Standard Companion Guide

Refers to the Implementation Guide Based on X12 Version 005010X222A1 Health Care Claim: Professional

(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	Timely Filing - Loop 2300 Segment NTE (Claim Note) EBP Codes - 2400 Loop Segment NTE (Line Note)
1.2	9/17/2020	TPL/COB - Loops 2320, 2330A, 2330B, & 2430 Unique Patient Control Number Required - Loop 2300 Segment CLM01

HIPAA 837 Professional 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: Professional (837) ASC X12N/005010X222A1, 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.

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HIPAA 837 Professional Claims Companion Guide

1. INTRODUCTION

This Companion Guide is intended to be used in conjunction with the "837 Professional Claim Companion Guide Specifications for Public Sector Behavioral Health" for the version "Consolidated Documents: May 2006 005010x223 and June 2010 005010X222A1."

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 Professional 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: Professional (837) (referred to Professional Claim in the rest of this document) for the purpose of submitting Professional 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 Professional Claim and must be used in conjunction with the TR3 instructions. The CG is intended to assist you in implementing electronic Professional 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: Professional (837) ASC X12N/005010X222A1 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 (837P) is allowed per transmission. Multiple 837P 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 Professionals should contact their current clearinghouse vendor to discuss their ability to support the Professional Claim transaction, as well as associated timeframe, costs, etc.

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

2.3. CERTIFICATION AND TESTING OVERVIEW

Optum does not certify Providers or Clearinghouses.

2.4. TESTING WITH Optum

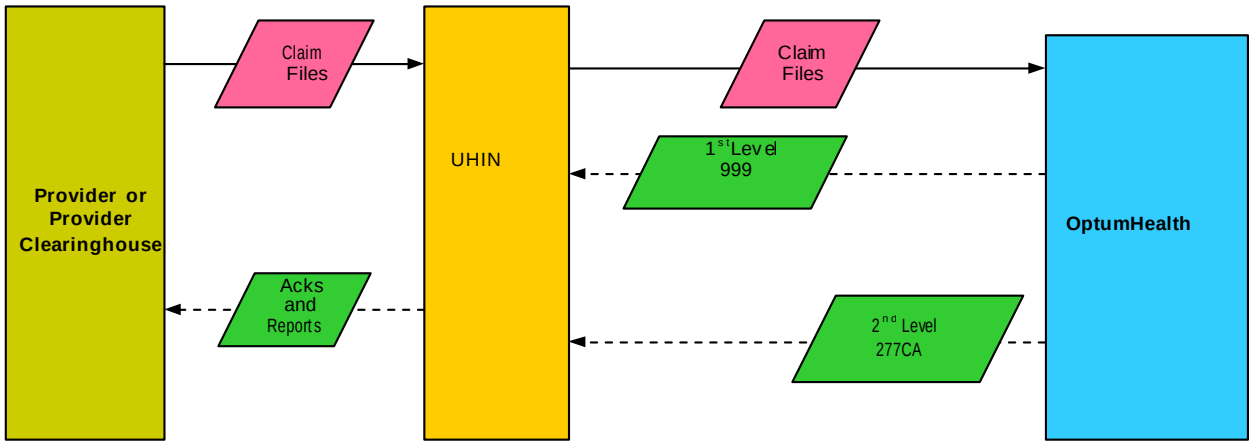
Clearinghouse Connection:

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

3. CONNECTIVITY WITH THE PAYER / COMMUNICATIONS

3.1. PROCESS FLOWS

Batch Professional 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 Professionals should contact their current clearinghouse vendor for information on the most current process.

3.4. COMMUNICATION PROTOCOL SPECIFICATIONS

Clearinghouse Connection:

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

3.5. PASSWORDS

Clearinghouse Connection:

Physicians and Healthcare Professionals 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 Professionals 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 Optum Health 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 Optum Health 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. Professional 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. Professional Claim with the value 'II' (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
70		**ST**		**TRANSACTION SET HEADER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
70		ST	01	Transfer Set Identifier Qualifier	R	Valid Value: "837" – Health Care Claim
70		ST	02	Transaction Set Control Number	R	A unique control number assigned by the Sender for this functional group for this transaction.
70		ST	03	Implementation Convention Reference	R	Valid Value: "005010X222A1"
71		**BHT**		**BEGINNING OF HIERARCHICAL TRANSACTION**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
71		BHT	01	Hierarchical Structure Code	R	Valid Value: "0019" – Information Source, Subscriber, Dependent
71		BHT	02	Transaction Set Purpose Code	R	Valid Values: "00" – Original "18" – Reissue
72		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.
72		BHT	04	Transaction Set Creation Date	R	CCYYMMDD
72		BHT	05	Transaction Set Creation Time	R	HHMM
72		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
74	**1000A**			**SUBMITTER NAME LOOP**	**R**	
74	***1000A***	***NM1***		***SUBMITTER NAME***	***R***	
75	1000A	NM1	01	Entity Identifier Code	R	Valid Value: "41" – Submitter
75	1000A	NM1	02	Entity Type Qualifier	R	Valid Values: "1" – Person "2" – Non-Person Entity
75	1000A	NM1	03	Submitter Last or Organization Name	R	Follow Implementation Guide for this data element.
75	1000A	NM1	04	Submitter First Name	S	Follow Implementation Guide for this data element.
75	1000A	NM1	05	Submitter Middle Name	S	Follow Implementation Guide for this data element.
75	1000A	NM1	08	Identification Code Qualifier	R	Valid Value: "46" – Trading Partner Number
75	1000A	NM1	09	Submitter Identifier	R	Submitter's Trading Partner Number (TPN) supplied by UHIN.
76	***1000A***	***PER***		***SUBMITTER EDI CONTACT INFORMATION***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
77	1000A	PER	01	Contact Function Code	R	Valid Value: "IC" – Information Contact
77	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.
77	1000A	PER	03	Communication Number Qualifier	R	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone
77	1000A	PER	04	Communication Number	R	Contact communication number/address
77	1000A	PER	05	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone
78	1000A	PER	06	Communication Number	S	Contact communication number/address
78	1000A	PER	07	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone
78	1000A	PER	09	Communication Number	S	Contact communication number/address
79	**1000B**	**NM1**		**RECEIVER NAME LOOP**	**R**	
79	***1000B***	***NM1***		***RECIEVER INDIVIDUAL OR ORGANIZATIONAL NAME***	***R***	
79	1000B	NM1	01	Entity Identification Code	R	Valid Value: "40" - Receiver
79	1000B	NM1	02	Entity Type Qualifier	R	Valid Value: "2" – Non-Person Entity
80	1000B	NM1	03	Receiver Name	R	"OptumHealth PS"
80	1000B	NM1	08	Information Receiver Identification Number Qualifier	R	Valid Value: "46" – Electronic Transmitter Identification Number
80	1000B	NM1	09	Receiver Primary Identifier	R	HT006885-001
81	**2000A**			**BILLING/PAY-TO PROVIDER LOOP**	**R**	
81	***2000A***	***HL***		***BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
81	2000A	HL	01	Hierarchical ID Number	R	Follow Implementation Guide for this data element.
81	2000A	HL	03	Hierarchical Level Code	R	Valid Value: "20" – Information Source
82	2000A	HL	04	Hierarchical Child Code	R	Valid Value: "1" – Additional Subordinate HL Data Segments
83	***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. This PRV is not used when the Billing or Pay-to Provider is a group and the individual Rendering Provider is in loop 2310B. The State requires that the individual provider is identified for each claim/service when it is reported to the State.
83	2000A	PRV	01	Provider Code	R	Valid Value: "BI" – Billing Provider
83	2000A	PRV	02	Reference Identification Qualifier	R	Valid Value: "PXC" – Taxonomy Code
83	2000A	PRV	03	Provider Taxonomy Code	R	Provider Taxonomy Code
84	***2000A***	***CUR***		***FOREIGN CURRENCY INFORMATION***	***S***	***Not used***
87	**2010AA**			**BILLING PROVIDER NAME LOOP**	**R**	

