



625 State Street  
Schenectady, NY 12305

MVP Health Care

# Testing and Implementation Guide

*ANSI X12 837 Version 4010X096A1  
Health Care Claim: Institutional*

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## VERSION CHANGE LOG

<b>Version 1.0 Original</b>	<b>May 16,2005</b>
<b>Add new 277U Requirements</b>	<b>July 29, 2005</b>
<b>Updated Implementation Procedures, added sign off sheet.</b>	<b>August 10,2005</b>
<b>Add segments CAS, and AMT for COB information</b>	<b>August 17,2006</b>
<b>Add rules for submission of secondary Medicare Claims</b>	<b>August 18, 2005</b>
<b>Add rules for submission of secondary Commercial Claims</b>	<b>August 21,2006</b>
<b>Added in NPI rules.</b>	<b>October 13, 2006</b>
<b>Updated NPI rules</b>	<b>May 22, 2008</b>
<b>Updated 277U Status Messages</b>	<b>April 27, 2009</b>

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## INTRODUCTION

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

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## PURPOSE

The purpose of this document is to provide the information necessary to submit Institutional Health Care Claim transactions electronically to MVP Health Care. **This companion guide is to be used in conjunction with the ANSI X12N implementation guides.** The companion guide supplements, but does not contradict or replace any requirements in the implementation guide. The HIPAA implementation guides can be obtained from the Washington Publishing Company by calling 1-800-972-4334 or are available for download on their web site at [www.wpc-edi.com/hipaa/](http://www.wpc-edi.com/hipaa/). Other important websites:

Workgroup for Electronic Data Interchange (WEDI) – <http://www.wedi.org>  
United States Department of Health and Human Services (DHHS) – <http://aspe.hhs.gov/admnsimp/>  
Centers for Medicare and Medicaid Services (CMS) – <http://www.cms.gov/hipaa/hipaa2/>  
Designated Standard Maintenance Organizations (DSMO) – <http://www.hipaa-dsmo.org/>  
National Council of Prescription Drug Programs (NCPDP) – <http://www.ncpdp.org/>  
National Uniform Billing Committee (NUBC) – <http://www.nubc.org/>  
Accredited Standards Committee (ASC X12) – <http://www.x12.org/>

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## SPECIAL CONSIDERATIONS

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### Request Transactions Supported

This section is intended to identify the type and version of the ASC X12 Health Care Claim: Institutional transaction that MVP will accept.

- |   |
|---|
| <ul style="list-style-type: none"><li>• 837 Health Care Claim: Institutional – <b>ASC X12N 837 (004010X096A1)</b></li></ul> |
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### Response Transactions Supported

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

- |   |
|---|
| <ul style="list-style-type: none"><li>• 277U Unsolicited Claim Status – <b>ASC X12N 277U (004040X167)</b></li></ul>   |
| <ul style="list-style-type: none"><li>• 997 Functional Acknowledgement – <b>ASC X12N 837 (004010X096A1)</b></li></ul> |

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### Communication Specifications

MVP currently supports the receipt of the 837, Health Care Claim: Institutional, in batch mode only. The file can be uploaded via the Internet, SFTP (Secure File Transfer Protocol) or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

MVP will transmit the 997 Functional Acknowledgement in batch mode to its trading partners. The file can be uploaded via the Internet, SFTP (Secure File Transfer Protocol) or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

MVP will transmit the 277U Unsolicited Claim Status in batch mode to its trading partners. The file can be uploaded via the Internet, SFTP (Secure File Transfer Protocol) or FTP (File Transfer Protocol) – with PGP encryption.

File naming conventions will be assigned at part of the testing process.

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## Use of the 837 Institutional Health Care Claim

The 837 Institutional Health Care Claim is designed to submit claim information electronically to the payer (MVP).

• Key Fields:

1. Nation Provider ID Qualifier NM108 - XX
  - a. Billing Provider Identifier (Loop 2010AA – NM109)
  - b. Pay-To Provider Identifier (Loop 2010AB – MN109)
2. Assignment Indicator (Loop 2000B – SBR01)
3. Subscriber Last Name (Loop 2010BA – NM103)
4. Subscriber First Name (Loop 2010BA – NM104)
5. Subscriber Identifier (Loop 2010BA – NM109)
6. Subscriber Date of Birth (Loop 2010BA – DMG02)
7. Patient Last Name (Loop 2010CA – NM103)
8. Patient First Name (Loop 2010CA – NM104)
9. Patient Identifier (Loop 2010CA – NM109)
10. Patient Date of Birth (Loop 2010CA – DMG02)
11. Unique Patient Account Number (Loop 2300 – CLM01)
12. Place of Service (Loop 2300 – CLM05-1)
13. Diagnosis Code (Loop 2300 – HI01-2)
14. Service Dates (Loop 2400 – DTP03)
15. Revenue Code (Loop 2400 – SV201)
16. Procedure Code (Loop 2400 – SV202-2)
17. Requested Amount (Loop 2400 – SV203)
18. Service Unit Count/Quantity (Loop 2400 – SV205)

## Use of NPI

MVP requires all providers and facilities to use their National Provider Identifier (NPI) number on all electronic transactions covered by HIPAA.

This means that when billing, providers and facilities must use NPI numbers not only for the billing, pay to, and attending fields, but also for all secondary provider fields such as ordering and operating provider when used. ***Tax ID number may only be used in connection with the billing or pay to provider loop.***

MVP requires providers with multiple specialties to submit their service location with ZIP + 4 and their taxonomy number.

Providers and facilities must **not** include their existing MVP provider ID or any secondary provider identifier in any of the provider loops except for TIN as required for billing/pay to loops.

If a provider or facility uses a MVP provider ID or any secondary provider identifier for electronic transactions, MVP will reject them for NPI non-compliance.

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**Secondary Payer and COB rules for Medicare Claims**

For correct processing of secondary payer Medicare claims the submission of information is as follows.

Loop and Segment	Value	Description
Loop 2000B/SB01	S	Secondary Payer
Loop 2300/CLM07	A	Assigned
Loop 2320/SB01	P	Primary Payer
Loop 2320/SB09	MB, MA	Type of Carrier
Loop 2320/OI03	Y, N	Assignment of Benefits
Loop 2320/OI06	A, I, M, N, O Y	Release of Information
Loop 2320/AMT01	B6	Allowed Amount Qualifier
Loop 2320/AMT02	Dollar amount	Allowed Amount
Loop 2320/AMT01	C4, or N1	Paid Amount Qualifier
Loop 2320/AMT02	Dollar amount	Paid Amount
Loop 2320/CAS02	1, 66, or 126	Deductible Amount Qualifier
Loop 2320/CAS03	Dollar amount	Deductible Amount
Loop 2320/CAS02	2, or 127	Coinsurance Amount Qualifier
Loop 2320/CAS03	Dollar amount	Deductible Amount
Loop 2320/CAS01	PR	Group Code Patient Responsibility

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**Secondary Payer and COB rules for Commercial Claims**

For correct processing of secondary payer Commercial claims the submission of information is as follows.

Loop and Segment	Value	Description
Loop 2000B/SB01	S	Secondary Payer
Loop 2300/CLM07	A	Assigned
Loop 2320/SB01	P	Primary Payer
Loop 2320/SB09	Any qualifier except MB and MA	Type of Carrier
Loop 2320/OI03	Y, N	Assignment of Benefits
Loop 2320/OI06	A, I, M, N, O Y	Release of Information
Loop 2320/AMT01	B6	Allowed Amount Qualifier
Loop 2320/AMT02	Dollar amount	Allowed Amount
Loop 2320/AMT01	C4, or N1	Paid Amount Qualifier
Loop 2320/AMT02	Dollar amount	Paid Amount
Loop 2320/CAS02	1, 66, 126	Deductible Amount Qualifier
Loop 2320/CAS03	Dollar amount	Deductible Amount
Loop 2320/CAS02	3	Copay Amount Qualifier
Loop 2320/CAS03	Dollar amount	Copay Amount
Loop 2320/CAS02	2, or 127	Coinsurance Amount Qualifier
Loop 2320/CAS03	Dollar amount	Coinsurance Amount

**277U Status Code List**

The 277U, Unsolicited Claim Status transaction is used to provide claim level acceptance and rejections for basic business edits.

