	***DTP***		***DATE - SERVICE DATE***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
436	2400	DTP	01	Date Time Qualifier	R	Valid Value: "472" - Service
436	2400	DTP	02	Date Time Period Format Qualifier	R	Valid Values: "D8" – CCYYMMDD "RD8" – CCYYMMDD- CCYYMMDD
436	2400	DTP	03	Service Date	R	Service Date
437	***2400***	***REF***		***LINE ITEM CONTROL NUMBER***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
437	2400	REF	01	Reference Identification Number	R	Valid Value: "6R" – Provider Control Number
438	2400	REF	02	Line Item Control Number	R	
439	***2400***	***REF***		***REPRICED LINE ITEM REFERENCE NUMBER***	***S***	***Allowed but not used for processing***
440	***2400***	***REF***		***ADJUSTED REPRICED LINE ITEM REFERENCE NUMBER***	***S***	***Allowed but not used for processing***
441	***2400***	***AMT***		***SERVICE TAX AMOUNT***	***S***	***Allowed but not used for processing***
442	***2400***	***AMT***		***FACILITY TAX AMOUNT***	***S***	***Allowed but not used for processing***
443	***2400***	***NTE***		***THIRD PARTY ORGANIZATION NOTES***	***S***	***Allowed but not used for processing***
444	***2400***	***HCP***		***LINEPRICING/REPRICING INFORMATION***	***S***	***Allowed but not used for processing***
451	**2410**			**DRUG IDENTIFICATION LOOP**	**S**	***Allowed but not used for processing***
458	**2420A**			**OPERATING PHYSICIAN NAME LOOP**	**S**	***Allowed but not used for processing***
463	**2420B**			**OTHER OPERATING PHYSICIAN NAME LOOP**	**S**	***Allowed but not used for processing***
468	**2420C**			**RENDERING PROVIDER NAME LOOP**		***Allowed but not used for processing***
473	**2420D**			**REFERRING PROVIDER NAME LOOP**		***Allowed but not used for processing***

478	**2430**			**SERVICE LINE ADJUDICATION INFORMATION LOOP**	**S**	**Required if claim has been previously adjudicated by payer identified in Loop 2330B (OTHER PAYER) and service line has adjustments applied to it.**
478	***2430***	***SVD***		***SERVICE LINE ADJUDICATION INFORMATION***	***S***	***Follow Implementation Guide for this Segment and all data elements. Required when an adjustment is being requested.***
482	***2430***	***CAS***		***LINE ADJUSTMENT***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
488	***2430***	***DTP***		***LINE CHECK OR REMITTANCE DATE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
489	***2430***	***AMT***		***REMAINING PATIENT LIABILITY***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
490		**SE**		**TRANSACTION SET TRAILER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**

10. APPENDECIES

10.1. IMPLEMENTATION CHECKLIST

The implementation check list will vary depending on your choice of connection; CAQH CORE Connectivity or Clearinghouse. However, a basic check list would be to:

1. Register with Trading Partner
2. Create and sign contract with trading partner
3. Establish connectivity
4. Send test transactions
5. If testing succeeds, proceed to send production transactions

10.2. BUSINESS SCENARIOS

Please refer to Section 4.4 above, which points to the appropriate website for Washington Publishing where the reader can view the 5010 Technical Report Type 3 (TR3, formerly known as Implementation Guide), which contains various business scenario examples.

10.3. TRANSMISSION EXAMPLES

Please refer to Section 4.4 above, which points to the appropriate website for Washington Publishing where the reader can view the TR3, which contains various transmission examples.

10.4. FREQUENTLY ASKED QUESTIONS

1. Does this Companion Guide apply to all OptumHealth payers?
No. The changes will apply to commercial and government business for OptumHealth using payer ID 87726.

2. How does OptumHealth support, monitor, and communicate expected and unexpected connectivity outages?
Our systems do have planned outages. For the most part, transactions will be queued during those outages. We will send an email communication for scheduled and unplanned outages.

3. If a 837 is successfully transmitted to OptumHealth, are there any situations that would result in no response being sent back?
No. OptumHealth will always send a response. Even if OptumHealth's systems are down and the transaction cannot be processed at the time of receipt, a response detailing the situation will be returned.

10.5. FILE NAMING CONVENTIONS

For more information, please contact your UHIN Account Manager. If you do not have an UHIN Account Manager, please contact UHIN at http://www.uhin.org/join or call 801-466-7705 for more information.