88	2010AA	NM1	01	Entity Identification Code	R	Valid Value: "85" – Billing Provider
88	2010AA	NM1	02	Entity Type Qualifier	R	Valid Values: "1" – Person "2" – Non-Person
88	2010AA	NM1	03	Billing Provider Last Name	R	Follow Implementation Guide for this data element.
88	2010AA	NM1	04	Billing Provider First Name	S	Required when 2010AA, NM101 = "1" Billing Provider First Name
89	2010AA	NM1	06	Billing Provider Middle Name	S	Follow Implementation Guide for this data element.
89	2010AA	NM1	07	Billing Provider Name Suffix	S	Not used
89	2010AA	NM1	08	Identification Code Qualifier	R	"XX" – NPI
90	2010AA	NM1	09	Billing Provider Identifier	R	Billing Provider NPI
91	***2010AA***	***N3***		***BILLING PROVIDER ADDRESS***	***R***	
91	2010AA	N3	01	Billing Provider Address Line	R	Address that coordinates with OptumHealth contract Service Location
91	2010AA	N3	02	Billing Provider Address Line	S	Address that coordinates with OptumHealth contract Service Location
92	***2010AA***	***N4***		***BILLING PROVIDER CITY/STATE/ZIP CODE***	***R***	
92	2010AA	N4	01	Billing Provider City Name	R	City that coordinates with OptumHealth contract Service Location
93	2010AA	N4	02	Billing Provider State	R	State that coordinates with OptumHealth contract Service Location
93	2010AA	N4	03	Billing Provider's Zip Code	R	Zip Code that coordinates with OptumHealth contract Service Location
93	2010AA	N4	04	Billing Provider's Country Code	S	Not Used
94	***2010AA***	***REF***		***BILLING PROVIDER SECONDARY IDENTIFICATION***	***R***	***Each submission must contain a minimum of 1- 2010AA REF segments.***
94	2010AA	REF	01	Reference Identification Qualifier	R	Valid Values: "EI" – Tax Identification Number "SY" – Social Security Number
94	2010AA	REF	02	Billing Provider Additional Identifier	R	Tax Identification Number Or Social Security Number
96	***2010AA***	***REF***		***BILLING PROVIDER UPIN/LICENSE INFORMATION***	***S***	***Not used***
98	***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.***
99	2010AA	PER	01	Contact Function Code	R	Valid Value: "IC" – Information Contact
99	2010AA	PER	02	Name	S	Required when the contact name is different than the name contained in the Submitter and/or Billing Name segments.
99	2010AA	PER	03	Communication Number Qualifier	R	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone
99	2010AA	PER	04	Communication Number	R	Contact communication number/address

99	2010AA	PER	05	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone
100	2010AA	PER	06	Communication Number	S	Contact communication number/address
100	2010AA	PER	07	Communication Number Qualifier	S	Valid Values: "EM" – Electronic Mail "FX" – Facsimile "TE" – Telephone
100	2010AA	PER	09	Communication Number	S	Contact communication number/address
	2010AB			**PAY-TO PROVIDER NAME LOOP**	**S**	**Required when the Pay-To Provider Address is different than the Billing Provider Address.**
101	***2010AB***	***NM1***		***PAY-TO PROVIDER NAME***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
101	2010AB	NM1	01	Entity Identification Code	R	Valid Value: "87" – Pay-to Provider
102	2010AB	NM1	02	Entity Type Qualifier	R	Valid Values: "1" – Person "2" – Non-Person
103	***2010AB***	***N3***		***PAY-TO PROVIDER ADDRESS***	***S***	***Required when the Pay-To Provider Address is different than the Billing Provider Address.***
103	2010AB	N3	01	Pay-To Provider Address Line	R	Line 1 of Pay-To Address
103	2010AB	N3	02	Pay-To Provider Address Line	S	Line 2 of Pay-To Address
104	***2010AB***	***N4***		***PAY-TO PROVIDER CITY/STATE/ZIP CODE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
104	2010AB	N4	01	Pay-To Provider City Name	R	
105	2010AB	N4	02	Pay-To Provider State	R	
105	2010AB	N4	03	Pay-To Provider's Zip Code	R	
105	2010AB	N4	04	Billing Provider's Country Code	S	Not Used
105	2010AB	N4	07	Billing Provider's Country Subdivision Code	S	Not Used
	2010AC			**PAY-TO PLAN NAME LOOP**	**S**	**Not Used (NOTE: If provided will be ignored and will not affect processing)**
106	***2010AC***	***NM1***		***PAY-TO PLAN NAME***	***S***	***Not Used***
108	***2010AC***	***N3***		***PAY-TO PLAN ADDRESS***	***S***	***Not Used***
109	***2010AC***	***N4***		***PAY-TO PLAN CITY,STATE,ZIP***	***S***	***Not Used***
111	***2010AC***	***REF***		***PAY-TO PLAN SECONDARY INDENTIFICATION***	***S***	***Not Used***
113	***2010AC***	***REF***		***PAY-TO PLAN TAX INDENTIFICATION NUMBER***	***S***	***Not Used***
114	**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.**
114	***2000B***	***HL***		***SUBSCRIBER HIERARCHICAL LEVEL***	***R***	
114	2000B	HL	01	Hierarchical ID Number	R	Must be numeric and incremental from preceding HL Segments within the transaction set.