- The following error codes are possible in the 277U

<b>A1</b>	<b>19</b>	Entity acknowledges receipt of claim/encounter.
<b>A3</b>	<b>30</b>	Subscriber/ Patient name mismatched.
<b>A3</b>	<b>33</b>	Subscriber/Patient id not found.
<b>A3</b>	<b>85</b>	MVP is not the policyholder's primary insurance carrier
<b>A3</b>	<b>88</b>	Patient not eligible/not approved for dates of service.
<b>A3</b>	<b>116</b>	Claim submitted to incorrect payer.
<b>A3</b>	<b>158</b>	Patient date of birth mismatch
<b>A3</b>	<b>481</b>	Claim/submission format is invalid: Multiple providers billed.
<b>A3</b>	<b>510</b>	Future date of service
<b>A6</b>	<b>145</b>	provider specialty/taxonomy code.
<b>A6</b>	<b>189</b>	Facility admission date
<b>A7</b>	<b>228</b>	Type of bill for UB claim
<b>A7</b>	<b>231</b>	Hospital admission type.
<b>A7</b>	<b>234</b>	Patient status.
<b>A7</b>	<b>249</b>	Place of service.
<b>A7</b>	<b>255</b>	Diagnosis code.
<b>A7</b>	<b>402</b>	Claim amount must be greater than zero
<b>A7</b>	<b>453</b>	Procedure Code Modifier(s) for Service(s) Rendered
<b>A7</b>	<b>454</b>	Procedure code for services rendered.
<b>A7</b>	<b>455</b>	Revenue code for services rendered.
<b>A7</b>	<b>460</b>	NUBC Condition Code(s)
<b>A7</b>	<b>461</b>	NUBC Occurrence Code(s) and Date(s)
<b>A7</b>	<b>462</b>	NUBC Occurrence Span Code(s) and Date(s)
<b>A7</b>	<b>488</b>	Diagnosis code(s) for the services rendered.
<b>A7</b>	<b>562</b>	National Provider Identifier (NPI)
<b>A7</b>	<b>634</b>	Remark Code
<b>A8</b>	<b>128/562/145</b>	Taxonomy not on file for tax id/NPI affiliation

**Note:**

A1 - The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.

A3 - Acknowledgement/Returned as unprocessable claim-The claim/encounter has been rejected and has not been entered into the adjudication system.

A6 - Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.

A7 - Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected.

A8 - Acknowledgement / Rejected for relational field in error.

**Note:** The codes and descriptions above are as the writing of this document. Although we will endeavor to keep this guide current, some changes may occur. If this does occur, please visit [www.wpc-edi.com](http://www.wpc-edi.com) for a complete list and detailed explanation please visit.

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## Delimiters Supported

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

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

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

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## Implementation of Claim Submission

There will be four phases of implementation.

1. Development Phase - An MVP Representative will contact the Client to review these procedures. MVP will set up a client specific profile to receive claim submissions, process claims, and send acknowledgments and business edit reports. In response. The client will create or modify their programs as necessary to provide MVP with the required data and to receive required data from MVP.
2. Test Phase – The client must notify MVP when they are ready to begin submitting test files. MVP and the client will set up a schedule to receive and send data across the desired media. Upon receiving the file, MVP will validate the file format and data for accuracy. MVP will run the file through the claims process, which will do a series of error checking. Upon completion of the claims process a business edit report will be created. The MVP IT Representative will test and identify all technical errors. During the testing phase, the EDI Coordinator will be responsible for the education of providers/hospitals with regard to EDI errors/failures. The Client will review and discuss any questions or problems with MVP. The goal will be to achieve a 100% HIPAA compliant claim submission, **and 80% or better for business edits** prior to going live.
3. Production - Once testing has reached an acceptance level and both parties have signed off, MVP will move the process into production and go live with the claim submissions. **For denied claims, call Provider Relations / Provider Claim Services.** All transaction error questions should be directed to the EDI Coordinators: 1-877-461-4911.
4. Post Production - MVP will closely monitor the client's claim submissions. MVP will insure that the client's claim submissions are being received, processed; an acknowledgement and business edit report is created and delivered to the client's mailbox properly.



**MVP Requirements for the ANSI X12 837 Transaction - Health Care Claim: Institutional**

Required?	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
<b>R</b>	<b>ISA</b>	<b>INTERCHANGE CONTROL HEADER</b>		
R	01	AUTHORIZATION INFORMATION QUALIFIER	00	No authorization information present in 02
R	02	AUTHORIZATION INFORMATION		Blank
R	03	SECURITY INFORMATION QUALIFIER	00	No security information present in 04
R	04	SECURITY INFORMATION		Blank
R	05	INTERCHANGE ID QUALIFIER	30	Federal tax ID
R	06	INTERCHANGE SENDER ID		Sender tax ID
R	07	INTERCHANGE ID QUALIFIER	30	Federal tax ID
R	08	INTERCHANGE RECEIVER ID	141650868	MVP Id
R	09	INTERCHANGE DATE	YYMMDD	Date of interchange
R	10	INTERCHANGE TIME	HHMM	Time of interchange
R	11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	U.S. EDI Community of ASC X12, TDCC and UCS
R	12	INTERCHANGE CONTROL VERSION NUMBER	00401	Draft Standards approved by ASCx12 thru 10/97
R	13	INTERCHANGE CONTROL NUMBER		Assigned by Sender, Must match IEA02
R	14	ACKNOWLEDGMENT REQUESTED	0	0 = NO
R	15	TEST INDICATOR	P OR T	Production or test
R	16	COMPONENT ELEMENT SEPARATOR	:	Delimiter
<b>R</b>	<b>GS</b>	<b>FUNCTIONAL GROUP HEADER</b>		
R	01	FUNCTIONAL IDENTIFIER CODE	HC	Health Care Claim 837
R	02	APPLICATION SENDER'S CODE	Sender tax ID	Sender's code
R	03	APPLICATION RECEIVER'S CODE	141650868	MVP tax ID
R	04	DATE	CCYYMMDD	Group creation date in format: CCYYMMDD:
R	05	TIME	HHMM	Creation time
R	06	GROUP CONTROL NUMBER		Assigned by sender
R	07	RESPONSIBLE AGENCY CODE	X	Accredited Standards Committee X12
R	08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	004010X096A1	Version/Release/Industry/Identifier Code

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<b>R</b>	<b>ST</b>	<b>TRANSACTION SET HEADER</b>		
R	01	TRANSACTION SET IDENTIFIER CODE	837	Health Care Claim
R	02	TRANSACTION SET CONTROL NUMBER		Must match SE02 control number
<b>R</b>	<b>BHT</b>	<b>BEGINNING OF HIERARCHICAL TRANSACTION</b>		
R	01	HIERARCHICAL STRUCTURE CODE	0019	Information source subscriber, dependent
R	02	TRANSACTION SET PURPOSE CODE	00	Original
R	03	REFERENCE IDENTIFICATION		Batch control number assigned by submitter
R	04	DATE	CCYYMMDD	Transaction set creation date
R	05	TIME	HHMM	Transaction set creation time
R	06	TRANSACTION TYPE CODE	CH	Chargeable
<b>R</b>	<b>REF</b>	<b>TRANSMISSION TYPE IDENTIFICATION</b>		
R	01	REFERENCE IDENTIFICATION QUALIFIER	87	Functional category
R	02	REFERENCE IDENTIFICATION	004010X096A1	Transmission Type Code
<b>Loop 1000A</b>				
<b>R</b>	<b>NM1</b>	<b>SUBMITTER NAME-1000A</b>		
R	01	ENTITY IDENTIFIER CODE	41	Submitter
R	02	ENTITY TYPE QUALIFIER	1, 2	1-Person, 2-Non-person entity
R	03	ORGANIZATION NAME/LAST NAME		Submitter Name
S	04	FIRST NAME		Submitter First Name
S	05	MIDDLE NAME		Submitter Middle Name
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter Id number
R	09	IDENTIFICATION CODE		Submitter tax ID
<b>R</b>	<b>PER</b>	<b>SUBMITTER EDI CONTACT INFORMATION-1000A</b>		
R	01	CONTACT FUNCTION CODE	IC	Information Contact
R	02	NAME		Submitter Contact Name
R	03	COMMUNICATION QUALIFIER	TE	Telephone
R	04	COMMUNICATION NUMBER		Area code + phone number

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<b>Loop 1000B</b>				
<b>R</b>	<b>NM1</b>	<b>RECEIVER NAME-1000B</b>		
R	01	ENTITY IDENTIFIER CODE	40	Receiver
R	02	ENTITY TYPE QUALIFIER	2	Non-person
R	03	ORGANIZATION NAME	MVP HEALTH PLAN	Receiver name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	46	Electronic Transmitter Id number
R	09	IDENTIFICATION CODE	141650868	Receiver Identifier
<b>Loop 2000A</b>				
<b>R</b>	<b>HL</b>	<b>HIERARCHICAL LEVEL</b>		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
NOT USED	02	HIERARCHICAL PARENT ID NUMBER		NOT USED
R	03	HIERARCHICAL LEVEL CODE	20	Information Source
R	04	HIERARCHICAL CHILD CODE	1	Additional subordinate HL data segment
<b>S</b>	<b>PRV</b>	<b>BILLING / PAY-TO PROVIDER SPECIALTY 2000A</b>		
R	01	PROVIDER CODE	BI, PT	Provider Code- BI-Billing, PT-Pay-To
R	02	REFERENCE IDENTIFICATION QUALIFER	ZZ	Mutually Defined
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code - Required if the provider has more then one specialty.
<b>Loop 2010AA</b>				
<b>R</b>	<b>NM1</b>	<b>BILLING PROVIDER NAME 2010AA</b>		
R	01	ENTITY IDENTIFIER CODE	85	Billing provider
R	02	ENTITY TYPE QUALIFIER	2	Non-person entity
R	03	NAME LAST		Organization name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED

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R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI number
<b>R</b>	<b>N3</b>	<b>BILLING ADDRESS</b>		
R	01	ADDRESS INFORMATION		Billing provider Address Line
S	02	ADDRESS INFORMATION		Billing provider Address Line
<b>R</b>	<b>N4</b>	<b>BILLING CITY / STAET / ZIP</b>		
R	01	CITY		Billing provider city
R	02	STATE		State
R	03	POSTAL CODE		Zip code
<b>R</b>	<b>REF</b>	<b>BILLING PROVIDER SECONDARY IDENTIFICATION</b>		
R	01	REFERENCE IDENTIFICATION QUALIFIER	EI	Provider Federal Tax ID
R	02	REFERENCE IDENTIFICATION		Provider Tax ID
<b>Loop 2010AB</b>				
<b>S</b>	<b>NM1</b>	<b>PAY TO PROVIDER NAME 2010AB</b>		
R	01	ENTITY IDENTIFIER CODE	87	Pay to provider
R	02	ENTITY TYPE QUALIFIER	2	Non-person entity
R	03	NAME LAST		Pay to provider last name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI Number
<b>R</b>	<b>N3</b>	<b>PAY-TO PROVIDER ADDRESS 2010AB</b>		
R	01	ADDRESS INFORMATION		Pay to provider address
S	02	ADDRESS INFORMATION		Pay to provider address

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<b>R</b>	<b>N4</b>	<b>PAY TO PROVIDER ADDRESS 2010AB</b>		
R	01	CITY NAME		Pay to provider city
R	02	STATE		Pay to provider state
R	03	ZIP		Pay to provider zip
<b>S</b>	<b>REF</b>	<b>PAY TO PROVIDER SECONDARY IDENTIFICATION</b>		*Note if supplying in Pay-To don't use
R	01	REFERENCE IDENTIFICATION QUALIFIER	EI	Federal Tax ID
R	02	REFERENCE IDENTIFICATION		Tax ID Number
<b>Loop 2000B</b>				
<b>R</b>	<b>HL</b>	<b>SUBSCRIBER HIERARCHICAL LEVEL 2000B</b>		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by the sender
R	02	HIERARCHICAL PARENT ID NUMBER		ID number of the next higher hierarchical segment
R	03	HIERARCHICAL LEVEL CODE	22	Subscriber
R	04	HIERARCHICAL CHILD CODE	0 or 1	No subordinates or has subordinates
<b>R</b>	<b>SBR</b>	<b>SUBSCRIBER INFORMATION 2000B</b>		
R	01	PAYER RESPONSIBILITY SEQUENCE CODE NUMBER	P, S	Primary Payer, Secondary Payer If claim is for primary payer then "P" else if claim is for secondary payer then "S".
S	02	INDIVIDUAL RELATIONSHIP CODE	18	Self (required when subscriber is patient)
S	03	REFERENCE IDENTIFICATION		Group number
S	04	NAME		Group name
NOT USED	05	INSURANCE TYPE CODE		NOT USED
NOT USED	06	COORDINATION OF BENEFITS CODE		NOT USED
NOT USED	07	YES/NO CONDITION OR RESPONSE CODE		NOT USED
NOT USED	08	EMPLOYMENT STATUS CODE		NOT USED
S	09	CLAIM FILING INDICATOR	HM	Health Maintenance Organization
<b>Loop 2010BA</b>				
<b>R</b>	<b>NM1</b>	<b>SUBSCRIBER NAME 2010BA</b>		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Subscriber last name
S	04	NAME FIRST		Subscriber first name

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S	05	NAME MIDDLE		Subscriber middle name
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Subscriber suffix
S	08	IDENTIFICATION CODE QUALIFIER	MI	Member Identification number
S	09	IDENTIFICATION CODE		MVP subscriber member number
<b>S</b>	<b>N3</b>	<b>SUBSCRIBER ADDRESS 2010BA</b>		
R	01	ADDRESS INFORMATION		Subscriber address
S	02	ADDRESS INFORMATION		Subscriber address
<b>S</b>	<b>N4</b>	<b>SUBSCRIBER ADDRESS 2010BA</b>		
R	01	CITY NAME		Subscriber City
R	02	STATE		Subscriber State
R	03	POSTAL CODE		Subscriber Zip
<b>S</b>	<b>DMG</b>	<b>SUBSCRIBER DEMOGRAPHIC INFORMATION 2010BA</b>		
R	01	DATE FORMAT QUALIFIER	D8	Date Time Period Format Qualifier
R	02	DATE TIME PERIOD	CCYYMMDD	Subscriber date of birth
R	03	GENDER CODE	F, M, U	Female, male, unknown
<b>Loop 2010BC</b>				
<b>R</b>	<b>NM1</b>	<b>PAYER NAME 2010BC</b>		
R	01	ENTITY ID CODE	PR	Payer
R	02	ENTITY TYPE QUALIFIER	2	Non-person
R	03	ORGANIZATION NAME	MVP Health Plan	Payer name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	PI	Payer ID
R	09	IDENTIFICATION CODE	141650868	Primary payer ID

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Loop 2000C		REQUIRED WHEN PATIENT IS NOT SUBSCRIBER		
<b>S</b>	<b>HL</b>	<b>PATIENT HIERARCHICAL LEVEL 2000C</b>		
R	01	HIERARCHICAL ID NUMBER		Unique number assigned by sender
R	02	HIERARCHICAL PARENT ID		ID number of the next higher hierarchical segment
R	03	HIERARCHICAL LEVEL CODE	23	Dependent
R	04	HIERARCHICAL CHILD CODE	0	No subordinates
<b>R</b>	<b>PAT</b>	<b>PATIENT INFORMATION 2000C</b>		
R	01	INDIVIDUAL RELATIONSHIP CODE		Individual relationship code
<b>R</b>	<b>NM1</b>	<b>PATIENT NAME 2010CA</b>		
R	01	ENTITY IDENTIFIER CODE	QC	Patient
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Patient last name
R	04	NAME FIRST		Patient first name
S	05	NAME MIDDLE		Patient middle initial
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Patient suffix
S	08	IDENTIFICATION CODE QUALIFIER	MI	Member Identification
S	09	IDENTIFICATION CODE		MVP member ID number
<b>R</b>	<b>N3</b>	<b>PATIENT ADDRESS 2010CA</b>		
R	01	ADDRESS INFORMATION		Patient address
S	02	ADDRESS INFORMATION		Secondary patient address
<b>R</b>	<b>N4</b>	<b>PATIENT ADDRESS 2010CA</b>		
R	01	CITY NAME		Patient city
R	02	STATE		Patient state
R	03	POSTAL CODE		Patient zip
<b>R</b>	<b>DMG</b>	<b>PATIENT DEMOGRAPHIC INFORMATION</b>		
R	01	DATE QUALIFIER	D8	Date Expressed in Format CCYYMMDD

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R	02	DATE PERIOD	CCYYMMDD	Date of birth
R	03	GENDER CODE	F, M, U	Gender
<b>LOOP 2300</b>				
<b>R</b>	<b>CLM</b>	<b>CLAIM INFORMATION 2300</b>		
R	01	CLAIM SUBMITTER'S IDENTIFIER		Patient account number
R	02	MONETARY AMOUNT		Total charges
NOT USED	03	CLAIM FAILING INDICATOR CODE		NOT USED
NOT USED	04	NON-INSTITUTIONAL CLAIM TYPE CODE		NOT USED
R	05	HEALTH CARE SERVICE LOCATION		HEALTH CARE SERVICE LOCATION
R	05-1	FACILITY CODE VALUE		Facility code
R	05-2	FACILITY CODE QUALIFIER	A	Uniform billing claim form bill type
R	05-3	CLAIM FREQUENCY TYPE CODE		Claim frequency code
R	06	RESPONSE CODE	Y or N	Provider signature on file indicator
S	07	PROVIDER ACCEPT ASSIGN	A or C	Provider accept Medicare assignment code
R	08	RESPONSE CODE	Y or N	Assign benefits indicator
R	09	RELEASE OF INFORMATION	A, I, M, N, O, Y	Release of information
NOT USED	10	PATIENT SIGNATURE SOURCE CODE		NOT USED
NOT USED	11	RELATED CAUSES INFORMATION		NOT USED
NOT USED	12	SPECIAL PROGRAM CODE		NOT USED
NOT USED	13	YES/NO CONDITION OR REPOSE CODE		NOT USED
NOT USED	14	LEVEL OF SERVIE CODE		NOT USED
NOT USED	15	YES/NO CONDITION OR REPOSE CODE		NOT USED
NOT USED	16	PROVIDER AGREEMENT CODE		NOT USED
NOT USED	17	CLAIM STATUS CODE		NOT USED
R	18	YES/NO CONDITION OR RESPONSE	Y or N	EOB indicator
NOT USED	19	CLAIM SUBMISSION REASON CODE		NOT USED
S	20	DELAY REASON CODE		Delay Reason Code
<b>S DTP DATE DISCHARGE 2300</b>				
R	01	DATE QUALIFIER	096	Discharge date
R	02	DATE FORMAT	D8	Time Expressed in Format HHMM
R	03	DISCHARGE HOUR	HHMM	Discharge Hour