115	2000B	HL	02	Hierarchical Parent ID Number	R	Follow Implementation Guide for this data element.
115	2000B	HL	03	Hierarchical Child Code	R	Valid Value: "22" – Subscriber
115	2000B	HL	04	Hierarchical Child Code	R	Valid Value: "0" – No Subordinate HL Segments
116	***2000B***	***SBR***		***SUBSCRIBER INFORMATION***	***R***	
116	2000B	SBR	01	Payer Responsibility Sequence Number Code	R	Valid Values: "P" – Primary "S" – Secondary "T" – Tertiary
117	2000B	SBR	02	Patients Relationship to Insured	R	Valid Value: "18" – Self
117	2000B	SBR	03	Insured Group or Policy Number	S	Not Used The PACMIS or other unique Identifier is reported at Loop 2010BA – NM109
117	2000B	SBR	04	Insured Group Name	S	Not Used
117	2000B	SBR	05	Insurance Type Code	S	Follow Implementation Guide for this data element.
118	2000B	SBR	09	Claim Filing Indicator Code	R	Valid Values: "11" – Other Non-Federal Programs (Non-Medicaid) "MC" – Medicaid
119	***2000B***	***PAT***		***PATIENT INFORMATION***	***S***	***Not used***
121	**2010BA**			**SUBSCRIBER NAME LOOP**	**R**	
121	***2010BA***	***NM1***		***SUBSCRIBER NAME***	***R***	
121	2010BA	NM1	01	Entity Identifier Code	R	Valid Value: "IL" – Subscriber
122	2010BA	NM1	02	Entity Type Qualifier	R	Valid Value: "1" - Person
122	2010BA	NM1	03	Subscriber Last Name	R	Patient's Last Name
122	2010BA	NM1	04	Subscriber First Name	S	Required by Optum to properly identify the Patient. Patient's First Name
122	2010BA	NM1	05	Subscriber Middle Name	S	Patient's Middle Name (if available)
122	2010BA	NM1	06	Not Used	S	Not Used
122	2010BA	NM1	07	Name Suffix	s	Not Used
122	2010BA	NM1	08	Identification Code Qualifier	R	Valid Value: "MI" – Member Identification Number
123	2010BA	NM1	09	Subscriber Primary Identifier	R	Medicaid PACMIS # when Medicaid OptumHealth assigned ID for Non-Medicaid
124	***2010BA***	***N3***		***SUBSCRIBER ADDRESS***	***S***	***Follow Implementation Guide for this Segment and all data elements. Please complete with available information.***
125	***2010BA***	***N4***		***SUBSCRIBER CITY/STATE/ZIP CODE***	***S***	***Follow Implementation Guide for this Segment and all data elements. Please complete with available information.***
127	***2010BA***	***DMG***		***SUBSCRIBER DEMOGRAPHIC INFORMATION***	***S***	***This segment is required for a claim to be accepted into the OptumHealth system.***
127	2010B	DMG	01	Date Time Period Format	R	"D8"

	A			Qualifier		
127	2010BA	DMG	02	Date of Birth - Patient	R	CCYYMMDD
128	2010BA	DMG	03	Gender - Patient	R	Valid Values: "F" – Female "M" – Male "U" – Unknown
129	***2010BA***	***REF***		***SUBSCRIBER SECONDARY IDENTIFICATION***	***S***	***This segment is required for a claim to be accepted into the OptumHealth system.***
129	2010BA	REF	01	Reference Identification Qualifier	R	"SY" Social Security Number
129	2010BA	REF	02	Subscriber Supplemental Identifier	R	Patient's Social Security Number
130	***2010BA***	***REF***		***PROPERTY AND CASUALTY CLAIM NUMBER***	***S***	***Not Used***
131	***2010BA***	***PER***		***PROPERTY AND CASUALTY SUBSCRIBER CONTACT INFORMATION***	***S***	***Not Used***
133	**2010BB**			**PAYER NAME LOOP**	**R**	
133	2010BB	NM1		**PAYER NAME**	R	
133	2010BB	NM1	01	Entity Identifier Code	R	Valid Value: "PR" – Payer
134	2010BB	NM1	02	Entity Type Qualifier	R	Valid Value: "2" - Non-Person Entity
134	2010BB	NM1	03	Payer Name	R	Valid Value: "OptumHealth"
134	2010BB	NM1	08	Identification Code Qualifier	R	Valid Value: "PI" – Payer Identification
134	2010BB	NM1	09	Payer Identification	R	HT006885-001
135	***2010BB***	***N3***		***PAYER ADDRESS***	***S***	***Accepted, but Not used***
136	***2010BB***	***N4***		***PAYER CITY, STATE, ZIP CODE***	***S***	***Accepted, but Not used***
138	***2010BB***	***REF***		***PAYER SECONDARY IDENTIFICATION***	***S***	***Accepted, but Not used***
140	***2010BB***	***REF***		***BILLING PROVIDER SECONDARY IDENTIFICATION***	***S***	***Accepted, but Not used***
142	**2000C**			**PATIENT HIERARCHICAL LOOP**	**S**	**DO NOT USE THIS LOOP; The patient is always the subscriber for Medicaid and other funded Behavioral Health Services.**
142	***2000C***	***HL***		***PATIENT HIERARCHICAL LEVEL***	***S***	***Not used***
144	***2000C***	***PAT***		***PATIENT INFORMATION***	***S***	***Not used***
147	**2010CA**			**PATIENT NAME LOOP**	**S**	**DO NOT USE THIS LOOP; The patient is always the subscriber for Medicaid and other funded Behavioral Health Services.**
147	***2010CA***	***NM1***		***PATIENT NAME***	***S***	***Not used***
149	***2010CA***	***N3***		***PATIENT ADDRESS***	***S***	***Not used***
150	***2010CA***	***N4***		***PATIENT CITY, STATE, ZIP CODE***	***S***	***Not used***
152	***2010CA***	***DMG***		***PATIENT DEMOGRAPHIC INFORMATION***	***S***	***Not used***