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<b>R</b>	<b>DTP</b>	<b>STATEMENT DATE 2300</b>		
R	01	DATE QUALIFIER	434	Statement date
R	02	DATE FORMAT	D8/ RD8	Date Time Period Format Qualifier D8-Date, RD8-Range
R	03	DATE TO RETURN TO WORK		Statement From or To Date- Date: CCYYMMDD or Range- CCYYMMDD-CCYYMMDD
<b>S</b>	<b>DTP</b>	<b>DATE ADMISSION 2300</b>		
R	01	DATE QUALIFIER	435	Admission date and hour
R	02	DATE FORMAT	DT	Date and Time Expressed in Format CCYYMMDDHHMM
R	03	DATE ADMISSION		Admission Date and Hour
<b>S</b>	<b>AMT</b>	<b>PATIENT AMOUNT PAID 2300</b>		
R	01	AMOUNT QUALIFIER	F5	Patient Amount Paid
R	02	MONETARY AMOUNT		Patient Amount Paid
<b>S</b>	<b>REF</b>	<b>PRIOR AUTHORIZATION OR REFERRAL NUMBER -2300</b>		
R	01	REFERENCE IDENTIFICATION QUALIFIER	9F,G1	Referral, prior authorization
R	02	REFERENCE NUMBER		Prior authorization or referral number
<b>S</b>	<b>NTE</b>	<b>BILLING CLAIM NOTE 2300</b>		
R	01	REFERENCE CODE	ADD	Additional information
R	02	MESSAGE		Free form data
<b>S</b>	<b>HI</b>	<b>HEALTH CARE DIAGNOSIS CODE 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BK	Principal diagnosis ICD-9 codes
R	01-2	INDUSTRY CODE		Diagnosis code
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BJ or ZZ	Admitting diagnosis or reason for visit for outpatient
R	02-2	INDUSTRY CODE		Diagnosis code
S	03	HEALTH CARE CODE INFORMATION		

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R	03-1	CODE LIST QUALIFIER	BN	U.S. office dept. health and human services E-code
R	03-2	INDUSTRY CODE		Diagnosis code
<b>S</b>	<b>HI</b>	<b>DIAGNOSIS RELATED GROUP INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	DR	Diagnosis related group (DRG)
R	01-2	INDUSTRY CODE		DRG code
<b>S</b>	<b>HI</b>	<b>OTHER DIAGNOSIS INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BF	Diagnosis
R	01-2	INDUSTRY CODE		Other diagnosis
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BF	Diagnosis
R	02-2	INDUSTRY CODE		Other diagnosis
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	BF	Diagnosis
R	03-2	INDUSTRY CODE		Other diagnosis
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BF	Diagnosis
R	04-2	INDUSTRY CODE		Other diagnosis
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BF	Diagnosis
R	05-2	INDUSTRY CODE		Other diagnosis
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BF	Diagnosis
R	06-2	INDUSTRY CODE		Other diagnosis
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BF	Diagnosis
R	07-2	INDUSTRY CODE		Other diagnosis
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BF	Diagnosis
R	08-2	INDUSTRY CODE		Other diagnosis

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S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	BF	Diagnosis
R	09-2	INDUSTRY CODE		Other diagnosis
S	10	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER	BF	Diagnosis
R	10-2	INDUSTRY CODE		Other diagnosis
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	BF	Diagnosis
R	11-2	INDUSTRY CODE		Other diagnosis
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	BF	Diagnosis
R	12-2	INDUSTRY CODE		Other diagnosis
<b>S</b>	<b>HI</b>	<b>PRINCIPAL PROCEDURE INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BP or BR	HCPCS principal procedure or ICD9 principal procedure
R	01-2	INDUSTRY CODE		Principal procedure code
S	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	01-4	DATE TIME PERIOD		Principal procedure code date
<b>S</b>	<b>HI</b>	<b>OTHER PROCEDURE INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	01-2	INDUSTRY CODE		Procedure code
S	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	01-4	DATE TIME PERIOD		Procedure date
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	02-2	INDUSTRY CODE		Procedure code
S	02-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	02-4	DATE TIME PERIOD		Procedure date
S	03	HEALTH CARE CODE INFORMATION		

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R	03-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	03-2	INDUSTRY CODE		Procedure code
S	03-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	03-4	DATE TIME PERIOD		Procedure date
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	04-2	INDUSTRY CODE		Procedure code
S	04-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	04-4	DATE TIME PERIOD		Procedure date
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	05-2	INDUSTRY CODE		Procedure code
S	05-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	05-4	DATE TIME PERIOD		Procedure date
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	06-2	INDUSTRY CODE		Procedure code
S	06-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	06-4	DATE TIME PERIOD		Procedure date
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	07-2	INDUSTRY CODE		Procedure code
S	07-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	07-4	DATE TIME PERIOD		Procedure date
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	08-2	INDUSTRY CODE		Procedure code
S	08-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	08-4	DATE TIME PERIOD		Procedure date
S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	09-2	INDUSTRY CODE		Procedure code
S	09-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	

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S	09-4	DATE TIME PERIOD		Procedure date
S	10	HEALTH CARE CODE INFORMATION		
S	10-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	10-2	INDUSTRY CODE		Procedure code
S	10-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	10-4	DATE TIME PERIOD		Procedure date
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	11-2	INDUSTRY CODE		Procedure code
S	11-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	11-4	DATE TIME PERIOD		Procedure date
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	BO or BQ	HCPCS procedure code or ICD9 procedure code
R	12-2	INDUSTRY CODE		Procedure code
S	12-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	
S	12-4	DATE TIME PERIOD		Procedure date
<b>S</b>	<b>HI</b>	<b>OCCURRENCE SPAN INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BI	Occurrence span
R	01-2	INDUSTRY CODE		Occurrence span code
R	01-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	01-4	DATE TIME PERIOD		Occurrence span date
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BI	Occurrence span
R	02-2	INDUSTRY CODE		Occurrence span code
R	02-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	02-4	DATE TIME PERIOD		Occurrence span date
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	BI	Occurrence span
R	03-2	INDUSTRY CODE		Occurrence span code
R	03-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	03-4	DATE TIME PERIOD		Occurrence span date

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S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BI	Occurrence span
R	04-2	INDUSTRY CODE		Occurrence span code
R	04-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	04-4	DATE TIME PERIOD		Occurrence span date
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BI	Occurrence span
R	05-2	INDUSTRY CODE		Occurrence span code
R	05-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	05-4	DATE TIME PERIOD		Occurrence span date
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BI	Occurrence span
R	06-2	INDUSTRY CODE		Occurrence span code
R	06-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	06-4	DATE TIME PERIOD		Occurrence span date
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BI	Occurrence span
R	07-2	INDUSTRY CODE		Occurrence span code
R	07-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	07-4	DATE TIME PERIOD		Occurrence span date
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BI	Occurrence span
R	08-2	INDUSTRY CODE		Occurrence span code
R	08-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	08-4	DATE TIME PERIOD		Occurrence span date
S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	BI	Occurrence span
R	09-2	INDUSTRY CODE		Occurrence span code
R	09-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	09-4	DATE TIME PERIOD		Occurrence span date
S	10	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER	BI	Occurrence span
R	10-2	INDUSTRY CODE		Occurrence span code

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R	10-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	10-4	DATE TIME PERIOD		Occurrence span date
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	BI	Occurrence span
R	11-2	INDUSTRY CODE		Occurrence span code
R	11-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	11-4	DATE TIME PERIOD		Occurrence span date
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	BI	Occurrence span
R	12-2	INDUSTRY CODE		Occurrence span code
R	12-3	DATE TIME PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD-CCYYMMDD
R	12-4	DATE TIME PERIOD		Occurrence span date
<b>S</b>	<b>HI</b>	<b>OCCURRENCE INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BH	Occurrence
R	01-2	INDUSTRY CODE		Occurrence code
R	01-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	01-4	DATE TIME PERIOD		Occurrence date
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BH	Occurrence
R	02-2	INDUSTRY CODE		Occurrence code
R	02-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	02-4	DATE TIME PERIOD		Occurrence date
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	BH	Occurrence
R	03-2	INDUSTRY CODE		Occurrence code
R	03-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	03-4	DATE TIME PERIOD		Occurrence date
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BH	Occurrence
R	04-2	INDUSTRY CODE		Occurrence code
R	04-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD

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R	04-4	DATE TIME PERIOD		Occurrence date
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BH	Occurrence
R	05-2	INDUSTRY CODE		Occurrence code
R	05-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	05-4	DATE TIME PERIOD		Occurrence date
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BH	Occurrence
R	06-2	INDUSTRY CODE		Occurrence code
R	06-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	06-4	DATE TIME PERIOD		Occurrence date
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BH	Occurrence
R	07-2	INDUSTRY CODE		Occurrence code
R	07-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	07-4	DATE TIME PERIOD		Occurrence date
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BH	Occurrence
R	08-2	INDUSTRY CODE		Occurrence code
R	08-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	08-4	DATE TIME PERIOD		Occurrence date
S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	BH	Occurrence
R	09-2	INDUSTRY CODE		Occurrence code
R	09-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	09-4	DATE TIME PERIOD		Occurrence date
S	10	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER	BH	Occurrence
R	10-2	INDUSTRY CODE		Occurrence code
R	10-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	10-4	DATE TIME PERIOD		Occurrence date
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	BH	Occurrence

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R	11-2	INDUSTRY CODE		Occurrence code
R	11-3	DATE TIME PERIOD FORMAT QUALIFIER		CCYYMMDD
R	11-4	DATE TIME PERIOD	D8	Occurrence date
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	BH	Occurrence
R	12-2	INDUSTRY CODE		Occurrence code
R	12-3	DATE TIME PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	12-4	DATE TIME PERIOD		Occurrence date
<b>S</b>	<b>HI</b>	<b>VALUE INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BE	Value
R	01-2	INDUSTRY CODE		Value code
NOT USED	01-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	01-4	DATE TIME PERIOD		NOT USED
R	01-5	MONETARY AMOUNT		Value code amount
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BE	Value
R	02-2	INDUSTRY CODE		Value code
NOT USED	02-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	02-4	DATE TIME PERIOD		NOT USED
R	02-5	MONETARY AMOUNT		Value code amount
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	BE	Value
R	03-2	INDUSTRY CODE		Value code
NOT USED	03-03	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	03-4	DATE TIME PERIOD		NOT USED
R	03-5	MONETARY AMOUNT		Value code amount
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BE	Value
R	04-2	INDUSTRY CODE		Value code
NOT USED	04-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	04-4	DATE TIME PERIOD		NOT USED

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R	04-5	MONETARY AMOUNT		Value code amount
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BE	Value
R	05-2	INDUSTRY CODE		Value code
NOT USED	05-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	05-4	DATE TIME PERIOD		NOT USED
R	05-5	MONETARY AMOUNT		Value code amount
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BE	Value
R	06-2	INDUSTRY CODE		Value code
NOT USED	06-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	06-4	DATE TIME PERIOD		NOT USED
R	06-5	MONETARY AMOUNT		Value code amount
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BE	Value
R	07-2	INDUSTRY CODE		Value code
NOT USED	07-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	07-4	DATE TIME PERIOD		NOT USED
R	07-5	MONETARY AMOUNT		Value code amount
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BE	Value
R	08-2	INDUSTRY CODE		Value code
NOT USED	08-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	08-4	DATE TIME PERIOD		NOT USED
R	08-5	MONETARY AMOUNT		Value code amount
S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	BE	Value
R	09-2	INDUSTRY CODE		Value code
NOT USED	09-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	09-4	DATE TIME PERIOD		NOT USED
R	09-5	MONETARY AMOUNT		Value code amount
S	10	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER	BE	Value

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R	10-2	INDUSTRY CODE		Value code
NOT USED	10-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	10-4	DATE TIME PERIOD		NOT USED
R	10-5	MONETARY AMOUNT		Value code amount
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	BE	Value
R	11-2	INDUSTRY CODE		Value code
NOT USED	11-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	11-4	DATE TIME PERIOD		NOT USED
R	11-5	MONETARY AMOUNT		Value code amount
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	BE	Value
NOT USED	12-3	DATE TIME PERIOD FORMAT QUALIFIER		NOT USED
NOT USED	12-4	DATE TIME PERIOD		NOT USED
R	12-2	INDUSTRY CODE		Value code
R	12-5	MONETARY AMOUNT		Value code amount
<b>S</b>	<b>HI</b>	<b>CONDITION INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	BG	Condition
R	01-2	INDUSTRY CODE		Condition code
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	BG	Condition
R	02-2	INDUSTRY CODE		Condition code
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	BG	Condition
R	03-2	INDUSTRY CODE		Condition code
S	04	HEALTH CARE CODE INFORMATION		
R	04-1	CODE LIST QUALIFIER	BG	Condition
R	04-2	INDUSTRY CODE		Condition code
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	BG	Condition
R	05-2	INDUSTRY CODE		Condition code

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S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	BG	Condition
R	06-2	INDUSTRY CODE		Condition code
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	BG	Condition
R	07-2	INDUSTRY CODE		Condition code
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	BG	Condition
R	08-2	INDUSTRY CODE		Condition code
S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	BG	Condition
R	09-2	INDUSTRY CODE		Condition code
S	10	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER	BG	Condition
R	10-2	INDUSTRY CODE		Condition code
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	BG	Condition
R	11-2	INDUSTRY CODE		Condition code
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	BG	Condition
R	12-2	INDUSTRY CODE		Condition code
<b>S</b>	<b>HI</b>	<b>TREATMENT CODE INFORMATION 2300</b>		
R	01	HEALTH CARE CODE INFORMATION		
R	01-1	CODE LIST QUALIFIER	TC	Treatment codes
R	01-2	INDUSTRY CODE		Treatment codes
S	02	HEALTH CARE CODE INFORMATION		
R	02-1	CODE LIST QUALIFIER	TC	Treatment codes
R	02-2	INDUSTRY CODE		Treatment codes
S	03	HEALTH CARE CODE INFORMATION		
R	03-1	CODE LIST QUALIFIER	TC	Treatment codes
R	03-2	INDUSTRY CODE		Treatment codes
S	04	HEALTH CARE CODE INFORMATION		

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R	04-1	CODE LIST QUALIFIER	TC	Treatment codes
R	04-2	INDUSTRY CODE		Treatment codes
S	05	HEALTH CARE CODE INFORMATION		
R	05-1	CODE LIST QUALIFIER	TC	Treatment codes
R	05-2	INDUSTRY CODE		Treatment codes
S	06	HEALTH CARE CODE INFORMATION		
R	06-1	CODE LIST QUALIFIER	TC	Treatment codes
R	06-2	INDUSTRY CODE		Treatment codes
S	07	HEALTH CARE CODE INFORMATION		
R	07-1	CODE LIST QUALIFIER	TC	Treatment codes
R	07-2	INDUSTRY CODE		Treatment codes
S	08	HEALTH CARE CODE INFORMATION		
R	08-1	CODE LIST QUALIFIER	TC	Treatment codes
R	08-2	INDUSTRY CODE		Treatment codes
S	09	HEALTH CARE CODE INFORMATION		
R	09-1	CODE LIST QUALIFIER	TC	Treatment codes
R	09-2	INDUSTRY CODE		Treatment codes
S	10	HEALTH CARE CODE INFORMATION		
R	10-1	CODE LIST QUALIFIER	TC	Treatment codes
R	10-2	INDUSTRY CODE		Treatment codes
S	11	HEALTH CARE CODE INFORMATION		
R	11-1	CODE LIST QUALIFIER	TC	Treatment codes
R	11-2	INDUSTRY CODE		Treatment codes
S	12	HEALTH CARE CODE INFORMATION		
R	12-1	CODE LIST QUALIFIER	TC	Treatment codes
R	12-2	INDUSTRY CODE		Treatment codes
<b>S</b>	<b>QTY</b>	<b>CLAIM QUANTITY -2300</b>		
R	01	QUANTITY QUALIFIER	CA	Covered actual
R	02	QUANTITY		Claim days count
R	03	COMPOSITE UNIT OF MEASURE		
R	03-1	UNIT OR BASIS FOR MEASUREMENT CODE	DA	Days

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<b>S</b>	<b>QTY</b>	<b>CLAIM QUANTITY -2300</b>		
R	01	QUANTITY QUALIFIER	NA	Number of non-covered days
R	02	QUANTITY		Claim days count
R	03	COMPOSITE UNIT OF MEASURE		
R	03-1	UNIT OR BASIS FOR MEASUREMENT CODE	DA	Days
<b>S</b>	<b>QTY</b>	<b>CLAIM QUANTITY -2300</b>		
R	01	QUANTITY QUALIFIER	CD	Co-insured actual
R	02	QUANTITY		Claim days count
R	03	COMPOSITE UNIT OF MEASURE		
R	03-1	UNIT OR BASIS FOR MEASUREMENT CODE	DA	Days
<b>S</b>	<b>QTY</b>	<b>CLAIM QUANTITY -2300</b>		
R	01	QUANTITY QUALIFIER	LA	Life-time reserve - actual
R	02	QUANTITY		Claim days count
R	03	COMPOSITE UNIT OF MEASURE		
R	03-1	UNIT OR BASIS FOR MEASUREMENT CODE	DA	Days
<b>S</b>	<b>HCP</b>	<b>HEALTH CARE PRICING - 2300</b>		
R	01	PRICING METHODOLOGY		
R	02	MONETARY AMOUNT		Repriced allowed amount
S	03	MONETARY AMOUNT		Repriced saving amount
S	04	REFERENCE IDENTIFICATION		Repricing organization Identifier
S	05	RATE		Pricing rate
S	06	REFERENCE IDENTIFICATION		Approved DRG code
S	07	MONETARY AMOUNT		Approved DRG amount
S	08	PRODUCT/SERVICE ID		Approved revenue code
S	09	PRODUCT/SERVICE ID QUALIFIER	HC	HCPCS codes
S	10	PRODUCT/SERVICE ID		Approved procedure code
S	11	UNIT OR BASIS FOR MEASUREMENT CODE	DA, UN	Days, units
S	12	QUANTITY		Approved service units
S	13	REJECT REASON CODE		Rejection message
S	14	POLICY COMPLIANCE CODE		Compliance code