154	***2010CA***	***REF***		***PROPERTY AND CASUALTY CLAIM NUMBER***	***S***	***Not used***
155	***2010CA***	***REF***		***PROPERTY AND CASUALTY PATIENT IDENTIFIER***	***S***	***Not used***
157	***2010CA***	***PER***		***PROPERTY AND CASUALTY PATIENT CONTACT INFORMATION***	***S***	***Not used***
159	**2300**			**CLAIM INFORMATION LOOP**	**R**	
160	***2300***	***CLM***		***CLAIM INFORMATION***	***R***	
160	2300	CLM	01	Claim Submitter's Identifier	R	Patient Control Number Must Be Unique
161	2300	CLM	02	Total Claim Charge Amount	R	Follow Implementation Guide for this data element.
161	***2300***	***CLM***	***05***	***Health Care Service Location Information (Composite Data Element)***	***R***	
161	2300	CLM	05-1	Type of Bill (Place of Service)	R	Valid Value: "B" – Place of Service Codes for Professional Services
161	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: "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.
161	2300	CLM	06	Provider Signature on File	R	Follow Implementation Guide for this data element.
162	2300	CLM	07	Medicare Assignment Code	R	Follow Implementation Guide for this data element.
162	2300	CLM	08	Assignment of Benefits Indicator	R	Follow Implementation Guide for this data element.
163	2300	CLM	09	Release of Information Code	R	Follow Implementation Guide for this data element.
163	2300	CLM	10	Patient Signature Source Code	S	Follow Implementation Guide for this data element.
163	***2300***	***CLM***	***11***	***Related Causes Information (Composite Data Element)***	***R***	
163	2300	CLM	11-1	Related-Causes Code	S	Follow Implementation Guide for this data element.
164	2300	CLM	11-2	Related-Causes Code	S	Follow Implementation Guide for this data element.
164	2300	CLM	11-4	Accident/Employment/Related Causes	S	Follow Implementation Guide for this data element.
164	2300	CLM	11-5	State or Province Code	S	Follow Implementation Guide for this data element.

164	2300	CLM	12	Special Program Code	S	Follow Implementation Guide for this data element.
165	2300	CLM	16	Participation Agreement	S	Follow Implementation Guide for this data element.
165	2300	CLM	20	Delay Reason Code	S	Follow Implementation Guide for this data element.
166	***2300***	***DTP***		***DATE – ONSET OF CURRENT ILLNESS OR SYMPTOM***	***S***	***Not used***
167	***2300***	***DTP***		***DATE – INITIAL TREATMENT DATE***	***S***	***Not used***
168	***2300***	***DTP***		***DATE – DATE LAST SEEN***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
169	***2300***	***DTP***		***DATE – ACUTE MANISFESTATION***	***S***	***Not used***
170	***2300***	***DTP***		***DATE – ACCIDENT***	***S***	***Not used***
171	***2300***	***DTP***		***DATE – LAST MENTRUAL PERIOD***	***S***	***Not used***
172	***2300***	***DTP***		***DATE – LAST X-RAY***	***S***	***Not used***
173	***2300***	***DTP***		***DATE – HEARING AND VISION PRESCRIPTION DATE***	***S***	***Not used***
174	***2300***	***DTP***		***DATE – DISABILITY DATES***	***S***	***Not used***
176	***2300***	***DTP***		***DATE – LAST WORKED***	***S***	***Not used***
177	***2300***	***DTP***		***DATE – AUTHORIZED RETURN TO WORK***	***S***	***Not used***
178	***2300***	***DTP***		***DATE – ADMISSION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
179	***2300***	***DTP***		***DATE – DISCHARGE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
180	***2300***	***DTP***		***DATE – ASSUMED AND RELINQUISHED CARE DATES***	***S***	***Not used***
182	***2300***	***DTP***		***DATE – PROPERTY AND CASUALTY DATE OF FIRST CONTACT***	***S***	***Not used***
183	***2300***	***DTP***		***DATE – REPRICER RECEIVED DATE***	***S***	***Not used***
184	***2300***	***PWK***		***CLAIM SUPPLEMENTAL INFORMATION***	***S***	***Not used***
188	***2300***	***CN1***		***CONTRACT INFORMATION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
190	***2300***	***AMT***		***PATIENT AMOUNT PAID***	***S***	***This segment is Required when the patient is responsible for any copayment amount.*** ***Follow Implementation Guide for this Segment and all data elements.***
190	2300	AMT	01	Amount Qualifier Code	R	Valid Value: "F5" – Patient Amount Paid
190	2300	AMT	02	Patient Amount Paid	R	Patient Amount Paid
191	***2300***	***REF***		***SERVICE AUTHORIZATION EXCEPTION CODE***	***S***	***Not used***
193	***2300***	***REF***		***MANDATORY MEDICARE (SECTION 4081) CROSSOVER INDICATOR***	***S***	***Not used***
194	***2300***	***REF***		***MAMMOGRAPHY CERTIFICATION NUMBER***	***S***	***Not used***
195	***2300***	***REF***		***REFERRAL NUMBER***	***S***	***Not used***