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S	15	EXCEPTION CODE		Exception reason code
<b>Loop 2310A</b>				
<b>S</b>	<b>NM1</b>	<b>ATTENDING PHYSICIAN NAME</b>		
R	01	ENTITY IDENTIFIER CODE	71	Attending physician
R	02	ENTITY TYPE	1 or 2	1-Person or 2-Non-person
R	03	LAST NAME		Attending physician last name
S	04	FIRST NAME		Attending physician first name
S	05	NAME MIDDLE		Attending physician middle initial
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Attending physician suffix
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI number
<b>Loop 2310B</b>				
<b>R</b>	<b>PRV</b>	<b>ATTENDING PROVIDER SPECIALTY</b>		
R	01	PROVIDER CODE	AT	Provider Code
R	02	REFERENCE IDENTIFICATION QUALIFIER	ZZ	Mutually Defined
R	03	REFERENCE IDENTIFICATION		Provider Taxonomy Code - Required if the provider has more then one specialty.
<b>Loop 2310C</b>				
<b>S</b>	<b>NM1</b>	<b>OPERATING PHYSICIAN NAME</b>		
R	01	ENTITY IDENTIFIER CODE	72	Operating physician
R	02	ENTITY TYPE	1	Person
R	03	LAST NAME		Operating physician last name
R	04	FIRST NAME		Operating physician first name
S	05	NAME MIDDLE		Operating physician middle initial
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Operating physician suffix
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		NPI number
<b>Loop 2310C</b>				
<b>S</b>	<b>NM1</b>	<b>OTHER PROVIDER NAME</b>		
R	01	ENTITY IDENTIFIER CODE	73	Referring physician
R	02	ENTITY TYPE	1	Person

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R	03	LAST NAME		Referring physician last name
R	04	FIRST NAME		Referring physician first name
S	05	NAME MIDDLE		Referring physician middle initial
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Referring physician suffix
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI number
<b>Loop 2310E</b>				
<b>S</b>	<b>NM1</b>	<b>SERVICE FACILITY LOCATION 2310E</b>		
R	01	ENTITY IDENTIFIER CODE	FA	Facility
R	02	ENTITY TYPE QUALIFIER	2	Non-person entity code
R	03	NAME LAST OR ORGANIZATION NAME		Laboratory/facility name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
S	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
S	09	IDENTIFICATION CODE		Laboratory/facility primary identifier
<b>R N3 SERVICE FACILITY ADDRESS</b>				
R	01	ADDRESS INFORMATION		Lab/facility address
S	02	ADDRESS INFORMATION		Lab/facility address
<b>R N4 SERVICE FACILITY CITY/STATE/ZIP</b>				
R	01	CITY NAME		Lab/facility city
R	02	STATE		Lab/facility state
R	03	POSTAL CODE		Lab/facility zip
<b>Loop 2320</b>				
<b>S</b>	<b>SBR</b>	<b>OTHER SUBSCRIBER INFORMATION 2320</b>		
R	01	PAYER RESPONSIBILITY SEQUENCE NUMBER	P, S	If claim is for secondary payer then this should equal "P" for Primary Payer else "S" for Secondary Payer
R	02	INDIVIDUAL RELATIONSHIP CODE		Individual Relationship Code
S	03	REFERENCE IDENTIFICATION		Group number

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S	04	NAME		Group or plan name
NOT USED	05	INSURANCE TYPE CODE		NOT USED
NOT USED	06	COORDINATION OF BENEFITS CODE		NOT USED
NOT USED	07	YES/NO CONDITION OR REPSONSE CODE		NOT USED
NOT USED	08	EMPLOYMENT STATTUS CODE		NOT USED
S	09	CLAIM FILING INDICATOR CODE	MB, MA, C1	Type of insurance code; Medicare Part B, Medicare Part A, Commercial. <b>See ANSI Guide for complete List.</b>
<b>S</b>	<b>CAS</b>	<b>LINE ADJUDICATION INFORMATION</b>		
R	01	CLAIM ADJUSTMENT GROUP CODE	PR, CO, CR, OA, PI	If multiple adjustment group codes available the “PR” adjustment group code is required to be the first CAS segment sent.
R	02	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	<b>CODE SOURCE 139:</b> Claim Adjustment Reason Code
R	03	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	04	QUANTITY		Adjusted Units - Claim Level
S	05	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	<b>CODE SOURCE 139:</b> Claim Adjustment Reason Code
S	06	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	07	QUANTITY		Adjusted Units - Claim Level
S	08	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	<b>CODE SOURCE 139:</b> Claim Adjustment Reason Code
S	09	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	10	QUANTITY		Adjusted Units - Claim Level
S	11	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	<b>CODE SOURCE 139:</b> Claim Adjustment Reason Code
S	12	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	13	QUANTITY		Adjusted Units - Claim Level
S	14	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	<b>CODE SOURCE 139:</b> Claim Adjustment Reason Code
S	15	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	16	QUANTITY		Adjusted Units - Claim Level
S	17	CLAIM ADJUSTMENT REASON CODE	1, 2, 3, 26, 66, 127	<b>CODE SOURCE 139:</b> Claim Adjustment Reason Code
S	18	MONETARY AMOUNT		Adjusted Amount - Claim Level
S	19	QUANTITY		Adjusted Units - Claim Level

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<b>S</b>	<b>AMT</b>	<b>COORDINATION OF BENEFITS (COB) PAYER PAID AMOUNT</b>		
R	01	AMOUNT QUALIFIER	C4, N1	Payer amount paid
R	02	MONETARY AMOUNT		Amount Paid
<b>S</b>	<b>AMT</b>	<b>COORDINATION OF BENEFITS (COB) ALLOWED AMOUNT</b>		
R	01	AMOUNT QUALIFIER	B6	Allowed – Actual amount
R	02	MONETARY AMOUNT		Amount Paid
<b>S</b>	<b>DMG</b>	<b>OTHER SUBSCRIBER DEMOGRAPHIC INFORMATION</b>		
R	01	DATE TIME PERIOD FORMAT QUALIFIER	D8	Date Period Format Qualifier
R	02	DATE TIME PERIOD		Other insured birth date
R	03	GENDER CODE	F, M, U	Female, male, unknown
<b>S</b>	<b>OI</b>	<b>OTHER INSURANCE COVERAGE INFORMATION 2320</b>		
NOT USED	01	CLAIM FILING INDICATOR CODE		NOT USED
NOT USED	02	CLAIM SUBMISSION REASON CODE		NOT USED
R	03	YES/NO CONDITION OR RESPONSE CODE	N/Y	Assignment of benefits indicator
NOT USED	04	PATIENT SIGNATURE SOURCE CODE		NOT USED
NOT USED	05	PROVIDER AGREEMENT CODE		NOT USED
R	06	RELEASE OF INFORMATION CODE	N/Y	Release of information code
<b>Loop 2330A</b>				
<b>S</b>	<b>NM1</b>	<b>OTHER SUBSCRIBER NAME 2330A</b>		
R	01	ENTITY IDENTIFIER CODE	IL	Insured or subscriber
R	02	ENTITY TYPE QUALIFIER	1	Person
R	03	NAME LAST		Subscriber last name
S	04	NAME FIRST		Subscriber first name
S	05	NAME MIDDLE		Subscriber middle
NOT USED	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		Subscriber suffix
R	08	IDENTIFICATION CODE QUALIFIER	MI	Member Identification number
R	09	IDENTIFICATION CODE		Subscriber ID number

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<b>Loop 2330B</b>				
<b>S</b>	<b>NM1</b>	<b>OTHER PAYER NAME 2330B</b>		
R	01	ENTITY IDENTIFIER CODE	PR	Payer
R	02	ENTITY TYPE QUALIFIER	2	Non-person
R	03	ORGANIZATION NAME		Other payer organization name
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	PI	Payer Identification
R	09	IDENTIFICATION CODE		Tax Id Number
<b>Loop 2330C</b>				
<b>S</b>	<b>NM1</b>	<b>OTHER PAYER PATIENT INFORMATION 2330C</b>		
R	01	ENTITY IDENTIFIER CODE	QC	Patient
R	02	ENTITY TYPE QUALIFIER	1	Person
NOT USED	03	NAME LAST		NOT USED
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PERFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	MI	Member Identification
R	09	IDENTIFICATION CODE		Other ins member number
<b>Loop 2400</b>				
<b>R</b>	<b>LX</b>	<b>SERVICE LINE 2400</b>		
R	01	ASSIGNED NUMBER		Line counter
<b>Loop 2401</b>				
<b>R</b>	<b>SV2</b>	<b>INSTITUTIONAL SERVICE LINE 2400</b>		
R	01	PRODUCT/SERVICE ID		Service line revenue code
S	02	COMPOSITE MEDICAL PROCEDURE IDENTIFIER		
R	02-1	PRODUCT/SERVICE ID QUALIFIER	HC	HCPCS/CPT code
R	02-2	PRODUCT/SERVICE ID		Procedure code
S	02-3	PROCEDURE MODIFIER		Modifier 1

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S	02-4	PROCEDURE MODIFIER		Modifier 2
S	02-5	PROCEDURE MODIFIER		Modifier 3
S	02-6	PROCEDURE MODIFIER		Modifier 4
R	03	MONETARY AMOUNT		Service line charges
R	04	UNIT OR BASIS FOR MEASUREMENT CODE		United of measure
R	05	QUANTITY		Service line units
R	06	UNIT RATE		Service line rate
<b>S</b>	<b>DTP</b>	<b>DATE- SERVICE DATE</b>		
R	01	DATE/TIME QUALIFIER	472	Service date
R	02	DATE/TIME FORMAT	D8/RD8	Date Time Period Format Qualifier – D8-Date, RD8-Range
R	03	DATE/TIME PERIOD		Service date in format: CCYYMMD or CCYYMMDD-CCYYMMDD
<b>S</b>	<b>HCP</b>	<b>HEALTH CARE PRICING - 2400</b>		
R	01	PRICING METHODOLOGY		Pricing/Repricing Methodology
R	02	MONETARY AMOUNT		Repriced allowed amount
S	03	MONETARY AMOUNT		Repriced saving amount
S	04	REFERENCE IDENTIFICATION		Repricing organization Identifier
S	05	RATE		Pricing rate
S	06	REFERENCE IDENTIFICATION		Approved DRG code
S	07	MONETARY AMOUNT		Approved DRG amount
S	08	PRODUCT/SERVICE ID		Approved revenue code
S	09	PRODUCT/SERVICE ID QUALIFIER	HC	HCPCS codes
S	10	PRODUCT/SERVICE ID		Approved procedure code
S	11	UNIT OR BASIS FOR MEASUREMENT CODE	DA, UN	Days, units
S	12	QUANTITY		Approved service units
S	13	REJECT REASON CODE		Rejection message
S	14	POLICY COMPLIANCE CODE		Policy Compliance code
S	15	EXCEPTION CODE		Exception reason code
<b>Loop 2410</b>				
<b>S</b>	<b>LIN</b>	<b>DRUG IDENTIFICATION 2410</b>		
NOT USED	01	ASSIGNMENT IDENTIFICATION		NOT USED

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R	02	PRODUCT/SERVICE ID QUALIFIER	N4	National Drug Code in 5-4-2 Format
R	03	PRODUCT/SERVICE ID		National Drug Code
<b>R</b>	<b>SE</b>	<b>TRANSACTION SET TRAILER</b>		
R	01	NUMBER OF INCLUDED SEGMENTS		Segment count
R	02	TRANSACTION SET CONTROL NUMBER		Unique number assigned by originator/must match ST 02
<b>R</b>	<b>GE</b>	<b>FUNCTIONAL GROUP TRAILER</b>		
R	01	NUMBER OF TRANSACTION SETS		Total number of transaction sets
R	02	CONTROL NUMBER		Assigned by sender
<b>R</b>	<b>IEA</b>	<b>INTERCHANGE CONTROL TRAILER</b>		
R	01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		Number of groups in the interchange
R	02	INTERCHANGE CONTROL NUMBER	Assigned by sender	Must match ISA13

**MVP Requirements for the ANSI 277U Transaction - Health Care Unsolicited Claim Status**

Required	ELEMENT	ELEMENT DESCRIPTION	VALUES	DESCRIPTION
<b>R</b>	<b>ISA</b>	<b>INTERCHANGE CONTROL HEADER</b>		
R	01	AUTHORIZATION INFORMATION QUALIFIER	00	NO AUTHORIZATION INFORMATION PRESENT
R	02	AUTHORIZATION INFORMATION		BLANK
R	03	SECURITY INFORMATION	00	NO SECURITY INFORMATION PRESENT
R	04	SECURITY INFORMATION		BLANK
R	05	INTERCHANGE ID QUALIFIER	30	US FEDERAL TAX ID QUALIFIER
R	06	INTERCHANGE SENDER ID	141650868	SENDER TAX ID
R	07	INTERCHANGE ID QUALIFIER	30	US FEDERAL TAX ID QUALIFIER
R	08	INTERCHANGE RECEIVER ID		RECEIVER TAX ID
R	09	INTERCHANGE DATE	YYMMDD	DATE OF INTERCHANGE
R	10	INTERCHANGE TIME	HHMM	TIME OF INTERCHANGE
R	11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	U	US EDI COMMUNITY OF ASC X12
R	12	INTERCHANGE CONTROL VERSION NUMBER	00401	VERSION NUMBER
R	13	INTERCHANGE CONTROL NUMBER	ASSIGNED BY SENDER	MUST MATCH IEA02
R	14	ACKNOWLEDGEMENT REQUESTED	0	NO ACKNOWLEDGEMENT REQUESTED
R	15	USAGE INDICATOR	P OR T	PRODUCTION OR TEST
R	16	COMPONENT ELEMENT SEPARATOR	:	COMPOSITE DELIMITER
<b>R</b>	<b>GS</b>	<b>FUNCTIONAL GROUP HEADER</b>		
R	01	FUNCTIONAL IDENTIFIER CODE	HN	HEALTH CARE CLAIM STATUS NOTIFICATION
R	02	APPLICATION SENDER'S CODE	141650868	MVP HEALTH PLAN
R	03	APPLICATION RECEIVER'S CODE		CODE FOR RECEIVER
R	04	DATE	CCYYMMDD	FUNCTIONAL GROUP CREATION DATE
R	05	TIME	HHMM	CREATION TIME
R	06	GROUP CONTROL NUMBER	ASSIGNED BY SENDER	MUST MATCH GE02
R	07	RESPONSIBLE AGENCY CODE	X	ACCREDITED STANDARDS COMMITTEE X12
R	08	VERSION/RELEASE/INDUSTRY IDENTIFIER CODE	004040X167	VERSION CODE

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<b>R</b>	<b>ST</b>	<b>TRANSACTION SET HEADER</b>		
R	01	TRANSACTION SET IDENTIFIER CODE	277	HEALTH CARE CLAIM STATUS NOTIFICATION
R	02	TRANSACTION SET CONTROL NUMBER		MUST MATCH SE CONTROL NUMBER
R	03	IMPLEMENTATION CONVENTIONAL REFERENCE	004040X167	Reference Number
<b>R</b>	<b>BHT</b>	<b>BEGINNING OF HIERARCHICAL TRANSACTION</b>		
R	01	HIERARCHICAL STRUCTURE CODE	0010	INFORMATION SOURCE
R	02	TRANSACTION SET PURPOSE CODE	08	STATUS
R	03	REFERENCE IDENTIFICATION		NUMBER USED TO IDENTIFY TRANSACTION BY ORIGINATOR
R	04	DATE	CCYYMMDD	TRANSACTION SET CREATION DATE
R	05	TIME	HHMMSS	
R	06	TRANSACTION TYPE CODE	TH	INDICATION THAT THIS IS RECEIPT ACKNOWLEDGEMENT ADVICE
	<b>2000A</b>			
<b>R</b>	<b>HL</b>	<b>HIERARCHICAL LEVEL 2000A - INFO SENDER LEVEL</b>		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY THE SENDER
NOT USED	02	HIERARCHICAL PARENT ID NUMBER		NOTE USED
R	03	HIERARCHICAL LEVEL CODE	20	INFORMATION SOURCE
R	04	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUB HL DATA SEGMENT IN HIER STRUCTURE
	<b>2100A</b>			
<b>R</b>	<b>NM1</b>	<b>PAYER NAME 2100A</b>		
R	01	ENTITY IDENTIFIER CODE	PR	PAYER
R	02	ENTITY TYPE QUALIFIER	2	NON-PERSON
R	03	ORGANIZATION NAME	MVP HEALTCARE	
NOT USED	04	NAME FIRST		NOT USED
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	PI	MVP ID
R	09	IDENTIFICATION CODE	141650868	MVP's TAX ID