196	***2300***	***REF***		***PRIOR AUTHORIZATION NUMBER***	***S***	***Required for all claims to be accepted into the Optum's claims system.***
196	2300	REF	01	Reference Identification	R	Accepted Value: "G1" – Prior Authorization Number
197	2300	REF	02	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
198	***2300***	***REF***		***PAYER CLAIM CONTROL NUMBER***	***S***	***This segment is required when codes "6", "7", or "8" are submitted in Loop 2300 CLM05-3.***
198	2300	REF	01	Reference Identification Qualifier	R	Must = "F8" – Original Reference Number
198	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
199	***2300***	***REF***		***CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER***	***S***	***Not used***
201	***2300***	***REF***		***REPRICED CLAIM NUMBER***	***S***	***Not used***
202	***2300***	***REF***		***ADJUSTED REPRICED CLAIM NUMBER***	***S***	***Not used***
203	***2300***	***REF***		***INVESTIGATIONAL DEVICE EXEMPTION NUMBER***	***S***	***Not used***
204	***2300***	***REF***		***CLAIM INDENTIFICATION NUMBER FOR TRANSMISSION INTERMEDIARIES***	***S***	***Not used***
206	***2300***	***REF***		***MEDICAL RECORD NUMBER***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
207	***2300***	***REF***		***DEMONSTRATION PROJECT IDENTIFIER***	***S***	***Not used***
208	***2300***	***REF***		***CARE PLAN OVERSIGHT***	***S***	***Not used***
209	***2300***	***K3***		***FILE INFORMATION***	***S***	***Not used***
211	***2300***	***NTE***		***CLAIM NOTE***	***S***	***Valid Values: NTE01 = "ADD"; NTE02 = "[TimelyFilingWaiverNumber]"***
213	***2300***	***CR1***		***ABULANCE TRANSPORT INFORMATION***	***S***	***Not used***
216	***2300***	***CR2***		***SPINAL MANIPULATION SERVICE INFORMATION***	***S***	***Not used***
218	***2300***	***CRC***		***AMBULANCE CERTIFICATION***	***S***	***Not used***
221	***2300***	***CRC***		***PATIENT CONDITION INFORMATION: VISION***	***S***	***Not used***
223	***2300***	***CRC***		***HOMEBOUND INDICATOR***	***S***	***Not used***
225	***2300***	***CRC***		***EPSDT REFERRAL***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
228	***2300***	***HI***		***HEALTH CARE DIAGNOSIS CODE***	***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.***

229	2300	HI	01-1	Diagnosis Type Code	R	Valid Value: "BK" – Principal Diagnosis "ABK" – Principal Diagnosis
229	2300	HI	01-2	Diagnosis Code	R	DSM-5, ICD-9 or ICD-10
230	2300	HI	02-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
230	2300	HI	02-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
231	2300	HI	03-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
231	2300	HI	03-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
232	2300	HI	04-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
232	2300	HI	04-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
233	2300	HI	05-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
233	2300	HI	05-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
234	2300	HI	06-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
234	2300	HI	06-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
235	2300	HI	07-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
235	2300	HI	07-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
236	2300	HI	08-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
236	2300	HI	08-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
237	2300	HI	09-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
237	2300	HI	09-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
238	2300	HI	10-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
238	2300	HI	10-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
239	2300	HI	11-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
239	2300	HI	11-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
240	2300	HI	12-1	Diagnosis Type Code	S	Valid Value: "BF" – Diagnosis "ABF" – Diagnosis
240	2300	HI	12-2	Diagnosis Code	S	DSM-5, ICD-9 or ICD-10
241	***2300***	***HI***		***ANESTHESIA RELATED PROCEDURE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
241	2300	HI	01-1	Code List Qualifier	R	Valid Value: "BP" – Health Care Financing Administration Common Procedural Coding System Principal Procedure

242	2300	HI	01-2	Anesthesia Related Procedure	R	HCPC Procedure Code
242	2300	HI	02-1	Code List Qualifier	R	Valid Value: "BO" – Health Care Financing Administration Common Procedural Coding System Principal Procedure
242	2300	HI	02-2	Anesthesia Related Procedure	R	HCPC Procedure Code
244	***2300***	***HI***		***CONDITION INFORMATION***	***S***	***Not used***
254	***2300***	***HCP***		***CLAIM PRICING/REPRICING INFORMATION***	***S***	***Not used***
259	**2310A**			**REFERRING PROVIDER NAME LOOP**	**S**	
259	***2310A***	***NM1***		***REFERRING PROVIDER NAME***	***S***	***Not used***
262	***2310A***	***REF***		***REFERRING PROVIDER SECONDARY IDENTIFICATION***	***S***	***Not used***
264	**2310B**			**RENDERING PROVIDER NAME LOOP**	**S**	***Required when the Rendering Provider NM1 information is different than that carried in either the Billing Provider NM1 or the Pay-to Provider NM1 in the 2010AA/AB loops respectively.***
264	***2310B***	***NM1***		***RENDERING PROVIDER NAME***	***S***	***Required if this Loop is present.***
265	2310B	NM1	01	Entity Identifier Code	R	Valid Value: "82" – Rendering Provider
265	2310B	NM1	02	Entity Type Qualifier	R	Valid Values: "1" – Person "2" – Non-Person Entity
265	2310B	NM1	03	Rendering Provider Last or Organization Name	R	
265	2310B	NM1	04	Rendering Provider First Name	S	Required when NM102 = "1"
265	2310B	NM1	05	Rendering Provider Middle Name	S	
265	2310B	NM1	07	Rendering Provider Name Suffix	S	Not used
266	2310B	NM1	08	Identification Code Qualifier	R	Valid Value: "XX" – NPI
266	2310B	NM1	09	Rendering Provider NPI	R	NPI
267	***2310B***	***PRV***		***RENDERING PROVIDER SPECIALTY INFORMATION***	***S***	***Required when this Loop is present.***
267	2310B	PRV	01	Provider Code	R	Valid Value: "PE" – Performing Provider
267	2310B	PRV	02	Reference Identification Qualifier	R	Valid Value: "PXC" – Taxonomy Code
267	2310B	PRV	03	Provider Taxonomy Code	R	Taxonomy Code
269	***2310B***	***REF***		***RENDERING PROVIDER SECONDARY IDENTIFICATION***	***S***	***Required when this Loop is present.***
269	2310B	REF	01	Reference Identification Qualifier	R	Valid Value: "G2"– Provider Number
270	2310B	REF	02	Rendering Provider Secondary Identifier	R	State Medicaid Provider ID
271	**2310C**			**SERVICE FACILITY LOCATION LOOP**	**S**	