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NOT USED	10	ENTITY RELATIONSHIP CODE		NOT USED
NOT USED	11	ENTITY IDENTITY CODE		NOT USED
	<b>2200A</b>			
<b>R</b>	<b>TRN</b>	<b>CLAIM SUBMITTER TRACE NUMBER 2200A</b>		
R	01	TRACE TYPE CODE	1	REFERENCED TRANSACTION TRACE NUMBER
R	02	REFERENCE IDENTIFICATION		MVP HEALTH CARE EXTERNAL CORE SYSTEM NUMBER.
<b>R</b>	<b>DTP</b>	<b>CLAIM SERVICE DATE 2200A</b>		
R	01	DATE/TIME QUALIFIER	050	CLAIM RECIEPT DATE
R	02	DATE PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	03	DATE TIME PERIOD		CLAIM RECEIPT DATE
S	DTP	CLAIM SERVICE DATE 2200A		
R	01	DATE/TIME QUALIFIER	009	CLAIM PROCESS DATE
R	02	DATE PERIOD FORMAT QUALIFIER	D8	CCYYMMDD
R	03	DATE TIME PERIOD		CLAIM PROCESS DATE
	<b>2000B</b>			
<b>R</b>	<b>HL</b>	<b>HIERARCHICAL LEVEL 2000B - INFO RECEIVER LEVEL</b>		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY SENDER
R	02	HIERARCHICAL PARENT ID NUMBER		ID NUMBER OF NEXT HIGHER HIERARCHICAL SEG
R	03	HIERARCHICAL LEVEL CODE	21	INFORMATION RECEIVER
R	04	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUBORDINATE HL
	<b>2100B</b>			
<b>R</b>	<b>NM1</b>	<b>INFORMATION RECEIVER NAME 2100B</b>		
R	01	ENTITY IDENTIFIER CODE	41	SUBMITTER
R	02	ENTITY TYPE QUALIFIER	1, 2	PERSON, NON-PERSON
R	03	ORGANIZATION NAME		LAST NAME, ORGANIZATION NAME
S	04	NAME FIRST		FIRST NAME
NOT USED	05	NAME MIDDLE		NOT USED
NOT USED	06	NAME PREFIX		NOT USED
NOT USED	07	NAME SUFFIX		NOT USED

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R	08	IDENTIFICATION CODE QUALIFIER	FI	FEDERAL TAX ID
R	09	IDENTIFICATION CODE		VENDOR TAX ID
	<b>2200B</b>			
<b>R</b>	<b>TRN</b>	<b>CLAIM SUBMITTER TRACE NUMBER 2200B</b>		
R	01	TRACE TYPE CODE	2	REFERENCED TRANSACTION TRACE NUMBER
R	02	REFERENCE IDENTIFICATION		VALUE OF THE BHT03 DATA ELEMENT FROM THE SUBMITTED 837 CLAIM FILE
	<b>2000C</b>			
<b>R</b>	<b>HL</b>	<b>HIERARCHICAL LEVEL 2000C - SERVICE PROVIDER LEVEL</b>		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY SENDER
R	02	HIERARCHICAL PARENT ID NUMBER		NUMBER OF NEXT HIGHER HIERARCHICAL SEG
R	03	HIERARCHICAL LEVEL CODE	19	PROVIDER OF SERVICE
R	04	HIERARCHICAL CHILD CODE	1	ADDITIONAL SUBORDINATE HL DATA SEGMENT
	<b>2100C</b>			
<b>R</b>	<b>NM1</b>	<b>PROVIDER NAME 2100C</b>		
R	01	ENTITY IDENTIFIER CODE	1P	RENDERING PROVIDER
R	02	ENTITY TYPE QUALIFIER	1,2	PERSON, ORGANIZATION
R	03	NAME LAST		LAST NAME, ORGANIZATION NAME
S	04	NAME FIRST		FIRST NAME
S	05	NAME MIDDLE		MIDDLE INITIAL
S	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		NOT USED
R	08	IDENTIFICATION CODE QUALIFIER	XX	National Provider ID
R	09	IDENTIFICATION CODE		NPI number
	<b>2000D</b>			
M	HL	HIERARCHICAL LEVEL <b>2000D-PATIENT LEVEL</b>		
R	01	HIERARCHICAL ID NUMBER		UNIQUE NUMBER ASSIGNED BY SENDER
R	02	HIERARCHICAL PARENT ID NUMBER		NUMBER OF THE NEXT HIGHER HIERARCHICAL SEG
R	03	HIERARCHICAL LEVEL CODE	PT	PATIENT
R	04	HIERARCHICAL CHILD CODE	0	ADDITIONAL SUBORDINATE HL DATA SEGMENT
	<b>2100D</b>			
R	NM1	PATIENT NAME 2100D		

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R	01	ENTITY IDENTIFIER CODE	QC	PATIENT
R	02	ENTITY QUALIFIER	1	PERSON
R	03	NAME LAST		PATIENT LAST NAME
S	04	NAME FIRST		PATIENT FIRST NAME
S	05	NAME MIDDLE		PATIENT MIDDLE INITIAL
S	06	NAME PREFIX		NOT USED
S	07	NAME SUFFIX		NOT USED
S	08	IDENTIFICATION CODE QUALIFIER	MI	PATIENT IDENTIFICATION
S	09	IDENTIFICATION CODE		MVP MEMBER ID NUMBER
	<b>2200D</b>			
R	TRN	CLAIM SUBMITTER TRACE NUMBER 2200D		
R	01	TRACE TYPE CODE	2	REFERENCED TRANSACTION TRACE NUMBER
R	02	REFERENCE IDENTIFICATION		PATIENT ACCOUNT NUMBER
<b>R</b>	<b>STC</b>	<b>CLAIM LEVEL STATUS 2200D</b>		
R	01	HEALTH CARE CLAIM STATUS		ANSI CATEGORY CODE FROM CODE SOURCE 507
R	01-1	INDUSTRY CODE		<b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	01-2	INDUSTRY CODE		ANSI STATUS CODE FROM CODE SOURCE 508 <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
NOT USED	01-3	ENTITY IDENTIFIER CODE		NOT USED
R	01-4	CODE LIST QUALIFIER CODE	65	HEALTH CARE CLAIM STATUS CODE
R	02	DATE	CCYYMMDD	EFFECTIVE DATE
R	03	ACTION CODE	WQ	THE WQ INDICATES THAT IT IS NECESSARY TO REVIEW INFORMATION IN THE 2200D LOOP FOR INFORMATION ON THE STATUS OF INDIVIDUAL CLAIMS.
R	04	MONETARY AMOUNT		TOTAL CLAIM CHARGES
NOT USED	05	MONETARY AMOUNT		NOT USED
NOT USED	06	DATE		NOT USED
NOT USED	07	PAYMENT METHOD CODE		NOT USED
NOT USED	08	DATE		NOT USED

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NOT USED	09	CHECK NUMBER		NOT USED
S	10	HEALTH CARE CLAIM STATUS		ANSI CATEGORY CODE FROM CODE SOURCE 507
R	10-1	INDUSTRY CODE		<b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	10-2	INDUSTRY CODE		ANSI STATUS CODE FROM CODE SOURCE 508 <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
S	10-3	ENTITY IDENTIFIER CODE		NOT USED
R	10-4	CODE LIST QUALIFIER CODE	65	HEALTH CARE CLAIM STATUS CODE
S	11	HEALTH CARE CLAIM STATUS		ANSI CATEGORY CODE FROM CODE SOURCE 507
R	11-1	INDUSTRY CODE		<b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
R	11-2	INDUSTRY CODE		ANSI STATUS CODE FROM CODE SOURCE 508 <b>Note:</b> For a reference to MVP used codes see codes identified during the introduction of this document.
S	11-3	ENTITY IDENTIFIER CODE		NOT USED
S	11-4	CODE LIST QUALIFIER CODE	65	HEALTH CARE CLAIM STATUS CODE
S	12	FREE FORM MESSAGE TEXT		MESSAGE TEXT
<b>S</b>	<b>REF</b>	<b>PAYER CLAIM IDENTIFICATION NUMBER 2200D</b>		
R	01	REFERENCE IDENTIFICATION QUALIFIER	1K	PAYER'S CLAIM NUMBER
R	02	REFERENCE IDENTIFICATION		MVP HEALTH CARE'S EXTERNAL SYSTEM REFERENCE NUMBER. <b>Note:</b> This is not the same as the claim number used for payment.
<b>S</b>	<b>REF</b>	<b>PAYER CLAIM IDENTIFICATION NUMBER 2200D</b>		
R	01	REFERENCE IDENTIFICATION QUALIFIER	D9	SUBMITTER'S NUMBER
R	02	REFERENCE IDENTIFICATION		IDENTIFIER THAT WAS SUBMITTED BY THE TRADING PARTNER IN THE REF*D9 OF THE 837 CLAIM BEING ACKNOWLEDGED.
<b>S</b>	<b>DTP</b>	<b>CLAIM SERVICE DATE 2200D</b>		
R	01	DATE/TIME QUALIFIER	232	CLAIM STATEMENT PERIOD START
R	02	DATE PERIOD FORMAT QUALIFIER	RD8	CCYYMMDD - CCYYMMDD
R	03	DATE TIME PERIOD		CLAIM SERVICE PERIOD

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<b>R</b>	<b>SE</b>	<b>TRANSACTION SET TRAILER</b>		
R	01	NUMBER OF INCLUDED SEGMENTS		TOTAL NUM OF SEGMENTS INCLUDING ST AND SE
R	02	TRANSACTION SET CONTROL NUMBER		VALUE IN SE02 MUST BE IDENTICAL TO ST02
<b>R</b>	<b>GE</b>	<b>FUNCTIONAL GROUP TRAILER</b>		
R	01	NUMBER OF TRANSACTION SETS INCLUDED		
R	02	GROUP CONTROL NUMBER		ASSIGNED BY SENDER
<b>R</b>	<b>IEA</b>	<b>INTERCHANGE CONTROL TRAILER</b>		
R	01	NUMBER OF INCLUDED FUNCTIONAL GROUPS		
R	02	INTERCHANGE CONTROL NUMBER		ASSIGNED BY SENDER/MUST MATCH ISA13