271	***2310C***	***NM1***		***SERVICE FACILITY LOCATION***	***S***	***Required when the location of the Service is different than that carried in Loop 2010AA (Billing Provider).***
272	2310C	NM1	01	Entity Identifier Code	R	Valid Value: "77" – Service Location
272	2310C	NM1	02	Entity Type Qualifier	R	Valid Value: "2" - Non-Person Entity
272	2310C	NM1	03	Last or Organization Name	R	Follow Implementation Guide for this data element.
272	2310C	NM1	08	Identification Code Qualifier	S	Accepted Values: "XX" – NPI
273	2310C	NM1	09	Rendering Provider Identifier	S	NPI
274	***2310C***	***N3***		***SERVICE FACILITY LOCATION ADDRESS***	***R***	***Required when this loop is present. Follow Implementation Guide for this Segment and all data elements.***
275	***2310C***	***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.***
277	***2310D***	***REF***		***SERVICE FACILITY LOCATION SECONDARY IDENTIFICATION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
282	**2310D**			**SUPERVISING PROVIDER NAME LOOP**		**Not used**
287	**2310E**			**AMBULANCE PICK-UP LOCATION**		**Not used**
292	**2310F**			**AMBULANCE DROP-OFF LOCATION**		**Not used**
297	**2320**			**OTHER SUBSCRIBER INFORMATION LOOP**		**Required when other payers are involved in paying on this claim.**
297	***2320***	***SBR***		***OTHER SUBSCRIBER INFORMATION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
298	2320	SBR	01	Payer Responsibility Sequence Number Code	R	Valid Values: Please see the Implementation Guide for values.
298	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
299	2320	SBR	03	Insured Group or Policy Number	S	Other Insurer's ID for this person.
299	2320	SBR	04	Other Insured Group Name	S	Follow Implementation Guide for this data element.

299	2320	SBR	05	Insurance Type Code	S	Valid Values: "12" – Medicare Secondary Working Aged Beneficiary or Spouse w/ Employer Group Health Plan "13" – Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period "14" – Medicare Secondary, No-fault Insurance including Auto is Primary "15" – Medicare Secondary Worker's Compensation "16" – Medicare Secondary Public Health Service (PHS) or Other Federal Agency "41" – Medicare Secondary Black Lung "42" – Medicare Secondary Veteran's Administration "43" – Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) "47" – Medicare Secondary, Other Liability Insurance is Primary
300	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 "OF" – Other Federal Program (includes Medicare Part D) "TV" – Title V "VA" – Veteran Administration Plan "WC" – Workers' Compensation "ZZ" - Unknown
301	***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.***
303	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
303	2320	CAS	02	Claim Adjustment Reason Code	R	
303	2320	CAS	03	Adjustment Amount	R	
303	2320	CAS	04	Adjustment Quantity	R	
303	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

303	2320	CAS	06	Adjustment Amount	S	
304	2320	CAS	07	Adjustment Quantity	S	
304	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
304	2320	CAS	09	Adjustment Amount	S	
304	2320	CAS	10	Adjustment Quantity	S	
304	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
305	2320	CAS	12	Adjustment Amount	S	
305	2320	CAS	13	Adjustment Quantity	S	
305	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
305	2320	CAS	15	Adjustment Amount	S	
305	2320	CAS	16	Adjustment Quantity	S	
306	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
306	2320	CAS	18	Adjustment Amount	S	
306	2320	CAS	19	Adjustment Quantity	S	
307	***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.***
307	2320	AMT	01	Amount Qualifier Code	R	Valid Value: "D" – Payor Amount Paid
307	2320	AMT	02	Other Payer Paid Amount	R	Other Payor Paid Amount (Can = 0)
308	***2320***	***AMT***		***COORDINATION OF BENEFITS (COB) PAYER NON-COVERED AMOUNT***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
308	2320	AMT	01	Amount Qualifier Code	R	Valid Value: "A8" – Non-covered Charges - Actual
308	2320	AMT	02	Other Payer Paid Amount	R	Other Payor Paid Amount (Can = 0)
309	***2320***	***AMT***		***REMAINING PATIENT LIABILITY***	***S***	***Not used***
310	***2320***	***OI***		***OTHER INSURANCE COVERAGE INFORMATION***	***R***	***Information in this segment applies only to the payer identified in Loop 2330B***

310	2320	OI	03	Benefits Assignment Certification Indicator	R	Valid Values: "N" – No "W" – Not Applicable (use when patient refuses to assign benefits) "Y" - Yes
311	2320	OI	04	Patient Signature Source Code	S	Required when a signature was executed on the patient's behalf. Valid Value: "P" – Signature generated by provider because patient was no physically present for services
311	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
312	***2320***	***MOA***		***MEDICARE OUTPATIENT ADJUDICATION INFORMATION***	***S***	***Not used***
315	**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.**
315	***2330A***	***NM1***		***OTHER SUBSCRIBER NAME***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
316	2330A	NM1	01	Entity Identifier Code	R	Valid Value: "IL" – Subscriber
316	2330A	NM1	02	Entity Type Qualifier	R	Valid Value: "1" - Person
316	2330A	NM1	03	Other Insured Last Name	R	Other Subscriber Last Name
316	2330A	NM1	04	Other Insured First Name	R	Other Subscriber First Name
316	2330A	NM1	05	Other Insured Middle Name	S	Other Subscriber Middle Name (if available)
316	2330A	NM1	06	Not Used	S	Not Used
316	2330A	NM1	07	Other Name Suffix	S	Not Used
317	2330A	NM1	08	Other Subscriber Identification Code Qualifier	R	Valid Value: "MI" – Member Identification Number
317	2330A	NM1	09	Other Subscriber Primary Identifier	R	Other Subscriber Primary Identifier
318	***2330A***	***N3***		***OTHER SUBSCRIBER ADDRESS***	***S***	***Not used***
319	***2330A***	***N4***		***OTHER SUBSCRIBER CITY, STATE, ZIP CODE***	***S***	***Not used***
321	***2330A***	***REF***		***OTHER SUBSCRIBER SECONDARY INFORMATION***	***S***	***Not used***
322	**2330B**			**OTHER PAYER NAME LOOP**	**S**	**The 2330A Loop is required when Loop ID 2320 - Other Subscriber Information is used. Otherwise, this loop is not used.**
322	***2330B***	***NM1***		***OTHER PAYER NAME***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
322	2330B	NM1	01	Entity Identifier Code	R	Valid Value: "PR" – Payer
322	2330B	NM1	02	Entity Type Identifier	R	Valid Value: "2" – Non-Person
323	2330B	NM1	03	Other Payer Organization Name	R	Other Payer Organization Name

323	2330B	NM1	08	Identification Code Qualifier	R	Valid Value: "PI" – Payer Identification
323	2330B	NM1	09	Other Payer Identifier	R	Other Payer Identifier
324	***2330B***	***N3***		***OTHER PAYER ADDRESS***	***S***	***Not used***
325	***2330B***	***N4***		***OTHER PAYER CITY, STATE, ZIP***	***S***	***Not used***
327	***2330B***	***DTP***		***CLAIM CHECK OR REMITTANCE DATE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
328	***2330B***	***REF***		***OTHER PAYER SECONDARY IDENTIFICATION AND REFERENCE NUMBER***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
328	***2330B***	***REF***		***OTHER SECONDARY IDENTIFIER***	***S***	***Not used***
330	***2330B***	***REF***		***OTHER PAYER PRIOR AUTHORIZATION NUMBER***	***S***	***Not used***
331	***2330B***	***REF***		***OTHER PAYER REFERRAL NUMBER***	***S***	***Not used***
332	***2330B***	***REF***		***OTHER PAYER CLAIM ADJUSTMENT INDICATOR***	***S***	***Not used***
333	***2330B***	***REF***		***OTHER PAYER CLAIM CONTRAL NUMBER***	***S***	***Not used***
334	**2330C**			**OTHER PAYER REFERRING PROVIDER LOOP**	**S**	**Not used**
338	**2330D**			**OTHER PAYER RENDERING PROVIDER LOOP**	**S**	**Not used**
342	**2330E**			**OTHER PAYER SERVICE FACILITY LOCATION LOOP**	**S**	**Not used**
345	**2330F**			**OTHER PAYER SUPERVISING PROVIDER LOOP**	**S**	**Not used**
349	**2330G**			**OTHER PAYER BILLING PROVIDER LOOP**	**S**	**Not used**
352	**2400**			**SERVICE LINE LOOP**	**R**	
352	***2400***	***LX***		***SERVICE LINE NUMBER***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
352	2400	LX	01	Assigned Number	R	Claim Line Number
353	***2400***	***SV1***		***PROFESSIONAL SERVICE LINE***	***R***	
354	**2400**	**SV1**	**01**	**Composite Medical Procedure Identifier**	**R**	
355	2400	SV1	01-1	Product or Service ID Qualifier	R	Valid Value: "HC" - HCPCS (and CPT) codes
355	2400	SV1	01-2	Procedure Code	R	Procedure code for this line item
355	2400	SV1	01-3	Procedure Modifier 1	S	Follow Implementation Guide for this data element.
355	2400	SV1	01-4	Procedure Modifier 2	S	Follow Implementation Guide for this data element.
355	2400	SV1	01-5	Procedure Modifier 3	S	Follow Implementation Guide for this data element.
356	2400	SV1	01-6	Procedure Modifier 4	S	Follow Implementation Guide for this data element.
356	2400	SV1	01-7	Description	S	Follow Implementation Guide for this data element.

356	2400	SV1	2	Line Item Charge Amount	R	Follow Implementation Guide for this data element.
357	2400	SV1	3	Unit or Basis for Measurement Code	R	Follow Implementation Guide for this data element.
357	2400	SV1	4	Service Unit Count	R	Follow Implementation Guide for this data element.
357	2400	SV1	05	Place of Service Code	S	Please provide for county/state reporting. Follow Implementation Guide for this data element.
358	**2400**	**SV1**	**07-1**	**Composite Diagnosis Code Pointer**	**R**	
358	2400	SV1	07-1	Diagnosis Code Pointer	R	Follow Implementation Guide for this data element.
358	2400	SV1	07-2	Diagnosis Code Pointer	S	Follow Implementation Guide for this data element.
358	2400	SV1	07-3	Diagnosis Code Pointer	S	Follow Implementation Guide for this data element.
358	2400	SV1	07-4	Diagnosis Code Pointer	S	Follow Implementation Guide for this data element.
359	2400	SV1	09	Emergency Indicator	S	Required when the service is known to be an emergency by the provider.
359	2400	SV1	11	EPSDT Indicator	S	Required if Medicaid services are the result of a screening referral.
359	2400	SV1	12	Family Planning Indicator	S	Not used
360	2400	SV1	15	Co-Pay Status Code	S	Follow Implementation Guide for this data element.
361	***2400***	***SV5***		***DURABLE MEDICAL EQUIPMENT SERVICE***	***S***	***Not used***
364	***2400***	***PWK***		***LINE SUPPLEMENTAL INFORAMTION***	***S***	***Not used***
365	***2400***	***PWK***		***DURABLE MEDICAL EQUIPMENT CERTIFICATION***	***S***	***Not used***
370	***2400***	***CR1***		***SPINAL MANIPULATION SERVICE INFORMATION***	***S***	***Not used***
373	***2400***	***CR3***		***DURABLE MEDICAL EQUIPMENT CERTIFICATION***	***S***	***Not used***
375	***2400***	***CRC***		***AMBULANCE CERTIFICATION***	***S***	***Not used***
378	***2400***	***CRC***		***HOSPICE EMPLOYEE INDICATOR***	***S***	***Not used***
380	***2400***	***CRC***		***DMERC CONDITION INDICATOR***	***S***	***Not used***
382	***2400***	***DTP***		***DATE - SERVICE DATE***	***R***	***Follow Implementation Guide for this Segment and all data elements.***
382	2400	DTP	01	Date Time Qualifier	R	Valid Value: "472" - Service
382	2400	DTP	02	Date Time Period Format Qualifier	R	Valid Values: "D8" – CCYYMMDD "RD8" – CCYYMMDD- CCYYMMDD
383	2400	DTP	03	Service Date	R	Service Date
384	***2400***	***DTP***		***DATE - PRESCRIPTION DATE***	***S***	***Not used***
385	***2400***	***DTP***		***DATE - CERTIFICATION REVISION DATE***	***S***	***Not used***
386	***2400***	***DTP***		***DATE - BEGIN THERAPY***	***S***	***Not used***

				DATE		
387	***2400***	***DTP***		***DATE – DATE LAST SEEN***	***S***	***Not used***
389	***2400***	***DTP***		***DATE – TEST***	***S***	***Not used***
390	***2400***	***DTP***		***DATE - SHIPPED***	***S***	***Not used***
391	***2400***	***DTP***		***DATE - LAST X-RAY***	***S***	***Not used***
392	***2400***	***DTP***		***DATE – INITIAL TREATMENT***	***S***	***Not used***
393	***2400***	***QTY***		***AMBULANCE PATIENT COUNT***	***S***	***Not used***
394	***2400***	***QTY***		***OBSTETRIC ANESTHESIA ADDITIONAL UNITS***	***S***	***Not used***
395	***2400***	***MEA***		***TEST RESULT***	***S***	***Not used***
397	***2400***	***CN1***		***CONTRACT INFORMATION***	***S***	***Not used***
399	***2400***	***REF***		***REPRICED LINE ITEM REFERENCE NUMBER***	***S***	***Not used***
400	***2400***	***REF***		***ADJUSTED REPRICED LINE ITEM REFERENCE NUMBER***	***S***	***Not used***
401	***2400***	***REF***		***PRIOR AUTHORIZATION OR REFERRAL NUMBER***	***S***	***Not used***
403	***2400***	***REF***		***LINE ITEM CONTROL NUMBER***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
403	2400	REF	01	Reference Identification Number	R	Valid Value: "6R" – Provider Control Number
404	2400	REF	02	Line Item Control Number	R	
405	***2400***	***REF***		***MAMMOGRAPHY CERTIFICATION NUMBER***	***S***	***Not used***
406	***2400***	***REF***		***CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) IDENTIFICATION***	***S***	***Not used***
407	***2400***	***REF***		***REFERRING CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER***	***S***	***Not used***
408	***2400***	***REF***		***IMMUNIZATION BATCH NUMBER***	***S***	***Not used***
409	***2400***	***REF***		***REFERRAL NUMBER***	***S***	***Not used***
411	***2400***	***AMT***		***SALES TAX AMOUNT***	***S***	***Not used***
412	***2400***	***AMT***		***POSTAGE CLAIMED AMOUNT***	***S***	***Not used***
413	***2400***	***K3***		***FILE INFORMATION***	***S***	***Not used***
415	***2400***	***NTE***		***LINE NOTE***	***S***	***Valid Values: NTE01 = "DCP"; NTE02 = "EBP-[code]-...-[code]"***
416	***2400***	***NTE***		***THIRD PARTY ORGANIZATION NOTES***	***S***	***Not used***
417	***2400***	***PS1***		***PURCHASED SERVICE INFORMATION***	***S***	***Not used***
418	***2400***	***HCP***		***LINE PRICING/REPRICING INFORMATION***	***S***	***Not used***
425	**2410**			**DRUG IDENTIFICATION LOOP**	**S**	**Not used**
433	**2420A**			**RENDERING PROVIDER NAME LOOP**	**S**	**Not used**
439	**2420B**			**PURCHASED SERVICE PROVIDER NAME LOOP**	**S**	**Not used**
444	**2420C**			**SERVICE FACILITY LOCATION LOOP**		**Not used**
452	**2420D**			**SUPERVISING PROVIDER**		**Not used**

				LOOP		
457	**2420E**			**ORDERING PROVIDER LOOP**		**Not used**
468	**2420F**			**REFERRING PROVIDER LOOP**		**Not used**
473	**2420G**			**AMBULANCE PICK-UP LOCATION**		**Not used**
478	**2420H**			**AMBULANCE DROP-OFF LOCATION**		**Not used**
483	**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.**
483	***2430***	***SVD***		***SERVICE LINE ADJUDICATION INFORMATION***	***S***	***Follow Implementation Guide for this Segment and all data elements. Required when an adjustment is being requested.***
487	***2430***	***CAS***		***LINE ADJUSTMENT***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
493	***2430***	***DTP***		***LINE ADJUDICATION DATE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
	2440			**FORM IDENTIFICATION CODE LOOP**	**S**	
495	***2440***	***LQ***		***FORM IDENTIFICATION CODE***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
497	***2440***	***FRM***		***SUPPORTING DOCUMENTATION***	***S***	***Follow Implementation Guide for this Segment and all data elements.***
499	**2440**	**SE**		**TRANSACTION SET TRAILER**	**R**	**Follow Implementation Guide for this Segment and all data elements.**
499	2440	SE	01	Number of Included Segments	R	Valid Value: "837" – Health Care Claim
499	2440	SE	02	Transaction Set Control Number	R	A unique control number assigned by the Sender for this functional group for this transaction.

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.